**Research Report
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DfEE

Provision for Children with Speech and Language Needs In England and Wales

Facilitating Communication Between Education and Health Services

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Executive summary

Background

In 1998, the Speech and Language Therapy Working Group was set up by the Department for Education and Employment (DfEE) and the Department of Health (DH), shortly after a parallel Working Group was set up in Wales by the National Assembly for Wales (NAfW). Both groups were formed to address a series of issues related to the provision of speech and language therapy (SLT) in schools. As a part of this process, the DfEE, DH and NAfW jointly funded the present study in 1999, to report on existing provision across England and Wales and to help facilitate the process of collaboration between health and education services. The study extended the remit of the Working Groups from children in receipt of speech and language therapy to include all children with speech and language needs.

Procedure

The project was designed in three interlocking phases.
Phase 1 - This phase involved the development of a questionnaire aimed to ascertain information about current provision. This was circulated to all SLT managers in Health Trusts with a community children's service and 50% of all LEA managers in England and Wales.
Phase 2 – Fifteen LEA/Health Trust collaborative pairs[1] were targeted for a more detailed qualitative analysis of the factors determining the process of collaboration between health and education services. In each site interviews were carried out and then analysed at managerial (including health commissioner), practitioner and parental level. As a validation of this process five of the fifteen Phase 2 sites were then analysed separately with each of these three levels integrated.
Phase 3 - The third phase comprised a series of five meetings made up of managers, practitioners and parents from across England and Wales. The results of the first two phases were summarised and participants were asked to comment on the validity of the findings, to ensure that no major themes had been ignored and to contribute to the discussion of the way forward.

Current services

The survey of those responsible for SLT services indicated that caseloads and waiting lists are highest for the primary (5-11) age-group. Per year-group, however, they are greatest for the 0-4 year olds. The mean ratio of SLTs to child population is 1: 4257 and both population size and number of therapists correlate with size of ongoing caseload. SLT services employ a mean of 14.3 whole time equivalent paediatric therapists; however, the range is wide. About a fifth have no SLT assistants. Over half report problems with recruitment and retention. There is great variation in the proportion of cases managed predominantly in an educational setting. 57% of services report that they manage over half of their caseload in this setting. Over two-thirds of SLT departments provide a service to mainstream schools although 35% of services report no funding of SLT posts to mainstream or special provision by the LEA. Approximately

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[1] These pairs represented LEAs and Trusts which covered the same geographical area and had both responded to the phase 1 questionnaire. Purposive sampling was employed to identify authorities with different levels of perceived collaboration.

60% of the children receiving such a service at primary and secondary level have a statement. Provision to language units is most common at primary level, in terms of number of units covered, sessions offered and numbers of children seen. Schools/units for children with moderate learning difficulties, and severe/pervasive learning difficulties are the most commonly covered special provisions. There is very little SLT provision to sites for children with emotional/behavioural difficulties, or to non-statutory educational provision, e.g. FE colleges. Very few therapists are fluent in any community language other than English.

The survey of those responsible for LEA services indicated that about 40% of children with statements of educational need have speech and language needs and 10% of children with statements are estimated to have speech and language as a primary need;. By far the greatest proportion of peripatetic language support staff is available to children in the Early Years and primary phases. A large proportion of LEAs (83-93%) report no specialist peripatetic service. Language units are mainly provided in the primary phase; less than a third of LEAs make this provision at nursery level, and about a fifth at secondary level. 55% of LEA respondents report funding no SLT sessions.

Key themes

Thirteen key themes were identified from the study. These themes are interdependent: stresses in the system created in one area inevitably have a "knock on" effect on others.

Funding

The joint concepts of inclusion and equity espoused by most respondents put considerable pressure on the existing services. There was a consensus that there were generally too few SLTs and other professional groups to provide the necessary skill mix. There was an overwhelming need to clarify the way in which these services are funded and while there are currently opportunities available under the recently introduced "partnership flexibilities", there is also a need for the issue of new funding to be addressed at a national level. The report found a case for LEAs to act as lead commissioners but not providers of SLT services.

The need for common data sets

In many areas mutually agreed data sets were not available and this effectively militates against common strategic planning. There is a good case for the use of "needs assessment" with agreed parameters as a baseline for service organisation.

The identification process

As a part of the needs assessment process there is a case for authorities to exploit the recently introduced baseline assessment at school entry. Although such an approach would not make it possible to identify children identified through the health system before that age, it would have the advantage of exploiting a statutory requirement and thereby contributing to the common data set.

Co-terminosity between LEAs and Health Trusts

Only 14% of the authorities sampled had co-terminous boundaries and this can be a

very real issue in terms of the equity of provision. This is not an issue which can be readily resolved but the potentially negative impact may be lessened by joint strategic planning and the application of common audit measures. This issue is likely to get more rather than less complex as budgets are devolved downwards from Health Trusts to Primary Care Trusts and further devolved from LEAs to head teachers

Collaboration between LEAs and Health Trusts

There was a very widespread recognition of the need for collaboration between the different agencies and a broad recognition of the difficulties in achieving this. In general more is known about practitioner level collaboration. For example, it is known to be effective where the professionals involved have a clear understanding of each other's roles; where therapists are prepared to take account of the educational context; where teachers understand the importance of language to the whole curriculum; and where school systems support therapists' involvement, e.g. liaison time, well-planned SEN meetings. Our interviews indicated that less is known about collaboration at a managerial level. Shared vision and the development of a joint strategic plan are clearly central issues and again this may be facilitated by common data sets.

Models of provision for supporting children with speech and language needs

The majority of SLT services were committed to offering an education based model of service provision provided that the necessary support mechanisms were in place. They were less keen to assume that support within the educational system was a suitable goal if these mechanisms were not in place. There is a case for a better understanding of different types of intervention models. For example the "consultative model" should not be taken to mean that all SLT time is devoted to working indirectly through teaching assistants.

Throughout the study respondents expressed concern about the need to maintain an adequate level of organisation for speech and language therapy services. There is a risk that too devolved a level of organisation is likely to reduce opportunities for professional development and specialisation and in turn may exaggerate difficulties with recruitment and retention.

The size and changing nature of caseloads of children with speech and language needs

There is an increasing demand for the services of SLTs and reports suggested that this is exacerbated as more children with speech and language difficulties are being placed in mainstream schools. Inevitably this pressure affects service delivery.

The size of SLT caseloads varies considerably across England and Wales. Clearly it would be helpful to give some indication of the most appropriate level of caseload. Given the range of needs of different groups of children with speech and language difficulties it is difficult to be prescriptive. The benchmark figure of 40 children per SLT has demonstrable validity as far as senior practitioners are concerned. Of course services may be designed around schools rather than individual children and a comparable benchmark for a therapist working full time in the education service would be 5-10 schools per therapist depending on proximity, number of children with difficulties, etc.

The report identified particular shortfalls in service provision to children in secondary school and to those with emotional and behavioural difficulties.

Prioritisation systems

Prioritisation is a key feature of both health and SEN service provision but not of mainstream education. Where prioritisation systems co-exist they do not necessarily concur. Lack of consensus is likely to lead to a confused message being conveyed to parents. This needs to be carefully monitored as a part of the interagency strategic plan.

The recruitment and retention of speech and language therapists

A number of managers from both health and education services indicated that there were often difficulties recruiting to SLT posts. In part this is simply a matter of workforce planning, an issue which is being addressed directly by the NHS consortia which are now funding places on SLT pre-registration courses. There are moves afoot to increase the number of speech and language therapy places on such courses and this increase has started to feed through to an increase in places as from 2000. However LEAs are not currently represented on NHS consortia and their needs have not to date been recognised.

Retention of SLTs is an important professional issue which has been well documented. There is a need for the development of an educational specialism which is attractive to speech and language therapists, allowing them recognition and status as autonomous and adequately remunerated professionals.

Education, training and continuing professional development

Concern was expressed by all parties that there was insufficient knowledge about various aspects of provision for children with speech and language needs. These gaps can often be traced to differences in basic training and needs to be addressed by the professional bodies concerned. But it also needs to be recognised in the range of training offered within services. A clear need was identified for the development of accredited training programs which are delivered and attended by the different professional groups. Clearly it is appropriate for a broader understanding of many of the relevant issues to permeate through the system (to managers, practitioners and parents) and for it not simply to be seen as a matter of providing basic skills training to Learning Support Assistants (LSAs).

Expectations of colleagues and parents

There is a need to acknowledge the differences in perception of the various parties in the process. At one level this is an issue related to training but it goes beyond the dissemination of information. Parents, teachers, LSAs and SLTs may approach the needs of children from a radically different perspective. For example, there may be a different perception of the aims of intervention, whether it is a process of bringing children's language skills up to normal levels (filling the gaps), whether it is a matter of facilitating the child's access to the curriculum or whether it is a question of removing obstacles to the child's access to society as a whole. These understandings are rarely explicit.

The role played by parents and carers

Parents were generally keen to be actively involved in the education process . However, for many the process was expressed in terms of frustration, struggle, and conflict. Some authorities have gone some way to overcoming this by going out of their way to win the trust of parents in the pre-school period, a process frequently facilitated by the involvement of SLTs. Of particular concern in this study was the perceived lack of collaboration between health and education services. Again differences between the agencies fuelled parents uncertainties. Interestingly, where parents were most satisfied with the provision offered they perceived the agencies to be collaborating effectively.

Issues which specifically relate to Welsh and English as an additional language

Many of the issues concerning Welsh and other bilingual populations were common to all services. However there are very few bilingual speech and language specialists and there is a great need for appropriate culturally relevant materials. There may be value in developing alternative methods for delivering services to rural communities.

Recommendations

Eighteen specific recommendations were derived from these themes.

Recommendation 1
> That there be a renewed emphasis on the role that speech and language plays in mediating all the child's experiences in school and at home.

Recommendation 2.
> That the greater part of the provision for school-aged children with speech and language needs should be embedded within the curriculum and take the child's educational context into consideration.

Recommendation 3.
> That services work together to appraise the level and type of inequities in existence, and put appropriate mechanisms in place to address these inequities.

Recommendation 4.
> That a funding stream be explored that runs from the DfEE to LEAs (co-ordinated by both DfEE and DH), for the commissioning of services to children with speech and language needs within educational contexts.

Recommendation 5.
> That LEAs act as lead commissioners through local NHS providers of SLT services for children in educational contexts.

Recommendation 6.
> That SLT managers offering services for children with speech and language needs should be in a position to negotiate appropriate models of service delivery.

Recommendation 7.
> That the new joint funding partnerships be exploited to provide pooled designated budgets for services for children with speech and language needs.

Recommendation 8.

    That the level of funding in general be considered in the light of the apparent shortfall between reasonable levels of provision and what is currently available.

Recommendation 9.

    That specific funding needs to be ear marked for areas of unmet need, namely provision for children in secondary schools, those with emotional and behavioural difficulties, and those for whom English is an additional language.

Recommendation 10.

    That specific funds be allocated to addressing a number of issues arising out of this study.

Recommendation 11.

    That SLT departments should continue to be organised at a level sufficient to provide for appropriate specialist management and professional development.

Recommendation 12.

    That structures be put in place to enable joint strategic planning across Trust and LEA.

Recommendation 13.

    That Trusts and LEAs jointly review the implementation of processes to improve practitioner level collaboration.

Recommendation 14.

    That national and local mechanisms be put in place to monitor the level of collaboration and disseminate effective collaboration.

Recommendation 15.

    That both Trusts and LEAs take the joint issues of recruitment and retention seriously in planning services.

Recommendation 16.

    That the curricula of initial training and education courses for SLTs and teachers prepare the different professional groups to work effectively within the education system with children with speech, language and communication needs.

Recommendation 17.

    That there be a comprehensive accredited system of educational and training opportunities for all staff working with children with speech and language needs.

Recommendation 18.

    That a programme of research be jointly commissioned between the DH and the DfEE and/or the Welsh Assembly, following the model laid down by the NHS Health Technology Assessment programme, to address directly a number of the evidence gaps identified in this study.

Chapter 1 - Introduction

Key Issues

- A wide range of children with speech and language needs is currently being identified.

- Speech and language needs can be problematic in themselves. They can directly impact on educational achievement and in many cases can result in mental health difficulties and in social exclusion.

- The needs of these children are met by a number of different professionals in both health and education services.

- A variety of different models of service delivery operate across the country.

- One of the most significant contributions is made by the speech and language therapy profession. This group is one of the main focuses of this report.

- The number of referrals to speech and language therapy services is growing as knowledge of services develops and with the increased demand to cover children in mainstream schools.

- There has been an increase in the number of speech and language therapists but demand outstrips supply.

- Tensions have arisen as health and education services attempt to reconcile their different frameworks.

1.1   Describing Speech and Language Needs

Communication is at the heart of the educational process. Language, whether written or spoken, is the most effective medium for a child to show that he or she understands a topic in class and can access the curriculum. But communication is equally key to the child's broader well being and mental health. Being able to convey personal and social needs to friends and family is an integral part of the process of growing up.

For the majority of children this facility to understand and to express is taken for granted. However, there is a substantial group of children who have additional speech and language needs. There is some discussion about the exact size of this group, but it is likely that it is of the order of 10% of all children[2] [3], a figure which may rise in areas of social disadvantage. This represents a substantial number of children in any school and provision for them is likely to be an important concern for every Head Teacher.

Speech and language needs can be very diverse, ranging from those which occur in the absence of other developmental conditions (often known as primary or "specific" speech and language difficulties), to those secondary to other developmental conditions

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[2]   Tomblin JB, Records N, Buckwalter P, Zhang X, Smith E, O'Brien M (1997) Prevalence of specific language impairment in kindergarten children *Journal of Speech Language and Hearing Research* 40, 6, 1245

[3]   Mackeith R, Rutter M (1972) A note on the prevalence of language disorders in young children. In Rutter M, and Martin J (eds.) *The Child with Delayed Speech*. London: Heinemann.

such as cerebral palsy, autism, hearing impairment or learning difficulty[4]. Communication is a multi-modal facility subsuming a wide range of different skills and abilities (speech, vocabulary, grammar, narrative, pragmatic skills, non-verbal communication) and there is the potential for the child to have difficulties in any one area, or indeed, any combination. There are children with articulation difficulties or stammers which, although relatively discrete, can be very debilitating. Others experience difficulty formulating or understanding sentences and there are others who have marked difficulties in social interaction, so called "pragmatic" or sometimes "complex" communication difficulties. Furthermore, communication skills vary in the extent to which they are directly related to the child's overall level of ability. Similarly they vary in severity. So at one level a child may have a mild phonological delay in the pre-school years which may be predictive of subsequent literacy difficulties but which is not greatly affecting the child's lifestyle. At another level a child may have a debilitating dyspraxic condition which adversely affects all their interactions with peers. Similarly one child may be poor at formulating grammatical structures relative to their peers but this may be within the broad range of the class and not stand out, while another child may have the grammatical skills of a four year old when entering the third year of primary school. A speech and language need is contextually dependent, being relative to the nature of the child's impairment and the extent to which it is deemed that additional support is required.

While these difficulties are significant in their own right, their impact on the child's ability to perform effectively in school or at home is equally important. School can be a quintessentially frustrating experience and it is little surprise that many children have difficulty following instruction and accessing the curriculum[5, 6]. Furthermore they often present with marked emotional and behavioural difficulties[7, 8, 9], and consequently are at increased risk of both social exclusion and disorders of mental health[10]. Given what is known about numbers of children involved[11], and the long term impact of serious speech and language impairments[12, 13], the issue of the effective provision for these children is one which needs to be addressed as a matter of some urgency.

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[4]   The distinction between primary and secondary difficulties runs through this report. Although in many cases it has proved difficult to be clear where the boundaries between the two lie, the distinction is one that is readily recognised by those working in both education and health sectors.

[5]   Dockrell J, Lindsay G (1998) The ways in which speech and language difficulties impact on children's access to the curriculum *Child Language Teaching and Therapy* 14, 117-133

[6]   Dockrell J, Lindsay G (in press) Specific speech and language difficulties and literacy. In Nunes T and Bryant P (eds.) *Handbook for Literacy London*: Kluwer Academic

[7]   Cantwell DP, Baker L, Mattison RE (1990) The prevalence of psychiatric disorder in children with speech and language disorder: an epidemiological study *Journal of the American Academy of Child Psychiatry* 18, 450-461

[8]   Lindsay G, Dockrell J (in press) The behaviour and self esteem of children with specific speech and language difficulties *British Journal of Educational Psychology*

[9]   Botting N, Conti-Ramsden G (2000) Social and behavioural difficulties in children with language impairment *Child Language Teaching and Therapy* 16, 2, 105-120

[10]   Jones J, Chesson R (2000) Falling through the screen *Bulletin of the Royal College of Speech and Language Therapists* July 8-9

[11]   Law J, Boyle J, Harris F, Harkness A, and Nye C (1998) Screening for speech and language delay: a systematic review of the literature *Health Technology Assessment* 9 (2)

[12]   Johnson CJ, Beitchman JH, Young A, Escobar M, Atkinson L, Wilson B, Brownlie EB, Douglas L, Taback N, Lam I, Wang M (1999) Fourteen year follow-up of children with and without

1.2   Provisions for children with Speech and Language Needs

There is a wide range of professional support available in England and Wales. This includes medical professionals (paediatricians, neurologists, audiologists, psychiatrists, clinical psychologists) involved in the assessment procedure, and a range of education professionals (special needs co-ordinators [SENCOs], class teachers, specialist teachers for language impairment, educational psychologists [EPs]) responsible for provision within the child's educational context, involving both assessment and intervention. In addition there are the teaching assistants (TAs), a group which includes learning support assistants (LSAs) responsible for administering programmes within the classroom. Bridging health and education services are the speech and language therapists (SLTs). This professional group spans both the medical and the education systems, bringing to the classroom specialist expertise related to the underlying communication impairments experienced by the children and appropriate intervention techniques to match those impairments[14]. Although each of these professional groups has its own area of specialist knowledge, it is common for the roles to overlap. For example, each will have a view of the child's needs. These may be contradictory and can be confusing for parents. The goal for them all is the well being of the individual child and co-ordinated management is the key to effective provision.

Historically, children with marked speech and language needs have been provided for in specialist schools and units. A comprehensive review of the relevant legislation relating to special needs in general, and speech and language needs in particular, is provided in Table 1.1. For many of those with primary speech and language difficulties, the most common provision has been the "language unit" (or more recently "language resource base") attached to a mainstream school. For those with more generic learning difficulties, this might be a separate school for children with moderate (MLD) or severe learning difficulties (SLD). In addition there has also been provision for children with other specific disabilities, of which speech and language needs are recognised as a feature (physical disabilities, hearing impairment or autism). In the majority of such units speech and language services have been provided on a regular basis as a support for class teachers.

However, the trend in education legislation over the past twenty years has been away from segregated provision for children with special educational needs and towards inclusive education[15]. The philosophy underpinning the concept of inclusive education is broader than education itself.

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speech/language impairments: speech/language stability and outcomes *Journal of Speech, Language and Hearing Research* 42, 744-761

[13]   Clegg J, Henderson J (submitted) Developmental language disorders: changing economic costs from childhood in adult life *Mental Health Research Review*

[14]   It is important to recognise that alongside communication difficulties the speech and language therapist also deals with children's feeding difficulties.

[15]   Education Acts: DES 1981, 1988; DfEE 1993, 1996; Code of Practice on the Identification and Assessment of Special Education Needs, DfEE, 1994; Excellence for All Children, DfEE, 1997; Excellence for All: Meeting Special Educational Needs: A programme of action, DfEE, 1998; The revised national curriculum for 2000: What has changed?, QCA/99/513 (QCA publications); The SEN Code of Practice and Associated legislation - Proposed Changes and areas for Revision, DfEE, 1999.

The ICIDH categorisation of *impairment, disability, handicap* has also been influential in focusing the inclusion agenda[16]. The ultimate goal is to achieve a fully inclusive society where the handicapping effects of disabilities and impairments are reduced by changes made to the very fabric of society. Educational contexts offer a logical starting point in terms of ensuring that the entitlements of those with disabilities to access the educational curriculum alongside their peers are met, as well as education by process of the next generation of children who will become adults in the society of the future. Despite this clear direction internationally and from central Government, there continues to be significant variability in the patterns of inclusion across LEAs.[17]

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[16] World Health Organisation (1980) International Classification of Impairment Disability and Handicap (ICIDH) and World Health Organisation (in preparation) International Classification of Impairments, Activities and Participation (ICIDH-2).

[17] Gascoigne MT (in press) Managing children with communication problems in mainstream schools and units. In Kersner M and Wright J (eds.) *Speech and Language Therapy with Children: the decision making process.* David Fulton

Table 1.1   The development of provision for children with special educational needs in general and for children with speech and language needs in particular[18]

Education			Health / Speech and Language	
1889	· Compulsory education for deaf and blind	**1880**		
1899	· LEAs permitted to provide for children with epilepsy, mental or physical defects	**1890**		
		1900	· Manchester Education Authority appoints 'remedial teachers' for children with speech problems	1906
		1910	· London County Council recognises the need for the provision of treatment for children who stammer and four school clinics are opened	1918 ↓
		1920	· Specialist training courses for speech therapy are founded	1925
1944	· LEAs have a duty to provide special education for all but the "ineducable" who are provided for by Health Authorities. Eleven categories of handicap specified	**1940**	· College of Speech Therapists is established	1945
			· National Health Service Act, 1946	1946
			· NHS comes into being on 5 July 1948	1948
		1960	· Porritt report - called for unification of service delivery from hospitals, general practice and local health authorities	1962
			· Salmon report - recommended development of nursing profession and structure	1967
1970	· Education (Handicapped Children) Act 　1. LEAs take on responsibility for the education of all children 　2. Abolished the term "ineducable"	**1970**	· Quirk report – recommends the unification of speech therapy within the field of health	1972
1976	· LEA's required to make provision in 'ordinary' schools where possible		· National Health Service Reorganisation Act (implemented in April 1974)	1973
1981	· Education Reform Act 　1. Defined concepts of special educational need 　2. Introduced statutory assessment procedures	**1980**		
			· Griffiths report - introduced "managers" as opposed to "administrators" into health service management. Led to the development of defined structures within speech therapy departments	1983
1988	· Education Reform Act: Introduced the National Curriculum, Local Management of Schools, identification of special educational needs through Statements		· Community Care: Agenda for Action	1988
1989	· Lancashire Judgement		· Working for Patients - introduced the purchaser provider split and GP fund-holding	1989

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[18] Gascoigne MT (in preparation) *SLT Provision to Educational Services: past, present and future*.

	Education		Health / Speech and Language	
		1990	· Caring for People: Community Care in the next decade and beyond · NHS and Community Care Act	1990
1991	· Scottish Office Report on Speech and Language Therapy	**Children's Act 1991**		1991
1992	· Further & Higher Education Act – independence for all institutions catering for 16+			

1993	· FEFC responsible for ensuring provision for students with Learning difficulties
	· Education Act
	  1. Introduction of Grant Maintained Schools (including special schools)
	  2. SEN - Code of Practice; Statutory provision for special educational needs which are both at a Statemented level; Statutory policies to meet SEN; time limits of assessment; Appeals procedure – SEN Tribunals; Transition plans from school to adult life
			· Making London Better (response to the Tomlinson report)	1993

1994	· Code of Practice published			
1996	· Education Act - Schools are responsible for making provision for children with SEN.	**Children's Service Plans 1996**		
1997	· LEA's responsible for the assessment and placement of pupils with Statements. Parental choice has to be taken into account · White Paper - Excellence in all schools · Green Paper - Excellence for all children		· The New NHS: Modern, Dependable	1997
1998	· Harrow Judgement · Meeting Special Educational Needs - a programme for action			
			· SLTs vote to join CPSM · Health Act 1999	1999
2000	· National Curriculum 2000 · Consultation of the SEN and Disability Bill – proposed changes and areas for revision · Consultation of the Revised Code of Practice for SEN	**2000**		

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[18] Gascoigne MT (in preparation) *SLT Provision to Educational Services: past, present and future.*

Although, as indicated above, there are a great many professionals involved in provision for children with speech and language needs, the group which is the focus of much of the discussion in the present report is the speech and language therapy profession. This group is largely employed within the NHS and covers a great many clinical specialisms. Of these, the one most relevant here is the ability to address the speech, language and communication needs of children in the early years and school period. The traditional model of service delivery provided by speech and language therapists is based within a clinical setting (health centre, child development centre or hospital), with the child and the parent receiving intervention direct from the therapist. In recent years, this has largely given way to a more holistic or ecological model of intervention with an emphasis placed on taking the classroom into account and working via others who have regular direct contact with the child. This shift has been dictated by the research literature and practical experience which suggests that the context in which the child learns is critical. But it has also developed in response to the changes in special educational provision outlined above. In many ways it has followed the pattern set by the educational psychology profession, which has moved from a service emphasising work with individual children, to one which makes extensive use of consultation[19].

Although this need to integrate practice into the educational context is variably applied across England and Wales, its importance is widely acknowledged. As the second edition of Communicating Quality[20] (a handbook of standards and guidelines produced by the Royal College of Speech and Language Therapists) indicates:

Aims/Principles of Service Delivery:
1. *To provide a service which involves a high degree of shared knowledge, skills expertise and information among all those involved with child.*
2. *To provide speech and language therapy assessment and intervention for children with speech and language difficulties as an integral part of their school life, ensuring that speech and language therapy input is part of a total programme for the child.*
3. *To recognise and implement highly flexible working practices with the focus on the everyday social and learning context of the child.*
4. *To acknowledge that a speech and language therapy service in a mainstream school is a specialist services and not simply a speech and language therapy 'clinic' located in a school;*
5. *To deliver the service in such a way as to enable education staff to incorporate the aims of the speech and language therapy programme...in the context of the broad curriculum. (p54)*

A variety of different methods of service delivery have been identified, and it is now possible to look at service delivery as being defined along a number of different parameters e.g. intervention provided:-

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[19] Kelly D, Gray C (2000) *Educational psychology services (England): Current role, good practice and future directions* Nottingham: DfEE Publications

[20] Van der Gaag (ed) (1996) *Communicating Quality 2: Professional standards for speech and language therapists* London: Royal College of Speech and Language Therapists

a.   directly by the speech and language therapists or indirectly by the teacher or learning assistant;
b.   within or outside the classroom;
c.   in groups or individually;
d.   intensively or at regular intervals;
e.   for a limited or extended duration.

This range of options for the provision of speech and language therapy for these children is recognised in the draft revised Code of Practice for Special Educational Needs. Provision can include:-

> …a variety of activities including classroom observation of the child to assess the effect of the child's language difficulties and monitor progress, liaison with the SENCO, class teacher or learning support assistant to discuss how programmes of therapy can best be delivered in the classroom and to agree targets and strategies, working individually or in a small group with the child for assessment or therapy, liaison with parents about how they can help to deliver the therapy programme at home, participating in IEP planning and reviews, attending annual reviews and providing in-service training to staff.[21]

While it is possible to identify what is common practice, it is important that a model of service delivery should be developed on the basis of what is known to work. What then of the evidence for the impact of speech and language therapy? This has been closely examined in a recent systematic review of the literature related to early language screening[10]. This review covered children up to seven years of age and focused on children with primary speech and language delays. It is clear that there remains relatively little high quality evidence (some 22 studies) and what there is refers to speech and language intervention in the pre-school period. Here the evidence is promising, with significant gains to be obtained relative to control group children who had received no intervention.

However, it is important that these gains were achieved in what might be termed a clinical model that is within a clinical setting and restricting the effects of the intervention to measurable language outcomes. They are not set within a mainstream nursery or school and very little attention has, to date, been paid to the impact on the child's ability to cope in a classroom. Interestingly, for all but speech difficulties, the results were as good if the intervention was carried out indirectly – by the child's parent – under the guidance of a speech and language therapist. There is little comparable evidence for other types of indirect intervention using teachers, LSAs or indeed school-based models of provision of support for children with speech and language needs. One exception to this is a study which reported significant advantages of a mainstream speech and language therapy model relative to a clinic based model, albeit with a relatively small number of subjects[22]. But many gaps remain in this literature and, unsurprisingly, teachers and speech and language therapists rely heavily on developing models of best practice based on their own experience.

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[21] DfEE (2000) *SEN Code of Practice on the Identification and Assessment of Special Education Needs* [consultation document] London: DfEE

[22] Johnson M, Thomas J (1995) *The Canterbury and Thanet Mainstream School Project* Unpublished report available from Speech and Language Therapy Department, Kent and Canterbury Hospital, Ethelbert Road, Canterbury Kent CT1 3NG

1.3 The Relationship between Education and Health Services

It is now widely recognised that interagency collaboration is the only effective solution to the management of complex problems. Indeed the NHS Plan for Health suggests that a series of changes have been put in place explicitly to "*remove the outdated barriers between health and social services which have got in the way of people getting the care they need when they need it*"[23]. Although the 1999 Health Act explicitly addresses the issue of collaboration between Social Services and the NHS in provision of services, for example for the elderly, it is clear that the same sort of arrangement could as easily operate between LEAs and the NHS. The Act also promotes collaboration between local councils and the NHS by allowing the use of pooled budgets, lead commissioning and integrated providers.

Despite these new opportunities and despite a widespread recognition of the need to collaborate, establishing effective collaboration is not easy. The obstacles to interagency collaboration have been well-documented[24] (see Table 1.2). There is often a particularly uneasy relationship between health and education services in the provision of speech and language therapy. Indeed, Dessent suggests that what has been termed the "border dispute"[25] between health and education services on this matter is symptomatic:

> *...separatism in terms of responsibilities is endemic at both national and local level. For example, the clear inability of the DFE and the DOH to come up with a sensible resolution to the provision of speech therapy for children with special educational needs is itself a significant indictment of the failure of co-operative work at a national level. (p.12)*

This is echoed in the terms of reference for the Working Group specifically set up to address issues around provision for children with speech and language needs.

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[23]   Department of Health (2000) *The NHS Plan – A plan for investment, A plan for reform* London DH

[24]   Dessent A (1996) *Options for partnership between health, education and social services* Tamworth: NASEN publications

[25]   Dyson A, Lin M, Milward A (1998) *Effective Collaboration between Schools, LEAs and the Health and Social Services in the Field of Special Needs* Sudbury: DfEE Publications

The (Excellence for All Children) Green Paper drew attention to the difficulties in securing therapy services for children with SEN, which partly result from the different statutory responsibilities and priorities of health authorities and LEAs, and lack of clarity over funding. The difficulties are most pronounced in the area of speech and language therapy but similar issues apply to occupational therapy and physiotherapy. There was clear agreement on the nature of the problem but not on possible solutions.[26]

Table 1.2   Obstacles to interagency collaboration

Organisational/structural	Resources
Different services administered by different agencies;	Funding channelled to separate committees and agencies;
Large complex agencies with multiple sub-systems;	Limited 'corporate' budgets;
Lack of 'co-terminosity'	Resource constraints;
Professional	Lack of clarity about budget responsibilities;
Separate training and conceptual background;	Conflicting policy priorities;
Different vocabulary relating to need (medical/educational);	Partnership is time consuming and expensive.
Inter-professional rivalry (power and decision making);	**Political/Attitudinal**
Loyalty to own agency/service.	Lack of political/managerial commitment to interagency co-operation;
Legislation	Lack of officer faith in effectiveness of interagency co-operation.
One agency has principal 'ownership';	**Pressures**
Legislation 'overload';	'Innovation overload'
Discrete statutory responsibilities;	Agencies dominated by internal priorities;
Poor transferability and cross-referencing of legislation.	Restructuring.
Taken from Dessent A (1996) *Options for partnership between health, education and social services* Tamworth: NASEN publications	

In part the difficulties in this area stem from the fact that, while speech and language therapy services are nested within the NHS, the greater part of the provision for children with special educational needs is made within education services. Thus the management falls to one service while deployment often falls to another. This issue has been highlighted by recent legal judgements which have emphasised the ultimate role of education services in meeting the needs of children with speech and language needs. The "Lancashire Judgement" indicated that the provision of speech and language therapy services could be educational, even though speech and language services were delivered through the NHS[27]. More recently the "Harrow Judgement" tested the contention in the 1994 Code of Practice that the "prime" responsibility for

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[26]   *SEN Programme of Action*, DfEE November 1998 (p.34)

[27]   R v. Lancashire County Council ex parte M, 1989

children with an identified educational speech and language need rested with the health service while, if the child's needs were described in Part 3 of the statement of educational need, the "ultimate" responsibility rested with the education authority[28]. The judgement stated that the ultimate responsibility fell to the Education Authority when the speech and language therapy service was able to demonstrate a shortfall in resources which meant that they were unable to meet the identified need. This has been taken up in the draft revised Code of Practice[21].

Despite these judgements, the difficulties around appropriate levels of provision have almost certainly been exacerbated by a year on year increase in demand for speech and language therapy services of about 5%[29]. This increase can probably be attributed to a greater awareness amongst parents and educationalists of the value of the support provided for children with speech and language needs by this professional group. Although speech and language therapy services have also increased, the number remains relatively small. Establishments of six SLTs per 100,000 population correspond to a target first identified some thirty years ago[30], but are far short of a more recent target of 26 for the same head of population based on relatively conservative prevalence figures[31]. This increase in demand needs to be off-set against increasing recruitment and retention problems within the speech and language therapy profession[32]. To a certain extent this is being addressed in current plans in the NHS to expand the therapy professions, but these changes will take some time to filter through and, until they do, matters around supply and demand of speech and language therapy services will remain an important issue[33].

The potential for confusion arising out of this situation is recognised in the Green Paper *Excellence for all Children*[34] and is the target of many of the initiatives put forward in *Meeting Special Educational Needs: A Programme of Action*[35]. Each Health Trust and Local Educational Authority has to negotiate a mutually acceptable relationship, and over time this has resulted in variation and inequity of service provision across England and Wales. This process was further complicated by the introduction in the 1990s of the internal market in the NHS, requiring services to be responsive to local demand. This led to an increase in services associated with swallowing disorders, adults with learning difficulties and also children with statements of special educational need. It also led to the need to negotiate contracts with different services, but an audit of this process

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[28] R. v. London Borough of Harrow ex parte M, 8 Oct 1996

[29] Department of Health (1998) *Speech and Language Therapy Services: Summary information for 1997-98 England*

[30] Quirk R (1972) *Report of the Committee of Enquiry into Speech Therapy Services* London: HMSO

[31] Enderby P, Davies P (1989) Communication Disorders: Planning a service to meet the needs *British Journal of Disorders of Communication* 24, 301-331

[32] Rossiter D (2000) Recruitment and retention: the black and white picture *Bulletin of the Royal College of Speech and Language Therapists* July pp12-14

[33] Department of Health (2000) *The NHS Plan – A plan for investment, A plan for reform* London DH

[34] Department for Education and Employment (1997) *Excellence for All Children: Meeting Special Educational Needs* London: HMSO

[35] Department for Education and Employment (1998) *Meeting Special Educational Needs: A Programme of Action* London HMSO

indicated that the majority of these contracts (69%) were negotiated by managers external to speech and language therapy services[36].

One of the most pervasive differences in the cultures of education and health services is philosophical[37]. For example, McCartney has drawn a distinction between the emphasis conventionally placed by speech and language therapists on deficiencies *within* the child, whereas the educational model emphasises the appropriate action necessary to optimise the child's learning environment as was advocated in the report of the Warnock Committee[38, 39]. Indeed, there is a lingering concern that interventions deriving from the health system are primarily concerned with cure. But practice dictates that there are other areas of difference between the two systems. There is a statutory obligation to provide education to all children, whereas the health system prioritises on the basis of case status, which in turn is defined by potential outcome. A child who is very sick is prioritised over another who is not. Speech and language therapists work within this system and prioritise accordingly. Given the relatively small number of therapists, there is a pressure to prioritise only the more severe cases, while recognising that many other children may have speech and language needs which could be addressed. The tendency then is for the education and SLT services to become dislocated, because need may be construed very differently between the two services. The SEN system may in fact be more akin to the prioritisation system of the SLT service, because SEN is self-evidently selective.

It is recognised that the issues are likely to be both specific to education and speech and language therapy services, and general, in so far as they focus on the effective implementation of organisational change and collaboration between professionals in different organisations. Some work has already been done in this area, but to date this has either been of general relevance to special needs[40], rather narrowly constrained in terms of practitioner issues within a limited number of English speech and language therapy services[41], or has related to provision in Scotland [42].

The Scottish study does have particular relevance for the present project, because it looked at speech and language needs of pupils with special educational needs, emphasised the importance of collaboration and considered the issue of the most effective models of practice. The report indicated that the needs of these children were not being well met across Scotland. It highlighted the fact that demand for speech and language therapy services continued to outstrip supply. The main difference in the current study is the emphasis placed on collaboration throughout the NHS and LEA

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[36] Mays N, Pope C (1997) *Speech and Language Therapy Services and Management in the Internal Market: A National Survey* London: Kings Fund Publishing

[37] Wright J, Kersner M (1998) *Supporting Children with Communication Problems: Sharing the workload* London : David Fulton

[38] McCartney E, MacKay G, Cheseldine S, McCool S (1998) The development of a systems analysis approach to small scale educational evaluation *Educational Review* 50 65-73

[39] Department of Education and Science (DES) (1978) *Warnock Report: Committee of enquiry into the education of handicapped children and young people* London: HMSO

[40] Dyson A, Lin M, Milward A (1998) *Effective collaboration between schools, LEAs and the Health and Social Services in the field of Special Needs* Sudbury: DfEE Publications

[41] Jowett S, Evans C (1996) *Speech and Language Therapy Services for Children* Slough NFER

[42] Reid J, Millar S, Tait L, Donaldson ML, Dean EC, Thomson GOB, Grieve R (1996) *Pupils with Special Educational Needs: The role of speech and language therapists* Edinburgh: SOEID

systems, from parent, through practitioner, to manager, and the importance attached to the strategic implementation of collaboration.

No such report has yet been produced for Wales and, partly for this reason, the Welsh Assembly has been involved in the present project. This has signalled the need to address issues around the provision for children with speech and language needs in the Welsh context. The need to have the Welsh language permeating the provision of health and social sectors is one which has already been addressed directly[43] [44]. The second of these two documents specifically addresses issues around the provision of speech and language therapy in Wales. The author suggests that issues around provision of language support are particularly relevant to this service as "*an area of work in which language and its use are essential and integral elements*" (p.36). It pinpointed the relatively low number of SLTs (one third of the figure of 26 per 100,000 quoted by Enderby and Davies[32]) and the relative scarcity of SLTs who are able to work in the Welsh language. This last issue is particularly important as "*the local pattern of Welsh speaking is changing dramatically with a significant increase in Welsh speakers aged 3 to 15 which may have long term effects on patterns throughout the entire population over time. As in all other fields the provision of Welsh-medium services cannot be sensible based on present demand.*" (p.38).

As a result of the general difficulties associated with collaboration across agencies, and particularly those which relate to the interface between education and speech and language therapy services, a consensus has yet to develop across England and Wales on how to implement effective collaboration. Despite this, a tremendous effort is being expended on the search for solutions, and a number of descriptions of successful models of collaborative working have recently been published[45, 46, 47]. Moreover, in the autumn of 1998, the government set up (under the auspices of the Department for Education, the Department of Health and the National Assembly for Wales) a Speech and Language Therapy Working Group, to address a series of issues related to the provision of speech and language therapy in schools. As one of its tasks, the Working Group commissioned the present study, to establish existing provision across England and Wales, to help facilitate the process of collaboration and to promote effective provision of services to children with speech, language and communication needs.

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[43] Davies E (1999) *The Language of a Caring Service: Guidance on Providing a Sensitive Bilingual Service focusing on the Health, Social Care and Justice Sectors* Cardiff: Welsh Language Board

[44] Misell A (2000) *Welsh in the Health Service: The Scope, Nature and Adequacy of Welsh Language Provision in the National Health Service in Wales* Cardiff: Welsh Consumer Council

[45] Topping C, Gascoigne MT, Cook M (1998) *Excellence for all children: a redefinition of the role of the speech and language therapist.* Proceedings of the RCSLT Conference Communicating the Evidence September Liverpool

[46] Luscombe M, Shaw L (1996) *Agreeing priorities for a school service* Bulletin of the Royal College of Speech and Language Therapists December

[47] Hoddell S (1995) *Building confidence and communication* Bulletin of the Royal College of Speech and Language Therapists February

Chapter 2 - Aims, Objectives and Methodology

2.1   Terms of reference

In 1998, the Speech and Language Therapy Working Group was set up by the Department for Education and Employment (DfEE) and the Department of Health (DH), shortly after a parallel Working Group was set up in Wales by the National Assembly for Wales (NAfW). Both groups were formed to address a series of issues related to the provision of speech and language therapy (SLT) in schools. As a part of this process, the DfEE, DH and NAfW jointly funded the present study in July 1999, to establish existing provision across England and Wales, and to examine factors which promote effective provision of services.

The **aims** of the present study were to:-
1.   Contribute significantly to the quality of services to children with speech and language needs by informing the process of collaboration between health and education services.
2.   Identify effective joint provision. For provision to be effective it must be
   - *equitable*, in the sense that it does not give preference to any one group unless that preference is clearly prioritised beforehand by both health and education service providers;
   - *inclusive*, in the sense that it allows the child to maximise his or her potential within available mainstream provision where possible;
   - *comprehensive*, in the sense that all those involved in the provision of services are able to provide appropriately for the needs of the child;
   - *pervasive* throughout the institutions providing the service. Good practice must be acknowledged, planned, expected and supported by the institutions concerned in collaboration with one another and should not be the sole preserve of the individual practitioners (teachers and speech and language therapists) who have daily contact with the children concerned.

"Effective" also means that, in terms of outputs, the potential disadvantage experienced by the child as a result of the speech and language difficulties will be removed or minimised by the provision both in the short and the long term. Finally, to be effective a service must work with parents and children in accordance with the principle set out in paragraph 1.2 of the 1994 SEN Code of Practice: "*Effective assessment and provision will be secured where there is the greatest possible degree of partnership between parents and their children and schools, LEAs and other agencies.*"[48]

The **objectives** of the study were to:-
   - outline patterns of delivery of provision of services in mainstream and special educational settings for children with speech and language difficulties;
   - identify key features of the relationship between health and education services that should be seen as critical for services to be offered effectively. This is may be at an institutional or a practitioner level;
   - identify features of the relationship between health and education services which may impede the effective delivery of services;

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[48]   Department for Education (1994)*Code of Practice on the Identification and Assessment of Special Education Needs*, London: DfE.

- in collaboration with the managers of health and education services, practitioners and parents, provide practical suggestions for the implementation of recommendations arising out of the study.

The study relates to all children with speech, language and communication needs within the 0-16 age range, where part of this provision takes place within a school or early years establishment.

2.2 Methodology

The project was designed in three interlocking phases.
1. Phase 1 - The horizontal phase
2. Phase 2 - The vertical phase
3. Phase 3 - The 'research into practice' phase

These phases were designed to develop one from another and to act as a multi-method cross validation.

2.2.1 Phase 1 - The horizontal phase

This phase involved the development of a questionnaire, which was then circulated to all speech and language therapy managers in Health Trusts supporting a community paediatric SLT service, and 50% of all LEA managers. (After reviewing demands on LEAs at the time of the study, the DfEE thought it appropriate to limit the sample to 50%.) The LEA sample was selected using the following method.
1. English LEAs were organised in ascending order of proportion of children on roll who had a statement, on the basis of Statistical First Release: SEN in England: January 1999.
2. Alternate LEAs were sampled from the resulting list *(Appendix I)* to produce a 50% sample.
3. The sample was checked to ensure 40-60% representation from each of Unitary, Metropolitan, Shire and London Borough LEAs, i.e. to ensure the sample was balanced between LEA types.
4. Welsh LEAs were selected in a similar manner, using data relating to the number of pupils with statements of SEN per 10,000, from January 1998. The results of this selection have not been reported, in order to protect the anonymity of the Welsh sites selected for participation in Phase 2.

In this phase, the research team formulated a questionnaire to access the baseline data for the study[49]. The questionnaire was piloted in July/August 1999 by nine SLT managers and seven LEA managers (two of each from Wales). The LEA managers came from the 50% of LEAs who were not due to receive the final questionnaire. Comments were also sought from the National Network for Educators of the Language Impaired (NNELI), the Education Working Group of the Royal College of Speech and Language Therapists, and the Special Education Consortium (a body representing parents' interests). The questionnaires were sent out in September 1999 and the last one to be processed was returned in the first week of December 1999. In all, 266 questionnaires were sent out and 189 returned. This gave a response rate of 65% (56/86) for the LEAs and 74% (133/180) for the Health Trusts.

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[49] The questionnaires used are not included in this report but may be obtained from the first author.

The questionnaire accessed three types of information – about collaboration, about service profile and, in Wales, about Welsh language issues. In the first part, respondents were required to indicate which of a predetermined set of collaborative mechanisms were in place and their effectiveness:

- Does joint planning occur at management level – e.g. between the SLT service manager and the budget holding manager for SEN within the LEA?
- Does joint planning occur at practitioner level?
- Is there a shared strategy with regard to inclusion?
- Are there quality assurance mechanisms in place for review and monitoring of the impact of provision and are these monitored by both education and health services?
- Is the SLT service represented on the SEN placements panel (or equivalent)?
- Are there regular opportunities for reciprocal training between SLT and educational staff?

Part 1 of the questionnaire was used as a mechanism for the purposive sampling of case study sites for Phase 2. Hence, the results from Part 1 of the questionnaire are reported separately (in Chapter 4) because they relate directly to the identification of the case study sites.

The greater part of the questionnaire (Parts 2 to 4) was made up of request for numerical data regarding services. The key themes for the data collection at this stage were:

- The number of speech and language therapists and specialist language teachers in the area concerned.
- The number of children with speech and language needs. A distinction was drawn between those with and those without statements of educational need. Where children were provided for under the NHS, but not within education services, this was identified.
- Any arrangements for the joint commissioning of Speech and Language Therapy services – the number of posts in education funded exclusively by health, by education, joint-funded, or funded through the independent/voluntary sector (e.g. I-CAN).
- An indication of the proportion of children with speech and language needs who do receive adequate services, and those who do not, either because they are on waiting lists or because they are identified but not provided with services.
- The number of children with speech and language needs with associated difficulties (i.e. other levels of professional involvement).
- Priorities in the areas covered. For example, issues such as bilingualism and multiculturalism, most notably with respect to Wales, and to inner city populations with high proportions of immigrant groups and groups for whom English is an additional language.

In order to maximise response rate, the project developed headed note paper incorporating DfEE, DH and Welsh Assembly logos. Short pieces were also written for the Times Educational Supplement and the Bulletin of the Royal College of Speech and Language Therapists to alert practitioners and managers to their need to contribute to the project. In order to promote interest in and understanding of the project and its objectives, information related to the project was made available on the City University and DfEE websites.

2.2.2 Phase 2 - The vertical phase

Following the completion of Phase 1 and the collation of the data on collaboration from Part 1 of the questionnaire, a procedure was devised for the purposive sampling of sites for Phase 2. The aim of this sampling procedure was to identify fifteen sites, ten which had high collaboration scores and five which did not. The procedure for the purposive sampling is given in Appendix II[50].

Interviewing in phase 2
Once the sites were selected, all were contacted and interviews were arranged. The Speech and Language Therapy manager was the point of contact for the Trust provision, the LEA education officer to whom the Phase 1 questionnaire had been sent was the point of contact for the LEA, and the Parent Partnership Officer (PPO) was the point of contact for the parents. Commissioner interviewees were accessed via the SLT managers and/or NHS Executive Directories[51]. Interviews were organised at three levels – managers, practitioners and parents.

Managers
Fourteen strategic managers and an additional fourteen operational managers within LEAs were interviewed, totalling 28 LEA managers in all. The precise status of the LEA representatives varied from site to site (5.1). While the manager of speech and language therapy services was always involved, other more junior managers were sometimes brought in at an operational level, leading to a total of 22 SLT managers being interviewed. One Trust Directorate Manager with a specific interest in SLT was also interviewed. Seven health commissioners were interviewed by telephone, representing a mixture of Health Authority and PCG strategic planners and commissioners.

Practitioners
These included a total of 59 education practitioners and 53 SLT practitioners. The education staff were, in most cases, accessed via the LEA manager who returned the questionnaire, with the criteria that they should have some experience and view of working with SLTs, and that they should represent as broad a range of professionals from within Education as possible. Amongst the education staff were 7 specialist teachers for language impairment (based in language units/bases and peripatetic), 7 educational psychologists, 11 peripatetic SEN teachers, 3 Head Teachers, 14 primary school SENCOs, 3 secondary school SENCOs, 11 mainstream primary teachers, 2 mainstream secondary teachers and 1 LSA. The speech and language therapists were those working in specialist units/schools, resource bases, mainstream schools and/or community clinics.

Parents
PPOs were asked to identify a spread of parents in terms of the ages of their children and in terms of a range of speech, language and communication needs experienced. Thirteen groups, comprising from one to eight parents, were interviewed, totalling 74 parents.

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[50] The anonymity of the case study sites and interviewees has been preserved in this report. Readers wishing to follow-up specific examples of good practice may contact the Disability and SEN Team at the DfEE.

[51] Published by the NHS Executive; Crown Copyright 2000. Available at http://www.doh.gov.uk/nhsexec/nhseros.htm

Interview schedules

The key themes for the interviews in Phase 2 were initially envisaged to be as follows[52]:

- Managers', teachers' and therapists' perceptions of the strengths of their individual services;
- Managers', teachers' and therapists' perceptions of issues blocking effective provision (including philosophical and financial difficulties);
- Teachers' and therapists' perceptions of their roles and responsibilities with regard to each other and the advantages that the different roles bring for the learner;
- Teachers' and therapists' perceptions of their specialist knowledge and skills re: learners with speech and language impairments in educational settings;
- Previous relevant training - professional development experiences of teachers, learning support assistants and speech and language therapists;
- Parents' perceptions of specialist provision within an educational setting.

2.2.3   Phase 3 - "Research Into Practice" phase

The third phase was introduced to maximise the potential for the implementation of the recommendations. The aims of the phase were:

- to note participants' reactions to the data from Phases 1 and 2;
- to ensure that the data were valid;
- to ensure that no major themes had been ignored;
- to identify examples of good practice which could be used as exemplars.

The results from Phases 1 and 2 were drawn together into a summary document and presentation, which acted as the basis of five health/education working meetings, termed "Research into Practice" days. Meetings were carried out in Manchester, Leicester, Newcastle, Bristol and London. Managers, practitioners and parents from all LEAs, Health Authorities and Trusts with community children's services were invited to each meeting. Those who had contributed to Phase 2 were given first refusal. In each case, the response rate exceeded the number of places available, and those selected to be involved were balanced in mixed groups according to whether they were managers, practitioners or parents. In Bristol, a specific group was identified to enable issues related to service development in Wales to be drawn out. Forty places were allocated in each venue, with the exception of London where eighty places were allocated.

Each session began with a presentation of the Phase 1 and 2 data, which was followed by discussion time in small groups. During this discussion time, participants were required to address a series of questions arising out of the data from Phases 1 and 2 and the presentation (Appendix III). The groups appointed a note-keeper, who then presented a summary of their discussion to the meeting as a whole, by means of an acetate on an overhead projector. (The questions for discussion were refined and focused after the third meeting [Newcastle].) The acetates were then collected and analysed as a part of the Phase 3 data set.

In addition members of the research team sat in on the discussions. They did not participate, but made notes in the following areas:
a)   Intensity of feeling about particular issues.

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[52] The interview schedules used are not included in this report but may be obtained from the first author.

b)	Which professionals tended to feel strongly about which issues.
c)	Any new issues which had not been picked up by the research team to date.
d)	These notes were summarised and included in the analysis of Phase 3.

## 2.3	Structure of the report

To facilitate reading the report, the results are presented in the Phase 1-3 order discussed above. Chapter 3 includes all of the Phase 1 data, with the exception of the Part 1 information on collaboration, which is included as a separate chapter (Chapter 4) leading into the reporting of the Phase 2 data. Chapter 5 looks at the Phase 2 manager data combining themes from both LEA and SLT managers, as well as Health commissioners. Chapter 6 examines the education and SLT practitioner data and Chapter 7 looks at the responses of the parents. Chapter 8 goes on to integrate the data presented so far and picks out the responses in typical LEA sites (a Shire county, a Metropolitan borough, a London borough, a Unitary authority and a Welsh authority). Chapter 9 summarises the Phase 3 data. Finally, Chapter 10 goes on to look at key themes across the whole study and picks out some specific recommendations which arise.

The appendices will allow the reader to check on details of the methodology which are not available in the text. The full questionnaire schedule used in Phase 1 and the interview schedules used in Phase 2 are not included, but are available from the first author. Full transcriptions from the manager interviews, the cassette recordings made of all of the interviews in Phase 2, and the raw material from Phase 3 are also available, but are not included in the text. References have been cited in footnotes at the bottom of each page, precluding the need for a specific section for literature at the end of the document. A glossary follows the appendices to allow the reader to check the meaning of specific terminology and abbreviations.

Chapter 3 - Provision in England and Wales

Key findings

SLT responses:

- Caseloads and waiting lists are highest for the primary (5-11) age-group. Per year-group, however, they are greatest for the 0-4 year olds.

- The mean ratio of SLTs to child population is 1: 4257.

- Population size and number of therapists correlate with size of ongoing caseload.

- There is great variation in the proportion of cases managed predominantly in an educational setting by SLT services. 57% of services report that they manage over half of their caseload in this setting.

- SLT services employ a mean of 14.3wte paediatric therapists; however, the range is wide. About a fifth have no speech and language therapy assistants.

- Over half report problems with recruitment and retention.

- Over two-thirds of SLT departments provide a service to mainstream schools. Approximately 60% of the children receiving such a service at primary and secondary level have a statement

- Provision to language units is most common at primary level, in terms of number of units covered, sessions offered and numbers of children seen.

- MLD and SLD/PMLD schools/units are the most commonly covered special provisions.

- There is very little SLT provision to sites for children with emotional/behavioural difficulties, or to non-statutory educational provision, e.g. FE colleges.

- 35% of services report *no* funding of SLT posts by the LEA.

- Very few therapists are fluent in any community language other than English.

LEA responses:

- About 10% of children with statements are estimated to have speech and language as a primary need; 40% have speech and language at any level of need.

- By far the greatest proportion of peripatetic language support staff is available to children in the Early Years and primary phases.

- A large proportion of LEAs (83-93%) report *no* specialist peripatetic service.

- Language units are mainly provided in the primary phase; less than a third of LEAs make this provision at nursery level, and about a fifth at secondary level.

- 55% of LEA respondents report funding *no* SLT sessions
.

3.1   Introduction

In this chapter, we report the results of a national survey of LEAs, and of all Health Trusts which provide community speech and language therapy services to children within England and Wales. The survey covered all the relevant Trusts, and a sample of 50% of LEAs (a requirement of the DfEE to limit the information sought of LEAs and

schools).[53] The data reported here relate to all respondents to the survey, whereas in Chapter 4 data are presented from only those SLT/LEA pairs where both reciprocal partners responded. Discussion of these results is presented in Chapter 8, where these data are integrated with information from Phase 2 of the study (the interviews with professionals and parents in the purposively sampled case study sites).

This chapter reports the results from England and Wales as a whole, firstly from the 133 SLT services which responded and secondly from the 56 LEAs. Then the particular issues relating to Wales are discussed separately for nine Welsh SLT services and six Welsh LEAs. In the responses to questions reported below, there were varying numbers of respondents who did not report data, often not knowing what the data were.

3.2 Speech and language therapy services

3.2.1 Caseload

The highest caseload and waiting list figures were for pre-school children (0-4 years), followed by primary-aged children (5-11 years), with caseload numbers for secondary-aged children the lowest.

Caseloads varied by *age group* with the highest number for 5-11 year olds followed by 0-4 year olds, with secondary age caseloads much lower *(Fig. 3.1).* However, as the number of years covered by each category varies, the highest caseload per *year-group* was for pre-school – 146 per year-group, against primary with 123 per year-group, and secondary with 33 per year-group.

Waiting lists for assessment and treatment differed. Those for assessment for children 0-4 years old were about 4 times higher than for 5 - 11 year olds, themselves four times higher than for 12-16 year olds. Waiting lists for treatment were twice as high for 0 – 4 compared with 5 – 11 year olds. Rates for 12-16 year olds were lowest, reflecting the natural history of language delay.

Figure 3.1   Mean number of children on caseload by age group

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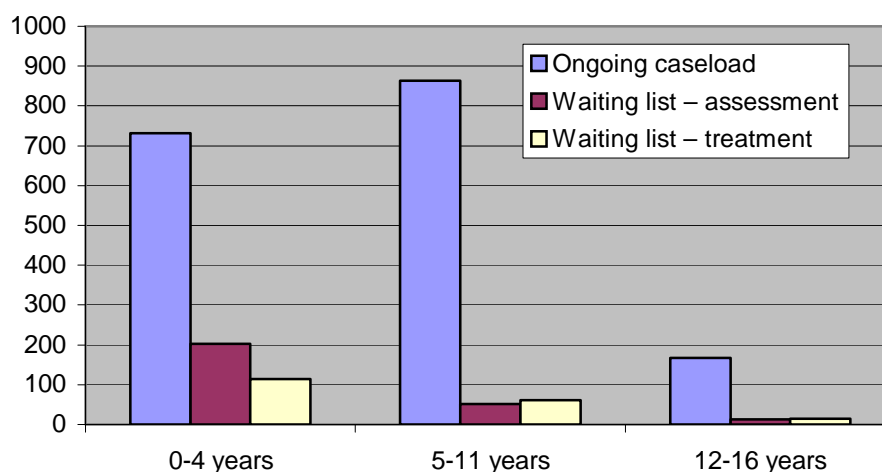
[53]   Chapter 2 and Appendix I, respectively, report details of the methodology and sample selection.

Ongoing caseload ranges varied greatly: 31-2500 (0-4 year olds), 0-2206 (5-11 year olds), and 0-1193 (12-16 years). A similar picture is revealed with waiting lists. With respect to assessment waiting lists, ranges were reported as 0-1806 (0-4 years), 0-219 (5-11) and 0-332 (12-16 years). The comparable range for waiting lists for treatment were 0-718, 0-500 and 0-165.

The number of SLTs in post correlated significantly with ongoing caseload for all age groups (Spearman's rho .50 to .63), with waiting list for assessment across all ages (rho.35 - .57), and with waiting list for treatment for 0-4 and 12-16 years only (.37 and .36).

Area population correlated significantly with ongoing caseload, with correlations being higher for younger age groups: rho = 0.60 (p<.001) for age 0-4; rho = 0.42 (p<.001) for age 5 – 11; rho = 0.37 (p<.002) for age 12-16 years. (NB. Population statistics are as reported by the respondents).

Size of population correlated significantly with the size of waiting list for assessment for all age groups, but not with the size of waiting list for treatment at any age.

3.2.2 Caseload within education

Within the 0-4 age range, it was most common for up to a quarter of children to be managed predominantly in education. At the primary stage (KS 1,2) there was greater variation, but approximately 57% of services reported managing over half their caseloads within education. At secondary level, there was even more variation.

SLT managers were asked to estimate the proportion of the caseload managed predominantly within educational settings54 *(Table 3.1)*. The proportions generally increased with age.

Table 3.1 Proportion of caseload managed predominantly in education

Age band	0%	1-25%	26-50%	51-75%	76-100%
0-4	15	68	12	5	0.4
5-11	1	18	23	35	22
12-16	2	29	10	21	38

3.2.3 Staffing

The average ratio of SLT to child population was 1:4257. The mean size of the children's services was 14.3 fte SLTs and 1.5 fte SLT assistants. However, 20% of respondents reported having no SLT assistant posts. There was only one SLT assistant for every 9.5 SLTs.

The mean size of a child service was 14.3 fte SLTs and 1.5 SLT assistants, but the range was substantial in both cases: from .60 – 35.2 SLTs, and 0-10.5 SLT assistants. While this partly reflects size of child population, Figure 3.2 indicates that this is not the

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54 i.e. where the main site for support for speech and language skills was an educational setting.

full answer. Child populations per SLT vary greatly. Most services reported a child population per SLT of up to 6000, but a minority had up to 9500 per SLT[55].

Table 3.2 Mean staffing of children's service

	Fte	N
Speech and language therapist posts	14.3	126
SLT assistant posts	1.5	127

Figure 3.2 Speech and language therapist posts against child population

child population per SLT
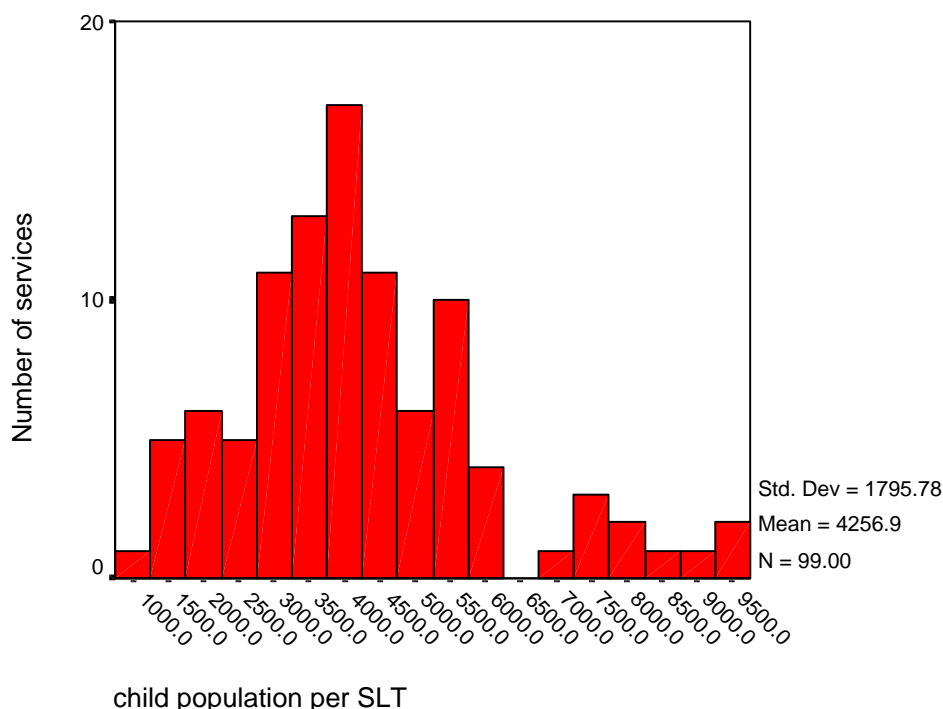
3.2.4 Recruitment and retention

Problems with recruitment and retention were reported to affect service delivery to education by 55% of SLT respondents; there was no correlation between the size of the service and whether such problems were reported.

Over half of the SLT managers reported recruitment and retention difficulties. This represents a more positive view than that expressed by the LEAs, where 80% reported such difficulties (see Section 3.3.7). Problems identified are presented in Figure 3.3. The various types of problem contributed to the difficulties arising when gaps in service occurred.

Recruitment The highest number of difficulties were reported in recruiting to the more experienced grades who could liaise and advise appropriately. New graduate applicants, accessible only for a short period during the academic year (possibly due to

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[55] Data collected for the NHS Trust Annual Non-Medical Workforce census cannot be used for direct comparison as, for England, the figures are rounded to the nearest 10 posts (with an indication of services with five or fewer posts). Also, given that the mean in our sample was about 14 fte, the appropriateness of such statistics must be in doubt.

taking on rotational posts in their first year), need time and support on recruitment to *"ease in"* to their post, reducing the frequency of contact in schools. Moreover, failure to attract experienced staff was associated with the short-term nature of contracts offered (usually through LEA-funded posts), which deterred longer- qualified applicants. The result of these difficulties was gaps in service. The following comment, typical of many received, summarises the impact of these difficulties:

> *"Schools tend to spend periods of time carrying a vacancy, with partial cover only, whilst the recruitment process takes place."*

Specific areas of SEN provision could also be difficult e.g. specialist deaf and physical disability posts, autistic spectrum; but some reported that positions in mainstream schools were also difficult to fill.

Figure 3.3 Recruitment and retention difficulties
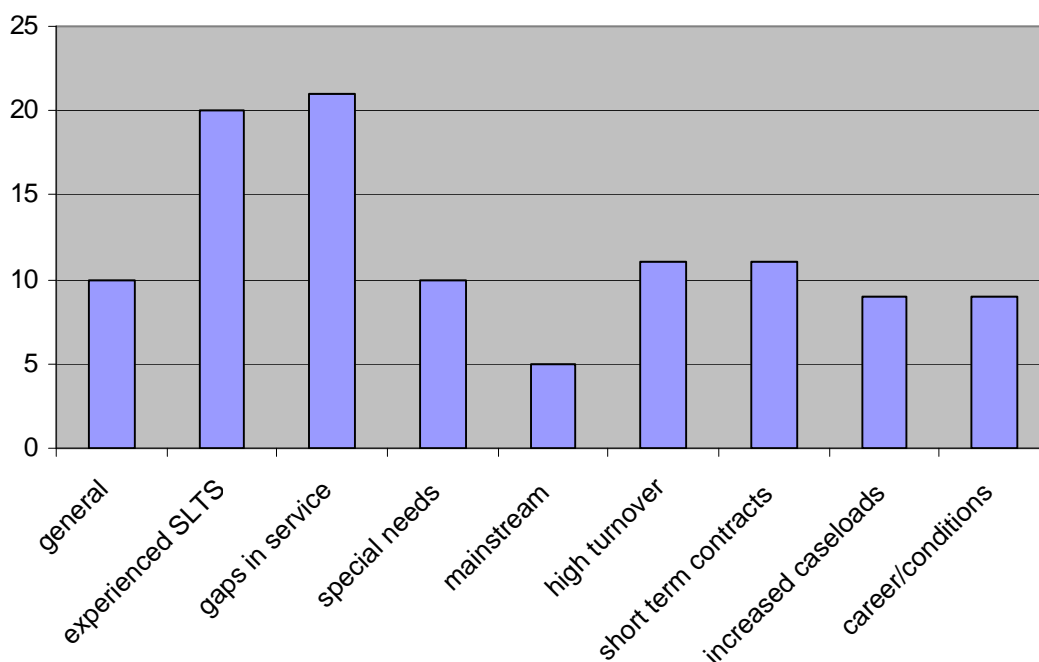
High turnover of staff This was a difficulty arising from the short-term contract issue, and was seen to affect the quality of provision offered, particularly in terms of continuity. A number of respondents referred to the engagement of locums following failure to recruit, and this was felt again to jeopardise the consistency, rather than the quality, of service which could be offered. From the service perspective, engagement of locums was seen to be less than ideal in terms of funding, caseload management and support/supervision of staff.

Retention of staff in mainstream could be problematic if the service were purely advisory, with any direct therapy delivered by SLT assistants, as this deprived SLTs of the opportunity for hands-on therapy. Maternity leave was identified by many interviewees as a factor threatening continuity of provision, with the possibility that posts may remain unfilled for the duration of the leave taken.

Caseloads Increased caseloads were identified by a number of respondents as a direct result of recruitment/retention difficulties, with detrimental results in terms of both

waiting lists for clients and perceived greater stress for SLTs. It was suggested that in turn this could lead to more periods of leave through ill health, and increased turnover in staff.

Funding of posts and career structure *"Cost cutting"* was a phrase which featured in the remarks of many interviewees who noted difficulties in recruitment, and many noted that finances do not allow for comprehensive cover arrangements to be made, affecting continuity of care. One interviewee, noting that approval must be sought from the NHS Trust Executive to advertise a post, indicated that the Executive's cost cutting policy had led to fewer applicants for posts where salary reductions had been made. Moreover, as education posts are often annually funded, and only for 39 weeks, another pointed out that this does not give recurrent funds for the budget, so that problems arise when a new post is being created.

Another respondent suggested that lack of flexibility in SLT grading structure to upgrade SLTs who develop skills in the post hinders career advancement, and is a force working against retention. The comment of one interviewee: *"Lack of funding, development and investment affects our service delivery to education"*, neatly summarises the views of many. All the above refer to the effect of problems of recruitment and retention upon service delivery to *education*; nevertheless, one respondent suggested that problems with recruitment and retention affect *all* service delivery.

3.2.5 Service profile: schools vs clinics

Over two thirds of respondents reported that they operated a designated mainstream school service[56]. Services which did not provide a mainstream service to schools still provided a substantial time allocation from clinic time to education-related activities.

Those SLT departments which did not operate a service to mainstream were asked to report the proportion of clinic time which was spent on education-related activities. These comprised direct therapy on school site; training school-based staff through modelling specific techniques; discussing language programmes to be carried out by school staff; contribution to individual education plans (IEPs); and a consultative role at annual reviews and/or case conferences.

The range of hours worked per week on such activities by this sub-group of services was very wide, from 2 to 600 hours per week (mean 95, SD 121). Owing to the presence of some large services, it is useful to note also the median, much lower at 42.8 hours per week. Hence, services which did not provide a designated mainstream service to schools still provided a substantial time allocation *from clinic time* to education-related activities.

3.2.6 Provision to mainstream settings

The pattern of service delivery to mainstream schools is clear and consistent across different measures: the main focus is the primary age range, with pre-school provision about a fifth of this, and secondary schools receiving about a

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[56]   i.e. sessions devoted exclusively to working in mainstream settings.

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tenth. About a half of services do not make provision to nursery or secondary schools.

SLT services were asked about the profile of service delivery to educational settings: to mainstream schools, to language units/resource bases, and to other special provision. As services were known to differ in their organisation of allocations, respondents were invited to report the numbers of sessions by term time only if this was more appropriate. These data are not reported here, as the results were similar to those for year-round contracts. The findings are presented in Figures 3.4 and 3.5.

The pattern of service delivery to mainstream was affected by the relative number of nursery, primary and secondary schools, as well as any prioritisation by the service. The highest mean number of institutions therefore, was for primary (64), followed by nursery (12) and secondary (7). Also, about a half of respondents reported no nurseries or secondary schools receiving a service. (49% and 47% respectively, whereas this was the case for just 12% of primaries.)

Figure 3.4 Mean number of schools and sessions per week
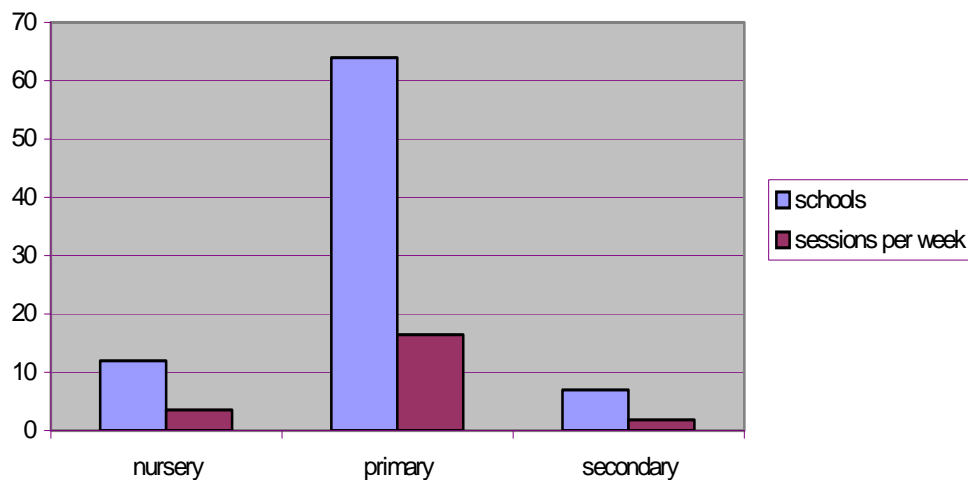
The numbers of sessions and numbers of children on the caseload followed the same trend *(Fig. 3.4)*. These data are consistent, in that the numbers of schools and sessions provided by place of education are in proportion to the number of children on the caseload. Also, the provision to nurseries is approximately pro rata to primary, but provision to secondary is much less than pro rata.

Figure 3.5 Percentage of children by Code of Practice stage
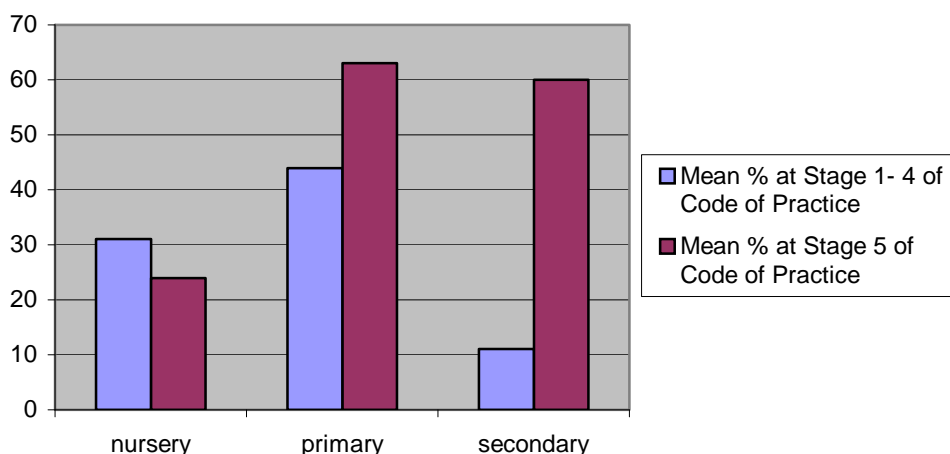
Code of Practice The relative proportion of children at Stages 1 – 4 compared with Stage 5 of the Code of Practice varied with educational phase. At nursery, many children are being assessed, whereas in primary and secondary schools the majority of children receiving a service have statements *(Fig. 3.5).* It is also interesting to note that half of the SLT respondents reported that for their service to secondary schools, *all* pupils were at Stage 5, whereas for nurseries and primary schools, 16% and 35% respectively reported this.

3.2.7 Provision to language units/resource bases

The highest level of provision was to primary language units/resource bases.

As shown in Figure 3.6, SLT services provided their highest mean number of sessions to primary language units and resource bases, which were also most numerous. However, the modal number of primary units was just 1, while for both nursery and secondary stages it was 0. Hence, the most common response for nursery and secondary was that there was no such designated provision (70%, 75% respectively). Primary was reported to have a more substantial range but, even so, 88% of SLT managers reported there being no more than 3 primary language units.

Figure 3.6 Provision to language units/resource bases
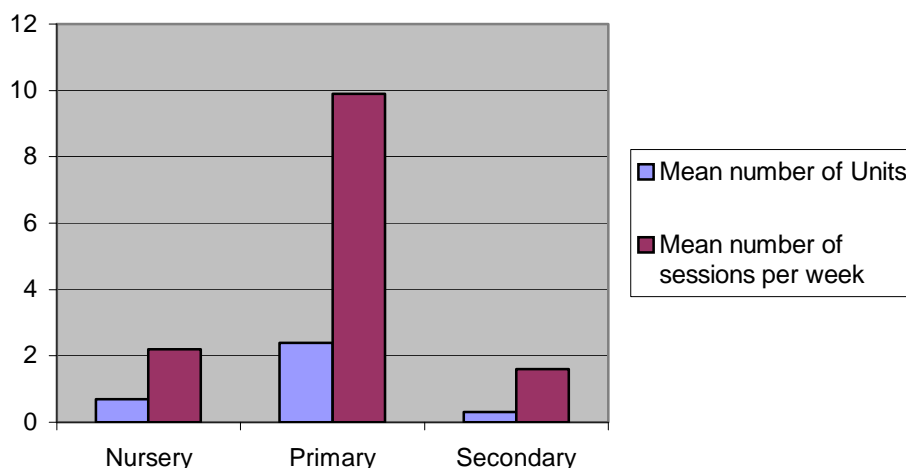
The sessions provided to each age band reflect the distribution of facilities, with a mean 9.9 sessions per week to primary, 2.2 to nursery and 1.6 to secondary. More sessions are allocated to mainstream than to these designated facilities (i.e. primary mainstream v. primary units/resource bases = 16.5: 9.9 sessions per week). However, the latter are relatively few in number, but presumably cater for children with more complex speech and language needs.

The numbers of children on the caseload indicate that designated nursery units receive a disproportionately low number of sessions: while the mean primary caseload of 29 receives 9.9 sessions per week, the mean nursery caseload of 14 receives 2.2 sessions per week.

Figure 3.7 Percentage of children by Code of Practice (Language units)
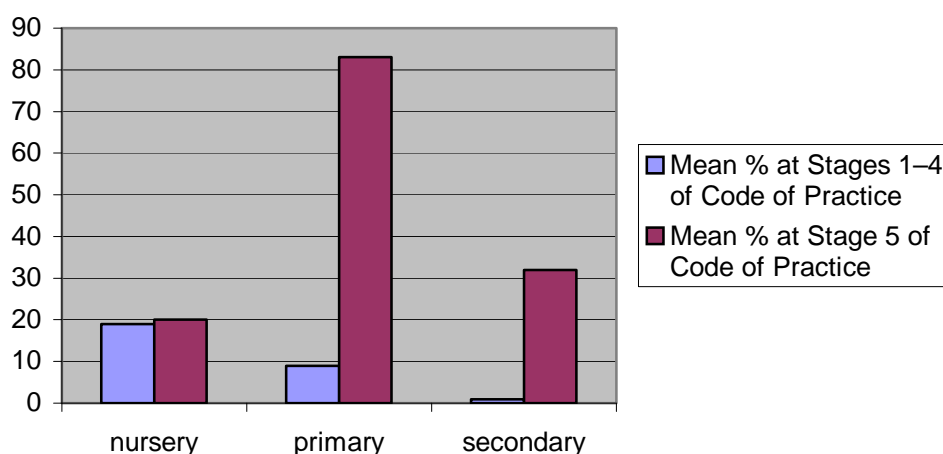
The relative proportion of children in language units at Stages 1 – 4 compared with Stage 5 of the Code of Practice varied greatly across the age range *(Fig. 3.7)*. At primary, nearly ten times as many children had a statement as at Stages 1–4; at nursery, the numbers were almost the same; while at secondary, the caseload was very heavily directed to children with statements (1:32). (NB. A high proportion of services reported *no* children in secondary units who were on any stage of the Code of Practice.)

3.2.8 Other special provision

Provision for children with moderate learning disabilities was the most likely to receive support.

Table 3.3 reports the mean numbers of schools/units/resource bases for various SEN categories. In many types of special provision no SLT service was reported, although this may represent a lack of educational provision for children with these types of special educational need to which SLTs could provide a service*.*

Table 3.3   Mean number of schools/units/resource bases receiving support from an SLT service

Type of provision	Mean
Moderate learning difficulties	3.2
Severe LD/PMLD	2.5
Autistic spectrum	1.0
Physical disability	0.9
Specific learning difficulty	0.3
Hearing impairment	1.6
Emotional and behavioural difficulties	0.3
Pupil Referral Units	0.1
Other sites	0.6

Table 3.4 indicates the sessions allocated and the numbers of children in these provisions. The majority of SLT time was allocated to children with moderate learning disabilities, or severe learning disabilities/profound and multiple learning disabilities, the two largest groups. Note that where services allocated sessions on a term time only basis, the mean numbers of sessions were lower, but were often reduced more than expected pro rata.

Table 3.4   Mean caseload and number of sessions allocated per week to other special provision

	Sessions per week	Sessions per week (term time only)	Number of children on caseload
Moderate learning disability	7.7	6.6	111
Severe LD/PMLD	9.6	5.6	122
Autistic spectrum	3.5	2.2	23
Physical disability	3.7	2.1	27
Specific learning difficulty	0.9	0.6	5
Hearing impairment	3.6	1.9	21
Emotional and behavioural difficulties	0.2	0	2
Pupil Referral Units	0.1	0.2	0.4
Other sites	2.0	1.5	15

However, 41% reported that no provision was made to facilities for children with autistic spectrum disorders, 37% for physical disabilities and 87% for children with specific learning difficulties. With respect to children presenting with behavioural difficulties, there were also low rates of provision: 81% made no provision to facilities for children with emotional and behavioural difficulties and 96% no provision to Pupil Referral Units.

A number of respondents took the opportunity here to enlarge on the nature of provision. Replies focused predominantly upon ways in which their provision was funded, highlighting a range of issues, as the following examples illustrate.

Funding One of these interviewees indicated that *"SLD departments (units) [2] have funding from LEA, others financed by Health, except EBD/hearing impaired[1] where the schools purchase SLT from our department."*

Operational constraints A number of other interviewees expanded on their numerical descriptions of provision to demonstrate more fully the operational changes/constraints experienced, as for example:

> *"The differences (in provision) are historical and organisational and reflect the different parts of the service's ability to take on Total Communication or inclusive policy."*

Assessment centres Many of those who described some "other" service provision referred to "assessment centres".

> *"Assessment and intervention nursery for children aged 2-5 years for range of special educational needs. Places partly stage V and partly Stage IV."* [for 38 children]

"Assessment" centres were reported as serving varying needs, particularly in respect of speed of throughput of pupils, as can be seen from the two following, contrasting, comments:

> *"Units [2] with fairly rapid throughput, assessing children's complex needs in a multi-disciplinary setting. Statements for most children prepared during this period. Variety of disabilities including autism, cerebral palsy, complex medical disorders. (38 children is a "snapshot" of numbers: total passing through in a year is greater than this); 4 sessions."*

> *"An LEA-funded assessment centre for children with special needs of pre-school age, although some 4-5 year olds also attend. NB – does not operate as assessment centre, as many children stay a long time! + 1 social services-funded playgroup for children with SEN."*

Complexity Noteworthy is the complexity of children's needs in addition to speech and language difficulties highlighted by respondents, e.g.:

> *"1 pre-school assessment placement for children with complex needs. Multi-disciplinary team assesses the children with a view to determining their needs in terms of education and therapy provision."* [5 SLTs, 5 assistants (2 ½ hrs each), 28 children]

Complementing the above, many respondents described the variety of specialist units, and a number of comments are included below to illustrate the breadth of provision:

> *"[One] Aspergers unit opened Sept. 99, 3 children in it now, to rise to 6 in total. Input from SLT is equivalent to level these cases received in mainstream (or less). At very early stages currently and no prior discussion with SLT re provision we could give."*

> *"[1] language resource centre – in mainstream primary school, integrated model with up to 12 primary aged students based in their mainstream*

classroom with "cocktail" of support, based on individual needs, provided by Lang. Teacher, SLT, SLTA, 2 NNEB's and other support assistants and class teacher. LEA purchase SLT from our service + SLTA" [5 sessions SLT, 10 sessions SLTA (TTO), number of children unspecified.]

"1 language unit: children attend a mainstream primary/nursery class and visit the unit for 2 sessions a week. SLT and teachers at the unit liaise with mainstream class. It is a Stage III/statemented provision." [11 sessions 43 children].

Portage A complexity of demand was linked by some interviewees with operation of a Portage system*:*
"Therapy time is also used to support Portage. All have very mixed needs, many with autism." [Interviewee refers to 2 units – SEN provision/assessment centre + 1 social services playgroup for pre-school special needs – 8 sessions allocated per week, 66 children].

3.2.9   Factors influencing service delivery across education and health settings

Overall, comments centred on the demands placed on the service by high and varied caseloads in a context of stretched financial and staffing resources.

Some respondents presented factors simply as a list. While it seems likely that these were placed in order of importance, it cannot be assumed that this was always the case, so no special account has been taken here of the order in which individuals have listed factors, neither has any comparative analysis been made between lists.

Demands placed on the service Many respondents referred to caseloads which stretch the service's capacity to give adequate provision, some identifying high actual numbers of clients, others the nature of clinical need as the most challenging in this respect. A few identified changing clinical needs, one experiencing *"a more complex and diverse case mix";* a number of interviewees reported increasing numbers of autistic spectrum cases. The "*clinical need"* of the child and more broadly *"child's needs"*, appeared frequently in questionnaire entries.

Staffing resources The many comments which referred to *"staffing available"* focused upon staffing levels, but also upon *"skill mix issues"* and the fit between qualifications/skills of therapists and the nature of clients' needs. A number of interviewees linked all these factors with the availability, and willingness, of staff to support speech/language therapy work in schools. Many comments echoed those made about staffing, and indicated lack of funding, high staff turnover and recruitment difficulties as factors influencing pattern of service delivery, whether in schools or clinics.

Location Availability of *"accommodation"* within schools and clinics was a factor identified by several respondents, as was its geographical location. Comments noted the time and cost implications of the latter for clients/therapists, with potential for impact on *"equity"* of provision.

The comments of one respondent, who describes the geography of the LEA as *"small and compact which facilitates communication",* contrast with those of another interviewee who notes: *"…requirement to provide equitable services across large*

geographical patch", bringing into focus the diversity of contexts in which service delivery takes place.

Several respondents included *"the most appropriate setting in which to meet the child's needs"* as an influencing factor. One of these noted a preference for seeing statemented children within school; another suggested that working with parents is more difficult in school settings.

Parental choice, relating to choice of home, school or health centre was mentioned by one interviewee as an influencing factor, and parental, as well as schools/school staff expectations in terms of outcomes by a number of others.

Effectiveness of delivery and outcomes Many comments indicated that concern with outcomes is a central issue influencing pattern of service delivery. *"Effectiveness of therapy intervention"*, *"Clinical effectiveness"* and *"effective therapy"* were typical phrases used. One interviewee indicated that the target of outcome, whether curriculum-related or communication-related determines provision: "*we only do the latter, unless LEA funds are available for the former."*

LEA policy Collaboration, or lack of collaboration with the LEA, was mentioned by a number of respondents. There were seven references to good collaboration with the LEA, e.g.: *"Communication with LEA has improved markedly in last 12 months"*; *"Close partnership with LEA led to recognition of pressure on service by development of Language Resource Centre and the subsequent funding of these posts".*

An almost equal number of references to poor collaboration were received (6), e.g.: *"On occasion LEA sets up new resources and expects SLT sessions (there is little to no consultation"*, *"Reorganisation of LEA (several times!!) prevents progress with meetings – we've tried many times".*

There were several more neutral, or ambiguous references, e.g.: *"Pursuit of a model of partnership/empowerment in relation to working practices with LEA".*

In addition, there were specific references to the impact of LEA funding policies, for example the *"withdrawal of funding by LEA for a mainstream service for children with MLD/SLD".*

The LEA's inclusion policy was identified by several respondents as a key influence upon service delivery. Several interviewees reported a lack of consultation/collaboration on the part of the LEA in policy decisions.

Overall, many respondents felt that historical factors underlay relationships with other agencies, the nature of some policy decisions, and patterns of service delivery. The political context in which service delivery took place was emphasised in the comments of numerous respondents. Notwithstanding the force of patterns established historically, however, a number of interviewees pointed to changing trends in Education, not least the greater and earlier integration of children with significant needs in mainstream settings. These respondents included *"flexible response to ever changing needs"* in their reply.

3.2.10 Other educational provision

The Sure Start initiative, with 35% of respondents, showed the highest involvement.

A sizeable minority (10%) reported providing a service to Further Education (FE) Colleges which educated 14 – 16 year olds, and 6% to voluntary bodies undertaking this task, but the majority of comments related to the Sure Start Initiative, linked by a few respondents to WILSTAAR. The fullest description was as follows:

> *"4 wte SLTs to be employed as key members of Sure Start teams to provide very early identification and intervention (something like WILSTAAR) and planning and delivery of a wide range of services to families in our Sure Start area including drop-ins, training, direct and indirect intervention, autistic unit, as part of a multi-disciplinary team".*

Table 3.5   Service to other educational provision

	%Yes	%No
Young offender institutions	2	98
Social Services institutions providing education to 5 – 16 year olds	2	98
FE Colleges educating 14 – 16 year olds	10	90
Voluntary bodies educating 14 – 16 year olds	6	94
Sure Start	35	65

Plans for Sure Start were at various stages of submission and implementation. For most interviewees who mentioned Sure Start, however, involvement was in a preliminary phase, and confirmation of bids was still awaited, as was clarification of if, or how, funding would be allocated. Several interviewees reported designation of "trailblazer" status.

A number of respondents gave brief details of service provision to colleges of FE. These included the following entries: *"a service offered and run via schools", "following young people known to us in special schools (usually) who go on to college"* and *"advisory, relating to SLD pupils".*

One interviewee noted private contracts held with Scope, and the only other reference to involvement with a voluntary body reported provision of SLT input to a *"specialist 50 wk/yr PMLD school which is part of a charity".*

3.2.11 Special educational provision

About one third of children with SEN known to the service had statements. Over 90% of statements were reported to specify the children's speech/ language/communication needs. However, satisfaction was less clear cut – 56% of SLT managers expressed satisfaction with the description of the children's speech/ language/communication needs in statements, but 44% were dissatisfied.

Those SLT managers that had data (two-thirds did not) were asked to state the actual numbers of children with and without statements and how many of their statements specified the child's speech and language and/or communication needs. Respondents who did not have this information were asked to make estimations.

The proportion of children with SEN known to the service with and without a statement was similar whether the respondent had access to actual data or made estimations. Mean estimated proportions were 63% without statements, while the percentage derived from actual data was 71%.

The following comment of one respondent summarises the views of many with respect to satisfaction with the statement:

> *"Satisfied with how <u>need</u> is described, but not with how provision is described (place in statement and description)".*

The Part (or Section) of the statement in which speech/language/ communication needs are specified has been contentious, as there are implications for which service makes provision to meet the needs identified, Education or Health. Many of those who expressed dissatisfaction were in disagreement with the section into which needs are placed by the LEA, e.g.:

> *"In the wrong section. Speech Therapy represented in Section 5 instead of Section 3."*

Several respondents felt that allocation of needs to a Section was *"hit and miss"*, so that whether SLT is considered a Health or Education matter was *"simply ad hoc",* and a number of interviewees felt that children were wrongly allocated as a result. Several suggested that only pressure from parents resulted in location of a child's needs to Section 3. Nevertheless, a number of interviewees reported degrees of collaboration with LEAs over the statutory assessment and statementing process, for example: "*System is jointly agreed between Education and Health"; "We have liaised with the LEA and have a shared understanding of what our terminology and descriptions mean*".

3.2.12 Funding

Thirty five per cent of SLT managers reported that the LEA funded no SLT posts.

The remainder reported that the LEA funded between 0.1 and 9.3 fte posts, with a mean of 1.4 fte. In addition, 11 respondents reported also having SLTs funded by a second LEA (range from .04 – 4.9 fte, mean 0.6 fte) and three reported either 1 or 2 fte SLTs from other LEAs. Also, 17% of respondents reported having SLTs funded by an alternative source, e.g. I-CAN (range 0 – 3.0 fte, mean 0.15).

3.2.13 Resource issues: prioritisation

A large majority (87%) of respondents reported that there was a system of prioritisation in their service, with severity the most common factor. Only a third of SLT managers reported operating the prioritisation system in collaboration with other agencies at present, although others were working towards this.

Figure 3.8 Prioritisation
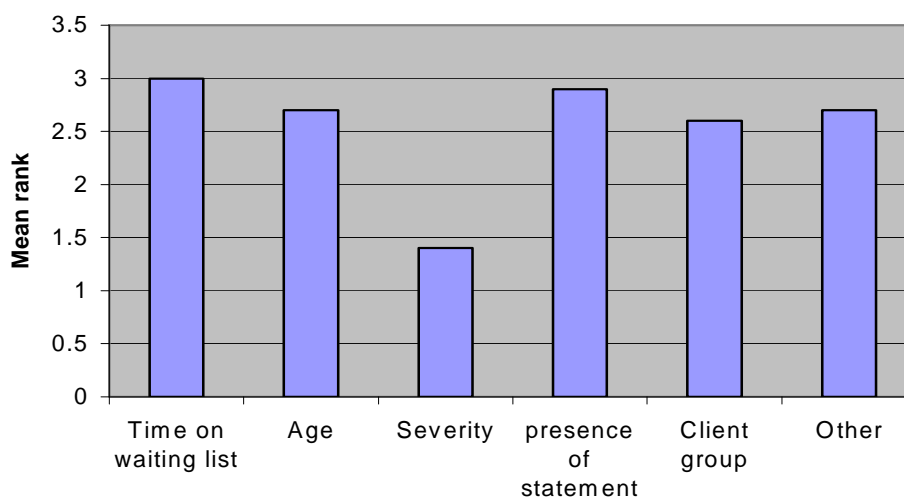
The most frequently stated basis for prioritisation was *severity* of the children's difficulties; this was the highest ranked priority with a mean ranking of 1.4, and clearly more highly ranked than any other factor *(Fig.3.8)*. While 70% rated severity as the top priority, the remaining factors (apart from 'other') were all ranked first by fewer than 20% of respondents. Also of interest are the 'other' factors, which varied between respondent, but which as a group ranked second.

A third (33%) of SLT managers reported that their prioritisation system was operated in collaboration with another agency, e.g. the LEA.

About half the respondents gave further information concerning their prioritisation system(s). Varying degrees of collaboration were noted by about one third of the respondents. The strongest form was exemplified by the following: "*a joint audit with schools, LEAs and SLT Service", "close discussion with schools", " working with LEA to develop future systems for prioritisation", and "discussed with other local (SLT) services*".

A number of other interviewees referred to partially collaborative systems of prioritisation, as illustrated by the following comment: "*No formal system in collaboration with LEA, but useful informal validation by discussing priorities with teachers (more so in special school sector)*." The following respondent described a mixed pattern of collaboration: "*In our cluster group project, prioritisation occurs in collaboration with SENCOs. The rest of the service makes decisions unilaterally, I'm afraid! In special schools it is more collaborative*."

Many respondents referred simply to a criterion-based system of prioritisation, as shown in Figure 3.8, e.g. "*prioritisation is on clinical symptoms and clinical need – not on other pressures*". A few described systems with very clearly defined acceptance criteria, e.g.: "*the system has four parameters of equal rating: severity of language, severity of difficulty of speech, anxiety/commitment, prognosis/age in relation to disorder*". Several individuals noted that prioritisation was based on a Health Trust proforma, but one interviewee indicated that the system in place, while criterion-based, allowed for clinical judgement exceptionally to override the priority rating and the point at which a child is accepted for therapy.

A number of respondents referred to current piloting of a prioritisation system. One of these noted that the resultant information system would incorporate prioritisation on the computer, another indicated that the newly developed system would include some collaboration with the LEA.

3.2.14 Services to children with English as an additional language

Only 8 services reported having an SLT fluent in the predominant community language, 6% of the total sample.

Respondents were asked how many of their paediatric staff were fluent in (up to) the three predominant community languages in the population covered by their service.

Predominant community language A total of 28 different community languages were reported by 130 respondents. Figure 3.9 reports the six predominant languages (other than English and Welsh - services in Wales were asked to complete this section for languages other than Welsh – separate information on the Welsh language is presented below).

The most prevalent community language specified was Punjabi by 26% of respondents, with other languages from the Indian sub-continent (including also Mirpuri and Silheti) being the most heavily represented. In addition to Cantonese (7%), Mandarin and 'Chinese' were also mentioned, so resulting in 10% of respondents. One respondent noted British Sign Language as a community language.

Figure 3.9 Percentage of services with predominant community languages
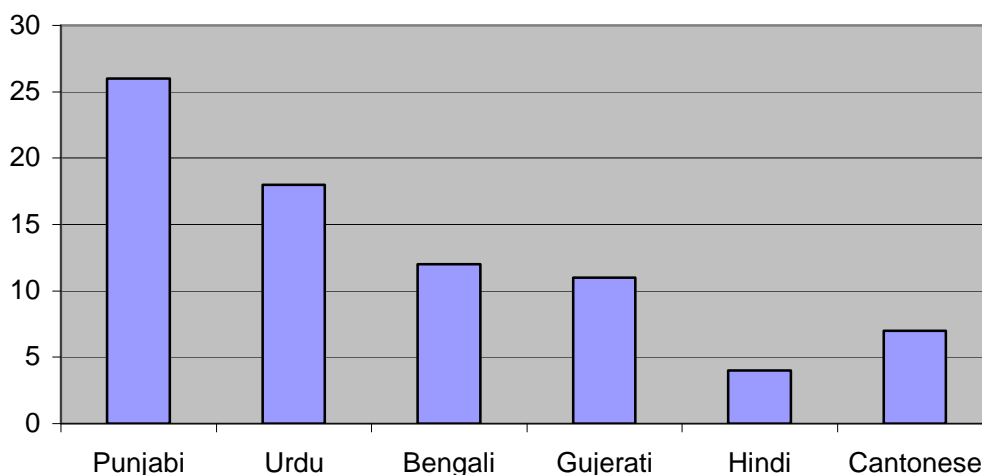
Fluency in a community language Across England and Wales just fifteen SLTs and seventeen SLT assistants, working for 14.0 and 14.4 fte respectively, were reported as fluent in community languages (Table 3.6). The most common languages were Punjabi and Urdu, with about half of both bilingual SLTs and SLT assistants being fluent in these languages. Overall, only 8 services reported having an SLT fluent in the predominant community language, 6% of the total sample. Compare this with Wales, where 6 of the 9 services, two thirds, reported having an SLT fluent in Welsh (Section 3.4.1).

Statistics on services for children with EAL Only 18 of the 133 respondents indicated that they collected statistical information specifically about services for children with English as an additional language.

***Table 3.6   Numbers and full time equivalents of SLTs and SLT assistants fluent
in a community language throughout England and Wales***

	SLT		SLT Assistants	
	N	Fte	N	Fte
Punjabi	4	3.5	8	6.1
Urdu	3	2.5	3	3.5
Gujerati	4	4.0	3	3.0
Hindi	1	1.0	1	0.5
Cantonese	1	1.0	-	-
Mirpuri	-	-	1	1.0
Bengali	-	-	1	0.4
Yiddish	2	2.0	-	-
Totals	15	14.0	17	14.4

Assessment of children with EAL in their community language SLT managers
were asked to state whether assessment was available in health settings in the
community language(s) specified. As shown in Table 3.7, assessment in the first
community language by an SLT is a minority occurrence, reported by only 9 (7%) of
respondents. The most common method in a third (44) of cases was by use of a
translation service, or interpreter who has no specific training with regard to speech and
language development. A similar picture pertains with respect to therapy in health
settings, and both assessment and therapy in education settings – the predominant
approach is the use of translators/interpreters with no specific training in speech and
language development.

However, the numbers of SLT departments reporting that they offered a service of any
kind in the child's community language reduced from 56% for assessment in health
settings to 32% for therapy (also in health settings), to only 24% for therapy in
education settings.

***Table 3.7   Children with EAL: % of services providing assessment and therapy
in their community language, in health and education settings***

	Health settings		Education settings
	Assessment	Therapy	Therapy
SLT	7	3	2
Co-worker	14	11	8
Translation service	33	16	10
Other	2	2	4

3.3   Local Education Authorities

50% sample of all Local Education Authorities (LEAs) in England and Wales was
surveyed. Of the 75 LEAs, 56 responded. As with the SLT survey, not all respondents

provided information to each question, so for different items, percentages are based on the respondents for that item, unless otherwise stated.

3.3.1 SEN profile

Primary speech/language/communication needs are specified In the case of 8% of children with statements. Over a third of all children with statements have some level of speech/language/communication need specified in their statement.

About two thirds of LEAs (66%) reported collecting data on children aged 5 – 16 at Stages 1–4 of the Code of Practice. Those LEAs which did collect data were asked to provide actual figures (as at 31 March 1999), whereas the other LEAs were asked to provide estimates of proportions of children with SEN. (NB. It was judged more appropriate to request estimates of proportions than actual numbers). Table 3.8 shows the mean number of children registered at different stages of the Code of Practice, either as actual numbers, or estimated percentages.

It is noteworthy that although two thirds of LEAs stated they collected data for Stages 1-4, the numbers responding were generally lower: 34% for Stages 1 to 2, 43% for Stage 3 and the highest for Stage 4, with 54%.

Table 3.8   Mean number of children registered at different stages of the Code of Practice

	Stages 1-2	Stage 3	Stage 4
Actual number of children registered	6016	2006	90
Estimated % of children registered	14.2%	7.2%	1.4%

Respondents were then asked whether they collected data on the number of children with speech, language and/or communication needs specified in their statements. As above, further information was sought as actual numbers or estimated proportions. A high proportion of the total sample (75%) reported that they collected such data where there were primary needs, while 27% reported collecting these data for any level of need.

Table 3.9 indicates that the mean number of children with speech, language and/or communication needs specified on their statements was 164 for primary needs. However there was wide variation (range 4-906). A higher number was indicated for children with any level of speech/language/communication need, but as only 7 LEAs responded to this item, its representativeness is questionable.

Table 3.9   Mean number of children with speech language and/or communication needs specified in their statement

	Children with primary speech/language/ communication need	Children with any level of speech/language/ communication need
Actual number	164	235
Estimated %	8%	38%

The responses from LEAs which estimated proportions of children showed 8% of children had statements specifying a child had primary speech/language/communication needs and over a third of all children with statements (38%) had some level of speech/language/communication need specified in their statement.

3.3.2 Specialist language support teachers and learning support assistants (LSAs) working with speech and language

LEAs have low numbers of peripatetic specialist language teachers and LSAs, an average of just 0.5 specialist teachers per LEA, mainly for Key Stages 1 and 2. Over 80% reported no such staff for early years to KS2 and over 90% had no specialist staff at KS3/KS4.

LEAs reported an average of 2 primary language units/resource bases each, but just 0.6 nursery and 0.3 secondary. The majority of LEAs made no such provision at nursery and secondary stages.

For every 100 children receiving peripatetic language teacher support during the primary period, only 3 receive it at secondary.

LEAs were asked to report on the specialist staff, both peripatetic and language unit/resource based, available to work specifically with children with speech/language/communication needs, together with the number of schools/units covered and the number of children across the LEA receiving each type of provision.

Peripatetic There is a major difference between the number of schools/units serviced at early years to Key Stage 2 (KS2) (mean 8.6) compared with KS3/KS4 (mean 0.5). This is reflected also in the number of children receiving this provision (Table 3.10). Note also the very low average numbers per LEA of specialist language support teachers and LSAs.

Table 3.10 Mean number of specialist language teachers and learning support assistants (LSAs)

	No. schools/ units	No. Specialist Language Support teachers (fte)	No. Learning support assistants (fte)	No. children across LEA receiving provision
Peripatetic language support service to mainstream schools for Early Years KS1/KS2 (based centrally)	8.6	0.5	1.1	56
Peripatetic language support service to mainstream schools for KS3/KS4 (based centrally	0.5	0.1	0.1	1.4

Across the sample there was a mean of only 0.5 fte specialist teachers per LEA at Early Years to KS2, and 0.1 fte at KS3/KS4 *(Table 3.10)*. The mean for LSAs was higher in the younger age group at 1.1, but only 0.1 for the KS3/KS4.

Furthermore, in each case, large numbers of LEAs provide *no* service: 83% at early years to KS2 and 93% at KS3/KS4. As a corollary, the proportions of LEAs reporting no children receiving this service are also high: 62% up to KS2 and 90% at KS3/KS4 *(Table 3.11)*.

*Table 3.11 Percentage of LEAs **not** providing a peripatetic specialist language support to mainstream schools*

	No. of services to schools (%)	No. of specialist language support teachers (%)	No. of learning support assistants (%)	No. of children receiving a service (%)
Early Years to KS2	83	66	78	62
KS3/KS4	93	88	95	90

Language units/resource bases Table 3.12 presents the means for the numbers of units/resource bases, specialist language support teachers and LSAs, and number of children receiving the provision for nursery, primary and secondary stages.[57]

Table 3.12 Mean numbers of specialist language support teachers and learning support assistants (LSAs) in Units/Resource Bases

	No. of unit/resource bases	No. of Specialist Language Support teachers (fte)	No. of learning support assistants (fte)	No. of children across the LEA receiving provision
Nursery	0.6	0.4	0.8	7
Primary	2.0	2.7	3.0	30
Secondary	0.3	0.6	0.8	7

LEAs reported an average of 2.0 primary language unit/resource bases each, but the mean numbers for nursery and secondary were just 0.6 and 0.3 respectively. Furthermore, as Table 3.13 indicates, the majority of LEAs made no such provision at nursery and secondary stages – 68% and 79% respectively. On the other hand, only 13% of LEAs did not make primary language unit/resource base provision. (NB. As the numbers responding to this question varied from 44 to 48 of the 56 LEAs, the actual percentage of LEAs not making provision is likely to be higher, and hence the mean number of units lower. A similar caveat applies to the subsequent data).

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[57] Language Units were defined as 'where the children are in a separate class for most of the time, with their own specialist teacher and SLT'. Resource bases were defined as 'where the children are educated in their mainstream year group for most of the time, with specialist teacher and SLT available on site for a significant proportion of the week'

Table 3.13 Percentage of LEAs not *providing language unit/resource base provision*

	No. services to units/Resource base (%)	No specialist language support teachers (%)	No. of learning support assistants (fte)	No children receiving a service (%)
Nursery	68	76	73	63
Primary	13	11	18	7
Secondary	79	77	80	71

3.3.3 Speech and language therapists

The majority of SLT posts were on the payroll of Health, with only about 10% on the LEA payroll. Four out of five SLT posts in language units were on the Health payroll.

LEAs were asked for information on SLTs providing a service to mainstream educational settings/groups, and to special educational provision. Information was sought on whether the SLTs were on the payroll of (i.e. employed by) the LEA, Health Trust or other agencies, or whether there was no service provided to that setting. The various ways of delivering funding make this issue problematic: LEAs were asked to specify where SLTs were on the LEA payroll. However, inconsistencies in the data suggest that some LEA managers may have misinterpreted the question, and that some SLTs may actually have been on the Health payroll, and merely *funded* by the LEA, wholly or as a joint funded initiative.

Mainstream The provision and funding of SLTs in mainstream are described in Table 3.14. The majority of posts were reported to be on the payroll of Health rather than the LEA, with only about 10% of LEA respondents for each type of child group reporting that the SLTs were on the LEA payroll. The percentage of LEAs who reported having *no* SLTs on their payroll ranged from just 16% for the younger children at Stages 1-4, to nearly a third (30%) for the older children at Stages 1 – 4 of the Code of Practice. No LEAs reported having SLTs provided by other agencies for mainstream educational settings.

Table 3.14 *Funding of peripatetic SLT services to mainstream educational settings/groups*

	% on the payroll of			
	LEA	Health	Other Agencies	No SLT service
Early Years to KS2, children at Stage 5	11	85	0	17
Early Years to KS2, children at Stages 1 – 4	9	75	0	16
KS3/KS4, children at Stage 5	9	73	0	20
KS3/KS4, children at Stages 1 – 4	7	50	0	30

Special provision A higher proportion of LEAs reported SLT posts on their payroll for special provision *(Table 3.15)* especially for primary language units/resource bases (22%) and special provision other than designated language units/resource bases for

Early Years to KS2 (17%). However, SLT posts were reported to be on the Health payroll in a higher proportion of LEAs, e.g. 82% of LEAs reported SLT posts for language units/resource bases at primary were on the Health payroll.

Table 3.15 Percentage of LEAs reporting funded SLT posts in special education provision

	% on the payroll of			
	LEA	**Health**	**Other**	**No service**
Language unit and/or resource base (nursery)	10	63	5	11
Language unit and/or resource base (primary)	22	82	2	2
Language unit and/or resource base (secondary)	10	42	5	25
Other special provision for Early Years/KS1/KS2	17	80	0	11
Other special provision for KS3/KS4	12	61	3	13

3.3.4 Funding and resources

Special needs support for children with statements who had speech and language needs was generally considered appropriate by LEAs.

The proportions of children with statements whose primary disability lies in the area of speech and language but who were judged *not* to be receiving appropriate support (e.g. because they were on a waiting list for a particular type of placement) are shown in Table 3.16. Such inadequate provision was judged relatively uncommon, with the majority (54%) stating this occurred for 0-15% of children – however, note that 4% reported this occurring for over 60% of children, a third of LEAs did not provide a view, and a further 8 did not answer.

Table 3.16 Proportion of children with statement whose primary disability is speech and language not receiving appropriate SEN support

	0 – 15%	**16 – 30%**	**31 – 45%**	**46 – 60%**	**> 60%**	**Don't Know**
% LEAs	54.2	6.3	0	0	4.2	33.3

3.3.5 Number of full time SLTs on the LEA payroll

The mean number of SLTs on the LEA payroll was 0.2 (range 0 – 2.5). However, the majority (78%) stated they employed no SLTs.

3.3.6 SLT sessions purchased from the local Health Trust

Where SLTs providing a service to Education were on the Health Trust payroll, LEAs were asked to state the number of sessions purchased per term. The variation was wide, 0 to 265 sessions, with a mean of 13.4 for the first (and in many cases only) Trust. However, given the heavy skew to the results, the median and mode provide better representations of the average, being 0 in each case. Fifty five per cent of respondents reported buying no sessions from the Trust, and a total of a further 36%

bought between 0.6 and 15 sessions per term. Only 3 and 2 LEAs respectively purchased between 2 and 10 sessions per term from second or third Trusts, and 4 purchased between 0.5 and 12 sessions (mean 0.90) from alternative sources, e.g. I-CAN.

3.3.7 Recruitment and retention

Four fifths of LEAs (80%) reported that recruitment and retention problems significantly affected service provision within educational settings, with just 11% reporting no such effect. This compares with the 55% of SLT managers who reported such problems.

3.4 Speech and language therapy provision in Wales

Most services had SLTs fluent in Welsh who assessed monolingual and bilingual children in Welsh.

Section 3.2 included information from SLT managers from both England and Wales. In this section, we provide information on provision specifically to Welsh–speaking children. Ten SLT managers from Wales responded, but one provided no data on this section; hence the effective number of respondents for analysis purposes is 9.

3.4.1 Staff fluent in Welsh

As shown in Table 3.17, two services report no SLTs fluent in Welsh, while 7 reported this for SLT assistants. The highest number of SLTs fluent in a service was 2.

Table 3.17 Number of services with SLTs and SLT assistants fluent in Welsh

	SLT	SLT Assistants
0 fte	2	7
0.4	1	0
1	4	2
2	2	0

3.4.2 Children who are Welsh speaking

The majority of the 8 services which responded reported the prevalence of both monolingual and bilingual Welsh–speaking children known to their services as 0–9%. However, one service had between 10 and 24% of each, while one had 25–49% monolingual and two reported 25–49% bilingual Welsh – speaking children *(Table 3.18).*

Table 3.18 Percentage of children who are Welsh speaking

	0-9%	10-24%	25-49%	50%+	No response
Monolingual	6	1	1	0	2
Bilingual	5	1	2	0	2

Respondents were asked to describe resources specifically allocated to children who are monolingual in Welsh or bilingual in Welsh and English. There were only four comments in this section; one respondent reported Welsh language clinics in each LEA area, with specialist special needs provision to schools. Another indicated provision of 6 sessions of therapist time, and the availability of resources/worksheets for photocopying. The third and fourth respondents entered simply "Reynell II translation" and "(name of Authority) Articulation Test".

3.4.3 Assessment in Welsh

As shown in Table 3.19, the majority of services had SLTs who assessed monolingual and bilingual children in Welsh, with two using a translation service and one a co-worker. This is in contrast to the limited provision for other bilingual children throughout England and Wales reported in Section 3.2.14.

Table 3.19 Number of SLT services providing assessment in Welsh

SLT	7
Co-worker	1
Translation service	2
Other	0
Not available	1

3.4.4 Speech and language therapy in Welsh

Again the majority of services were able to provide therapy through a Welsh-speaking SLT, in health settings, but use of a co-worker in education settings was frequent.

Table 3.20 Number of SLT services providing speech and language therapy in Welsh

	Health settings	Education settings
SLT alone	6	4
Co-worker	1	4
Translation service	3	3
Other	0	0
Not available	1	1

Respondents were asked about proposals/plans for developing their assessment and intervention practices for Welsh-speaking children. Three of the seven replies received in this section referred to recruitment of Welsh speakers who can deliver assessment and therapy packages. One of these had put in a bid for a Welsh SLT for the Health Authority area, whose services could be used between Trusts. One respondent indicated that Welsh classes are held on an ongoing basis for staff who are not bilingual, while a bilingual therapist attends a committee to develop new resources in the Welsh language.

There were references by two interviewees to the Welsh Language Committee, and one of these replies indicated that much work is ongoing between SLTs in Wales and

the National Assembly for Wales regarding assessment and practice in the Welsh language, to include work on Welsh Web, translation of health promotion leaflets, Welsh advice leaflets and translation of therapy resource material into Welsh. Repeated bids for funding had not yet been successful. One respondent reported that there are currently *"no plans, as this has not been a problem to date"*.

3.4.5 LEA provision in Wales

Special needs assessment in Welsh was available in most LEAs from bilingual educational psychologists.

3.4.6 Children who are speaking

Two of the six Welsh LEAs which responded reported that up to 9% of children in educational provision are monolingual Welsh speakers – 4 did not know. Half the LEAs reported that between 10 and 24% of the children are bilingual Welsh/English, the other half did not know.

Table 3.21 Percentage of children who are Welsh speaking

	Number of LEAs				
	0-9%	**10-24%**	**25-49%**	**50%+**	**Don't know**
Monolingual Welsh speakers	2	0	0	0	4
Bilingual Welsh speakers	0	3	0	0	3

Only one LEA reported that there were resources specifically allocated to children who are monolingual in Welsh/bilingual in Welsh and English.

3.4.7 Assessment in Welsh

LEAs were asked whether special needs assessment was available in Welsh and, if so, how it was delivered. The only method available, in 5 of the 6 LEAs, was by an educational psychologist, while one LEA reported they had no means of conducting special needs assessment in Welsh.

3.4.8 Special educational support in Welsh

As Table 3.22 indicates, the most common approach (3 LEAs) was to deliver special educational support to Welsh speaking children with speech, language and communication needs by specialist teachers alone. Two LEAs, however, had no provision.

Table 3.22 Number of LEAs providing special educational support in Welsh

Delivery by specialist teacher alone	3
Delivery through co-worker	1
Delivery through translation service	0
Other	1

3.4.9 Proposals for development

Only two of the six Welsh LEAs reported having proposals/plans for developing the assessment and special education support services for Welsh-speaking children.

3.4.10 Provision in Wales: A summary

The surveys of Health Trusts and LEAs in Wales have indicated that an important proportion of children with speech/language/communication needs are either bilingual or mono-lingual Welsh speakers. The size of this population varies between areas, but also represents a tendency to a higher proportion of the caseload of SLTs, than of children in educational provision. For example, while the highest proportions for LEAs were up to a quarter bilingual, and up to 9% mono-lingual *(Table 3.21)*, for SLTs there were Trusts reporting up to half the children they worked with being either bi- or mono-lingual Welsh speakers.

Most Trusts and LEAs had staff available who were able to assess children in Welsh, with both SLTs and SLT assistants in Trusts, and educational psychologists in LEAs. While therapy and the delivery of special educational provision were available in Welsh in most Trusts and LEAs, there was a minority of each which did not provide this service.

The comparability of issues in Wales compared with England will be reported in the following chapters, but it is worth noting here that, in absolute terms, the provision for mono- and bi-lingual children in Welsh is substantially higher than for children throughout England and Wales with a different community language. While only 8 of the 133 services in the England and Wales total sample reported having an SLT fluent in the predominant community language *(i.e. 6% of the total sample)*, in Wales 6 of the 9 services in the sample *(two thirds)* reported having an SLT fluent in Welsh.

Chapter 4 - Degrees of collaboration

Key findings

- A large proportion of both LEA and SLT managers report meeting to develop a joint approach for delivery of SLT services to Education.

- LEA and SLT managers differ in their perception of whether the outcomes of these meetings contribute to Development Plans in their partner organisation.

- There is also an issue over the definition of 'joint strategic planning'.

- Both parties report effective meetings between practitioners.

- Approximately a third of respondents report SLT representation on SEN placement panels, and rate it highly where it does occur.

- About 95% of SLT services offer training to Education staff, and approximately half of the LEAs responding reciprocate. Joint training occurs on a more *ad hoc* basis, with only about 30-40% of respondents involved.

- LEAs rate SLT services to children with statements more highly than those to children on Stages 1-3 of the Code of Practice. SLT managers also appear a little dissatisfied with the provision made by LEAs.
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4.1 Introduction

Part 1 of the questionnaire was designed to give an indication of the level of collaboration between the Local Education Authority (LEA) and the speech and language therapy (SLT) service(s) in each area, and the perceived effectiveness of this collaboration. LEA managers and SLT managers were sent the same questionnaire and were asked to complete the information requested for each of their partner LEAs or Trusts. This chapter reports on the degrees of collaboration reported by the questionnaire respondents in cases where both reciprocal partners returned the questionnaire.

Of the 75 questionnaires sent to LEAs, 56 were returned (65%). From these, 91 'cases' were generated, due to the fact that each LEA liaised with one or more Trusts. For their part, the SLT managers returned 133 out of a possible 180 questionnaires (74%). This generated 92 'cases'. A case is therefore defined as an LEA/SLT 'collaborative pair'.

Initially, two datasets were generated, the first describing collaboration from an LEA perspective, the second from an SLT manager perspective. The size of the datasets for each type of respondent (LEA vs. SLT) was different (91 and 92 cases respectively), as LEAs sometimes reported on a collaborative relationship where the SLT service had not returned the questionnaire, and vice versa. In addition, only 50% of LEAs were sampled, so SLT managers may have been reporting on collaborative arrangements where the LEA in question had not been a questionnaire recipient.

A subset was extracted from these two datasets, which included **all cases where both LEA and SLT questionnaire recipients in a collaborative pair had responded**. From the original 91 LEA cases and 92 SLT cases, a subset of 66 cases was identified.

Percentages given in the following report refer to this subset, and are proportions of the number of cases (collaborative pairs) identified who responded to particular questions, rather than proportions of the number of respondents *per se.*

4.2   Joint planning between SLT and education

This section asked about the frequency and effectiveness of planning meetings between the LEA manager with responsibility for special educational needs (SEN) and the SLT manager.

4.2.1 Frequency of meetings

In 92.4% of cases, LEA managers said they did meet with the SLT manager. Of these, the highest proportion (70.5%) said this occurred on a termly basis, with 8.2% and 3.3% reporting monthly and yearly meetings respectively. SLT managers also reported a high proportion of cases (83.3%) where they met with their LEA counterparts to discuss a joint approach, but the largest proportion of these (45.5%) did not specify how frequently this occurred. Only 38.2% reported termly meetings. (Figs. 4.1 & 4.2)

4.2.2 Contribution to service development plans

In 65.6% of cases, the LEA managers said that the outcomes of these meetings contributed to an LEA Development Plan, and in 51.5% of cases to an SLT Service Development Plan. (In the remainder of cases this either did not occur, or the LEA manager was not aware of whether it did or not.)

Conversely, just under a third (30.3%) of SLT managers felt sure that the outcomes of these meetings contributed to LEA Development Plans, and 71.2% reported that the outcomes fed into their own Service Plans. (Fig.4.3)

Either managers did not share information about their Development Plans, or they had differing opinions over what constituted a valid contribution to a Plan.

4.2.3 Effectiveness of manager meetings

On a scale of 1 (not effective) to 5 (very effective), LEA managers gave these meetings an effectiveness score of 3 or greater in 94.5% of cases. [Mean: 3.71; SD: 0.76; Mode/median: 4 (50.9%)]. SLT managers reported a similar level of effectiveness in fewer cases (78.2%) [Mean: 3.27; SD: 0.89; Mode/median: 3 (36.4%)]. (Fig. 4.4).

**Figure 4.1   Percentage of managers reporting joint planning meetings**
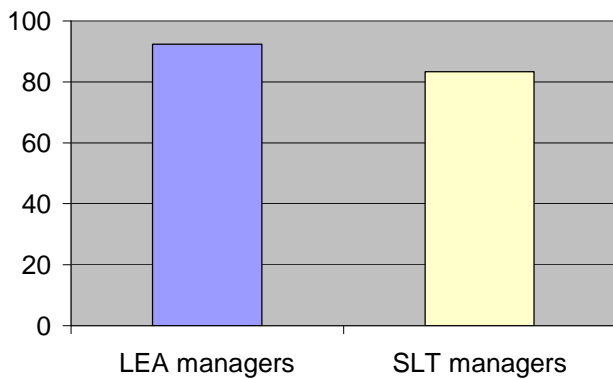
Figure 4.2   Percentage of managers reporting frequency of joint planning meetings
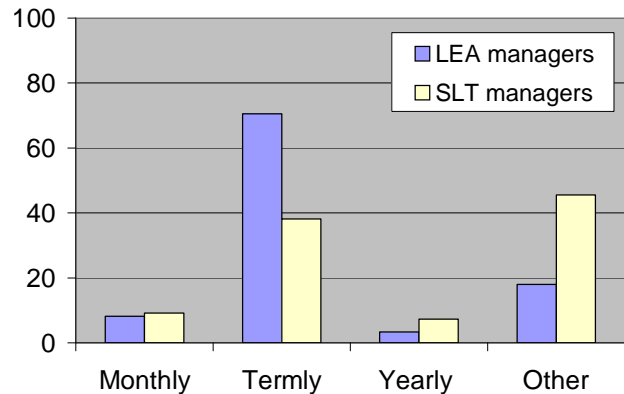
Figure 4.3   Percentage of managers reporting contribution of meetings to development plans
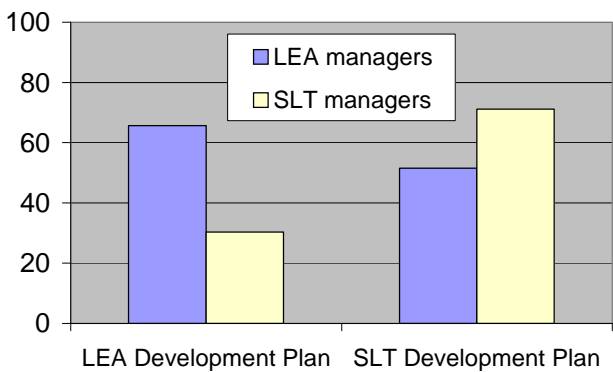

Figure 4.4   Percentage of managers reporting effectiveness ratings of joint planning meetings
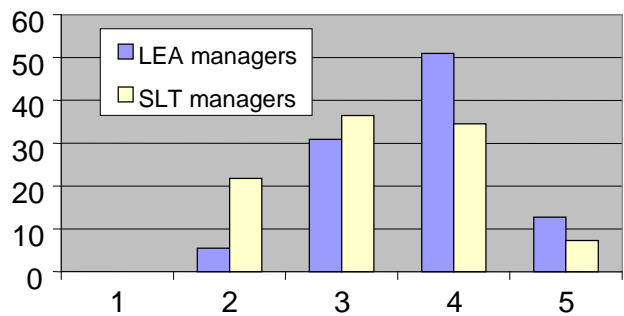
4.3   Inclusion

This section asked managers to report on any joint strategic plans with regard to the inclusion agenda, and the effectiveness of such plans.

4.3.1 LEA responses

The inclusion of children with speech, language and/or communication needs into mainstream settings was a priority for LEAs in 95.5% of cases. Of these, 65.2% said they were developing a joint strategy with the SLT service with regard to inclusion, and 94.8% (n = 36) gave these arrangements an effectiveness score of 3 or greater on a scale of 1-5. [Mean: 3.45; SD: 0.69; Mode/median: 3 (50%)] *(Figs. 4.5, 4.6, 4.7)*

4.3.2 SLT responses

In contrast, SLT managers reported that inclusion was a priority for their LEA counterparts in 84.6% of cases, but only 34.8% reported that they had developed a joint strategy to address the issue. Of the 20 case respondents who rated the effectiveness of joint planning with regard to inclusion, 75.0% (n = 15) gave it a score of 3 or greater, considerably fewer than the proportion who made the equivalent rating in the LEA

dataset. [Mean: 3.10; SD: 0.85; Mode/median: 3 (45.0%)]. *(Figs. 4.5, 4.6, 4.7)*

With two-thirds of LEA managers but only one third of SLT managers reporting a joint strategy with regard to inclusion, there was clearly an issue of definition.

Figure 4.5   Percentage of managers reporting inclusion as a priority for the LEA
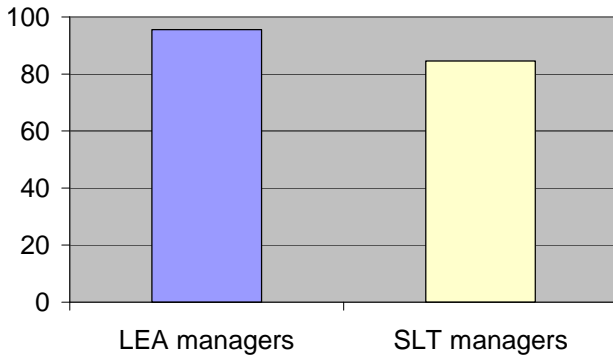
Figure 4.6   Percentage of managers reporting a joint LEA/SLT inclusion strategy
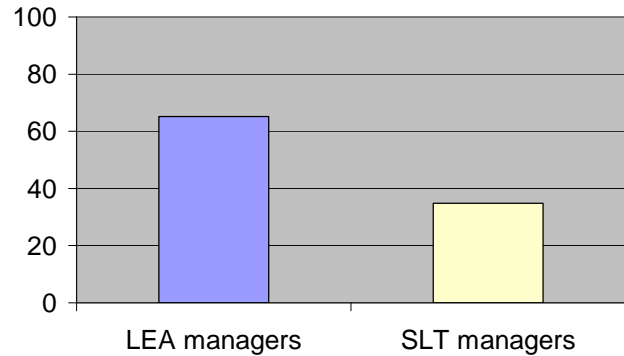
Figure 4.7 Percentage of managers reporting effectiveness ratings of joint inclusion strategies
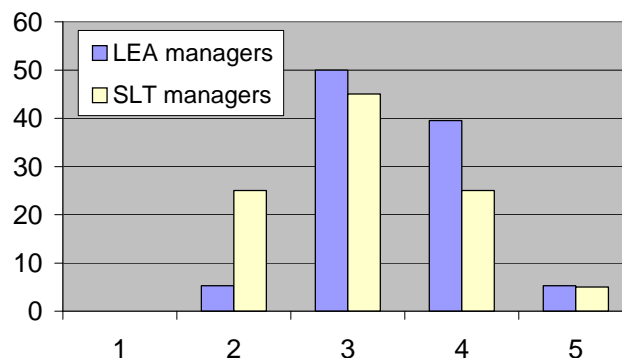
4.4   Service development at practitioner level

This section asked the LEA and SLT managers to give an indication of any collaborative work at practitioner level (e.g. joint meetings/working groups to discuss policy, develop criteria, etc.) and its effectiveness. Findings in this area were more comparable, although the LEA managers did rate the effectiveness of the meetings somewhat more highly than their SLT colleagues.

4.4.1 LEA responses

LEA managers reported that key education staff (e.g. educational psychologists, learning support services) met with SLTs to discuss policy, develop criteria, etc. in 90.9% of LEA/SLT collaborative pairs. 49.2% of these did this termly, with 40.7% meeting on an *ad hoc* basis. An effectiveness score of 3 or greater was reported in 96.5% of cases. [Mean: 3.72; SD: 0.73; Mode/median: 4 (50.9%)]. *(Figs. 4.8, 4.9, 4.10)*

4.4.2 SLT responses

From the SLT perspective, in 71.2% of SLT/LEA pairs were therapists reported to meet with key education staff. In the greatest proportion of cases (46.8%) this happened on a termly basis, while 42.6% met on an *ad hoc* basis. An effectiveness score of 3 or greater was reported in 83.0% of cases. [Mean: 3.40; SD: 0.92; Mode/median: 3 (38.3%)]. *(Figs. 4.8, 4.9, 4.10)*

Figure 4.8   Percentage of managers reporting practitioner meetings
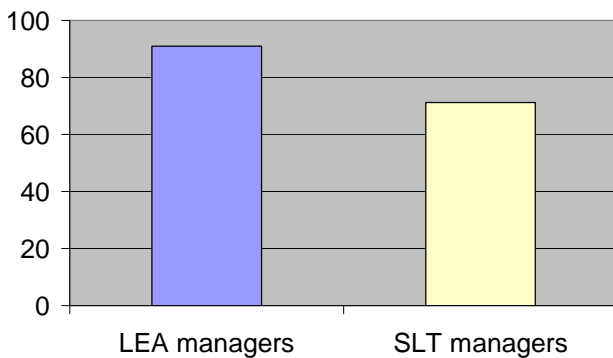
Figure 4.9   Percentage of managers reporting frequency of practitioner meetings
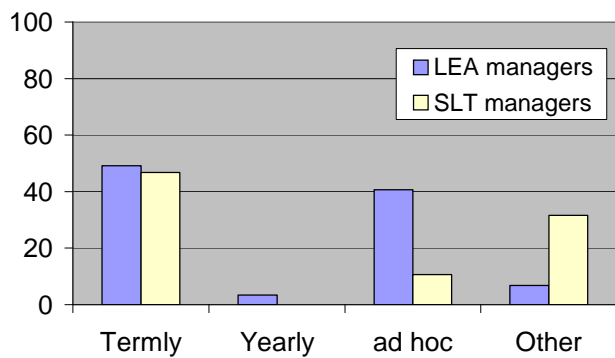
Figure 4.10   Percentage of managers reporting effectiveness ratings of practitioner meetings
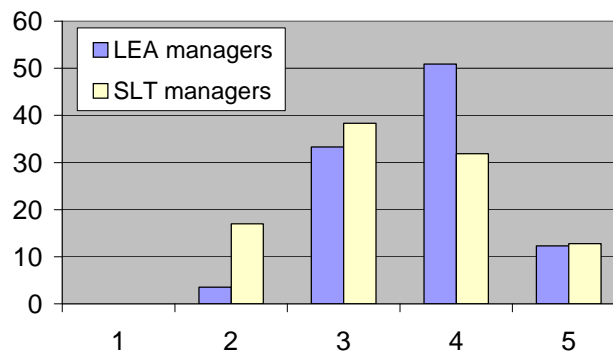
4.5   Operational issues

Managers were asked to indicate the existence of any quality assurance mechanisms (e.g. SLT outcome measures, progress with IEP targets, movement up/down the SEN register) and their effectiveness.

4.5.1 LEA responses

LEA managers reported the use of quality assurance mechanisms in over three-quarters (78.8%) of cases, with 74.9% of these having an effectiveness rating of 3 or greater. [Mean: 3.10; SD: 0.82; Mode/median: 3 (44.2%)]. *(Figs. 4.11, 4.12)*

4.5.2 SLT responses

According to SLT managers, 66.7% of cases had these mechanisms in place, of which 78.6% were given an effectiveness value of 3 or greater. [Mean: 3.21; SD: 0.90; Mode/median: 3 (38.1%)] *(Figs. 4.11, 4.12)*

NB. It appeared that respondents were rating their own quality assurance mechanisms, as opposed to those which were jointly devised. In addition, most reported the standard practice of reviewing IEP targets at a case by case level, but few referred to any mechanism for collating the outcomes of IEP targets across the LEA

Figure 4.11 Percentage of managers reporting use of quality assurance mechanisms
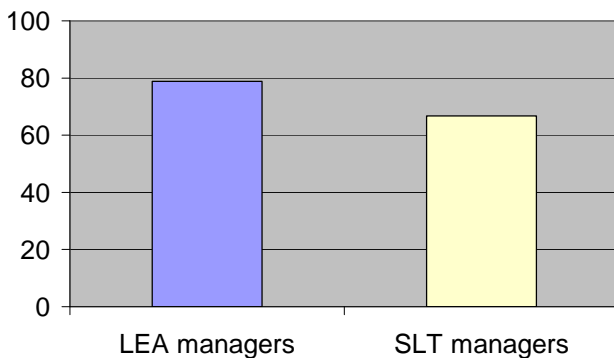
Figure 4.12 Percentage of managers reporting effectiveness ratings of quality assurance mechanisms
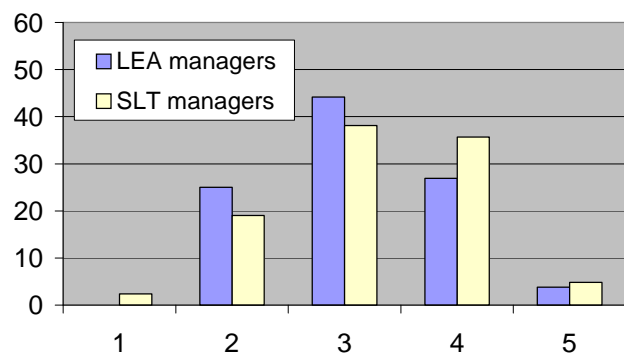
4.6   SEN placements panel

Managers were asked whether the SLT service was represented on the SEN placements panel (or equivalent) and about the effectiveness of such arrangements.

4.6.1 LEA responses

According to LEA managers, 31.8% of LEA/SLT pairs had a representative from the SLT service on their SEN placements panel. In cases where SLTs were represented, 85.7% of case respondents reported this to have an effectiveness rating of 3 or greater. [Mean: 3.38; SD: 0.86; Mode/median: 3 (42.9%)]. *(Figs. 4.13, 4.14)*

4.6.2 SLT responses

Similar figures were reported by SLT managers, although they appeared somewhat more convinced of the effectiveness of the arrangement. 31.8% of cases recorded SLT representation on the placements panel. Where this arrangement was in place, 90.5% gave an effectiveness rating of 3 or greater, with over half (57.2%) rating this as 4+. [Mean: 3.52; SD: 0.75; Mode/median: 4 (52.4%)]. *(Figs. 4.13, 4.14)*

**Figure 4.13 Percentage of managers reporting SLT representation on SEN placements panel**
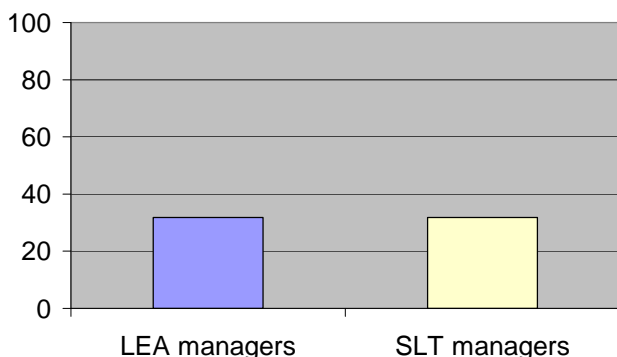
Figure 4.14 Percentage of managers reporting effectiveness ratings of SLT representation on SEN placements panel
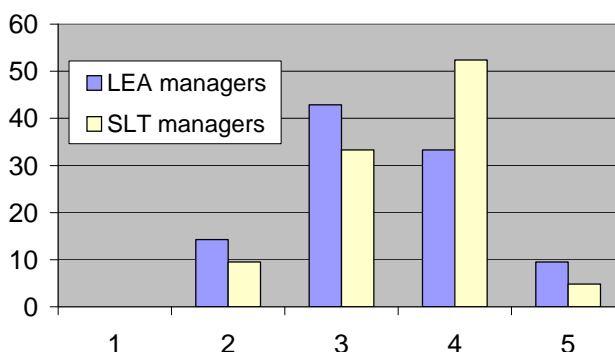
4.7   Continuing professional development (CPD)

Managers were asked to report on reciprocal and joint training arrangements for educational and SLT staff. These findings were comparable across the board, with SLTs rating the effectiveness of training arrangements only slightly more highly than LEA managers.

4.7.1 LEA responses

According to LEA managers, 30.8% of LEA/SLT pairs had staff who received joint training, and this was mostly on an *ad hoc* basis (57.1%), although 23.8% did so on a termly basis. *(Figs. 4.15, 4.16)*

They reported that SLTs did contribute significantly to the CPD of education staff (95.2%), but the reciprocal arrangement was less common (51.6%). The LEA managers reported these arrangements to have an effectiveness rating of 3 or greater in 85.9% of cases. [Mean: 3.56; SD: 0.95; Mode/median: 4 (35.1%)] *(Figs. 4.17, 4.18, 4.19)*

4.7.2 SLT responses

From the SLT perspective, 42.4% of LEA/SLT pairs had joint training arrangements for SLT and Education staff, with 82.1% of this occurring on an *ad hoc* basis. *(Figs. 4.15, 4.16)*

A large majority of SLTs (93.9%) were involved in the training of Education staff, with the reciprocal arrangement being in place in 65.2% of cases. The SLT managers reported these arrangements to have an effectiveness rating of 3 or greater in 88.6% of cases. [Mean: 3.59; SD: 0.88; Mode/median: 4 (49.2%)]. *(Figs. 4.17, 4.18, 4.19)*

(NB. Respondents may have been rating the training rather than the usefulness of collaboration)

Figure 4.15 Percentage of managers reporting jointly received training
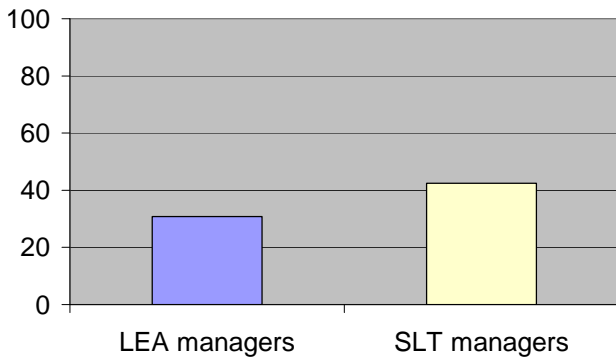
Figure 4.16 Percentage of managers reporting frequency of jointly received training
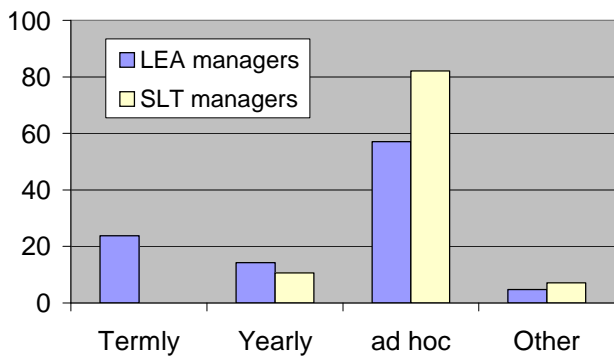
Figure 4.17 Percentage of managers reporting training of education staff by SLTs
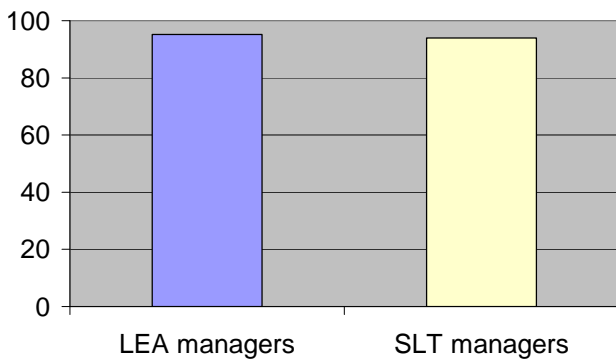
Figure 4.18 Percentage of managers reporting training of SLTs by education staff
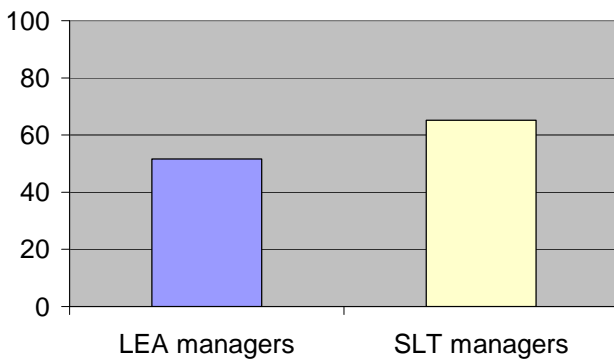
Figure 4.19 Percentage of managers reporting effectiveness ratings of joint and reciprocal training
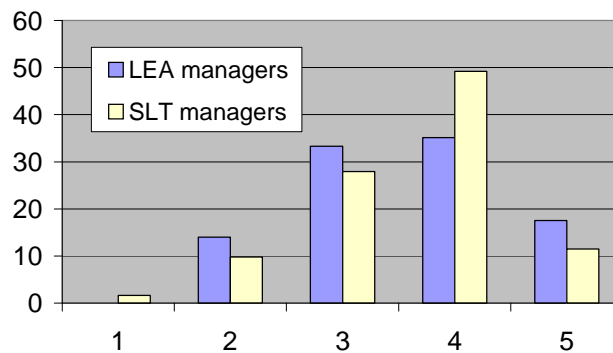
4.8   Adequacy of provision

Both LEA and SLT managers were asked to rate the extent to which the provision made by their collaborative partner(s) met the needs of children whose primary disability lay in the area of speech, language and/or communication, and/or who were identified on the Code of Practice.

4.7.1 LEA responses

In over two-thirds of cases (70.8%), LEA managers gave a rating of 3 or greater to SLT services for children with statements, and no services were given the lowest rating. [Mean: 2.92; SD: 0.76; Mode/median: 3 (52.3%)]. This contrasts with the rating they gave to SLT services for children at Stages 1-3 of the Code of Practice, where only 40.6% of cases were given a rating of 3 or greater, and no services were given the highest rating. [Mean: 2.45; SD: 0.78; Mode/median: 2 (53.1%)]. *(Fig. 4.20)*

4.7.2 SLT responses

Reciprocally, there was a similar pattern to the latter with regard to the satisfaction of the SLT services with the provision made for these children by the LEAs. In just over half (59.4%) of cases, the LEA provision was given a rating of 3 or greater by the SLT managers. No LEAs were given the highest rating. [Mean: 2.64; SD: 0.8; Mode/median: 3 (46.9%)]. *(Fig. 4.20)*

Figure 4.20 Percentage of managers reporting effectiveness ratings of joint and reciprocal training
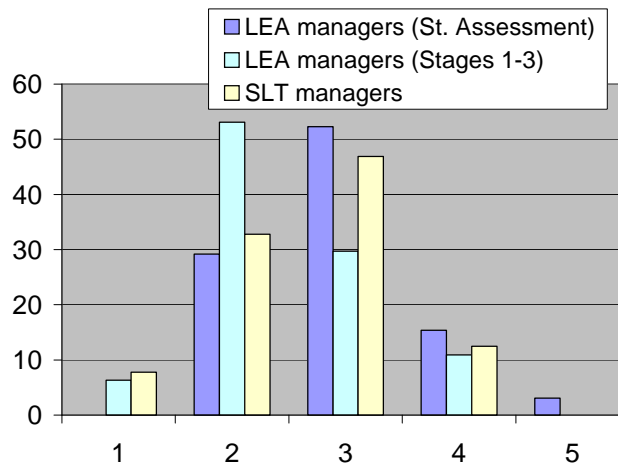
Chapter 5 - Managers' Viewpoints

Key findings

- LEAs and SLT services on the whole want to collaborate effectively.

- Various interagency fora exist, although these do not always relate specifically to SLT services.

- There are issues over what constitutes joint 'strategic' planning. Non-parallel organisational structures exacerbate difficulties in definition and communication.

- Parents are not at present routinely involved in strategic planning.

- Effective collaboration is underpinned by a shared philosophy, and a commitment to the process of joint problem-solving.

- Shared audit leads to information about pupil needs, as well as better mutual understanding.

- Non-co-terminosity raises issues of equity, as well as complicating the collaborative picture.

- Devolution of commissioning powers, i.e. to PCTs and Head Teachers, could increase the complexity of collaborative mechanisms and deepen inequities.

- SLT is not high on the Health Commissioning agenda.

- There is a call for increased clarity regarding responsibility and funding for therapy across Education and Health. A multiplicity of models currently exists.

- Various models of SLT service delivery operate within schools – highly collaborative sites emphasise the need for flexibility and are explicit about the "package" of therapy a child can expect to receive.

- Training and continuing professional development for teachers, SLTs and LSAs are considered a strategic priority.

Strategic Themes

5.1   The interviewees

The LEA managers who commented on strategic partnerships with their respective Health Trusts were positioned primarily at second or third tier within their LEAs. The second tier managers had titles such as 'Head of Services to Schools' or 'Head of Pupil Support Services' and most performed the role of Assistant Director. Third tier managers were typically SEN managers or advisers for SEN. Four Principal Educational Psychologists were interviewed, but their positions within the LEA varied from second to fourth tier, as well as their links with other services. A larger shire LEA had developed a structure that included the specialist role of Inspector for Language and Communication.

Most of the speech and language therapy managers in the case study sites were responsible for the delivery of 'cradle-to grave' SLT services to their local population. Alongside these overall service managers, therapists with a specific remit for one or more aspects of children's services were also interviewed, typically 'Co-ordinator of Paediatric Services', 'Principal Speech and Language Therapist (Mainstream Schools)', 'Chief of Paediatric Learning Disabilities'. Some interviewees were responsible for managing children's therapy services as a whole, i.e. Physiotherapy and Occupational Therapy, in addition to SLT. In sites where the overall management responsibility for SLT rested outside the service (at Directorate level), the Trust usually employed a Professional Adviser from within the SLT service. In a case in point, the Director of Child and Family Services and the SLT Professional Adviser chose to be interviewed together.

Seven Health Service strategic planners/commissioners were interviewed by telephone. Because of the current transition of commissioning responsibilities from Health Authorities to Primary Care Groups/Trusts, and to some extent, because of the low profile of speech and language therapy services on the commissioning agenda, identification of appropriate interviewees was often a challenge. Some participants were involved in the strategic planning of services with the Health Authority, others in commissioning roles within the PCG.

5.2   Service structures and processes

Most LEA/Trust pairs indicated a desire to work collaboratively and there was much goodwill expressed in the interviews.

One significant factor that emerged was the variation in service structures, notably the difference between smaller unitary or metropolitan LEAs and the shire counties. Similarly, SLT departments were characterised more by their variability than their consistency of structure and line management. Further to this, there were few parallels between the organisational structure of one agency and another *(Fig. 5.1)*

5.2.1 Joint fora

There appeared to be two main types of strategic interface between LEAs and 'Health': firstly, meetings aimed at the development of children's services as a whole, and secondly, meetings with a specific focus on the development of therapy services.

In the first case, officers within the LEA usually interfaced with representatives from the Health Authority (the strategic planning body and erstwhile commissioner of local health services) for the strategic planning of children's services. Sometimes one or more Trusts (the providers of health services) were also represented. These meetings had various titles, for example 'Joint Strategic Team', or 'Children's Strategy Group', and typical membership included the Director and/or Assistant Director of Education, a health commissioner and the Trust's Chief Executive or Community Paediatrician. One issue was that within such structures speech and language therapists were not always represented directly. There was a view within some LEAs, usually at second tier level, that the effective development of strategy demanded the involvement of the most senior personnel.

> '*I think we see the Children's Strategy Group as an important driving force…it is important that each Trust and each agency is represented at the highest level*' (Assistant director of education, London)

However, in some cases, it was the view of both speech and language therapy managers and LEA officers that the purchaser/provider split within the Health Service was confusing for some LEAs, and that educationalists were not always talking to the right people to get results.

> '*It isn't necessarily about having the Health Authority there, because that relies on the Health Authority talking to the Trusts, and that isn't there. If they invite the Health Authority then we try and muscle in so that the Trust hears it as well, and that has taken about 18 months to get over, but they are better now. They tend to ask the right people these days.*' (Directorate Manager, Child and Family Services, 'shire' Trust 1)

Even when Trust representatives were included in these strategic meetings, therapy managers sometimes felt that the people involved, usually medics, were in that role for historical reasons and were now ill-equipped to speak for them.

> '*There are meetings, but they have been really medical, and it's all the consultants who go. They don't always know how the therapists are thinking or working and I think that's been a gap…*' (Manager, Children's Therapy Services, 'shire' Trust 2)

The second type of strategic interface, evidenced in the more highly collaborative LEAs/Trusts, was that with a specific focus on the development of therapy services. This was expressed through joint strategic planning groups involving the Speech and Language Therapy Service itself. These usually met on a termly or quarterly basis, and typical participants were the Speech and Language Therapy Manager and/or therapist(s) with a managerial responsibility for children's services, the Assistant Director of Education, and one or two further officers from within the LEA, e.g. Head of Services to Schools, Head of SEN, Head of the Statutory Assessment Service.

In sites where there were several Trusts interacting with one LEA partner, groups had been formed to include the Assistant Director of Education, various other LEA officers, and the SLT Manager from each of the Trusts.

Health Authority involvement was generally less common at these meetings. However, in one site, the attendance of a representative from the Health Authority was an ongoing arrangement. In another, the Health Authority member was involved in the initial conception of the joint strategy, then withdrew until bids for further funding were made.

One proactive Trust/LEA pair had also involved their local Parent Partnership organisation in the strategy meetings.

Matters discussed at these therapy-focussed meetings included, for example, developing systems that would ensure equity of SLT delivery across Trust/LEA boundaries; joint development of provision; information-sharing about demands and opportunities facing each agency; joint development of training; and so on.

About half of the Speech and Language Therapy Managers interviewed reported the existence of these therapy-focused joint strategic planning groups. Most LEAs in the Phase 2 sample, however, reported no strategic involvement in the planning of therapy services. This contrasts with the study's findings from Phase 1, where 92.4% of LEA managers reported meeting with the SLT manager to discuss joint plans for delivery of services. There was clearly an issue over what constituted 'strategic' planning. Fixed-term inter-agency meetings had addressed specific problems as they occurred, but the need for a permanent 'instant consultation mechanism' between agencies was identified by both parties for joined-up thinking to work.

> *'There isn't actually a strategy group that meets, either the Health Authority or the Trust or the LEA…And the kind of thing that has happened has been sort of ad hoc approaches.'* (SLT Manager, Welsh Trust 2)

> *'It is a good idea to have some sort of regular forum that's agenda'd…Otherwise we're never proactive, we always have to react to something that Education have done.'* (Children's Services Manager and SLT Professional Adviser, 'shire' Trust 2)

5.2.2 Roles of key players

The role and status of the key players in a collaborative partnership had important consequences for strategic planning. In high collaboration LEAs where second tier managers had the explicit strategic role of 'Inclusion Officer', this was one of the factors which may have driven the agenda of change towards a model of therapy services operating in mainstream schools. In high collaboration LEAs where the Principal Educational Psychologist was a key player, such a position offered the advantage of influence over both strategic decisions and operational cultures.

The status of education managers was significant for driving things forward and this related to both their powers to make decisions, as well as their influence on the setting of priorities within the LEA agenda. Within Trusts, the Speech and Language Therapy service sometimes found it useful to have close links with their Directorate Manager, which then broadened their sphere of influence. In one Trust, the Director of Child and

Family Services was line manager for SLT staff, and also Vice-Chair of the Early Years Partnership between Health and Education,

> *'…which opens up a whole ream of people you can get access to much easier…'* (Directorate Manager, 'shire' Trust 1)

It was not always the case that therapy managers had less influence than their Education colleagues did. For instance, in one high collaborating Trust, the Paediatric Therapy Manager represented the Trust on several inter-agency strategy development groups, alongside the Consultant Paediatrician.

At operational level, key players were more easily identified and frequent meetings took place in the highly collaborative sites, often including the roles of SEN manager, principal educational psychologist, advisor for SEN, and speech and language therapy manager. Frequently two people who knew each other well were in a position to drive things forward; in some sites this was the Principal Educational Psychologist and the Speech and Language Therapy Manager. Managers expressed frustration about situations when the their counterparts attending such meetings were not in an equivalent role within their service structure, and were obliged to report back and consult before matters could progress. Part of the difficulty at both strategic and operational level was that the agencies did not have parallel structures, therefore identifying key players who had the necessary information as well as the necessary influence sometimes proved difficult. It will be noted from *Fig. 5.1* that the consultant community paediatrician is not usually in a direct line management relationship with the speech and language therapy service.

Health Authority

Health Service Trusts

e.g. Strategic Lead for Children's Services, Commissioner for Community Services

Trust Board
Executive & Non-Executive Directors
e.g. Chief Executive,
Medical Director

LEAs

Consultant Community Paediatrician

Directorate Managers,
Locality Managers

First tier — i.e. Director of Education

SLT Manager,
Therapies Manager,
Professional SLT Adviser

Second tier — i.e. Assistant Director of Education (eg. Inclusion Development Officer, Principal Educational Psychologist)

Chief of Paediatrics,
Mainstream Schools Co-ordinator,
Head of Schools Services,
Head of SEN

Third tier — e.g. SEN Officer, Principal Educational Psychologist, SEN Adviser

Fourth tier — e.g. SEN Officer, Principal Educational Psychologist

Typical group liaison:

Children's Strategy Groups

Therapy-focused groups

Fig. 5.1 *Organisational Structures (PCGs not shown). [NB. This figure shows typical structures only; some service structures may not be represented here.]*

5.3 Collaboration: driving forces

5.3.1 Shared commitment

Where joint planning had occurred at strategic level, one driving force was a strongly held belief by the managers involved that multi-professional collaboration is essential.
'Doing it together is better than going it alone' (SEN manager, shire LEA)

This commitment to 'joined-up thinking' was largely influenced by the values of individuals in key positions within the Trust, the LEA and the Health Authority.
'Personalities are crucial because it doesn't matter what systems you set up, if the people don't want to work together we can all say we've got our own priorities and look inwards. We do genuinely want to work together (here) and there isn't a blame culture.' (SEN manager, shire LEA)

The joint commitment of health and education managers to the processes of change was emphasised in highly collaborative partnerships. In some LEAs the local agenda necessitated potentially difficult change, for example reassuring parents that there would not be a reduction in therapy as a result of special school reorganisation. The willingness of the managers to work together to solve problems and generally 'take the rough with the smooth' was paramount.

5.3.2 Shared philosophy

Working towards a shared culture with the therapy manager was emphasised by several LEA managers in highly collaborative partnerships. The inclusion agenda was a strong driving force in many LEAs, managers articulating the belief that multi-agency working is essential to deliver an effective inclusive education. This was a mutual process with emphasis on the sharing of values about inclusion and how this related to mainstream-based models of service delivery and closure of clinics or special schools in some cases. LEA managers talked favourably of the SLT manager's position regarding working in educational settings:
'She was the kind of manager who would come and say, strategically now, "How do we manage my service actually working with education colleagues?"'
(Principal educational psychologist, metropolitan LEA)

Most of the speech and language therapy managers also acknowledged the inclusion agenda as significant. However, for those who had developed services into mainstream contexts, the belief that therapy was most effective when delivered in a child's everyday environment (be that mainstream school or special school) appeared to be at the core of their rationale, as much as inclusion per se.
'For years I've always felt that we ought to be delivering within the child's environment, that is, school.' (Therapies manager, 'metropolitan' Trust 1)

In other LEAs where high levels of collaboration occurred, the managers stressed the importance of language to curriculum success, believing that therapists could make a difference. Such values were influenced by a related background of the strategic manager, the high collaborators including a parent of a child with a language need and others with direct SEN experience. The SLT managers also emphasised the

importance of their education colleagues having a clear understanding of what speech and language therapists could offer in an educational context.

'Culture is changing in Education – they recognise that SLT is not a separate entity to what goes on in the classroom. They now recognise that it's all part and parcel of the child's development…' (SLT manager, Welsh Trust 1)

'[The LEA manager] has got a real interest and an adaptive understanding of children with language and communication difficulties, and she really values what we have to offer as professionals.' (SLT manager, 'metropolitan' Trust 2)

The need for a shared philosophy between the LEA and the Health Service was corroborated by the Early Years Development Manager of a well-known educational charity for children with speech and language difficulties.

'It only works where both Health and Education see speech and language impairment as a priority to them. We often get approached by a Health Authority who cannot interest Education at that moment or vice versa.' (Early Years Development Manager, I-CAN)

Without this 'shared understanding', therapists felt that they were 'talking at cross-purposes with key people' (Principal SLT, London). In order to effect real change, this philosophy needed to exist at the highest levels within the LEA.

'There is an understanding at the top that Speech and Language Therapy is something quite fundamental…' (Head of Children's SLT, 'shire' Trust 3)

By way of contrast, a second tier LEA manager in a situation of minimal collaboration was vocal about his mistrust of therapy and pointed out that he was in a position to block strategic change.

Figure 5.2 Factors influencing collaboration

Drivers	Helpful conditions	Blocks
Joint strategic group	Co-terminosity	Responsibility for therapy unresolved
'Joined-up' thinking	Small LEA	Boundaries
Shared vision/culture	Stable relationships	Instability and staff change
Inclusion	Process approach	Culture clash
LEA manager background	Good communication systems	Mistrust of therapy
High language need	Reciprocal awareness of agendas	Roles and hierarchies
Problem-solving		
Use of audit data		

5.3.3 Shared audit

Where LEAs made use of an audit tool to identify need, this was typically utilised at the time of the implementation of the Code of Practice in 1995, or following re-organisation into a unitary authority in 1997. Use of an audit strategy had the advantage of not only providing useful information about pupil need, but, where it had been conducted jointly by health and education staff, it had the additional effect of leading to better mutual understanding. There was a general feeling that it was important to understand the population before strategic direction could be agreed, and this included pupils at Stage

3 as well as Stage 5. An audit tool had also been used to gain information about the needs of teachers in mainstream schools, leading to the inclusion of training in the strategic plan. Many LEAs, however, had no mechanism to determine the needs of the population of youngsters with speech, language and communication needs and certainly no system that fitted with the data collection methods of the speech and language therapy service.

A recurring refrain from SLT managers, both in the interviews and the Phase 1 questionnaire, was that any audit they undertook had to be carried out 'by hand', due to lack of access to IT systems.

5.3.4 Parent power

The input of 'influential and clued-up' parents was acknowledged by all agencies as a force encouraging LEAs, HAs and SLT services to work together.

5.4 Collaboration: conditions

5.4.1 Co-terminosity

Conditions in which high levels of collaboration occurred between LEA managers and speech and language therapy managers included co-terminous boundaries, or situations where one LEA was co-terminous with two Trusts, and the Trusts had agreed between them a common approach to working with Education. When each agency had only one reciprocal partner, not only was the identification of key players easier, but the opportunity for relationships to develop increased. Size of LEA may also be a factor here since co-terminosity occurred in only smaller LEAs.

> *'The confrontation and friction and tensions that exist between the Health Trust and LEA…we don't see that in (place name) [because] we are a very small authority and we've just got one Health Trust'.* (SEN manager, unitary LEA)

One Health Authority and LEA who had entered into a joint-funding arrangement had taken advantage of the purchaser-provider split within Health to buy their SLT provision from only one source:

> *'The Health Authority and the LEA…decided they wanted one provider of services in the (place name) area, they didn't want two providers, they wanted to move forward.'* (Therapies manager, London)

5.4.2 Joint problem-solving

A factor that emerged consistently linked to high collaboration was the situation where the LEA and the Trust managers knew each other well and were committed to get together to solve a local problem.

> *'We're lucky, the hard core of speech and language therapists have stayed, we do know each other well'.* (SEN advisor, Wales)

This development of relationships and effective communication was more likely to occur when there had been stable staffing. Linked to this was what was described as commitment to a 'process approach', in other words both managers shared the belief that talking through problems together over time was likely to lead to better solutions.

'It is about being able to say, "Okay, things aren't working, how do we look forward?"…' (Principal SLT, London)

'Education have undergone restructuring, personnel have changed…so we're now at the point where we are having to nurture relationships again, but I think that's what you have to do…It's about having the time to spend with people so that there is an understanding, a shared thinking…' (Therapies manager, 'metropolitan' Trust 1)

The Health commissioners also commented that it was necessary to invest extra time in 'forging co-operative links'.

Successful collaboration in one Trust/LEA pair had been linked to stability at all three levels – on the ground, within middle management and at the 'ultimate' strategic level: '*It's almost like you put those three in place and things start to shift…*' (Principal SLT, London). Having said that, two other Trusts in situations of high collaboration had found that it was only when strategic management within the LEA changed to include some 'more flexible, positive thinkers', that fruitful dialogue could take place.

5.4.3 Reciprocal awareness of agendas

In high collaborating LEA/Trust pairs, a key theme which emerged was the awareness each partner had of the demands facing the other, in terms of central government directives, local political agendas and professional/service priorities, and a willingness to consider these when jointly developing strategy.

'I think there has been a recognition of a difference in terms of central directives between Education and Health…I also think there's a recognition that…it's only possible to achieve something through negotiating and giving ground on both points of view…' (Principal SLT, London)

'The purpose of [the meetings is] not just to review figures…but also to flag up any potential issues that may be occurring both from an Education and a Health agenda strategically…' (Therapies manager, London)

This reciprocal awareness of agendas was something that had to be worked on.

'There was a very low level of understanding when we set off…Although we had a good relationship, they (the LEA) had certain ideas and philosophies about how things were done…[There's been] a willingness to understand and a desire to move forward, however painful that may be.' (Paediatric SLT Co-ordinator, 'metropolitan' Trust 2)

One potential source of conflict was over children with and without statements. LEAs had to give priority to children with statements of special educational need, whereas the clinical needs of children who were not statemented may have been perceived as just as important by the SLT service. Some commissioners also felt that children with statements were unfairly prioritised. Those LEA/Trust pairs who had resolved this had been through a process of detailed discussion, '*going back to first basics in terms of what was it that both Health and Education…were trying to do.*' (Principal Educational Psychologist, London Borough). The Principal SLT in the same London borough reflected the view of several others elsewhere:

'There was a fundamental recognition that was the key turning point, that the only way we could make this work was to do something that was professionally viable…(in terms of prioritising children according to clinical need).'

The Educational Psychologist concluded that '*it was only possible to work this one out while working collaboratively…there was not a "single agency" route through, because of the nature of the problems.*'

Some SLT managers in situations of high collaboration could see opportunities for further joint strategic planning which had not yet been taken up, such as sharing data about children identified at a pre-school level who were likely to have special educational needs. These managers were keen to emphasise the broader input SLT/Health services could have to inter-agency strategic planning, a perspective shared by some of the Health commissioners.

5.5 Collaboration: barriers

5.5.1 Whose responsibility?

The most significant factor that hindered the process of collaboration was identified as the issue of 'ultimate responsibility' for speech and language therapy. The feelings about this were so strong in LEAs that this is dealt with separately (5.6).

5.5.2 Boundary issues

Next, the differing boundaries of Health Trusts and LEAs were reported to be problematic. Two situations arose, the most common being when the LEA had to deal with several Trusts (such as in shire areas), which resulted in complex, time-consuming arrangements.
> *'We've so many people to deal with, and spend so much time on process, there's not enough time for planning'.* (Inspector for LCD, shire LEA)

Secondly, some LEAs found that if their Trust partner also had to deal with other LEAs, the SLT manager had to consider equity of provision across LEAs, which could constrain the strategic direction[58]. In the most complex of cases, both situations existed simultaneously, i.e. one LEA had several Trusts to deal with, and some of those Trusts also had other LEA partners. It is interesting to note that of the 66 collaborative pairs identified in our Phase 1 sample, only nine were co-terminous.

Where a large LEA was dealing with several Trusts, sometimes the smaller Trusts in the arrangement felt overlooked.
> *'It might be by virtue of the fact that* (place name) *is such a small part of* (county)*, that we were an after-thought…'* (SLT manager, city Trust)

Health commissioners commented that the development of partnerships was less easy where PCGs were not co-terminous with Local Authority boundaries. One expressed

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[58] In a case in point, where one LEA was funding SLT input for autistic children and the other wasn't, two children served by the same Trust but separated by an education authority boundary received radically different levels of provision.

the view that if the boundaries of PCGs and district councils were co-terminous, it would encourage council involvement in Health Improvement Programmes.

Boundary issues caused further difficulties for SLT managers if two or more neighbouring LEAs had come to an arrangement whereby children would be placed in 'over-the-border' provision. If the placement also crossed 'Health' boundaries, SLT services were left in the position where they were not funded to provide a service to the incoming children, leading to gross inequity.

5.5.3 Organisational inconsistency

Considerable variability in job titles as well as positions within the LEA mirrored the concerns voiced by the speech and language therapy managers regarding the difficulties in identifying significant key players for the strategic planning of speech and language therapy services.

> '…you need to know who to go to for what…it takes you a while to find out it's absolutely no good talking to X, you need to go one step up or one step back.' (SLT Professional Adviser, 'shire' county)

Restructuring in either the Health service or in Local Education Authorities often resulted in staff changes, making identification of key players difficult and disrupting relationships. The need for continuity was emphasised for this sort of strategic planning:

> 'I do have certain contacts I hold onto, but if roles change I haven't a clear picture.' (SEN manager, shire LEA)

> 'We're in a state of flux, new networks will need to be developed'. (County SEN manager, shire LEA)

> 'We have quite a difficulty quite working out who's doing what [in the SEN Department] because they keep on shifting around.' (SLT manager, Welsh Trust 2)

Where strategic developments had started in the absence of a permanent joint strategic planning group, and LEA personnel then changed, therapy managers lamented that there was then no-one to 'carry the policy through'. Even in contexts where there was continuity of staff, if lines of communication and 'project leadership' responsibilities had not been clarified, the work would draw to a halt.

> 'Because [SLT] is a fringe thing [within the LEA], all of [the LEA managers] sort of meddle, but don't really make the effort to take [it] on board…' (Head of Children's SLT, 'shire' Trust 4)

The absence of a permanent therapy-focused strategic planning group in some areas had meant that therapy managers' attempts at collaboration with Education had been focused at an inappropriate level.

> 'I made the mistake of trying to target individual school heads and I felt quite isolated, like the outsider going in.' (Therapies manager, 'metropolitan' Trust 1)

It was implied that strategic support from the LEA would have facilitated communication with Head Teachers. Where this was lacking, the therapy manager often felt that 'the vision' was not effectively 'owned' by schools.

'We've been concerned about…how much of that (the joint strategy) was actually permeating down to individual schools [from the LEA]…It's still been very much individual therapists negotiating with individual teachers in individual schools…whereas I think we were hoping that it would be acknowledged [as] a good way to work for the county.' (SLT manager, urban/ 'shire' Trust 3)

There was a recognition from both agencies in the high collaboration sites that the commitment of Heads to an authority-wide system of SLT service delivery was 'crucial', in view of their increasing power over budgets since the devolution of funding to schools. There was also a view that the commitment of school governors was equally important, '*because actually the Head Teacher is accountable to the governors more than he is accountable to the Education Authority.*' (Paediatric Therapies manager, city/ 'shire' Trust)

5.5.4 Primary Care Groups

The recent transfer of commissioning from Health Authorities to Primary Care Groups (PCGs), and the imminent conversion of PCGs to Primary Care Trusts (PCTs), was causing both LEA and SLT managers some concern.

'At least with the Health Authority we've been talking to one body almost…I'm now having to look at how to keep children's services on the agenda for seven or eight organisations (PCGs) instead of for one (HA).' (Children's Services manager, 'shire' Trust 2)

Having spoken with the chairman of one of her local PCGs, one therapies manager reported that

'…they are worryingly not wanting to touch children's services with a barge-pole…simply because they do realise it is so complex and there are so many interface issues with other agencies…' (Therapies manager, London)

In one large rural area where two Trusts had just merged, there was some hesitancy to 'put a lot of work in' on standardising the SLT service across the county, in view of 'the next change which is on the horizon about PCGs'. Elsewhere, there was concern about GPs (the main professional group of commissioners in PCGs) possibly not wanting to take responsibility for the funding of SLT into mainstream schools, and not really understanding the 'SLT into Education' agenda. This was a view echoed by some Health Authority representatives, who felt commissioning GPs would have priorities other than SLT.

Generally speaking, Health Authority and PCG interviewees felt there would be little direct impact resulting from the commissioning transition. Some, however, saw advantages, e.g. the opportunity to respond more sensitively to local needs in view of the smaller population base, increased time to look at service outcomes.

5.5.5 Differing agendas across LEAs, Trusts and Health commissioners

Different strategic priorities
A culture clash was described by managers working in areas with low collaboration. The conflicting agendas of the Health Trust could be attributed to different legislative pressures: 'different strategic priorities leading to different directions.' The constraints placed on the speech and language therapy manager were cited as the central difficulty

by one LEA manager, who summarised the priorities of health service commissioners as the "4 C's":

> *'clinical, curing, coronaries and cancer'.* (County SEN manager, shire LEA)

The commissioners confirmed the view that the National Service Frameworks regarding mental health, coronary heart disease and cancer[59] took precedence over speech and language therapy when it came to allocating resources, 'because SLT is not top of any political agenda'.

Indeed, part of the difficulty perceived by SLT managers was that speech and language therapy issues were low on the agenda for both Health and Education agencies.

> *'We think that we're probably not a priority. They (the LEA) obviously have a big agenda, we tend to be fairly small-fry…'* (SLT manager, urban/ 'shire' Trust 2)

It was felt that other pressures often prevented authorities from looking outside of themselves, e.g. for LEAs, special measures, new unitary status; for Health Authorities, budget deficits. Indeed, in one case study site, a joint bid for funding from I-CAN had fallen through at the eleventh hour, because the LEA was having to make changes as a result of a poor OFSTED inspection.

Attitude of the Health Authority

It was interesting to note that when Health commissioners were asked about inter-agency strategic plans with regard to speech and language therapy, some referred to the Children's Services Plan, assuming this subsumed SLT. However, in most cases, there were no explicit objectives with regard to therapy services within the Plan.

One SLT manager said she found it "*a little disturbing*" that there was virtually nobody in her Health Authority with a professional background in health (as opposed to 'administration'). She felt the need to have a 'champion' within the HA who would promote speech and language therapy issues, because "*we are not a priority, never have been*". She reported that her greatest success in setting up useful contacts was when she had "*happened to meet somebody at a dance*". (SLT manager, urban/ 'shire' Trust 1)

Indeed one of the commissioners interviewed said he was "*probably one of the last Public Health Commissioners in the country…therefore my history of working directly with the children has helped to keep the profile of SLT high.*" (Strategic Lead for Child Health and Children's Services, 'metropolitan'/ 'shire' HA)

This tri-partite commitment was felt by many to be essential if service developments were to be successful. In at least two LEA/Trust pairs with high collaboration, there was frustration that their joint strategic plans had been blocked by the Health commissioner. In one case the Local Health Group (LHG) had refused to match LEA funding for a specialist speech and language nursery; in another, the LEA and SLT service had jointly presented the case for further funding to the HA, based on audit, but felt that their collaborative work had not been given the acknowledgement it deserved.

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[59] Department of Health (1998) *Modernising Health and Social Services: National Priorities Guidance 1999/00 – 2001/02*

Lack of consultation
For their part, SLT managers frequently cited examples of LEAs planning new provision with little or no consultation, which would have resource implications for the speech and language therapy service.

> '*They opened a unit for autistic children…without warning and then expected us to provide the therapy. It took two years for us to get the funding to provide a therapist for that unit.*' (SLT manager, urban/ 'shire' Trust 2)

Definition of client group
Definition of 'client groups' and 'clinical' priorities were seen to be other factors restraining collaboration between SLT services and LEAs.
> '*There's a lack of understanding [about our] clinical decision-making…one child might get lots of regular input and another child might just get consultative and they (the LEA) can't understand the difference…*' (Head of Children's SLT service, 'shire' Trust 4)

However, it was not always the case that SLT services had made their clinical decision-making processes explicit.

In one area where an education authority was employing its own speech and language therapist, the schools were determining which children the therapist should see, and appeared to have differing priorities:
> '*[Education] is looking at a different type of client to the ones that the SLT department is looking at.*' (SLT manager, urban/ 'shire' Trust 2)

Wider implications of speech, language and communication difficulties
More than one therapy manager referred to the link between adequate language skills and healthy psycho-social development, maintaining that many individuals and organisations with strategic power, from the Government downwards, were not consciously aware of the connection. The implication was that if resources were put into early identification and intervention for children with speech, language and communication needs, these children would then be diverted from developing secondary mental health problems, thus avoiding costly and unnecessary interventions in later life.

5.6   Responsibility for Speech and Language Therapy

The issue of greatest concern to all LEA managers relates to the current anomalous situation where the Health Authority have prime responsibility for speech and language therapy and receive the funding, but (where the child's speech and language needs are described in Part 3 of the statement) the LEA have ultimate responsibility, without the funding. This results in situations where, if Health is not in a position to provide the service that is expected by parents, LEA managers know that if taken to the SEN tribunal over non-provision, they themselves will lose, because the precedent was set by the famous 'Harrow judgement'[60].

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[60]   R. v .London Borough of Harrow ex parte M, 8 Oct 1996. (The judgement stated that "prime" responsibility for meeting a child's SLT needs as set out in Part 3 of the statement rests with the Health Authority. However, if the Health Authority do not have the resources to make the provision, as long as they have operated a clear prioritisation procedure, then "ultimate" responsibility to make provision rests with the LEA.)

'I feel very strongly about that. It is a complete nonsense that the law states that the LEA must provide what is in part 3 of the statement, and the SEN tribunal can direct us to make certain provision that includes SLT, but if then the Trust can't or won't provide it, what are we supposed to do?…I just find that so galling.' (Assistant director of education, London)

LEA managers found tribunals a costly waste of time over this matter, as they had no power over organisations other than the LEA. They felt 'frustrated' and 'vulnerable' and talked of the trust they needed to place in the therapy service because of the lack of control they had over the resources. They felt that the situation is 'unfair' and 'confusing to parents' who were not so much interested in who provided the service as long as it was delivered. They wanted action from the government on this, in terms of linking the responsibility for provision with the funding of therapy.

'We need supportive legislation to help us knock down a few of the barriers so that people can't retreat and say that is educational on that side of the line, and that is health on that side of the line'. (SEN manager, shire LEA)

When asked about solutions to this problem, there was agreement that the distinction between educational and non-educational provision should be dropped for speech and language therapy. Language should be accepted as an educational responsibility, therefore written in part 3 of the statement provided that responsibility for the therapy is with the agency receiving the funding. They wanted to avoid tribunals by giving parents local clarification of exactly what to expect from the LEA and what to expect from Health.

5.7   Funding models

There was considerable variation across England and Wales in terms of current funding arrangements for speech and language therapy, as indicated by the data in Phase 1. Some confusion surrounded the difference between direct employment of therapists by LEAs, and funding arrangements whereby the LEA hands over money to the Health Trust, who themselves manage and provide the service to school-aged pupils. In the case study sites, direct employment of speech and language therapists by the LEA was not found, although a small number of English LEAs are known to have developed such a model, so it is worthy of note that the data do not reflect this view. Some *schools* within the Phase 2 sites had, however, employed their own therapists.

5.7.1 Attitudes to funding

The range of attitudes to LEA-funded therapy mirrored the variation there was in funding models themselves. One LEA was reported to have adamantly taken the stance that they would not fund therapy, because the money to do so had been 'handed over' to the Health Service by LEAs in 1974.[61] Another LEA was committed to funding all school-based SLT provision, from Stage 3 of the Code of Practice (CoP) upwards, for children with specific language disorder and autism. There was a similar variety of opinion amongst SLT managers about this issue. One manager expressed the view that she was surprised that her partner LEA had 'got away with' not funding therapy for so long. Another said that her service was committed to delivering into education contexts, and saw any LEA funding as a bonus.

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[61] A reference to local government reorganisation, when SLT services were unified under the Health Service umbrella, rather than split between Health and Education as previously.

SLT managers reported resistance on the part of some health commissioners to commit funds to education-based services:

> *'They (the commissioner) said "The LEA are having enough of our time free already in schools"'.* (SLT manager, Welsh Trust 1)

In contrast, other commissioners had responded positively to bids for the development of services to schools. These arrangements were more often than not in tandem with funding from the LEA. One Health Authority reported that they were planning to set up a joint pilot with their co-terminous LEA, to determine who was the most appropriate lead commissioner of SLT for school-aged children. There was a suggestion that this role would best sit with the LEA. Generally, health commissioners described resource limitations as a major issue, the inclusion agenda being particularly challenging:

> *'Historically, we have found additional cash when statutory requirements changed, but it gets more and more difficult.'* (Health commissioner)

It is important to note that funding from the LEA was not necessarily a pre-requisite for effective collaboration, and not all interviewees saw lack of resources as a factor preventing inter-agency working (although at least two SLT managers described their services as being under-resourced per head of population).

Funding sources

Top-sliced Head Teacher budgets

LEA central SEN budget

Matched LEA/HA funding

What is funded

- ◆ Annual contracts: specific client groups
- ◆ Short-term contracts: specific objectives
- ◆ Training packages
- ◆ Sessions attached to specific children

Existing SLT resources
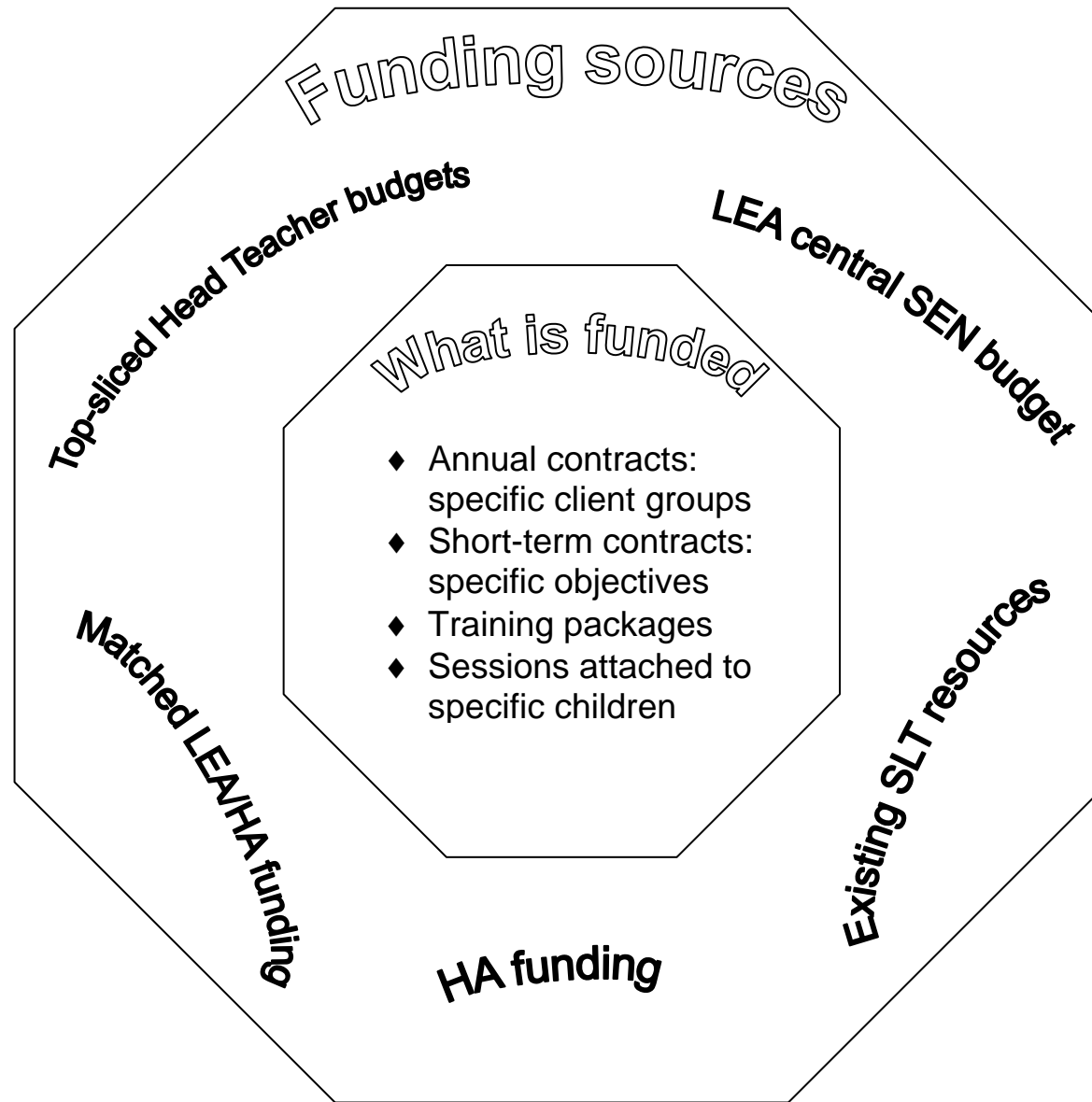
HA funding

Figure 5.3 Funding sources and 'projects' in the case study sites

5.7.2 Driving forces for LEA funding

Where funding transfer had taken place from the LEA to the Trust, driving forces within the LEA had led to this decision in some sites. For example an LEA inspection indicated language as a priority need in a unitary LEA, leading to central LEA funding of therapist posts. Concern from Head Teachers about slow rates of language development led them to agree to provide funding from their delegated budgets in one metropolitan LEA. In a London borough, a special school had agreed to the part-funding of a therapy post, but was nervous about the precedent it set. From time to time, LEA funding would come about because the education authority had created new special needs provision, but had overlooked the resource implications for the SLT service, so had agreed to meet the shortfall themselves.

5.7.3 Where funding was targeted and how it was sourced

Four main types of 'project' were the recipients of specific funding: renewable annual contracts for whole- or part-time SLT or SLT assistant posts for provision to specific client groups (with or without on-costs); training packages for education staff, usually LSAs; short-term contracts with specific objectives in mind (e.g. enhancing a school's signing skills to supplement use of a communication aid with a child); and sessions attached to specific children. (Fig. 5.3). Two or more of these arrangements could be found in some authorities.

The funding sources for these 'projects' also varied considerably. Many LEAs funded from a central SEN budget; in other cases, Head Teachers had agreed to an arrangement whereby the SEN budget devolved to them would be top-sliced. In situations where the Health Authority was also involved, arrangements took various shapes: some LEAs funded in the short-term, in the hope that the HA would bear the cost at some future point; others had joint commissioning arrangements protected through legal contracts. In one site, the LEA and the HA had agreed to match each other's funding for therapy posts and school nursing posts, with the arrangement that the funding would taper, such that one agency would eventually fully finance the SLTs, and the other the school nurses. Where the HA would not fund additional therapy, some SLT departments had had to take resources away from other areas of their service, as funding from the LEA was conditional on 'Health' matching the offer.

In addition, some LEA/Trust pairs had been successful in bidding for I-CAN grants, whereby the charity funded the establishment of a specialist speech and language provision, with the proviso that the LEA and Health service would bear the cost after a set time period. In the past, I-CAN made a fixed-term grant to meet the costs of the entire provision. Since 1999, however, LEAs and Health Authorities/Trusts have had to fund part of the provision themselves from the beginning, with I-CAN continuing to cover the employment and training of staff for a specified period. The I-CAN manager interviewed favoured this arrangement, as it led to an increased commitment from all parties from the outset.

In most of the situations where funding was LEA-sourced, the two agencies had set up Service Level Agreements (SLAs) so that both parties were clear about what the money was being used for. There were other SLT managers who used the funding flexibly for delivery of services into education at their own discretion, on the premise that as long

as input was provided at the level of expertise specified by the LEA, there would not be a problem. One SLT manager could see how this might be confusing for the LEA:

> *'There is lots of mixing and matching (of funding), which is difficult for the LEA…It is all being written out for them now.'* (SLT manager, Welsh Trust 2)

In some cases, funding arrangements were piecemeal, and had been driven largely by various tribunal cases, wherein there was an absence of strategic rationale. Some LEA managers even admitted they did not know how or why the situation had developed, referring to 'unknown historical reasons' and general lack of clarity about what they were paying for. Discrepancies between the reports of the SLT department and those of the LEA over the number of sessions being funded were not uncommon. There was also the problem of identifying who in the Health Trust to talk to in order to review a funding agreement, so the situation continued without review or an agreed direction.

5.7.4 Advantages and drawbacks of LEA/joint funding

Joint funding offered advantages: for example, the LEA was provided with a specialist service that was quality assured and met parental expectations. In terms of service delivery it offered potential to negotiate roles with the speech and language therapists in relation to specialist education personnel. From the SLT managers' point of view, joint funding placed speech and language therapy issues firmly on the LEA agenda, which could only be good for the children concerned.

There were some reservations about LEA funding, however. They fell into the categories of contractual arrangements, equity, pay and professional autonomy.

Contractual arrangements
With regard to contractual arrangements, LEAs would often fund short-term contracts or contracts renewable on an annual basis. This was a source of uncertainty for SLT managers and their staff, and managers often referred to the difficulty of filling posts for these types of contract, which were considered 'unattractive'. Managers also talked about the difficulties of becoming 'bogged down' in contractual arrangements. There was also the issue of whether contracts should be term-time only or year-round. Contracts linked to particular children were thought to be particularly problematic and contravened professional principles of offering an equitable service to all children, based on clinical priorities rather than funding.

Equity
Continuing with the theme of equity, in areas where one LEA funded therapy across several Trusts, the concern was how to allocate the funds equitably, when services had such different models of provision. One multi-Trust site had tried to address this by classifying their caseloads according to the same system, using the parameters 'severity/clinical need' and 'potential for progress'. However, consensus over definitions was not straightforward.

Reciprocally, the situation has already been described where one Trust received funding for autistic provision from one of its partner LEAs, but not the other, leading to two children within the same Trust boundary receiving radically different levels of provision. Not only was this thought to be inequitable for the children, it was felt to be unfair that one LEA should have to pay for a service, while another might potentially be able to get the same service 'free'.

The devolution of SEN funding from LEAs to schools raised some issues for SLT managers, namely whether all schools would be willing to fund SLT provision and/or training for their staff:

> *'Whilst there are clearly national frameworks for implementation in Education, and whilst the Local Authorities hold some of the money, the schools manage their own, and actually if they don't want to [fund], it's kind of hard to make them really.'* (Paediatric Therapies manager, city/ 'shire' Trust)

Managers also wondered whether Head Teachers would understand the need for particular specialisms within SLT, if they did decide either to fund therapy or employ their own SLT staff.

In one area, the devolution of funds had already resulted in the loss of flexibility of working for the LEA's peripatetic language support teacher. In the past, she had been able to run language groups at a central location (the local Health Centre) in collaboration with the SLT service. Now that all her time was committed to the schools, this was no longer possible.

Pay

Pay was an issue in areas where LEAs had funded the SLT service to train speech and language therapy assistants. The SLT services found that they invested time and effort into training the assistants, only to lose them to LSA posts within Education because the pay was better.

Professional autonomy

The fourth reservation expressed by the SLT managers with regard to LEAs funding therapy concerned the level of professional autonomy the SLTs would be able to maintain.

> *'There's a danger if you're employed (or funded) by Education…that you'll be pressurised into doing things that…you don't feel are professionally correct.'*
> (SLT manager, urban/ 'shire' Trust 1)

Linked to this was the experience of one Trust, whose reservations concerned the mechanisms by which funding was passed from central government to the statutory agencies. The Trust manager bemoaned the fact that any new money within Health was coming through to palliative care, intermediary care and adult mental health services.

> *'I'm fed up of being the person with no money and going cap in hand to Education.'* (Directorate Manager, Child and Family Services, 'shire' Trust 1)

In the same Trust it was felt that the LEA had the 'casting vote' over joint strategic developments because Education were providing all of the funding.

> *'(When) we're responding to…Education who've been able to secure funding from some form or other (sic)…we're not always necessarily in the strongest position to carry forward what <u>we</u> would see as a priority.' 'It's not an equitable relationship.'* (Professional Adviser and SLT manager, 'shire' Trust 1)

Lastly with regard to professional autonomy and priorities, some managers thought that if Education were responsible for funding therapy, the pre-school agenda may 'slip'.

5.7.5 Desire for clarification

There was a strong view that this 'messy' funding problem should be clarified, although opinion varied as to whether funding should be provided partly, or entirely, by Health or by Education. If from Health, the feeling was that funding needs to be protected for paediatric therapy services, as therapy cannot compete with acute services and preparing bids to the Health Authority is time wasting. If from Education, there are risks of short-termism if money comes from short-term grants, so a longer-term solution is needed. A few LEA managers argued for sole responsibility for the funding, stating advantages of having full power to deploy their own therapists where they would most be needed across the LEA. There could be advantage in giving delegated money to special schools, for example, provided that the money was ring-fenced for therapy. The majority, however, did not want sole responsibility because of their lack of experience of employing therapists, speaking of potentially 'messy' contractual issues. Mostly their reasons were related to the professional needs of therapists, as they recognised the experience of Health in providing direct support, ongoing professional development opportunities and the possibility of future career progression. These were reasons also cited by SLT managers for why they, in the main, wanted to stay employed by 'Health'. In addition to this was the need to maintain an overview of services, particularly across pre-school and school-aged provision.

> *'I would personally feel very strongly that I wanted to remain in the Health Service…because we have a very large service that provides lots of opportunities…I would want to maintain the integrity of the service across from pre-school to special school and mainstream schools…'* (Principal SLT, London)

In terms of potential funding models, standards funds bids were recognised as having been useful in the short term, but strongly criticised overall, and not providing a solution to the responsibility issue. They created opportunities for empire building as various professional groups could bid separately, which could lead to fragmentation of provision within the LEA. There were problems recruiting for a standards fund project since contracts were short-term and continuity was an issue when personnel started looking for new posts in good time before the end of a project.

It was agreed by both parties that joint funding/commissioning models have potential, and possibly a 3-way funding mechanism between Education, Health and Social Services. Such a model already exists for various services such as pre-school and home start. It represents a truly strategic model and has many potential advantages, relating to the model of service delivery within the LEA. How to protect funding for therapy services remains an issue, however, some arguing for ring fencing, but the level at which this should happen is unclear. LEAs could decide locally to prioritise funding for services to pupils with language needs, but some argued that there needs to be clarity from the government about the mechanism, and how it relates to the preparation of a joint strategic plan, otherwise school budgets will be squeezed:

> *'Unless the government directs additional resources into speech and language therapy through the LEA rather than the Health Authority, then it's going to have to come out of school budgets'.* (Assistant director, London)

5.8   Resource allocation

In relation to pupils with statements, LEAs operated various central systems of resourcing in order to allocate funds to schools. Banding systems included categories

of 'communication' or 'severe communication' in some LEAs, with differential amounts of funding attached. One model, jointly developed by speech and language therapists and education, was 5 levels of resourcing that took account not only of pupil need, but also of contextual factors relating to school readiness. Systems for pupils without statements were less clearly defined, although banding in some cases began at Stage 2 or 3 of the Code of Practice. Some LEAs had no system at all and the SEN panel was the only mechanism for gaining additional resources on a case by case basis. LEAs varied in terms of views on speech and language therapy attendance at such placement panels, only a handful of high collaborators agreeing that they should be represented.

One of the central predicaments faced by LEA managers was related to the usefulness of the statement for the purpose of allocating resources to pupils with speech, language and communication needs. There was a discrepancy between the LEA systems linked to the Code of Practice and the fact that speech and language therapists adopted a different system of prioritisation.

> *'Our dilemma here is that we work with pupils at Stages 3, 4 and 5 of the Code of Practice and the speech and language therapists work with anybody'.*
> (County co-ordinator, language and learning, shire LEA)

In an attempt to fit in with the LEA systems, some SLT departments had allocated their services on the basis of the Code of Practice, but this could lead to thinly spread services perceived as less effective by schools.

Devolving money to schools is at the heart of LEAs current agenda, but there was a warning that if LEAs do not have fair systems, there could be inconsistency and inequity in the way that schools decide to buy in services for pupils with speech and language needs.

For their part, the speech and language therapy managers had a wide range of approaches to allocating resources equitably across their caseloads. Some conceptualised 'resource allocation' at the level of spreading services across geographical areas, and responded to the interview question by discussing how they deployed their therapists into various localities and clinic sites (on the basis of waiting lists, deprivation, etc.) Others perceived the issue of 'resource allocation' to be at the level of the child. Nearly all services had devised prioritisation systems to determine whether a child should be taken onto the caseload post-assessment; fewer had developed explicit systems for determining the relative urgency of therapeutic intervention, or for deciding how much and what type of input a child could expect to receive. Therapy managers justified this by asserting the need to remain flexible in terms of provision, allowing therapy to be linked closely to the needs of a child at any given time. One manager felt that the professional judgement of her therapists was enough:

> *'The way services are delivered in special schools is entirely at the discretion of the therapist. They deliver in very different ways.'* (SLT manager, urban/ 'shire' Trust 1)

Scoring methods were used by some services to allocate children to broad levels of intervention. A low score would indicate discharge from the service; a medium score would result in advice to the caregiver and review; and a high score would indicate a priority for therapy. Some services operated "packages of care" or "management level"

systems to specify the service a child would receive. One service described their system as 'very prescriptive', with levels of input set at twice a week, once a week, twice per half term, three times a term, and once a year at Annual Review. Use of the sessions varied between one-to-one therapy, training sessions, setting targets and working with the LSA to differentiate the curriculum. The management levels were audited on a termly basis, and each child's level adjusted according to their needs. The knowledge of the school, the severity of the child's difficulty, the training needed and how often new resources needed to be taken into the school were all taken into account. This method of resource allocation had been dovetailed with an existing system of moderation within the LEA.

One service had adopted a strategy where therapy took the form of highly specific episodes of care, with clear time-bound objectives. At the end of an episode of care, the child was usually discharged, with the onus on the caregiver or school to re-refer if they felt the need. This meant that waiting lists were kept to a minimum. Another service was just going through the process of evaluating the effectiveness of therapy in special schools, with a view to re-deploying resources. They had just done the same with their services to pre-school provision, in response to resourcing challenges precipitated by the LEA opening many more nurseries.

Nearly all services said that their clinical prioritisation was not dependent on whether the child had a statement, although in practice, where school-based prioritisation systems specified that support in school had to be available, this usually meant an LSA 'attached' to a statement.

5.9 Training and continuing professional development

The strategic place of continuing professional development programmes varied considerably: in some sites it was clearly a key priority linked to the inclusion agenda, whilst in others it lacked strategic direction and different services within the LEA and 'Health' offered programmes based on operational relationships. Collaborative training plans devised jointly by therapists and education staff had emerged for many reasons. For example, an audit in mainstream schools revealed extensive misuse of terminology by teachers about language, leading to the development of a course about language development and IEP target setting. Training as a strategic priority was agreed in one LEA in response to the increase in tribunal cases over direct speech and language therapy. Another LEA made a plan to prioritise SENCO training following concern about increase in referrals to speech and language therapy and a query regarding the appropriateness of identification.

Standards funding was reported as a factor that helped the establishment of collaborative training plans for SENCOs, mainstream teachers and learning support assistants, although some expressed disappointment at failed bids and at the short-term nature of this system.

5.9.1 Training for teachers

Accredited training was part of the strategic agenda in many LEAs. There was agreement that teachers with specialist roles should be encouraged to pursue extended specialist training in the area of speech, language and communication difficulties. Several advantages were reported when teachers had undertaken advanced diploma level courses. They were useful in contributing to LEA training programmes for

mainstream staff, they could model skills in mainstream schools, and one LEA manager felt it gave an advantage to the LEA at tribunal cases when parents insisted on 'speech and language therapy' in part 3 of the statement. This LEA manager was, however, confused about the status of a diploma course for teachers, assuming erroneously that it was equivalent to the qualification gained by a speech and language therapist.

Accredited training for mainstream teachers was described also as a strategic priority by some LEA managers. This training was shorter in length, up to a maximum of one or two term's duration. Either teachers attended an accredited module at a local university, or a locally delivered course that had been awarded accreditation. Most LEAs, however, had no strategic plan to address the training needs of mainstream staff, despite the fact that inclusion was acknowledged as a driving force to target this group. SLT managers felt that pre-qualification teacher training should encompass more about language development and the role of the speech and language therapist.

Teachers employed to work in I-CAN provision were expected by the charity to have 'considerable experience' in working with children with speech, language and communication needs. In addition, a variety of I-CAN training courses were available, mainly aimed at integrating speech and language work with the curriculum. The Early Years Development Manager for I-CAN suggested that courses for teachers needed to be at times convenient to this professional group, and could potentially be modular or incremental.

5.9.2 Training for LSAs

Training for learning support assistants was identified as a growth area by most LEA managers. Concern was expressed about the considerable responsibility given to this large group of unqualified people.

> '…how to provide effective training for learning support assistants who historically have little training but work with the most needy.' (Principal educational psychologist, unitary LEA)

This was a view echoed by I-CAN's Early Years Development Manager, who felt that children with speech and language needs had a right to be supported by LSAs with specialist training. In fact, the status of LSA training varied considerably, some LEAs seeking accreditation at NVQ level, with others delivering local courses of variable length. The SLT managers also emphasised the importance of accredited training for LSAs, to acknowledge the skilled and valuable role these people had in the delivery of services.

The purpose of the training depended on the identified role of the support assistant. Where the role was distinctly specialist, in supporting the delivery of speech and language therapy programmes, typically speech and language therapists were involved in the planning and delivery of the course. Teachers and learning support assistants were encouraged to attend jointly in the case of mainstream schools. The need for flexibility in the delivery of such training was stressed, a programme delivered 'in bites' to ensure accessibility by this group of people.

5.9.3 Training for SLTs

Training for speech and language therapists about education was identified as a key area. One LEA manager described the 'shock' of therapists moving from a clinic to an

educational culture and suggested that it be addressed within their initial training. The need for key national agencies to identify the educational component of speech and language therapy courses was emphasised. One SLT manager also felt that newly qualified therapists were not equipped with the collaborative skills required for working in schools, nor the confidence to advise on strategies that they themselves had not experienced using:

> *'I think we are trained to be…in total control and autonomous and work independently.'* (Therapies manager, 'metropolitan' Trust 1)

Most SLT managers thought their staff would benefit from further training about curriculum issues, but one felt it was better learnt 'on-the-job' with the specific curricular context of the child in mind. There was a mixed reaction to the suggestion of a dual teacher-therapist qualification for all SLTs working in Education: some felt it would resolve some of the difficulties in defining role boundaries; others felt it would fragment therapy services and saw potential difficulties with pay and career structures.

Both SLT and LEA managers were generally committed to a collaborative training model, but some challenges were outlined in setting out a strategic plan for training. First of all, potential role conflict because of the involvement of several interested parties, with varying professional perspectives, namely speech and language therapists, educational psychologists and specialist teachers. Issues of role clarification and potential overlap of services needed to be addressed in order to overcome the tendency to be 'precious'. Next, the strategic difficulty of getting groups of people together to design a collaborative programme was time-consuming, especially in larger LEAs dealing with several Trusts. In areas of high collaboration, the SLT service advertised courses on a regular basis in the LEA's INSET menu.

Devolution of funding was viewed variously as either an opportunity or a threat for the strategic planning of training. The increased delegation of funding to schools means that Head Teachers now have the money to purchase trainers directly, including the potential employment of speech and language therapists. This model was not reported in the case sites, but fears were expressed of a potential imbalance in the system where some SLT services would provide training for free and some would levy charges.

5.10 Parents

Routine involvement of parents in strategic level planning was not reported in the case study sites. Consultation took place at the working group stage of the development of a plan, where there was an identified group of interested parents, such as locally organised groups like 'Communicate', or 'AFASIC'. Some managers expressed regret about not including parents at earlier stages of planning. For example, in one LEA it could have facilitated change from a clinic-based to a mainstream model as it would have raised awareness of the rationale for change. One fear was that parents would have difficulty handling the difference between representing their own child and representing the whole group of parents.

By contrast, parents were involved on the steering groups for the development of any new I-CAN provision, and all such services had to have a scheme for supporting parents individually or in groups.

A strategy used in some LEAs was to conduct a survey of pupils' parents at stage 3, triggered either by the educational psychology service or parent partnership officer. This contributed to collaborative developments such as a project for pupils with autistic spectrum disorders, and the writing of a series of information booklets about language learning in the home. However, even in one site of high collaboration, where parent representatives had been included on a joint strategic planning group, the SLT managers thought that the LEA still did not really understand the meaning of 'parent partnership':

> *'I think yet there's a long way to go for people of an Education background to understand that if you collaborate, you can't be in charge…I think the Authority still creates for parents the opportunities it thinks parents would want.'* (Professional Adviser, 'shire' Trust 1)

LEA managers commented on the high expectations of parents from the LEA. There was agreement that 'velcro-ed' therapy was seen by most parents as the 'magic solution' and that the system allowed them to go to tribunal to achieve this by getting it written in part 3 of the statement. LEA managers clearly wanted this situation resolved altogether as it created anxiety for them as well as the family. At least one LEA/Trust pair addressed this problem by attempting to be 'transparent'. This was expressed through very clear messages about the criteria for who was eligible for statutory assessment; terminology agreed between the agencies to describe a child's needs/provision; and presentation of a jointly devised cover sheet on the front of the statement explaining the SLT department's model of service delivery.

> *'It's important for parents to see that we're all working together for the child, not having arguments between ourselves about interpretations…'* (SLT manager, 'shire' Trust 1)

Parents' expectations about individual therapy led to a blockage in the system sometimes, in the transition from language unit provision to mainstream school, when a significant reduction in therapy became apparent.

LEA managers identified the main challenge in strategic terms to be how to prove the effectiveness of speech and language therapy to parents if the model changes from clinic to mainstream setting and from an individual to a consultative model of support.

> *'The issue is how to persuade the parents that they don't actually have to have hands-on therapy by a qualified, trained, expensive therapist, and that the programmes can be provided by the therapist, there can be ongoing advice and monitoring, but the actual delivery can be done by someone else.'* (Assistant director, London)

Second to this was the need for consistency of messages from key personnel, as they felt that parents became confused by different recommendations from various services. This view was further corroborated by the interviewee from I-CAN, who felt that the way to engage parents was to value their contributions and to give them 'the opportunities, the models and the confidence' to participate.

5.11   Welsh issues

The only strategic matter raised in the case sites that was a specific issue for Wales related to funding. The standards fund system is restricted to England and this was felt

to be a significant discrepancy by a manager whose LEA had decided to fund speech and language therapy without DfEE support.

Operational Themes

5.12   The interviewees and service structures

The LEA managers who commented on operational matters relating to the provision of services for children with speech, language and communication needs included co-ordinators of support services, SEN officers/managers, principal educational psychologists and one specialist educational psychologist for language and communication. One support service manager had management responsibility for the day to day operations of two speech and language therapists and two specialist language teachers within her support team. The speech and language therapy manager in this case maintained the overall professional management role for the therapists.

Within speech and language therapy services, it was usually the same interviewee(s) who had responsibility for both strategic and operational management of the service.

5.13   Operational partnerships: factors that help

Within the high collaboration group there were LEA/Trust pairs that had a tradition of joint services in schools, so, in these sites, operational roles and responsibilities were relatively well defined. More recent models had emerged as a direct result of additional funding for speech and language therapy, either from Head Teachers within a cluster of schools or from the standards fund, and whilst this was welcomed by operational managers, they made it clear that long-term planning necessitates alternative sources of funding. In one high collaborating LEA, protected time of two days a week had been given to an operational manager whose dedicated responsibility was to develop services for pupils with language and communication needs (shire LEA).

In LEA/Trust pairs where there was a sharing of responsibilities across the various services, and there had been negotiation of roles within the SLT/education team, several factors were at play to make this work well. A shared vision was key where it was based on a joint commitment to work in an educational context (where this was appropriate), whilst remaining flexible according to the needs of the population. Commitment to change was a key credential for managers, accepting that people's perception may need to change in order to achieve the shared vision.

Physical location of teams was a factor; therapists and specialist teachers who shared premises such as within an Education Centre were found to be able to communicate more effectively. Indeed, good systems of communication at all levels were considered essential, not only between the therapists and teachers but also between senior managers and practitioners, so that the direction of developments was fully understood. An understanding of each other's roles arose from talking together and negotiating how best to work together, which took time that needed to be prioritised.

5.14   Operational partnerships: factors that hinder

Recruitment of speech and language therapists was reported as a significant factor that got in the way of effective operational partnerships. Managers emphasised that it was not just a question of recruiting any therapists but people with the right attitudes, namely a willingness to work in classrooms and mainstream schools, as well those with particular skills, for example bilingual therapists in Wales. Not that values are a fixed phenomenon, the power of the speech and language therapy manager to influence the attitudes and confidence of her team was recognised. Retention of speech and language therapists added to the problem; staff turnover in therapy teams presented difficulties at school level whereby relationships were disrupted and time-consuming processes of assessment and programme planning had to be repeated.

When asked how the recruitment and retention problems could be addressed, there was a view amongst LEA managers that the use of speech and language therapy assistants provides a useful supply of stable personnel, although their role and training need to be carefully planned. Another belief among LEA managers was that offering therapy employment contracts within the LEA could help recruitment, provided that professional development opportunities and support were available. In contrast, many SLT managers felt that there would still not be enough therapists available, no matter who recruited them.

Systems that were rooted in historical relationships between the LEA and the Community Paediatricians or Medical Officers were another factor which made communication between the LEA and the SLT department difficult. Chief amongst these was the procedure for requesting advice for statutory assessment. In some areas the request was sent to the community paediatrician, whose responsibility it then was to pass the request on to the SLT department. Completed advice was similarly returned to the LEA via this route. Naturally, this built in an unacceptable delay to what was already a tightly time-constrained process, which did nothing to facilitate positive working relationships between therapy services and the LEA.

The issue of decision-making over placing children in special needs provision also arose. While many therapists were happy with the way the LEA allocated places, there were some reports, particularly in relation to Language Units, of the LEA either increasing the number of places in the provision without reference to the SLT service (thus putting a strain on SLT resources) and/or children arriving in the unit who were completely unknown to the SLT service.

Cultural differences between health and education personnel were found to block operational partnerships. LEA managers were highly critical of Trust managers who seemed to be locked in a clinical-medical model. The problem of non-attendance at clinics, and procedures whereby the child can get lost within the system (e.g. discharged due to DNA ['did not attend'] policy), worked against the principle of social inclusion. Within this model there was also the issue of limited communication between the therapist and the mainstream school; the school was disadvantaged by limited knowledge of the programme or appropriate techniques to use during the school day.

There was agreement by both LEA and SLT managers that a tension exists between the LEA inclusion agenda and the effective delivery of speech and language therapy services. Inclusion had been the driving force, in the perception of some LEAs, to

negotiate a shift from clinics to a school-based speech and language therapy service. For the SLT manager, the issue was often 'schools vs. clinics', as opposed to 'mainstream schools vs. special schools', although of course, greater inclusion presented challenges for the system, namely the difficulty of stretching the service over large numbers of schools, especially in view of the only measure of speech and language therapy service activity by the purchasers being number of face-to-face contacts with children. For example, one SLT service reported serving 30 children in ten schools 3-4 years ago, whereas now they were serving 40 children in 39 schools. LEAs and SLT services had been creative in finding solutions to this problem by collaborating with each other in the development of flexible working models.

A summary of factors supporting and hindering operational partnerships is given in Figure 5.4

Figure 5.4 Factors related to operational partnerships

What makes it happen?	What helps joint work?	What hinders joint work?
Tradition of joint working in schools	Shared vision/aims	Recruitment
Additional funding	Commitment to change	Retention
Management time	Joint location of teams	Cultural differences
	Communication systems	Inclusion
	Role clarification	
	Time to plan/solve problems	

5.15   Models of SLT service delivery in Education

In case study sites where speech and language therapy services were committed to working in educational settings, there was nonetheless considerable variation in models of service delivery. One issue surrounded the definition of terms used to describe the process of working in educational contexts. The terms 'consultative' and 'school-based' were used a great deal by interviewees from both LEAs and SLT services, but without a clear consensus across sites on the meanings of the terms. Distinctions can be drawn between 'consultative' work and 'hands-on' work; between 'school-based' work and 'clinic-based' work; and between 'curriculum-based' work and 'impairment-based' work, to name but three continua. It should be noted however that these continua need not be mutually exclusive, e.g. a service could conceivably offer a consultative model from a clinic base.

Examining the data of the high collaborators, where good operational partnerships were reported, a number of factors were clearly at play, serving to support or hinder such models.

5.15.1 Role clarification

Whilst role clarification across services was needed to avoid conflict, the high collaborators emphasised that this was not simply a question of job descriptions and service agreements, but a matter of engaging in joint processes. For example, several LEA/Trust pairs arranged joint study days where problems could be defined together and solutions suggested. Participation in such processes led to shared understanding, the beginning of using the same language to talk about working together and agreeing

goals. There was a view that current job titles should not constrain or limit the negotiation of potential roles:

> *'What I would really be interested in seeing are teams of people who have different training, whether it's in psychology, education or speech and language therapy, and they become a team, and then they forget what their title is in that team, they just do the job. I don't really like to see the carving up, that's really a job for the therapist or that's really a job for someone else. There needs to be a debate, but it may be appropriate for another member of the team to go in there'.* (Specialist educational psychologist for language and communication, shire LEA)

Several SLT/LEA pairs had devised, or were considering devising, systems designed to avoid duplication of work by professionals with overlapping skills. In the main, these involved education and SLT colleagues jointly categorising referrals according to severity, through an agreed moderating process. In one particular example of this sort of approach, the Educational Psychologist was then responsible for giving advice to schools about mild cases of speech and language difficulty, the language support teacher took responsibility for those with moderate difficulties, leaving the SLT to work in schools with the most severe/complex cases. This had the effect of very successfully cutting waiting lists for all parties.

5.15.2 School-based models

School clustering was a strategy used to overcome the problem of over-spread services in mainstream. Where clustering was widely used within one shire LEA, therapists fitted into the system by targeting groups of ten schools in a cascade model. An example of its use in a more focused way was in a unitary authority that targeted a group of schools with high language need. The therapists conducted clinic-based assessment and programme planning and liaised with each school's SENCO. The intervention was school-based, delivered by speech and language therapy assistants employed by the LEA, and supported by a link therapist.

A school/curriculum-based model of operation was preferred by LEA managers committed to inclusion, which may be contrasted with a clinical/medical model that continued to operate in some areas, whereby pupils were withdrawn from classes for individual therapy.

> *'Speech and language therapy should be delivered in mainstream because that's where the curriculum is'* (SEN officer, shire LEA)

This 'inclusive' model of therapy was defined as working in support of existing curriculum frameworks, such as within the literacy or numeracy hours, and involved the writing of programmes jointly with the class teacher, who knew the pupil best, where feasible. The benefit of such a school-based model was seen as not only for the pupil on the current caseload, but, more significantly, in terms of the longer term gains for the school, especially where the knowledge, understanding and skills of the SENCO were enhanced. SENCOs were thus seen as potentially key players in the effective delivery of therapy within schools, in an inclusive model.

5.15.3 Consultative models

Some SLT managers were strongly in favour of combining the above school-based model with a totally consultative one, whereby schools would be expected to fully

develop their own skills in helping children with speech, language and communication needs access the curriculum. In some areas, the vision was that schools would be able to devise their own IEP language targets with minimal intervention from the SLT service, using already-published material which broke curriculum targets down into small stages. The onus would then be on the school to contact the therapy service when they felt they needed more specialist support. The drawback with this model, as the same SLT service pointed out, was that schools varied greatly in their ability to judge when they *did* need further input:

> *'Some schools are really good at that…and some schools we think, "Oh, they probably do need something, but they're not contacting us."'* (Paediatric co-ordinator, 'metropolitan' Trust 1)

Another manager in a situation of high collaboration was not convinced that the consultative model allowed for the unique and specific skills of the speech and language therapist:

> *'There's a danger…if we go down the consultative model too much that we actually become teachers…that we've left the therapy bit behind.'* (Paediatric therapies manager, London)

Other managers commented on the compromise they had to make when operating a consultative model:

> *'Occasionally children will come up that really in your heart of hearts you feel you should be doing more for.'* (Head of Children's SLT service, 'shire' Trust 4)

Very few services operated a totally consultative model, i.e. with no hands-on work at all – most who worked in this way also modelled therapy techniques with individual children to education staff as part of their intervention.

LEA managers also saw that the consultancy role had advantages and disadvantages. They felt it provided a better value service since the therapist was released from the responsibility of delivering the programme. However, they saw the greatest benefit to be for the school since it could take ownership of meeting the children's speech and language needs and should develop skills and confidence over time. In one LEA, these two factors were what had precipitated their funding and the training of LSAs by the SLT service. The principal drawback was thought to be that schools could have less face to face contact with the therapist, so relationships could be harder to develop. This was overcome in some LEA/Trust partnerships by adopting a system where therapists worked in blocks of time in each school, for example focused contact for 6 to 8 weeks, working with class teachers and the SENCO. From the SLT viewpoint, liaison time, particularly with SENCOs, was considered vital, and schools who released teachers from their classes for this purpose were considered favourably.

5.15.4 Flexible models

SLT managers in high collaboration sites were themselves in favour of delivering therapy in the child's educational context, referring not just to the appropriateness of integrating language/communication targets and the curriculum, but also to the social development opportunities offered by the school environment. However, in one service heavily committed to school-based delivery of SLT, with excellent collaboration, it was nevertheless felt that there were times that they needed to offer therapy in a highly controlled context:

'Sometimes we need the clinic to actually target something very specific…like a particular aspect of comprehension skills…which you can try and address in school, but in my experience it's not always completely successful…' (Paediatric co-ordinator, 'metropolitan' Trust 2)

The vision of this SLT/education team was to have a mainly school-based service, but with the option of a clinic service for children (wherever they were on the Code of Practice) for time-limited blocks of therapy to meet specific targets. The aim was that the children could then move flexibly between one type of service delivery and another as their needs dictated.

Many therapists identified particular client groups as more appropriately receiving their therapy in a clinic context, children with stammers and cleft palates being the most often cited. However, it was generally felt that if a child's difficulties were impacting on their ability to access the curriculum, then the school environment was the most appropriate location of service delivery. For services not delivering in this way, resources were seen as the main constraint.

'I'm not convinced that taking children into clinic is the best way of doing it, but sometimes that's the only way we can do it.' (SLT manager, urban/ 'shire' Trust 1)

A feature of the high collaborating LEA/Trust pairs was what a principal educational psychologist in London referred to as the 'creative flexible response', in other words making the best use of both services to meet the needs of the population. This was clearly related to the systems used to identify the needs of the population in schools. In some LEAs an audit tool was used, but this demanded expertise on the part of the school as well as the LEA. Another question was whether the audit should be targeting children only on stages 3 to 5 of the code of practice, or earlier.

'As awareness is raised then children are being identified earlier…they're actually identifying more children who were having difficulty accessing the curriculum, because they (the children) just don't understand what's going on in the classroom.' (Special Needs Service Manager, unitary LEA)

The process of audit in this LEA was a victim of its own success in that so many children were identified that the manager felt that the evolving systems within the support services would need to adapt to respond to three groups of children: those with general access needs who were not on stages of the Code of Practice; those at Stage 3 who needed therapy input; and those with complex needs.

Figure 5.5 gives a summary of factors supporting and undermining speech and language therapy service delivery into education.

Fig. 5.5   Speech and language therapy service delivery in education

Works best where:	Works less well where:
Agreed SLT/education roles	Role tensions
SENCO key player	Staff turnover
Curriculum/peer contexts	LSAs untrained or unavailable
Blocked time in schools	Clinic model in schools
Population identified	Infrequent visits to schools
Flexibility	Population unclear
	Prioritisation systems unclear

5.15.5 Difficulties and challenges

In many LEAs there was no system to define the needs of the population in schools, particularly in those without a specialist language and communication dimension within their support services. Involvement of therapists was largely in relation to children on the Code and a risk of under-identification was acknowledged. In low collaboration LEA/Trust pairs another factor was the absence of a service agreement to outline roles. Managers were generally critical of models where the therapy input was sporadic, either because of recruitment and retention problems, or because of the model itself (for example, a quick termly visit followed by a programme that arrived several weeks later, and where there was limited time to liaise with teachers). Where a programme was left in school to be delivered by a classroom assistant, there were doubts expressed about the reliability of the training of this person.

The joint management of speech and language therapists within education raised many operational issues. In the site where they were managed within the support service (metropolitan LEA), cultural differences had been addressed at the contractual level, for example holiday entitlement within term time, who paid for travel and who to report to in the case of sickness. Contractual arrangements for training were negotiated separately, who delivered training and who attended whose training and when.

5.16   Learning Support Assistants (LSAs)

In sites that ranged across all types of LEA (unitary, metropolitan, shire, London borough and Welsh LEAs), increasing responsibility was given to learning support assistants (LSAs), and LEA managers sang the praises of speech and language therapy managers who supported this model of service delivery:

> *'We've had an openness about service delivery, the (speech and language therapy team) are willing to come and work in schools, they're willing to look at training up learning support assistants, they're willing to look at the delivery of speech and language therapy programmes through a learning support assistant in school, which I haven't come across in every authority I've worked in'.* (SEN manager, unitary LEA)

From their perspective, many SLT managers insisted that an LSA should be in place, in order for a consultative model to be successful. SLT prioritisation systems frequently included criteria relating to the level of support available in school, and this more often than not translated into the presence or absence of an LSA. The problem for many services was that, since the use of the SEN budget was at the school's discretion, the

availability of LSAs varied considerably from one situation to another. Policy on this also varied from one LEA to another, with some routinely providing LSAs for children at Stage 3 of the Code, while others did not provide until the child had a statement. This had the artificial effect of forcing SLT services to prioritise children according to whether they had a statement or not, when some of those same services maintained that prioritisation was by clinical need, not by statement. In some cases, school-based work with children considered by the SLT team to have a high clinical need was made very difficult:

> *'We're finding increasingly that the children that we prioritise who've got specific speech and language impairment aren't getting statemented and therefore haven't got an LSA. The statemented ones…jog along quite nicely because they have the LSA…particularly if it's a more global difficulty. It's just the more specific (language impaired) ones that are the issue.'* (Head of Children's SLT service, 'shire' Trust 4)

It would not be too much of an exaggeration to say that some SLT services had made the decision about whether to operate a consultative service partly on the basis of the availability of LSAs.

Many key issues emerged about expectations of the role of the assistant and readiness to undertake these duties. The title of 'speech and language therapy assistant' was felt to have advantages over 'learning support assistant' because it implied specialist skills and this was important for gaining parental confidence. Traditionally, SLT assistants (SLTAs) have been employed by Health Trusts and have had 'on-the-job' training in the delivery of speech and language programmes. In fact, there now exists an NVQ specifically for the recognition of the skills of SLTAs. LSAs, by contrast, are variously employed by education authorities or the schools themselves, and although many LEAs recognise a need for accredited training for them, this is not yet standard practice. Not insignificantly, there is a discrepancy in how much SLTAs and LSAs are paid, with the wage for LSAs being more attractive than that for SLTAs.

The role of the LSA varied from direct delivery of individual therapy programmes to group-work on social skills. Speech and language therapists were thought to be key to preparing them for such roles, sometimes by a model of formalised training but mostly by modelling and transferring skills:

> *'The LSA would work for say 6 or 8 sessions with the therapist coming in so they could actually build up their skills…then after 6 to 8 weeks that therapist could then move to another school and she would have left in place a certain model that the school could follow with the next group of children coming in'.* (SEN advisor, Wales)

The support for the school would then be gradually reduced over subsequent terms as the school staff gained in competence and confidence. It was a concern for some SLT managers that LSAs should have had more training than teachers about speech and language problems, which could lead to an imbalance in skill mix in the classroom.

Changing to such a model of service delivery via unqualified personnel places responsibility with both Health and Education to evaluate its effectiveness. A senior LEA 'inclusion officer' in a shire LEA suggested that this could be achieved by schools conducting small pieces of action research in response to the inclusion index, involving elements of not only the school ethos but practical delivery of the curriculum.

5.17 Support Services

LEA managers commented on the changing role of support services as a result of increased delegated budgets to schools. One effect was considerable reduction in specialist support with few services having specialist teachers for speech, language and communication. A specialist teacher was generally regarded to be a person who, ideally, had completed extended training (advanced diploma) in the area of specific speech and language difficulties. Operational managers saw their role as having responsibility within the team to attend on-going training and they were used as a resource to feed back information to colleagues. They were also key players in LEA training on language and communication. It is interesting to note that all the LEAs that employed specialist teachers were in the high collaboration group, and they had evolved integrated teams of therapists, specialist teachers and educational psychologists regardless of who funded the therapy.

Another result of the changing role of support services was the difference in the nature of the support, namely a shift from a model of direct contact with pupils with language needs to that of fulfilling a role for the LEA as well as the school. The LEA role was twofold, firstly to assist with needs analysis related to children with speech and language needs, and here it was paramount to develop systems that complemented those of the therapists. Secondly, they provided a monitoring role so that systems of resource allocation could be checked across the authority, but in relation to this function therapists were not involved. Finally, the role potentially dovetailed again with that of the therapists in providing advice and support to schools, in setting appropriate targets and programmes for individual pupils. Where support services had been disbanded, the SLTs perceived a corresponding rise in the reliance of schools on their expertise.

There was significant variation in how resources were allocated from support services to schools. Where the system was based on the stages 3 to 5 of the Code of Practice, this was seen as 'very unhelpful' and potentially unfair for pupils with speech, language and communication needs who could be denied access to support services.
> *'We want to obviate the need for them to have to go through to have statements really.'* (Support Service Manager, shire LEA)

The problem of the relevance of Code of Practice stages was overcome by a system where the support service manager wrote to schools each term to ask about speech and language needs, in response to which speech and language support time was allocated. The disadvantage of such a method was the possibility for inequity as it depended on the awareness of the SENCO about speech, language and communication needs.
> *'The fairness depends on the level of insight and knowledge that the SENCOs have got and how together they are in requesting this service.'* (Support Service manager, London)

In the site where two speech and language therapists were integrated within the support service model, the funding had been top-sliced from schools' budgets. The Head Teachers were therefore significant stakeholders within this model and the Support Service Manager was engaged in processes of consultation about systems of prioritisation.

5.18   Training and continuing professional development

Collaboration in the planning and delivery of training was seen to have several benefits at an operational level, not least the extent to which it contributed to a better mutual grasp of complex topics:

> '…getting a common appreciation of people's understanding of things such as "is a semantic pragmatic disorder the same as autism?", those kind of issues.' (Special Education Manager, shire LEA)

Working together on course delivery also created opportunities whereby understanding of each other's professional potential was realised, leading to better use of each other's skills. A variety of models of training were described for developing expertise in schools, just one being the formal delivery of courses at a recognised centre. Topics for central training or formal sessions in schools ranged from understanding pupil needs, how best to access the curriculum, and also how to use specialist techniques. The aim of such programmes was to transfer the expertise to school staff. Both LEA and SLT managers saw value in a hands-on model of training whereby therapists worked alongside teachers and learning support assistants to model techniques in schools. The 'blocked' model of therapy, where schools received intensive input for a period of several weeks was thought to be effective in transferring skills to school staff. Networking between schools was seen to be a useful strategy to overcome the fear and lack of confidence in schools of including children with significant language needs.

> 'What we want to try and set up now is networking between schools, because I think networking with other colleagues across schools who are dealing with the same kinds of children is INSET probably, in the richest sense.' (Principal educational psychologist, metropolitan LEA)

Figure 5.6 gives the typical content of LEA/SLT training courses

Figure 5.6 Content of LEA/SLT training courses

Topic	Example
Understanding pupil needs	Autism
Curriculum related	Literacy hour, history, geography
Specialist techniques	Makaton, communication aids, social use of language, Hanen

5.19   Parents

Operational partnerships involving speech and language therapists and education often centred on work in the early years. For example one SLT/LEA pair described their 'language promotion groups', where parents were referred by health visitors and attended a language enrichment group run jointly by an educational psychologist and a speech and language therapist. Another area of joint intervention was the development of intensive schemes for parents of pre-school children with autistic spectrum needs. The only complaint was that such schemes were fragile, as they were funded by short-term grants from the single regeneration budget.

Operational managers in LEAs where a mainstream-based service was delivered, saw their primary challenge to be sharing with parents the benefits of a model where a school-focused team had the expertise, and included a range of dedicated

professionals with different roles: class teacher, SENCO, specialist teacher, educational psychologist and speech and language therapist. There was agreement that there was a lot of work to do to convince parents that the benefits of such a model were equivalent to, if not better than, individual therapy. Furthermore, where the therapist supported an assistant to deliver the programme there were additional issues in helping parents to understand the advantages of this approach.

Therapists working in school-based services generally rued the loss of contact with parents. Where therapists were based within the LEA's Special Needs Service, there were some conflicts over whether contact with parents, such as the sending of reports, should be made directly (as SLT professional guidelines suggest), or through the school (which is the more usual route in an education context).

5.20 Welsh Issues

There were three issues raised by Welsh SLT and LEA managers that related to operational matters. Firstly, the geographical nature of a Welsh county limited the model of speech and language therapy provided in mainstream schools, because of the extensive cost of travelling for a peripatetic service. Next, the contribution of bilingual speech and language therapists was reported to be valuable, but recruitment and retention was a problem. This was addressed in part by employing bilingual speech and language therapy assistants, working through bilingual staff in schools, or borrowing bilingual therapists from other parts of the SLT department, e.g. acute services. Otherwise therapy in English was said to be 'not satisfactory'. Added to this, was the fact that assessment material was predominantly in English, resulting in translation of tests, and this raised issues relating to parental confidence. The problem is being addressed nationally in Wales: for instance, in response to recommendations by the All-Wales SLT group, Cardiff University is trying to set up a post-graduate qualification in speech and language therapy, restrained only by availability of funding.

An inspection of the other Phase 2 data reveals that the aforementioned issues are concerns of LEA managers in England too; bilingualism in London and other metropolitan cities, for example, and the spread of services in large shire LEAs.

Chapter 6 - Practitioners' Viewpoints

Key findings

- Collaboration at practitioner level is effective where:

    - the professionals involved have a clear understanding of each other's roles;

    - therapists are prepared to take account of the educational context;

    - teachers understand the importance of language to the whole curriculum;

    - school systems support therapists' involvement, e.g. liaison time, well-planned SEN meetings.

- Both therapists and educationalists feel time pressures prevent optimum joint working.

- In sites where roles have been formally negotiated, duplication of work is avoided, waiting lists are reduced and consistent messages are presented to parents.

- All professionals feel better access to training would improve their reciprocal understanding; jointly received training is perceived as particularly useful.

- Therapists feel they have less influence on the SEN assessment process than their education colleagues.

- A range of options for SLT support are available in high collaboration sites; most involve some modelling component for education staff.

- Equity of service provision is felt to be an issue where resources are limited.

- Both teachers and therapists regret not having more time to involve parents

6.1   Introduction

Speech and language therapy practitioners were interviewed in small groups of between two and six people. The therapists worked with a wide range of client groups (autistic spectrum, cerebral palsy/physical disability, cleft lip/palate, hearing impairment, learning disability, specific language impairment, etc.) and in a variety of settings (e.g. child development centres, community clinics, pre-school facilities, mainstream and special schools). All of the therapists had worked with class teachers and educational psychologists, with varying levels of intensity (through phone/letter contact, meetings and/or in ongoing team-work). Where LEAs employed language teachers, the therapists had also had liaison with these professionals. The educationalists included mainstream class teachers, language unit/resource base teachers, language teachers based centrally (usually in an SEN support team), teachers with a special interest in language impairment, SENCOs (from both primary and secondary phases) and educational psychologists.

In the discussion below the responses of educationalists and therapists are grouped separately. Understandably, it was easier to find the voice of the speech and language therapists, and commonalities across interviewees, because they represented a single professional group. It was more difficult to have one professional group within Education (for example, educational psychologists) speaking for others, because their

responses were heavily determined by their own experience of SLTs, which may have differed one from another, or in some cases may have been limited.

Many of the respondents were aware that colleagues in Health or Education were having to respond to a range of initiatives that they did not necessarily share. These have been outlined in Chapter 1 above, but the areas thought to be particularly relevant in Education were the introduction of the National Curriculum, literacy and numeracy strategies, the inclusion agenda and what was seen as 'the OFSTED culture'. The corresponding initiatives in Health which were seen to have an impact were the idea of the purchaser/provider split and the role played by primary care trusts/groups. The internal market in the Health Service was no longer in existence at the time of the interviews but a number of educational professionals commented on problems that arose when the body paying for the service was different from the body providing it.

6.2   Collaboration between speech and language therapists and class teachers

Therapists and teachers were asked to describe how they saw their respective roles in relation to children with speech, language and communication needs.

6.2.1 Strengths

For the teachers, the key issue was whether the SLT was prepared to make an effort to become a part of the school culture and this meant understanding the pressures of the classroom. In high collaboration sites, speech and language therapists and teachers saw themselves as having complementary roles, with each having skills and knowledge that they could bring to ensure a more holistic provision for the child. Many referred to collaboration as a joint problem-solving exercise, with the therapist bringing knowledge about communication and how the child's skills could be improved, and the teacher bringing knowledge of the education system and the classroom context.

Some teachers had clearly had a very positive experience of collaboration.
> *'I think our collaboration with the speech and language therapy service and theirs with us is really good…It works well all the time. There's nothing nicer than seeing one of the assemblies with [the SLT] doing all the signing and encouraging the children to speak clearly and open their mouths. It makes me feel really useless.'* (SENCO, unitary authority)

But the emphasis was almost invariably placed on the attitude of the SLT – there were those who did want to be involved and those who were more reluctant to be so.

The therapists put the success of this collaborative relationship down to four main factors, the most heavily emphasised being the teacher's knowledge and understanding about the role of the speech and language therapist. Other factors included an open, equal relationship, where it was 'safe' to be honest about what was and wasn't working; the time for liaison; and the attitude of the teacher to special needs as a whole:
> *'With SEN, it works well where teachers have some personal view that change for that child is necessary and possible – they have to accept it as their responsibility. If that is not in place, collaborative working is difficult.'* (SLT, London trust)

This last factor was linked to the 'SEN culture' of the school, and a positive attitude on the part of the teacher was usually to be found in schools which accepted SLT input as

integral to their functioning, and had created systems to allow for this, e.g. class cover to free up liaison time, involvement of the therapist in IEP meetings. In addition, the presence of an identified link person within the school helped to keep SLT on the agenda:

'You have so little time in school, that if you can have one member of staff who can work with the rest of the staff on your behalf, a link person, is very useful. That then keeps the communication issue to the fore.' (Clinical Co-ordinator, Mainstream Paediatric services, urban/ 'shire' trust 1)

Educational practitioners also identified a number of key benefits. Teachers with a special interest in communication particularly liked SLT expertise regarding speech and language, their willingness to share ideas, their contribution to the curriculum and specialist intervention expertise in areas such as feeding. The SENCOs were very positive about the additional parental perspective offered by the SLT, and the LSAs valued detailed programmes, learning resources brought by the SLT and specific tips on training certain activities notably related to speech sounds. They highlighted the need for a good knowledge of respective cultures and pinpointed some very specific issues related to physical working arrangements and joint time tabling of meetings.

Some therapists felt that their own adaptability contributed to the success of collaboration: they talked of 'overcoming' the medical model background to work in the educational model, and the need to be flexible in their response to the differing levels of commitment and skills in different schools. Reciprocally, therapists felt that it was also important for them to understand the pressures on the teacher, and not to make unreasonable demands on them. This knowledge was felt to have been acquired through working in an educational context.

'Working in schools has given me a greater understanding of the demands on the teacher and the classroom setting and the National Curriculum and where we can jointly work to set more appropriate targets. I found that when I was working more in community clinic, I didn't really fully understand the education system.' (SLT, 'metropolitan' trust 2)

Where therapists did spend more time on school premises, they had greater opportunity to make use of 'incidental' time (e.g. during breaks, at lunchtime) to engage in informal liaison with their teacher colleagues, which helped to foster better relationships.

6.2.2 Difficulties

In less collaborative sites there was some indication that the SLTs and education practitioners knew less about the potential role of the other party.

SLT understanding of the educational context
For the teachers, the main difficulties arose out of the speech and language therapists' lack of knowledge about the classroom and the curriculum. A number observed that this knowledge base had expanded in recent years but it remains an issue and the question was raised as to the extent to which educational practice was integrated to the basic training provided for speech and language therapists.

'The therapist I am working with this year works in a way very different to the way I have worked with the previous nine therapists. She does a lot of

withdrawal which is very unusual these days. You don't find many who work in that way.' (SENCO, Shire LEA)

Where it remained common practice there were clearly concerns.
'The whole point of getting kids in there (mainstream school) in the first place is to make them a part of the mainstream class. So by taking them out and bringing them back in again and having them have a bit of one to one with the lesson being introduced to them all over again but separately, that kind of defeats the object a bit.' (Mainstream teacher, metropolitan LEA)

Relevant targets and programmes
Teachers were clear that they benefited most from demonstration of intervention techniques and they did not welcome the practice identified in some schools of providing lists of activities, written programmes, which were out of the context of the main classroom activity. Similarly IEP targets written by therapists working in a clinical context were seldom meaningful and tended not to be adopted. In these cases, the specialist language teacher could act as a link between the therapist and the class teacher.
'Well, I think the children are getting a really good deal but I would think that it's heavily dependent on liaison. You know, it would be really good, it's a part of my job to make sure that the class teacher knows the (speech and language therapy) targets for the children.' (Specialist teacher, shire LEA)

Work pressures
While it was relatively straightforward to identify the key features of good practice, it was equally clear that the educationalists considered themselves to be under a lot of pressure and that when this became too great collaboration was likely to break down.

From the point of view of the speech and language therapists, difficulties in working collaboratively with teachers fell into four main categories: school attitude, teacher understanding, contractual issues and time.

School attitude
Therapists in all of the case sites, without exception, said that there was a huge variation from one school to another, both in their attitude to SLT, and in their ability to meet the needs of children with language difficulties. Collaboration was difficult where it appeared that the school did not have clear policies and procedures for SEN work.
'The situations that work well are where the school has their SEN needs under control themselves, so they seek your advice, invite you to the IEP meetings...it's where those things aren't in place in school anyway that it's really very hard to work, to give them programmes, to meet, everything becomes difficult then.' (SLT, London trust)

A common complaint was that some schools did not inform SLTs about annual reviews and IEP meetings in good time (if at all), meaning that the therapists were either already committed, and/or they could not prepare a report in time. There was an awareness amongst their educational colleagues that this was an issue.

It was reported to be very time-consuming having to build up an understanding of the therapist's role in every school visited:

'You sort of expect that there'll be some kind of standard…but I think we all find that every school is different, every teacher is different, you can't go in and have expectations, you have to go in and find where the level is, and educate them and discuss things with them and take it from there. It's incredibly time-consuming that every relationship needs building, there's no basic level of "we can assume these things are in place". If those things aren't in place…we can't do our jobs properly – yet, we have to carry on trying to do our job, because we have a responsibility to the child.' (SLT, London trust)

Therapists found that their input varied considerably from school to school from one extreme of being the 'therapist outsider', to the other of becoming involved in curriculum differentiation. The 'culture' of the school was seen to be determined by the attitude of the Head, and sometimes reflected a 'school-outside professional' apartheid, rather than an 'education-health' one:

'The support of the head teacher is very important - in one particular school we haven't got that and the message has got down that we haven't got a lot to offer. It applies to other services as well, not just SLT.' (SLT, 'shire' trust 4)

'If you have a head that is fired up and enthusiastic, then you find the staff are on board. If the Head teacher or SENCO doesn't see it as important for the teacher to meet with you, it has a huge impact.' (Clinical Co-ordinator, Mainstream Paediatric services, urban/ 'shire' trust 1)

Therapists did however recognise that the demands on schools were high:

'It's not all to do with teachers' attitudes to SLT, teachers do feel under a lot of pressure, all these people coming in from outside.' (SLT, 'metropolitan' trust 1)

Very often therapists felt they did not have influence over the attitude of Head Teachers, because they never got the chance to meet them. Occasionally, however, issues had been resolved at this level:

'We have overcome difficulties by meeting with the acting Head, being honest about the problems, and agreeing at the outset which children we'll see and what we'll do with them, then reviewing whether it happened, and if not, why not. If it's been our fault we'll acknowledge that, too. That has improved things.' (SLT, 'shire' trust 3)

Teacher understanding

In the same way as a good understanding on the part of the class teacher about the therapist's role had a positive effect on collaboration, so the opposite was true. Some therapists described resistance to them working in the classroom, and they put this down to a lack of understanding on the part of the teachers about the therapist's role, and about the impact of a language difficulty on the child's learning. The solution to this was seen to lie in offering training.

'We often come across an attitude which says "that's not my job, I'm a teacher, and I teach maths and sums, and you teach communication". In those circumstances, it's very often a case of putting some training in about the child's whole environment being a communication environment, not just SLT. And that it's a foundation stone for every aspect of learning, no matter what you're teaching in the classroom, it's language-based. If a teacher realises that, you're there.' (Specialist in Autism, urban/ 'shire' trust 1)

Another challenge was that teachers did not always realise the range of speech/language/communication difficulties a child could present with, and therefore might have different priorities from the SLT. For instance, several therapists commented that teachers did not often recognise comprehension difficulties, and did not understand why the therapist sometimes prioritised these children over the ones with more overt speech problems.

> *'The teachers in special schools see us as elocutionists - certainly they see their priorities for the children that we see should lie in children whose speech is poor rather than whose understanding is poor.'* (SLT, urban/ 'shire' trust 2)

Some therapists felt that teachers assumed that the skills of the therapist were only required for working with children with speech problems, and that the teachers could cope with the child's language difficulties themselves:

> *'A lot of the time they (the teachers) have this idea that they can deal with the language because they've been advised on these compensatory strategies [by the language teacher], and language is also picked up within the National Curriculum…whereas we see [it] very much as our role that we need to do the hands-on therapy…'* (Area co-ordinator, community clinics, urban/ 'shire' trust 2)

Contractual issues
The fact that SLTs were employed under 'Health' contracts meant that their terms and conditions did not sit well in an educational context, such as taking leave during term-time.

> *'The fact that we are based in schools (which we have to be to work effectively), yet we are employed by Health, with all the regulations and policies that go with that, that aren't necessarily what schools do, e.g. meetings when we can't be in school, that can be difficult for schools to understand.'* (SLT, London trust)

The peripatetic nature of the job was also not felt to be fully understood, with therapists perceiving that teachers did not appreciate that they had other commitments, and therefore could not always be available to meet them during the teachers' non-contact sessions.

Time
The last point reflects the pressure on time felt by both professions, which was often at the cost of adequate liaison. Lack of time and resources to input hands-on training to schools was also highlighted. Training was seen as a positive way to increase understanding of the therapist's role and the type of disorders they worked with.

> *'A lot of it comes down to the number of us that there are and the amount of time that you can give these schools, because you can only make them aware of what it is we're trying to do if you're there doing it, and if you're involving them…let them see what's happening and train them up to do it and then pull out.'* (Specialist SLT in Learning Disabilities, urban/ 'shire' trust 2)

6.3 Collaboration between speech and language therapists and language teachers

Two main types of language teacher were identified in the interview sites: those working in Language Units or Resource Bases (who may also have had additional

responsibility for an 'outreach' service, supporting specified children and their teachers in mainstream classes) and those providing a service to mainstream schools from a central office base. The word 'peripatetic' had been used to describe the latter group, but it appeared that this needed some definition.

6.3.1 Strengths

Some SLT services felt they worked well with language teachers, in terms of both intervention, and of training other professionals. In the majority of sites visited there were very positive reports of working relationships where therapists and teachers were based together in language units/bases. Therapists talked of the opportunity this afforded them to sit down with the language teacher and discuss roles, and to observe and take part in each other's work.

> *'We aim to have a totally integrated practice – we have actually written down how we can achieve that…We don't have boundaries, we're learning all the time.'* (Specialist therapist, language disorder, 'shire' trust 2)

The advantages of being physically based in one site was something that other practitioners also recognised as facilitating collaborative working. At least two services had set up arrangements where the therapists working into mainstream schools shared an office base with the LEA's special needs support service. This allowed for informal liaison on a day-to-day basis, leading to an understanding of the other profession's 'culture', built up over time.

For some services, there had been a recognition that there were aspects of overlap in the advice given to class teachers by therapists and language teachers. In these sites, systems were in place (or were being planned) aimed at avoiding this duplication. In one high collaborating LEA/SLT pair, this took the form of a joint moderation panel, also involving the Educational Psychologist, where children referred by the schools were allocated to a category of need (mild, moderate, severe/complex). The EPs would then be responsible for providing advice to schools about children with mild difficulties, the language teacher would have a caseload of children with moderate difficulties, leaving the therapist to work with the severe and complex cases.

A therapist summed up the advantages of working in such a model:

> *'It gives a positive message that we work here in an educational building: it shows that we are interested in working in an educational framework. Schools are very clear about what you're doing - teachers understand your role. It works best when there's that shared understanding of what you are trying to achieve.'* (SLT, London)

The raised profile of the SLT service through the alliance with the special needs support service was felt to be another advantage:

> *'The Primary Special Needs Team are very appreciative and they're going out there promoting SLT – and that can only be positive…'* (SLT, 'metropolitan' trust 2)

6.3.2 Difficulties

The above working practices were indicative of situations where roles had been negotiated and workable solutions achieved. Where this had not been the case, there was great strength of feeling about the difficulties this presented.

One of the issues which arose during the SLT interviews was a query about what constitutes a 'specialist' language teacher. This term has been avoided so far in this report, precisely because a received definition does not appear to exist. In the view of the therapists, the title should only be used by professionals who had undertaken post-graduate training, such as a diploma course in speech and language difficulties. Even where teachers had undertaken such courses, there could still be confusion over the status of the qualification, some LEA managers wrongly assuming it was equivalent to the qualification gained by a speech and language therapist.

Whether the language teachers had the qualification or not, in several areas the therapists felt, at best, that there was confusion over the contributions each profession could make to supporting children with speech and language needs, and, at worst, that their role was being usurped by the 'so-called specialist' support teacher for language. This was demonstrating itself, across more than one site, in schools deciding not to invite the SLT to annual review meetings 'because the language teacher would be going'; in referrals not being sent to the SLT department because they had gone to the language teacher; in the language teacher deciding which children she thought it was appropriate for the SLT to see; and in language teachers not making reference to the need for a child to see a speech and language therapist in their reports.

The greatest indignation from the therapists about this situation came where the language teacher had acquired all her experience and training within the SLT department itself. Therapists could often see how the situation had arisen:

> *'I can understand why schools may approach a teacher for an opinion - it's true of any professional group: you will tend to lean towards your own kind, or express an affinity with your own professional group...I suppose it's just a definition of boundaries, and should those schools be approaching the SLT department alongside the Language Unit teacher, rather than bypassing SLT...It may be access to our service, and if teachers want an opinion, that means a referral and the waiting times that go along with that, whereas the teacher in the Language Unit can quite possibly do an informal visit, which we simply can't. But it can mean that children crop up in Language Unit that we've never heard of.'* (Clinical Co-ordinator, Mainstream Paediatric services, urban/ 'shire' trust 1)

Therapists felt that there were aspects of service delivery that they could provide for children, which the language teacher couldn't, drawing a distinction between 'remedial' strategies aimed at removing an impairment and compensatory strategies:

> *'We all know that some children only need the compensatory strategies, but [some children with language difficulties] also need the therapy, they need the active involvement, and they need the target setting...and that is what you never, ever, ever get from the specialist speech and language support teacher, and that's what the children are lacking.'* (Area co-ordinator, community clinics, urban/ 'shire' trust 2)

The therapists saw an opportunity for complementary roles in this respect:

> *'There could be a gelling of roles with the specialist language teacher, because there is separate professional training, then the language teacher's role is more to advise on the compensatory strategies, teacher to teacher, and the SLT*

could be, in the context of working together, more concerned with the specifics.'
(SLT, Learning disabilities and autism, urban/ 'shire' trust 2)

6.4 Collaboration between speech and language therapists and educational psychologists

6.4.1 Strengths

Therapists saw great advantages in working collaboratively with Educational Psychologists (EPs). Joint assessments were considered very valuable, as reciprocal insights were gained and a consistent message was presented to the parents and other professionals. In one area, the links with the SEN support service had also improved liaison with the EPs.

> *'My relationship with EPs has changed since I started working for Education. They have a liaison meeting with the Primary Support Teachers every few weeks, which I have now been invited to, which has been really useful for sharing information.'* (SLT, 'metropolitan' trust 2)

One therapist described the benefits of an assessment team for children with autism, involving various health professionals and an EP.

> *'We own the diagnosis as a team, and that's a good foundation stone for future liaison between Health and Education, because you start off with that child's diagnosis together. Before, there was a lot of disagreement - children would go out of county for a diagnosis. I mean we still disagree, we disagree all the time, but that's quite healthy, because then face-to-face you can sort out where you're coming from. It's far better if you've got that person there in front of you than letters going back and forth.'* (Specialist SLT for Autism, urban/ 'shire' trust 1)

Therapists sometimes felt that an alliance with the EP team gave them more influence in liaison with schools.

> *'I've been working with a school where there have been issues of staff training, where we've wanted the school to have more knowledge, and the EP and also another member of the team who was going in were having the same sort of issues, so we arranged to do things jointly. So we had a planning meeting with the Head Teacher and the SENCO and the three other professionals, and it wasn't just me feeling as if it was a SLT issue, but it broadened it out, and the EP gave it a bit more kudos in a sense, because they could say in terms of children's education that the school needed to have some training. It strengthened the opportunities for changing the school more than one single service or one individual person could do.'* (SLT, London)

6.4.2 Difficulties

Therapists sometimes felt frustrated by the limited access they had to EPs. In some areas, If they were concerned about a child, they could not refer direct to the EP service – they had to wait until the child became a priority for the school. This became a problem if the school did not recognise the child's needs, and schools frequently prioritised children with behaviour problems over quieter, language impaired children.

> *'We refer to psychology, but they don't tend to accept the referral on the strength of our opinion, they then go to school and say how is this child*

doing…and I…realise that's what they have to do, but if school aren't having a problem, that's the end of it, and I personally don't feel that solves the issue, because we're left on our side with a child who's making poor progress, and just because school haven't appreciated the problem, doesn't mean there isn't a problem there.' (SLT, urban/ 'shire' trust 2)

As with teachers, relationships with EPs varied from one to another. There was sometimes felt to be little consistency of practice (for example in whether an EP conducted formal assessment or not), which meant that trying to develop inter-service protocols, e.g. joint assessment, was extremely difficult. Where roles and responsibilities had not been agreed, this could result in duplication of things like standardised assessments, thereby invalidating the results. (The same difficulty was reported to arise in relation to language teachers.)

Therapists often wanted assessments of a child's non-verbal skills in order to put their verbal skills into context. EPs were varied in their willingness to provide this, therapists thought possibly due to a difference in perception or definition of language disorder.

The joint working described in the previous section on 'Strengths' was contrasted sharply with the statutory assessment process, where the EP carried out their assessment independently, and came to conclusions on the basis of perhaps one encounter with the child, which may have contradicted the opinions of those who had ongoing contact.

'I feel Ed Psychs are not team players, partly because of the pressure they're under to be part of the statementing procedure…It can be very frustrating when you have worked closely with a child and feel that you know them well, and the Ed Psych comes in to do a one-off assessment and comes up with something entirely different. A meeting of professions would be highly valuable. But they are rushing around doing assessments in order to keep up with the timescale of the statement…' (SLT, urban/ 'shire' trust 2)

The advisory role of the EP was seen to have its drawbacks:

'Like us, they've got an awful lot of ideas and strategies, but they're even more consultative than we are. They might do a visit or an assessment once and then it is totally up to the school to carry it out. If things go wrong or if things don't quite work out, because they're not actually there to make suggestions, it's often left. And then they often get put in that position of everybody minimising what they have to say, just because they're not there very often.' (SLT, London)

6.5   Involvement in statutory assessment

In one high collaboration site, where there was joint strategic collaboration between the Head of the Statutory Assessment Service (who happened to be an EP by background) and the SLT manager, the therapists were very happy with the way their advice was used in statements.

'I think our reports carry more weight now, because we're very in touch with the statutory assessment office, they ring us all the time now to clarify reports. If I say I think a child needs a secondary language unit provision, we haven't got that resource, but they'll ask where they can go and look.' (SLT, 'metropolitan' trust 2)

This was the exception rather than the rule however, and many therapists felt their advice was not regarded in the same light as that of the educational psychologist, for example. This became a particular issue if, as the SLTs sometimes thought, the EPs were being led more by their knowledge of the provision that was available than by the needs of the child.

'I feel that they (the EPs) are working to a very strict remit from their education department…They will listen to you describe the problems that a child has and they will agree to a point…[but] they have in their head "placements", and if at the outset they can see a child fit very clearly into a placement, they'll go with it; if they can't, they won't.' (Area co-ordinator, community clinics, urban/ 'shire' trust 2)

The background of the people writing the statements was felt to make a difference. Where statementing officers had worked in SEN (and, in some cases, in SLT), the therapists felt that the statementing report reflected the advice they had submitted, and that the officers' experience of SEN resulted in a pertinent and relevant description of the child's needs.

Some therapists expressed a view that training in the preparation of statutory advice would be of benefit, particularly for therapists working in a clinic setting. Those who worked in schools commented on the way they had altered the style of their report-writing, since learning more about the educational setting and the options that were available. They felt that clinic-based therapists should have the opportunity to visit schools on a regular basis in order to facilitate this aspect of their work.

6.6   Support

There was a widespread recognition amongst educational staff that the LSA played a considerable part in the provision of services to children with speech and language needs. This issue had been specifically addressed in a project in one LEA.

'Every child should be able to go into mainstream school, with their brothers and sisters, but for some children that's going to be very, very difficult and that's what we've been trying to look at this year – how a mainstream class can provide for children with speech and language difficulties with some support for a speech and language therapist or a specialist teacher. The key seems to me to be the support staff...to see the SLT and…talk about particular children for whom they have responsibility.' (Specialist teacher, Metropolitan borough)

Therapists were asked to describe the principles which underpinned the way they supported teachers and LSAs with regard to children with speech, language and communication needs.

Most therapists in SLT departments which offered a school-based service said that this depended on the needs of the child, and generally speaking, the more severe the need, the more *'hands-on'* work would be undertaken. There was a wide variation in this however, with some services which worked into mainstream schools offering assessment and advice only, even for children with statements, and others offering blocks of weekly or twice-weekly therapy.

Most high collaborators offered a range of inputs, including one-to-one work with the child, joint target setting, modelling of therapy techniques, and giving advice on strategies. The work could take place both in and out of the classroom.

Many services said that the input they offered was decided very much in discussion with the class teacher.

> *'If I was working with a teacher I would discuss with them, as well, what they thought was the most appropriate way to support the child…With a different teacher and the same child you might work in a different way.'* (SLT, London)

The IEP meeting was felt to be an important forum for discussing and agreeing targets. It was felt that many mainstream teachers needed support to break tasks down into manageable targets for the IEP, whereas special school teachers' experience of working with children with special needs enabled them to do this more readily.

Many therapists talked of the *modelling* aspect of their work, and felt this was an essential component in the success of any intervention.

> *'It's an enabling process - if I am doing a lot of withdrawal it's with a view to enabling the staff to continue that, so that I can pull back and they can do more of what I'm doing. Imparting knowledge and enabling them to incorporate language activities into the curriculum rather than being something separate. The aim is that they can eventually set the targets themselves. You would never do one-to-one on your own, it would always be a demonstration.'* (SLT, 'statements' service, 'metropolitan' trust 2)

One therapist said her targets had become more functional since working in a school setting, and others said that they didn't necessarily ask the teachers to do anything fundamentally different: 'it's just changing the focus of an activity for a particular child.'

> *'It's not practical to ask [the teacher] to do something for 20 minutes with a child when they can actually incorporate it in a more functional way...if they can see that they're actually helping him, doing it in this functional way, then they'll tend to do it, it's less time-demanding as well.'* (SLT, 'metropolitan' trust 2)

There were some constraints on the way therapists worked in schools. These were related to the pressures of the curriculum and the use of LSAs.

> *'It can be very difficult for teachers to make changes that may be only necessary for one or two children, particularly with the curriculum - they have so much to fit in.'* (SLT, urban/ 'shire' trust 1)

Therapists saw a difference in the way they would support a teacher from the way they would support an LSA, the former being more to do with the use of functional strategies to help the child cope with the classroom context, and the latter relating to specific targets for the child. There was corroboration of the opinions of the SLT managers, who said that the amount of LSA time available really determined what type of support a child would get.

Another difficulty around use of the LSA was the conflict that sometimes existed between the expectations of the therapist and those of the teacher.

> *'Sometimes there are issues over withdrawing an LSA to observe, if the teacher wants them in the classroom.'* (SLT, London)

In SLT departments with clinic-based services, therapists would often set up a therapy programme to be carried out in school, then would judge on a case-by-case basis whether it was necessary to make a visit to discuss it with the teacher. Liaison frequently happened by telephone. Therapists operating this sort of service expressed frustrations that there was not more time to go into school to train whoever would be carrying out the programme. They also talked of the difficulty teachers had in finding the time to carry the programme out.

6.7   Equity

Those involved in the provision of educational services all acknowledged that there were a number of inequities in the system which meant that children routinely did not receive what they needed from the service. The most outstanding was the lack of availability of speech and language therapy provision. Many perceived that it was something of a lottery as to whether the children received what they needed once that need was identified. Even when the therapist was in post the fact that they functioned independently of the school and had extensive waiting lists and complex referral procedures meant that for some SENCOs the practical solution was to see the children themselves.

> *'I realise that there are pupils who I would have referred but wouldn't now because the referral system is somewhat cumbersome. It is easier for me to see them in school.'* (SENCO, 'shire' authority)

Whether a child had a statement of educational need or not clearly affected the resources allocated to him. This was appropriate if his need was greater than that of other children, but there was a recognition that there were often children with equivalent need in the classroom who, for whatever reason, did not have a statement. This scenario may have come about because the child was first identified in the pre-school period under the health system or it may have come about because the parent was more demanding of the services, but the effect is the same. For many parents the statement is the "holy grail", the only method of compelling the LEA to provide for their child and, as the discussion in Phase 3 indicated it was often the source of considerable frustration on the part of the parent.

Interestingly the parents' perception of what their child should be receiving once they were technically in receipt of speech and language therapy was also a cause for concern. Parents often pushed for one-to-one therapy on the grounds that they considered group or indirect therapy offered by teachers or LSA as being second best, a rationalisation of budgetary constraints.

> *'…you don't want to be fobbed off with the registrar when you need the consultant…'* (Specialist Language Teacher, London borough)

Where parents were effective in implementing this arrangement (for example, by means of tribunals, or simply persuasion) this could have a detrimental effect on the availability of services for others. In some ways this begs the question of whether it is possible to speak of equity of access to such a scarce resource. An interesting extension of this was the process by which children were 'de-statemented'. Parents who had fought tooth and nail to obtain the statement were very reluctant to see resources being withdrawn again if the statement was no longer considered appropriate. Teachers often felt that it was not necessary for the child to be 'nurtured throughout school', but parents had to consent to the change of affairs, and if they did not, resources may have been

retained for a child who was not considered in need. Again, effective lobbying on the part of the parent of one child may have mitigated against equity of access for other children.

Therapists were asked whether the system which operated in their area allowed appropriate access to speech and language therapy provision for all children with speech, language and communication needs. This question was related to issues concerning resource allocation. The systems operated by various services with regard to the allocation of resources have been discussed in Chapter 5. The aim of this section of the interview was to elicit therapists' views on the workability of those systems. 'Equity' in its purest sense refers to the ability of a service to make the same provision for two children with similar needs; therapists extended the concept, and also made reference to whether resources were adequate to meet the needs of their population.

Speech and language therapists working in school contexts necessarily had to take account of the methods LEAs and schools used to allocate their resources. In most LEAs, funds were allocated mainly on the basis of the statement. Therapists pointed out that some of those children who had statements were not necessarily a priority in terms of clinical need, and SLT services therefore resisted the notion of allocating resources on that basis. The SLT/LEA pair that had developed the system of sharing a single caseload between therapists, language teachers and EPs was proud of the fact that children were allocated to categories of need in spite of, rather than because of, their statement. However, in practical terms, the therapists found it easier to support the children with statements, because there was more LSA time associated with this level of provision, which was not routinely the case for a child at Stage 3 of the Code of Practice.

Many therapists talked of the quality of service a child received being heavily dependent on the collaborative commitment of the school, and thus not equitable. Where services depended on the school contacting them when they felt they needed more advice/input for a child, this relied on schools having the skills to do so, which led to some children being overlooked. Therapists also found that they gave a better service to schools where they had a lot of children on the caseload, by dint of the fact that they knew those schools more intimately because they spent longer there.

In areas where there was limited specialist provision (e.g. one language unit), inequities arose when the number of children who were eligible for a place exceeded the number of places available. Therapists often reported a significant difference in the level of support they could offer a child in a language unit compared with in a mainstream school. In areas with no language units, there were some children with severe language disorders whom therapists felt were not receiving adequate input.

> *'We do occasionally get children cropping up... [we have one now] with massive problems, and it's going to be extremely difficult to support him, because there's so much he doesn't know, he's way behind the National Curriculum and we don't have the provision that suits him, we'll just have to come up with the best we can in the circumstances that we have.'* (SLT, London Borough)

Waiting lists figured significantly in the equity discussion. Most services, including those with clearly defined criteria for resource allocation, found that they had to maintain a waiting list. In one service, where the style of service provision was different for pre-

school and school-aged children, youngsters had to go back onto a waiting list at age five as they transferred into statutory education. Another service spoke of delaying allocation of children to 'management levels' until they had the resources to meet the need.

> *'There are some children who we would like to put on M5 (highest management level) but we don't because we haven't got the resources.'* (SLT, 'metropolitan' trust 2)

Services where a full audit of need had been undertaken across schools certainly found themselves in the position of not being able to meet all the children's needs.

Therapists that operated from a clinic base saw their service as equitable in the sense that every child who did not turn up for an appointment was discharged. However, at another level, they perceived an inequity for the child itself, as it was dependent on the commitment of its parents.

Access to the service for bilingual families was felt to be particularly problematic, as literature had not always been translated. Letters and forms were also felt to disadvantage children whose parents could not read.

One therapist made this comment, which reflected the views of many:

> *'[There are] constraints of resources, time and staffing. You can't always follow the ideal pathway of care for each child, we do have waiting times, and children do have breaks from therapy, just so we can get other children in.'* (SLT, urban/ 'shire' trust 2)

6.8   Curriculum

Amongst the educationalists there was an explicit acceptance of the National Curriculum as a framework, although there was an anxiety expressed that one of the by-products of the curriculum and the literacy/numeracy hour was an inflexibility in the way that teaching staff were able to function. One of the costs was perceived to be a reduction in the time available for the classroom teacher to discuss children with special needs with outside staff – such as the speech and language therapists.

Although the literacy hour may have introduced inflexibility for some it had been identified as a real advantage, a meeting place for teacher and therapist. In some schools SLTs had come to play an important role in this activity.

> *'We have…the shared activity, shared reading, "literacy" activity, and then we go into three groups and each group in our class has an adult with them. Either myself, the teacher or the Speech and Language Therapist or the special support assistant. So with each of us they (the children) do something different every day. And that's where the speech and language therapist does a lot of therapy work via the literacy.'* (SENCO, London Borough)

Many educational practitioners also addressed the issue of curriculum differentiation and the impact of the inclusion agenda on SEN.

> *'How do you differentiate when you've got a class of 32? It's all very well, you know, sending children off to be included but it's important to recognise what it really means for the class teacher.'* (Specialist teacher, London Borough)

When asked about their priorities for supporting children with speech, language and communication needs, therapists working in educational contexts identified several areas of importance. These included improving the child's functional and social communication and addressing various skill areas which would facilitate access to the curriculum.

A number of the SLTs believed that the National Curriculum in its current form was not adequate for the purposes of children with speech, language and communication needs, and many SLTs called for it to be reworked altogether with a stronger emphasis on language and communication across the board. Therapists felt that the existence of a specific section on 'Speaking and Listening' a) reinforced the misconception that 'speech, language and communication' was a separate subject, rather than something which underpinned the whole curriculum, and b) led teachers to believe that this was the only subject area in which the therapist could be expected to support the child.

> *'Language is integral to all the curriculum: most things you target come into many aspects of the curriculum, e.g. sequencing comes into science, history, English, PE…You might do language work in literacy, or work on language concepts in maths, and this is where it can really start to work and the whole communication programme comes alive and becomes more interesting, for all parties concerned.'* (Specialist SLTs, Learning Disabilities/Autism, urban/ 'shire' trust 1)

There was also criticism that the 'Speaking and Listening' curriculum did not take a developmental perspective on speech and language skills, making it very difficult to dovetail therapy targets with curriculum goals.

The National Curriculum was felt to overlook the needs of children with SEN generally. There was concern that their training in the Curriculum led teachers to expect a certain level of ability of the children in their class, whereas many children still needed to work at a pre-curricular level. In special schools, particularly, it was considered inappropriate that pupils who had no use of a first language should be learning French. One group of special schools had addressed this difficulty, through discussion with, and advice from, the SLT service, by creating Communication Co-ordinator roles for one teacher in each school. These posts were created

> *'…in order to get language and communication back into the curriculum, [which had] fallen off the edge, because teachers are so busy teaching the curriculum, that therapists can't get their work in. The therapists have said what a huge difference it has made, because the teachers are able to talk to the other teachers in their own language…'* (SLT, 'shire' trust 3)

In contrast with the reservations over the 'Speaking and Listening' curriculum, there were aspects of the Literacy and Numeracy Strategies which had been welcomed, such as access to a common language around phonological awareness in Literacy, and lists of pre-requisite concepts and vocabulary in Numeracy. There was some concern that the 'mandatory' nature of the Literacy and Numeracy 'hours' had constrained schools from thinking flexibly about how they would involve therapists, but this issue was being resolved in some of the areas where therapists were offering a service and training into schools:

> *'As they (the teachers) learn more, they're prepared to be more flexible, like not making the child sit through a story in Literacy Hour when they're not getting anything from it, but being prepared to allow that child out to do something*

more useful. With shared (SLT and NC) targets they can do something that is accessing the Literacy Hour, but not in the same way.' (SLT, 'metropolitan' trust 2)

A difficulty for some therapists was that the school timetable did not always lend itself to school-based input:

'In terms of time, working around the curriculum can be hard, e.g. Literacy/Numeracy Hours, because with some children it's appropriate to work with them at those times, but with others it's not. Or you've got half an hour for them, and you want to spend it in the classroom, but that particular part of the lesson is not appropriate.' (SLT, London trust)

6.9   Training and continuing professional development

One of the key features of the discussions with both speech and language therapists and teachers was the need for a joint understanding of terminology and information about children with speech and language difficulties, relating to both accurate identification and appropriate intervention. Key to this, and this was a point emphasised by both groups of professionals, was the need for teachers to have a better understanding of language in relation to literacy. With the exception of those who had undergone post graduate training there was an awareness that the only way that teachers could make this link was from their own experience. Given the emphasis placed on this link by speech and language therapists this could present a fundamental obstacle to effective communication. This also linked in to the need for teachers to have a better understanding of child development as a whole. There were examples in the interviews where teachers criticised therapists for having too low expectations of the children (relative to the children's age) but this suggests a lack of understanding of the need to present material in a developmentally appropriate fashion (a point raised earlier in this chapter).

The lack of confidence shared by teachers in this area was exaggerated at secondary school level where subject teachers had even less experience of SEN than those teaching in primary school. While these differences in knowledge base can obviously be approached on an individual basis, as the discussion above indicates this is not an efficient way of developing a common vocabulary. The most effective way is through continuing professional development of various types.

In most authorities relevant training was available but the way in which it was applied varied considerably. At one level it was organised in an ad hoc fashion each service dealing with its own needs as they arose. Both health and educational services made use of external sources of training such as the course run by I CAN for those with a specialist interest in this area. There were some complaints about how locally these services were offered. In some authorities SLTs were actively encouraged to join in the LEAs programme of in-service training as recipients but there were also cases where the representatives of both services had put on training around the area of communication disability in collaboration. The joint working that this preparation had entailed was perceived to have positive effects in terms of future service delivery.

6.9.1 Training for teachers

As the therapists quoted above indicated, they favoured comprehensive postgraduate courses for teachers wishing to specialise in this area. It is clearly much more difficult to

pick up the level of knowledge required to manage this type of case load from single in-service training days. There is currently no formal training required for those wishing to specialise in this area in the way there is for those specialising in working with the deaf or the blind. One such course was the Masters course offered at the University of Newcastle. Although this has now been closed it had been run for a number of years and had made an invaluable contribution to the training of teachers in the North East. Similarly there is a course at the University of Kingston which provides for local need in the same way. There is also the distance learning course at the University of Birmingham but these courses remain relatively unevenly distributed across England and Wales. Finally, while the teachers welcomed the courses because they allowed them to focus on the topic in a way which was not practicable within the classroom they were anxious to promote the value of the training role provided by the therapist working in the classroom – "on the job" training – because training by demonstration often had the most immediate effect on their practice.

Therapists saw the training of education staff, particularly teachers, as fundamental to the success of collaborative working in an inclusive context. There was a frequently expressed view, echoing that of the SLT managers, that pre-qualification teacher training should take more account of special needs as a whole, and speech and language development in particular. Terms such as 'mandatory' and 'compulsory' were used in relation to the training needed by teachers and LSAs for working with children with speech, language and communication difficulties.

6.9.2 Skill mix

Whilst many services had set up INSET for LSAs through the LEA, it was the view of several SLT services that, whilst LSA training was desirable, in order to really change the level of background knowledge about children's speech and language needs within education, it was necessary to target training at teachers. One service had set up a rolling programme of training, which had developed in four stages: firstly there had been a course for SENCOs; secondly, the training had been modified for class teachers; thirdly, INSET for LSAs had been set up; and lastly, a second, more advanced course for teachers had been established. In starting with the teachers, therapists felt that an appropriate skill mix had been maintained in the classroom, and saw some complications in an LSA having greater understanding of a child's needs than the teacher. One area for concern for the SLT was the situation where training was taken up by LSAs but not classroom teachers. Clearly the culture of understanding of SEN must permeate all staff members if it is to be effective. This is true for the head teacher as it is for the SENCO and classroom teachers. Providing training for LSAs alone could effectively mean that the SEN process is delegated downwards. It would be an unsatisfactory state of affairs if the classroom teacher knew less about SEN in general and speech and language needs in particular than the LSA.

Some therapists felt that training delivered to a whole school was preferable to individuals attending a course centrally, because this would facilitate a change in school culture, rather than a single person 'swimming against the tide'. There was, however, a perception that some schools had priorities other than SEN for their training needs, such as the Literacy and Numeracy strategies. This conflict was exacerbated where SLT services charged for their training.

6.9.3 Training for SLTs

For their part therapists expressed a desire to learn more about the educational context, the role of teachers and the National Curriculum, but had generally been unable to find courses which they felt would meet their needs, e.g. an overview of subject areas, key stages and attainment targets. Therapists either addressed this problem by seeking information on an *ad hoc* basis from their education colleagues, or by focusing on specific aspects of the curriculum at a given time, depending on the needs of their caseload. Some therapists suggested that an extra year post-qualification training, working in education contexts might be a solution for those who wanted to work with children. This reflected the view of one of the managers, that the knowledge required to work in schools, such as the demands of curriculum planning on the teacher, could best be learnt 'on-the-job'.

6.9.4 Joint training

Therapists saw many advantages in receiving training jointly with their education colleagues. In areas where this had happened, therapists referred to the usefulness of the common understanding that had come about as a result.

> *'Joint training means you're coming from the same point, and you can really help to develop those things (learnt on the course) in school.'* (SLT, 'shire' trust 3)

Of particular interest were courses where teachers and therapists could learn more about joint target setting. More involvement of EP colleagues in such courses was thought to be beneficial, and therapists referred to occasions when they had had useful discussions with educational psychologists over dovetailing their objectives in individual cases.

In many areas, information about INSET or study days being offered by the other agency was gleaned in a rather hit-and-miss way, usually through a chance comment from a teacher to a therapist or vice versa. The fact that the information wasn't shared in a more official way was usually due to a lack of awareness that the training could be relevant for the other party.

A strategic overview certainly gave form to inter-agency training. Where therapists were being managed within a special needs support team, *reciprocal* training became a natural progression from the joint working situation. The therapists joined their education colleagues on their in-house training weekends, and contributed a substantial part of the programme. Joint *delivery* of training was also facilitated. In fact, in all cases where SLT services and special needs support teams had negotiated roles and responsibilities, jointly delivered training had become an integral part of the collaboration.

6.10   Working with parents

Amongst educationalists there was a clear need for working with parents but for many the demands of pastoral work were impractical due to lack of time.

> *'Teachers may be desperate to do pastoral work but it can be the "straw that breaks the camel's back" for a busy teacher.'* (Language teacher, 'shire' LEA)

In practice communication with parents was restricted to a workbook and occasional meetings. For some the meetings were vulnerable to other pressures.

> 'We have parent interviews. But I don't think we have had any this year (said in April). The main reason for this, this year, has been that class sizes were so large that we were very, very tight for time.' (Class teacher, metropolitan LEA)

There was a recognition that the speech and language therapist had specific training in this area and there were examples quoted of the contribution made by the SLT. The fear amongst those teachers who were interviewed was that time pressures effectively meant bringing in parents for case conferences and annual reviews and allowing consultation (parent of the school) at critical points but that there was often little or no regular contact allowing parents to follow their own agenda.

> ' You can't simply leave a group of children to go and talk to parents.' (Teacher, unitary LEA)

Having said that many of those who did work with parents saw that link as one of the most effective ways of sharing a common goal with them and "managing expectations". This was a term frequently referred to, suggesting that parental expectations were often unrealistically high given what the system could offer. It was also a way of matching up what parents wanted for their child and what the educational experts considered was needed.

> 'Parents start saying what they want rather than asking us (educational professionals) what he needs. Parents' expectations are very important.' (SENCO, metropolitan LEA)

There was a certain ambivalence here about what constituted a need. On the one hand all those questioned spoke about a needs-driven service with the child at the centre. On the other hand there was a clear recognition that there were, for example, local priorities around the provision of statements.

The reverse of this concerned parents who did not have the interest to discuss their children's needs. Effectively these children were disadvantaged because, in general, parents need to push to get things done. There was an awareness that the needs of these children were often simply overlooked.

> 'We are aware that we don't deal equally with all parents. For example there are those parents who are not articulate who we need to get to.' (Language teacher, metropolitan LEA)

For SLT departments which had developed a service into educational settings, the loss of contact with parents was a regret. Routine practice in SLT such as the taking of a case history became rare because of time constraints and the difficulties of organisation. Various methods were being used to try and maintain contact (e.g. home-school link books, invitations to observe therapy), but parents were reported to be inconsistent in their use of these systems.

Some services had developed standards for the frequency of contact they made with parents: the minimum standard ranged from three times a year to once a year.

Where therapists were managed within Education, differences in philosophy affected the contact therapists were making with parents. The therapists felt they had to adhere to professional guidelines, which stated that parents should be directly involved in every

stage of their child's management. However, the support service in which they worked saw the schools as its 'clients', and communicated with them, rather than the parents. This raised a conflict for the therapists – whether to follow their professional guidelines, or whether to integrate fully into the educational culture.

6.11   Factors which promote and inhibit effective collaboration

Both therapists and teachers were asked at the end of the interviews to say what they would choose to highlight as promoting or detracting from effective collaboration. These are presented in tabular form below.

Figure 6.1 Factors promoting and inhibiting collaboration

Factors promoting collaboration	Factors inhibiting collaboration
Clarity of vision on the part of the LEA;	Unwillingness of either side to respect the other's role and "make that extra effort";
Sufficient time for flexible working;	Too little time spent together;
Shared accommodation;	Separate accommodation;
Joint training;	Lack of understanding of curriculum and speech and language difficulties;
Respect for professional roles;	Lack of understanding of respective priorities;
Shared timetables;	Different terms and conditions;
Enthusiasm;	Defensiveness and suspicion;
Specific mechanisms such as joint audit;	Lack of common language;
Continuity of service;	Recruitment, retention and high turn around of SLTs;
Increasing expertise amongst SLTs and teachers specialising in this area;	Confidence of classroom teachers;
Emphasis on literacy means that teachers are becoming more specific about language;	Connection between oracy and literacy still not made by many teachers;
A desire to work at a systemic level.	A belief that increasing the budget is a panacea can be a useful excuse for inaction.

Chapter 7 - Parents' Viewpoints

Key findings

Parents emphasised the importance of:

- Early professional engagement with speech and language problems.

- Clear and prompt communication of information to them from agencies, with agencies taking a more pro-active role in initiating discussions with parents. Perceptions of good communication from agencies tended to be linked with appraisal of good inter-agency working.

- A named individual at all stages of assessment/provision to convey information/advice.

Of concern to parents were:

- The struggle experienced by some parents during the assessment/statementing process.

- Vaguely worded statements perceived to allow for provision which did not adequately reflect needs.

- Vagaries of provision perceived as inequitable: resource, rather than needs based, and provision 'shared' between children.

- The difficulties which time constraints, and lack of initial training for teachers, placed upon the ability of SLTs and class teachers to implement speech and language programmes effectively. There was a perceived requirement for greater mutual understanding of needs.

- Management of continuity of provision, particularly across educational transitions (e.g. from primary to secondary phase).

Parents praised:

- Some examples of good collaboration between LEA and Health.

- Provision received from the SLT service, once assessed.

- Individual therapists in providing advice, as well as therapy, and in taking the role of "champions" of a parent's cause (with some health visitors, doctors and other professionals also praised).

- Examples of integrated practice involving the SLT service.

- Language unit provision, particularly valued in facilitating different levels of integration as a child's needs change.

7.1 The interviewees

Interviews with the parents explored their perceptions of the impact which levels of collaborative relationship between Health and Education had upon SLT provision for their children up to the age of 16 years. While recognising the status of children themselves as frontline users of SLT provision, and the growing emphasis in a number of professional contexts on obtaining children's views, it was felt that the parents' role as negotiators of their children's access to provision would allow greater insight into issues of inter-agency collaboration.

In most cases, contact with parents was made through the Parent Partnership Officer, and in two cases through AFASIC. Contacts were asked to find a sample of, ideally, eight parents for group interview, whose children represented a range of ages and needs, and whose experience of provision varied in length. The children's ages ranged from three to fourteen and they had a mix of problems requiring speech and language provision (and frequently other therapy and/or medical treatment); some had recently received an initial assessment, others had been receiving input for a number of years. Interviews were held at clinics and on school premises.

The Parent Partnership Officer was present at thirteen of the venues, and having both "inside" information about individual cases, and details of local speech and language provision, was in a position occasionally to place in context replies given by parents.

It is not claimed that the parents who agreed to be interviewed are necessarily a representative sample of all parents of children receiving speech/language provision: the fact that Parent Partnership Officers had contact details for certain parents indicates a history of dialogue with them, suggesting clear articulation of their concerns. Nevertheless, the recurrence of issues highlighted by parents with a wide range of sampling characteristics suggests a wider prevalence of these views among the parent population.

The following text derives from notes taken from tape-recorded interviews. In no case was permission for tape recording refused. All quotes are from parents unless otherwise stated.

7.2 Assessment

7.2.1 Roles in the Assessment Process

Parents were asked about their first point of contact in the NHS or LEA, their role in the process of their child's assessment, and the role taken by other individuals who became involved. Crucially, parents were asked whether they had any sense of an exchange of ideas between the agencies involved.

For a number of parents, perinatal diagnosis of a medical problem brought into play professional involvement, with planning for the child's clinical and therapeutic needs at a very early stage; paradoxically, however early diagnosis of a major problem occasionally delayed engagement with the need for SLT, for example the early complex difficulties of a child with Down Syndrome had diverted attention from the likelihood of the need for SLT provision a little later in the child's life. Overall, however, parents of

children with severe disabilities had been able to achieve assessment and allocation of (perhaps several types of) therapy with relatively few problems.

There were also parents of children with moderate disabilities who had positive perceptions of the process.

'I've been very lucky, because everybody supported me: SLT, school teachers, paediatrician. I didn't struggle to get this place [in a language unit]'.

Many parents, however, reported the unwillingness of a health visitor or GP, as their first point of contact, or at a later stage, a classroom teacher, to take seriously their concerns about their child's development. Perceiving themselves unfairly labelled as "over anxious", these parents expressed considerable frustration at the resulting "lost" months or years during which they felt their child could have been benefiting from SLT provision.

'I had to beg my GP to refer me to a paediatrician. He said "if that's what you want." I felt it was not much to ask of him. So he referred me, and we've got a 5 hour assessment coming up.'

'I spent two years being passed around from pillar to post, no-one taking the slightest bit of notice of what I was saying.'

'…(name) was in an ordinary school in a class of thirty with one teacher who said: "don't worry, he'll be fine". How was he going to be 'fine'? I went in from time to time and he was not getting the attention he needs. He is now in a speech unit…again, this was me pushing all the time with the school, them saying "don't worry, he'll catch up".'

Many parents had formed the conclusion that if they were to go through the process again, they would need to insist at an earlier stage that health, and sometimes education, professionals heed their concerns, as a first step towards prompt assessment and earlier provision of speech and language (and other) therapies.

Almost every parent interviewed stressed the importance of *early* professional engagement with language (and other) difficulties, suggesting that denial of therapy because of funding constraints merely delays engagement with the problem until a time when the problem becomes more serious, placing still more demands upon resources.

'Getting the timing right is crucial, so that there is sufficient time to put the resources in place before a child enters nursery.'

Parents attributed early professional resistance to engagement with their concerns variously as slowness to recognise and identify presenting problems, or refusal to acknowledge a problem because of scant speech and language therapy resources in place to address it.

The notion that parents' expectations can/should be 'managed', discussed elsewhere in this report, has implications for their treatment at the early stages of their relationship with health and education professionals. A number of parents used phrases such as "*my world fell apart*", "*I was shell shocked*" [when a diagnosis was given]; perhaps a diagnosis had confirmed their worst fears, or perhaps they were previously quite unaware of the severity of their child's problems. Several parents emphasised a need, after a few days' reflection, for follow-up discussions to explore the implications of a

diagnosis: the initiative for this to come from a professional rather than the parent. Parents' comments suggested that discussion, communication and advice at these early stages could lay the ground for a realistic understanding of the role which a SLT will have to play as development needs unfold.

Those with more positive experience in the early stages of assessment had in some cases found a "champion" of their cause in their first dealings with the health visitor, GP or hospital doctor. These parents described the efforts of this "champion" as essential in securing access to key individuals who would advance the process of assessment. For these parents, the chance involvement of such a champion brought a positive result; nevertheless such involvement was considered necessary in order to fill a perceived vacuum left by the lack of a sense of a planned procedure which would guide them systematically through assessment.

7.2.2 Exchange of ideas

There were parents who had experienced quick assessment of their children's difficulties and provision of speech and language therapy, marked by positive collaboration among health/education professionals.

> '…the hospital doctor first noticed a problem, then all sorts of people: paediatrician, speech and language therapist, ed. psychs. worked together on a diagnosis, and they always kept me informed about people he'd have to see.'

This parent was one of a number who perceived an "exchange of ideas" between the various professionals involved in the assessment; and the comment about being kept informed highlights a priority which was expressed repeatedly by parents in all areas, in relation to all stages of assessment and provision.

The comment above contrasts with those from parents who described obtaining a diagnosis as 'a fight'.

> '…a real battle. They [Health and Education] don't actually talk: they write reports and read them, then the LEA dismisses them."

> "I don't feel Health or Education communicated sufficiently well with me. I had to mither them to get somewhere. Everything you want you have to chase up.'

Many other parents experienced assessment less as a discursive process between professionals, and more as a process which evolved in isolated stages; a child would be seen initially perhaps by a paediatrician, then by another professional: an educational psychologist for example. Many said that they assumed these individuals might confer privately, but had no evidence of such an exchange; less positively, a number regarded duplication of reports, or flat contradictions in their content, as evidence of a lack of communication between the professionals involved in producing them.

Overall, parents who perceived little inter-agency dialogue, or received little communication of information, experienced the process of assessment, and where applicable, the process of obtaining a statement isolating and alienating.

7.2.3 Statement of Needs

Questions about the assessment process brought responses from many parents about their experiences in obtaining a statement of needs; some parents described this process as "a struggle", "a fight", with much criticism of the amount of time taken for its completion, or revision.

> *'I asked for a reassessment in 97, and it's only just been settled by tribunal, which took two and a half years.'*

Many parents felt strongly that adequate access to speech and language provision could only be assured through a statement, a document which would both describe provision, and safeguard that provision from competing claims on the service.

> *'The statement is precious. If you're given provision with a statement they can't take it away from you and say "we haven't got the money to provide."'*

The majority of parents, in possession of a statement or otherwise, expressed the view that therapy recommendations are based on financial resources, rather than need. Resources for SLT are widely seen as inadequate, both in terms of the money made available, and in terms of scarcity of therapists due to maternity leave, and departures from the service. One parent referred, for example to 'a quick succession of SLTs, then no-one at all to replace those who have left'.

There was much criticism where statements included vague phrases such as, for example, *"as deemed necessary"*, *"regular speech therapy"*, and disappointment when such phrases translated into very infrequent therapy sessions and sporadic contact with an SLT. Some parents indicated that in practice they had had to 'push very hard with the school' for provision of SLT which they (and indeed often SLTs too) considered inadequate.

> *'She needs one-to-one, and that's what her teacher thinks, too. Then you hear of other people getting that and you think "why has that child got it and not mine?"'*

Parents recognise that funding for SLT is tight, but some feel that lack of resources should simply not qualify as an issue; for them the only relevance is that provision should be made for their child: somehow the resources must be found.

> *'...a lot of parents do sit back and just accept it [lack of resources for SLT]. I'm not prepared to do that. I want the best for my daughter.'*

The last two comments reflect both parents' perceptions of an inequitably allocated service provision, in recognising that parental determination and persistence can bring provision denied to the child of a less vociferous parent.

The suggestion that parents' expectations might be 'managed', in the sense that they can or should be persuaded that scarce resources render persistent attempts to obtain provision ineffectual, assumes special significance here. A professional decision to refuse or discontinue therapy in the genuine belief that it is unlikely to benefit a child is likely to be greeted with parental skepticism when that decision has been taken against a background of funding constraints. Moreover, wide publicity following tribunal decisions which find in favour of parents encourages other parents to persist for what they perceive as their children's right.

A number of parents were not aware of any special significance relating to the allocation of speech and language therapy to one section of a statement rather than another; however, those who were aware of this emphasised that SLT should be classified as an educational need, in that it affects a child's access to the National Curriculum (though there were areas where effective collaboration between Health and Education had resolved this issue). However, where needs were "wrongly classified" as a health issue, parents felt Education to be evading its responsibilities because of funding implications. More fundamentally, however, there was bewilderment that children's needs should be divided into education and health. A number of parents called for action to support the Government's "joined-up thinking" policy: 'what you need is a joint funding programme' was a view expressed by several parents.

Overall, parents perceived provision of SLT to be resource based, rather than based upon the needs of the child, though unsurprisingly, this view was less prevalent among those who had found the assessment process, and access to therapy, unproblematic.

7.3   Strategic planning

Questions in this section sought to explore the unfolding of speech and language provision after assessment had taken place. Parents were asked to what extent they were aware of a planning process at this stage, and whether they felt that Health and Education played equally balanced parts in planning.

There were many negative comments regarding co-ordination of planning.
'Co-ordination is lacking between departments which should be working together: SLT, occupational therapy, the LEA and school.'

'I've had to do a lot of co-ordination, a lot of phoning – I have the feeling that I have to keep people on their toes.'

For many parents, the planning surrounding allocation of speech and language provision appeared to take the form of a series of steps, rather than being brought about by a cohesive operation with balanced and shared input from Health and Education. A number of parents responded: 'what planning?', when asked 'How aware were you of a planning process?'. Comments indicate that many parents were quite unaware whether or not Health and Education had collaborated in the reports completed; the allegiances of those who had been involved in the preparation of reports came secondary to preoccupation with the details of provision being offered. A few parents had found the wording of reports inaccessible, and suggested that the nature and extent of provision being recommended could be clearly conveyed without the use of professional jargon.

However, questions about collaboration between departments typically produced comments on the quality of communications to parents, as evidenced, rather negatively by the following remark:
'"Are people talking to each other?" Well, if they are, they're not letting us know about it.'

Parents who felt that agencies were prompt and proactive in communicating information to them were more likely to have a good sense of collaboration between these

agencies, though sometimes lacked hard evidence that such collaboration had taken place.

Parents emphasised the need for a constant point of contact, a named individual who would initiate communication of information to them, and to whom they could turn for clarification of issues, or support in identifying the right professional to offer advice: a number of parents were not aware of the existence of a SENCO (special educational needs co-ordinator) in their child's school. At institutional level, several parents gave examples of good communication; for example, parents praised communication at a child development centre where a pre-school special needs teacher liaised between home, school and unit.

Questions which probed strategic planning prompted replies relating rather to service operation. Here, as at the assessment stage, a number of parents mentioned that a key individual had shown an interest in their case, and felt that this person's intervention had gained easier access to provision.

7.4   Service operation

Parents were asked what types of speech and language support their child was receiving, and whether support options were discussed between representatives of the LEA and Health Service; they were asked for perceptions of how these agencies had worked together, and how this had changed over time. Parents were also asked about the extent of their involvement in discussions about the nature and frequency of speech and language support to be received by the child.

Most parents made no distinction between inter-agency collaboration at the stage of service operation, and collaboration at the stage of assessment, and no parent identified a change in the degree of collaboration between health and education having occurred over time. A good number said they could no longer recall the details of what piece of information had come from which agency, and at which stage, once assessment had been made.

Arrangements for delivering speech and language input included: provision in a clinic located in a hospital setting, in an assessment centre, in a special school, in a mainstream classroom, in a language unit, in the child's home. In some cases, therapy was delivered on a one-to-one basis; other children received group therapy. Some received their therapy in a single block of time, rather than in sessions spaced at intervals. While some parents insisted on the superior benefits of one-to-one therapy, others felt that group therapy was producing good results. There was, however, resistance to the idea of 'shared' therapy, i.e. therapy shared across more than one child, where this was perceived as resource driven, rather than needs led.

A number of parents commented upon the provision of a learning support assistant from the school, accompanying the child to a clinic session to receive instruction from the SLT on implementation of a programme back in the classroom. For some this arrangement was working well; others gave a number of reasons why it was proving unsatisfactory: the parent considered the learning support assistant to have insufficient training to implement the programme efficiently; there was insufficient time allocated to implementation of the programme in the classroom; the effect on the child of taking him/her out of the familiar classroom environment was considered disruptive; a block of

time spent in clinic was felt to over-stretch the attention span of some children. In cases where a learning support assistant was not available to accompany the child, however, the likelihood of effective implementation in the classroom was often poorly rated by parents. Reasons given were the child's inability to do this for him/herself, also the teacher's lack of time, and/or lack of familiarity with the programme.

Some parents reported that they were encouraged by SLTs to continue a therapy programme at home, and reactions to this were mixed. While a number were clearly confident about doing this (some had taken courses about their child's disability and appeared well informed about the nature and implications of his/her problem), others regarded therapy as the domain of the professional. A number sympathised with their child's resistance to "doing work" at home. A few parents had been given conflicting advice from different therapists about the wisdom of continuing therapy at home, and in some cases about the form this therapy should take. In such cases, parents had decided to discontinue involvement with the therapy, in the fear of doing more harm than good.

All the parents interviewed agreed that they had been included in discussions about speech and language provision, though by no means all were satisfied that sufficient attention had been paid to their views. However, some parents were quite satisfied both with their involvement in the decision making process, and with the frequency and nature of therapy being provided.

> *'We've had everything we could have asked for: 1 year's speech therapy at a cluster, then on to a language unit. That's how the system should work.'*

> *'We've just had his review. There was the class teacher, the physiotherapist, psychologist, occupational therapist, speech and language therapist, support teacher: a whole body of people there looking at where he was, what he'd need in the future, which I thought was really helpful. The reports were very detailed – short term and long term.'*

One of the few negative comments about the nature of speech therapy given came from the father of an autistic boy, whose case had been taken over by an inexperienced practitioner following the resignation of his usual therapist. The boy had been shown a film featuring cats "talking" to one another. Unfortunately, however, the result was that the boy "left the room meowing". The father commented 'I could have told her that would happen, autistics are great mimics'. He suggested that a therapist experienced with autism would have anticipated the danger of showing this film; alternatively he felt that his own closer involvement with the nature of therapy to be used with his son, while not guaranteeing good results, would help to minimise failures of this type. The case indicates that some parents would like to be closely involved in discussions about the details of therapy to be given, in addition to more general discussions about therapy provision.

There was a high level of satisfaction with speech and language therapy provided, once access was achieved, and many, though not all, parents felt that more frequent sessions would bring benefits.

> *'Speech therapy itself is very good. Once they get it, people are generally happy with the service, it's just getting it, getting enough of it, and keeping it.'*

> *'(child's name) is in a brilliant class but she needs one-to-one therapy. She's not getting her needs met at the moment.'*

Many parents felt that a little therapy had brought good results, therefore more therapy would achieve still more improvements: perceived deterioration in their child's ability following discontinuation of therapy due to staff shortages lent force to the rationale of this argument for some parents. In a number of cases SLTs had decided to withdraw therapy, explaining that they felt the child 'no longer needs' the service, and parents typically greeted this with skepticism, commenting, for example: 'Is it that she doesn't need therapy, or is there simply a more urgent case?' Comments made here in respect of withdrawal of provision mirror those made regarding the assessment and statement provision: that decisions made are influenced by lack of resources to the extent that need becomes a secondary issue.

Again, communication was highlighted as an important element for parents. Where resources limited access to provision, the situation was only exacerbated if this was compounded by failure of communication.
> *'An SLT from the child development unit came down to the house once or twice a week until reception class. Then she left. We didn't see anybody for twelve months. I think someone was going into school, but nobody actually contacted us…'*

Very many parents, describing positive outcomes for children who had received SLT, singled out individual therapists for praise.
> *'I thought the SLT service was very, very helpful; I thought it was excellent. [The SLT] was in charge, working with him in a small group, and some individual work, and then supporting us as parents…she was excellent, explaining things to us and pointing things out …about how we could encourage him to speak.'*

Parents frequently referred to a therapist who had *"worked wonders"*, *"been fantastic"*. Paradoxically, the greater the success achieved by a therapist, the greater the disappointment when this therapist left the service, perhaps decided that therapy could be reduced for a particular child, or when responsibility for hands-on delivery of therapy fell to another individual.

Comments made by therapists themselves, featured in other sections of this report, suggest that an issue here is therapists' definition of their own role in provision: is that role ideally a consultative one, with the implication that others (teachers, support assistants, parents themselves), having been given advice by a speech and language therapist, take on the responsibility for hands-on therapy? Or should their role be, (and comments made by parents support the hypothesis that their role is seen in this way), a hands-on role with direct involvement with the child's therapy throughout?

Parents' perceptions of the true role of the therapist clearly have implications for the expectations that they will have of the way provision of SLT is implemented, and implications too for their expectations of other professionals, in particular the classroom teacher and learning support assistant. Evidence for this is to be found in views expressed by parents regarding the relationship between the SLT and classroom teacher: that a seamless mechanism for delivery of SLT is not necessarily negotiated through this relationship. Reasons for this failure, where it occurs, are perceived by

parents to be lack of communication or empathy between therapist and teacher, lack of time available to a teacher who has ongoing responsibility for perhaps around 30 children, and lack of sufficient appropriate training for the classroom teacher.

The perception of many parents was that the training received by the latter in special needs is inadequate to prepare them for early recognition and identification of difficulties generally, and to prepare them for work with speech and language therapy in particular. For example, the mother of a dyslexic child indicated:

> '…an unbelievable misunderstanding of the difficulties among teachers. He has short-term auditory memory problems, and teachers don't know what this is or how to help him. They don't see his memory as a problem.'

Nevertheless, there was acknowledgement, if frustration, regarding the time pressure under which teachers are working. One parent reported that the 'totally inadequate' discussion of her child's IEP had, for lack of an alternative time slot, been crammed into half an hour during a teacher's lunch break.

Overall, by far the greatest consensus among parents was about the need for greater understanding and collaboration at the level of SLTs and classroom teachers.

7.5   Examples of good practice

Parents were asked for specific examples of the best aspect of the service received from the speech and language therapy service and/or from the LEA. Many of the replies concerned praise for individuals, as already discussed: individual therapists perceived to have achieved remarkable results, or "champions" who had advanced parents' aims in obtaining provision. However, a number of parents gave examples of integrated practice involving speech and language therapy. These are briefly described as follows:

An "Opportunities" playgroup, set up by social services, and serviced by a speech and language therapist, was praised by several parents as an example of good practice; this playgroup had been set up for local children, with special needs children comprising one third of the total; it was described as having an environment which encouraged and supported the policy of inclusion effectively, and parents felt that both special needs and mainstream children derived benefits from learning to play together.

In another area, a Toy Library had been established in a local hospital, offering therapy sessions to about five children in an atmosphere that parents felt to be more "friendly" and less potentially threatening to the children than that of a clinic. The library was served by a range of therapists, whom a different group visited each day of the week. A speech and language playgroup on similar lines, housed in a school elsewhere, had 'provided a terrific service to children at a critical age: two to three. More should be spent on these, and there needs to be something following on from these playgroups in schools' (parent).

Parents in another location highlighted a child development unit as a medium through which particularly effective links had been fostered between children who had been identified with significant needs at an early age, the LEA and schools. This unit, run by a Health Trust, housed speech and language therapists, a paediatrician, occupational therapists and a pre-school teacher.

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A school building partially destroyed by fire had been rebuilt to house a multi-agency assessment centre for primary age children, with a similar development planned for older children at a second school. This arrangement received praise because its focus on special needs allowed 'everything to take place there', while allowing for (re)integration into mainstream school where possible.

The work done in language units was praised by parents in a number of different areas.
> *'The [nursery] unit is brilliant. It has input from social services, speech and language therapy, Health and Education, and is specially for children with language disorders, rather than speech and language difficulty.'*

Some parents expressed the view that in an ideal world (in which funding was not an issue), well-resourced language units would be attached to mainstream and special schools in every borough.

At one of these units, in which each class was staffed by a full-time teacher, a full-time special support assistant and a part-time speech and language therapist, features singled out for praise by parents were: the opportunity for all unit pupils to participate in some main school activities, including assembly, lunch and playtime; integration with an appropriate main school class for PE and games; some participation in shared learning with main school classes for educational drama and events connected with year-group activities. Parents particularly liked the fact that the level of integration depended upon the child's particular needs, some children being able to return to main school classes in the school without extra support. In this particular area, some children returned to their local school on leaving the language unit, and may have required support from that school's special needs department and/or community speech therapy. Other children continued to require special educational provision, which may have been at a secondary language resource base, a day special school or a residential special school.

In general, parents were sensitive to and appreciative of schools which offered a supportive ethos, and a flexible approach to children with special needs. A school won praise for its sympathetic attitude in arranging for groups of children to be set up, with the aim of helping a child with communication difficulties to develop her skill through the encouragement and involvement of mainstream children.

7.6   The Future

Parents were asked how transition was (or would be) handled from primary to secondary education, and about continuity of provision.

Unsurprisingly, there were parents who hoped that a current programme of therapy would avoid the need for continuity at a later stage of education, typically in cases where good progress had already been made, perhaps in the behavioural as well as communication aspects of a child's development; in such cases consensus of opinion favoured a child's early absorption into mainstream school life, perhaps with a little extra support from the class teacher. There were other parents who clearly had given little thought to the future: dealing with the present was proving problematic enough, and they were taking a "wait and see" attitude.

As already mentioned, however, continuity of provision is a major concern for parents in terms of non-availability of therapists and in some cases withdrawal of provision. As a separate, though related, issue however, many parents perceived as problematic the management of continuity of provision across educational transitions. For some parents, these concerns were about transition from nursery to full time education.

> *'They've kept doing assessments and the SLT said "there's nothing more I can do for her in this environment [playgroup]". I agree, there wasn't, but there needs to be something to follow on in school.'*

> *'At nursery there is an SLT and a teacher – the school has capitalised on the benefits of having a unit with eight places for children with particular speech and language difficulties. But at the end of infant school they go back to the villages, and the "luxury" of provision through the teacher and SLT is lost - they go back onto the resources of SLT in the community.'*

In addition, there were concerns that established communication links can be lost.

> *'Up to nursery there was always someone you could phone up, and the child development unit was brilliant – the paediatrician, SLT, physio. Then when you lost contact with them, there was nobody to approach. School doesn't have time, although they seem to want to help.'*

Similarly, parents of older children were dismayed to find that speech and language therapy would be unavailable at secondary level.

> *'We've been advised to start looking at all secondary schools to see what schools we think will be best: mainstream and special – but it's the support, getting the support in there!'*

A number of parents had resolved to find an out-of-area placement, rather than accept a within-boundaries placement they perceived to offer inadequate opportunities for speech and language (and frequently other) therapy provision. A few parents expressed the view that school heads are not keen to accept children with learning difficulties, 'showing displeasure as soon as special needs are mentioned'. The pressure of league tables was a suggested contributory factor here.

Many parents found themselves ill equipped to deal with the process of transition, particularly perhaps, from primary to secondary level. While general information about a school's facilities was available, parents were not necessarily able to relate this information to their own child's needs. A number of parents regretted that there was no individual with a remit to advise parents about an ideal placement, though there was recognition that this would be no guarantee of securing a place at the chosen school. Several parents were extremely grateful where guidance had been given: 'If it wasn't for her (the SLT), we would never have known about *(named)* school. If she was her daughter, that's where she would send her…'

Overall, parents expressed uncertainty and anxiety about their children's future education in general, and access to speech and language therapy in particular, though issues of transition were clearly of less concern at this stage to parents of younger children.

Chapter 8 - Case studies

Key findings

- Five LEA/Trust partnerships are described and evaluated from the perspective of key stakeholders: commissioner, managers, practitioners and parents

- Key themes emerge across the case studies

- SLT is a relatively low spending priority for health commissioners

- There are issues of:

  - co-terminosity

  - jointly agreed management of children with speech, language and communication

  - direct vs. indirect SLT support

  - the need for an appropriate training programme for Learning Support Assistants (LSAs)

8.1 Introduction

This chapter will present a 'vertical' analysis of five of the sites visited during Phase 2. The sites chosen illustrate a range of features influencing provision for children with speech, language and communication needs across the types of LEA: London Borough, Metropolitan Borough, Welsh Authority, Shire County and Unitary Authority. The aims of each case study analysis are as follows:

- To expose the factors which have influenced the evolution of the model of support for children with speech, language and communication needs in that specific authority. Issues include co-terminosity of boundaries, the LEA plan for inclusion, the history of collaborative work between health and education services in this site.

- To explore how this model operates in practice, including the philosophy of the model of support, systems for assessment and prioritisation of SLT caseloads, how resources are distributed.

- To evaluate the model from the commissioner, manager, practitioner and parent perspectives.

Key features will be extrapolated which have been found to be significant in support for children with speech, language and communication needs.

Diagrams have been constructed in order to represent the often-complex relationships between the LEAs and NHS Trusts that are the subjects of the case studies. The focal LEA, Trust and Health Authority for each case study have been given pseudonyms based on the type of authority they exemplify, for example, "LEA London" and "Trust Shire" in case studies 1 and 4. A number of other LEAs and NHS Trusts appear in these diagrams, as the vast majority of LEAs have relationships with more than one NHS Trust, some of which in turn have relationships with more than one LEA. Organisations which need to appear in the diagrams but are not the focus of the case study will be labelled alphabetically from A in the case of NHS Trusts, and

alphabetically from Z in the case of LEAs. Non-focal Health Authorities will be numbered.

8.2   Case Study 1: A London borough LEA and partner NHS Trust

Case study 1 describes a London Borough LEA servicing an area of high deprivation. There is one nursery language resource which is sited in a health setting and staffed by an SLT and SLT assistant, and one primary language unit which is sited in a mainstream school. The primary unit has staffing of 1.0 wte SLT, five specialist teachers for language impairment and five LSAs and serves 28 children. Budgets for SEN support are devolved to head teachers. However, there is a central LEA learning support service to offer specialist advice across the LEA. This service includes two specialist teachers for language impairment. LEA London also has a special school for children with autism, a special school for children with physical disabilities, and three special schools for children with learning disabilities. SLT services for children attending schools in LEA London are all provided by Trust London.

Table 8.1   Profile of special educational need relative to schools in LEA London

Number of schools		Number or percentage of children on Code of Practice Stages			Percentage of children with Statement of SEN	Number of children with SLT needs identified in Statements of SEN
Primary	Secondary	Stages 1/2	Stage 3	Stage 4		
49	9	3580	1206	136	3.9%	115 as a primary need

Trust London is a Community NHS Trust. The paediatric SLT teams provide a service to health centres, mainstream schools, language provisions and special schools. All but 0.6 wte funding comes from health commissioning.

Table 8.2   Profile of SLT service within Trust London

Children aged 0-16			SLT Children's services staffing		Ratios	
Total population (0-16)	Ongoing SLT caseload	SLT waiting list	SLTs	SLT assistants	SLT wte per capita population	Ongoing caseload per SLT
58,950	1218	429	32.8	3.0	1:1797	1:37

Percentage of population age 0-16 known to SLT service = 2.8%

Table 8.2 gives a profile of the SLT service relative to the population which it serves. These data are representative of Trust London's activity across its area of responsibility, which includes LEA London and LEA Z as represented in Figure 8.1 below. This shows a diagrammatic representation of LEA London's interactions with the NHS Trust in which the provider speech and language therapy services is based. The highlighted relationships indicate reciprocal sites which were involved in the interviews at Phase 2.

Figure 8.1 The Education and Health relationships for LEA London
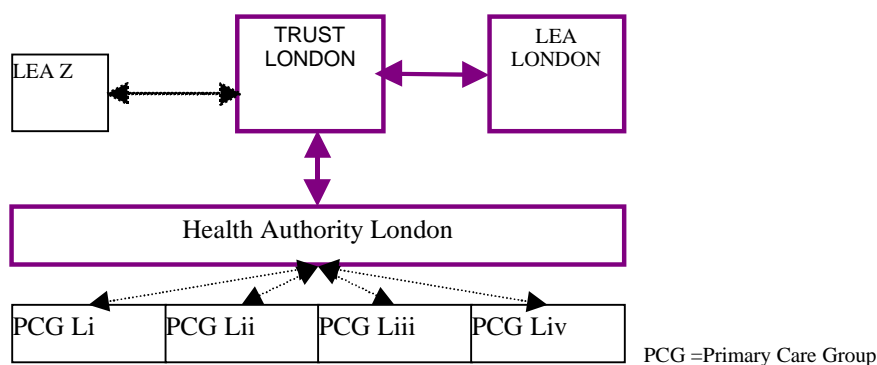
Health Authority London commissions SLT services provided by Trust London to both LEA London and LEA Z. None of the Primary Care Groups in the site have yet taken on a commissioning role in relation to the SLT service provided in LEA London's area. Potentially, PCGs Liii and Liv would be the relevant bodies in relation to LEA London, whilst PCGs Li and Lii would be relevant to the area provided for by LEA Z.

LEA London has been successful in securing monies from the Standards Fund in relation to support for children with speech, language and communication needs. The bid for these monies was in itself a collaborative venture, in that the bid was one of two linked bids involving the SLT service of Trust London, the second being led by LEA Z. Health Authority London supported bids from both LEAs.

8.2.1 Model of SLT service delivery

The team of SLTs providing a service to mainstream schools in LEA London are based within the LEA learning support service base. This is also true of the team providing a service to LEA Z. These arrangements have been in place since the teams were formed, and are felt to be a positive factor in promoting collaborative practice between the SLTs and specialist education colleagues. The SLTs in these teams are funded by health monies, employed and managed by SLT managers within Trust London. SLTs working in any school setting within Trust London are required to take their annual leave in school holidays as the norm. Up to five days annual leave in term time can be negotiated but this is on a case by case basis. During school holidays, SLTs based in schools may undertake some group work, for example with children moving into reception in the following year, or those in transition between KS2 and KS3. However, the school holidays are generally recognised to be a time that SLTs can appropriately spend on administrative tasks in respect of their caseloads, as well as planning and preparation of programmes and materials. They are not re-deployed into clinics or other health settings.

The management of children with speech, language and communication needs attending mainstream schools is guided by the Language and Communication Team, which is a multi-agency management group made up of SLT, Educational Psychology (EP) and Specialist Teacher. All children attending mainstream schools who are referred for support with their language and communication skills are reviewed by this team. Children whose difficulties are solely in the area of speech production are seen by the SLT service based in local health centres. Each individual child's needs in the area of language and communication are rated along a continuum of mild, moderate,

severe, complex. They are discussed at fortnightly meetings of the Language and Communication Team and a 'lead professional' agreed. Thus, it could be that an SLT is the lead professional for a child with a severe and specific language disorder, whilst a specialist teacher might be the lead professional for a child whose language needs are rated as 'moderate' and who also has a range of learning needs. An educational psychologist might take the role of lead professional for a child where the need is rated mild and where advice to the school regarding useful strategies is felt to be an appropriate level of support. This system of multi-disciplinary working results in a continuum of support being offered which crosses the professional divide.

SLTs working in the team providing a service to LEA London schools each have a group of schools for which they are responsible. This allows individual SLTs to make relationships with school staff and from the school perspective means that they have a consistent SLT with which to liaise. The number of visits which the SLT will make to a school is based on the known SLT need in the school. As a result of the referral system via the Language and Communication Team, SLTs have caseload of children who predominantly have severe/complex SLT needs. The SLT can decide what intervention is appropriate from a range which includes opportunities for direct intervention, training of LSAs, working individually or in groups. In addition, a programme of three week intensive language groups is ongoing in certain schools within the LEA. These group courses are delivered either by two SLTs or by an SLT and a specialist teacher. LSAs are always involved, as the groups also provide training.

Trust London also uses its commitment to the training of student speech and language therapists to support the work of both the under-five's nursery service and the service to mainstream schools. Teams of student speech and language therapists work in pairs to deliver additional group intervention in schools and nurseries.

8.2.2   Key issues

(a)   Development of the Language and Communication Team
(b)   Support for children with and without statements of SEN
(c)   Direct SLT input vs. a consultative model - especially parental perception of this issue
(d)   Waiting lists

8.2.2 (a) Development of the Language and Communication Team (LCT)

Commissioner

- The health commissioner interviewed expressed the view that SLT is a health need and should be provided by health, however, that the LEA can enable the service to be provided more effectively through collaboration such as the LCT

- A commissioning issue related to the LCT system is that GPs are not the main referring agents for SLT for school age children and that this will have significance when PCGs and later PCTs take over this role as they are GP led.

Manager

- The Principal EP reported a lead role in co-ordinating the LCT.

- The evolution of the team approach was reported to have been significantly influenced by the long term collaboration already in place between Specialist Teachers, SLTs and schools in the LEA

- The system of school referral with quite a detailed referral form was felt to increase the accountability and ownership of the schools in relation to the needs of the children

- The SLT managers interviewed expressed the view that the LCT had led to a shared responsibility for children with speech, language and communication needs between the SLT service and the LEA

- The physical base of the SLTs within the LEAs Learning Support Service was also felt to have contributed significantly to the collaborative culture leading to the LCT

- Having established the LCT framework within the mainstream primary phase, SLT managers reported the need to further develop the system into the secondary phase and possibly special schools.

Practitioner

- Mainstream teachers reported that the referral forms were long and the process complicated

- The specialist teacher reported that the development of the LCT had helped with role definition between team members and also for schools receiving support

- The training role for the specialist teacher was ever increasing as were the numbers of children for whom advice was required

- SLT practitioners also felt that the LCT had formalised working relationships in a positive way

- They reported increased contact and involvement from the EPS which was welcome

- The LCT framework had reduced instances of conflicting advice to schools or parents

- The information collated in the referral document formed a useful starting point for the SLT

- The LCT process ensured a multi-professional discussion of each child's needs

Parent

- The parent interviewed had not experienced the LCT system, as their child had been known to the services for some time prior to its development

- However, an interesting comment made was that collaboration and communication between health professionals could be improved, for example the co-ordination of advice between the SLT and Occupational Therapist involved with their child

8.2.2 (b) Support for children with and without statements of SEN

Commissioner
• The health commissioner supported Standards Fund bids on the basis that more children would have earlier access to support through collaboration. It is therefore appropriate that health prioritisation is not bound by the Statement of SEN

Manager
• The principal EP reported that historically SLT recommendations in Statements of SEN which the SLT service could then not meet gave the LEA difficulties in terms of legal challenges
• The development of the LCT has helped in ensuring that SLT resources are allocated on the basis of the child's language and communication needs regardless of the stage of the Code of Practice
• For children with Statements, the reference to support from the LCT also ensures equity in terms of resource allocation
• The SLT managers interviewed appreciated that the LEA had accepted that the SLT service needed a professionally justifiable system of resource allocation despite the difficulties that might pose in relation to Statements of SEN
• The LCT allowed the SLT input to be more accurately targeted at those children with the most significant language and communication needs whilst alternative support was available for children with less severe needs

Practitioner
• Mainstream teachers reported experiencing pressure from parents of children with Statements of SEN whose language and communication needs were not a high priority in the LCT system
• They also reported difficulties in implementing programmes and targets for children without Statements of SEN who did not have identified support from Learning Support Assistants (LSAs)
• SLT practitioners reported satisfaction at a philosophical level that they were able to consider the needs of children regardless of the child's stage on the Code of Practice
• Various 'packages of care' were described and the choice of appropriate intervention in a given term was reported to be a collaborative decision with the child's class teacher. A given child might access different packages of care in the course of an academic year
• SLT practitioners perceived that despite the LCT system, the LEA would still find it easier if they were to prioritise children with Statements of SEN
• The choice of which package of care might be delivered was in part influenced by the availability of LSA support in school to support a programme and LSA support is still reported to be mostly linked with a Statement of SEN

Parent
• The parent interviewed in this site was the parent of a child with a Statement of SEN
• They reported having had to 'fight' for resources and felt that the Statement of SEN was still the only way of protecting those resources
• They also commented that they felt that the only truly independent SLT report was one obtained privately

8,2,2 (c) Direct SLT input vs. a consultative model - especially parental perception of this issue

Commissioner
• The health commissioner for Health Authority London did not comment specifically on this point other than to be generally supportive of collaborative working

Manager
• The principal EP interviewed expressed a commitment to promoting support for speaking and listening within the curriculum and therefore the collaboration with SLTs and specialist teachers in raising skills in schools for supporting children was felt to be highly appropriate
• The LCT system allows for children with severe and / or specific language and communication needs to access direct intervention if appropriate
• SLT managers reported that the fundamental issue was the need for an understanding of the role of the SLT within education and how that role differs from a traditional SLT role in a clinical or medical setting
• Direct 1:1 therapy should be recognised as not always the most appropriate form of support for a child if the aim is to increase their access to the curriculum

Practitioner
• Mainstream teachers commented on the positive aspects of having SLT targets incorporated into Individual Education Plans (IEPs)
• However, the lack of additional support in the classroom to implement strategies was a problem for some if the child did not have identified time with an LSA
• The specialist teacher worked collaboratively with the SLT service as part of the LCT and was also involved in both consultative and direct support for children
• The SLT practitioners stressed that it was their carefully monitored caseload size together with the LCT prioritisation system which allowed them to offer a range of interventions including direct work

Parent
• The parent interviewed was clear that support should be classroom based and felt that ideally that should be delivered by an SLT
• LSAs were valued but not as a substitute for an SLT

8.2.2 (d) Waiting lists

Commissioner
• The health commissioner support for the Standards Fund bids was partly driven by the recognition that more children need to access services earlier

Manager
• The principal EP reported that waiting lists for SLT, sometimes of 2 years, were a big problem and a driving force in setting up the LCT. Evaluating the needs of the child at the outset, and identifying the most appropriate support from a continuum available, should reduce waiting times
• The SLT managers also experienced concerns regarding waiting list times. However, the LCT system was felt to be a positive means of addressing the issue, in that some children who might previously have been placed on the waiting list for the SLT service were now identified earlier as having needs which could be supported from another part of the team, e.g. specialist teacher
• The waiting list for this service also reflected the decision that a child could not be taken onto the caseload until the appropriate level of support was available

Practitioner
• Teachers reported frustration at the historically long waiting times for support from SLT services for children in school
• SLT practitioners were uncomfortable with the transition from the SLT service for under 5's to that for school aged children, as children who had been receiving a service from the under 5's SLT team effectively went back on the waiting list for the school based service

Parents
• The parent interviewed commented that the SLT service should be needs led and not resource led
• Practitioners commented that many parents of children who had been waiting for some time were already negatively disposed towards the service by the time intervention was offered, which made it more difficult to engage the parent

8.3 Case Study 2: A Metropolitan LEA and partner NHS Trust

"LEA Metropolitan" has co-terminous boundaries with "Trust Metropolitan" which provides the SLT service for LEA Metropolitan schools.

Table 8.3 Profile of special educational need relative to schools in LEA Metropolitan

Number of schools		Number or percentage of children on Code of Practice Stages			Percentage of children with Statement of SEN	Number of children with SLT needs identified in Statements of SEN
Primary	Secondary	Stages 1/2	Stage 3	Stage 4		
102	20	2446	910	78	1.6%	328 as any level of need

There is one primary language unit which is sited in a mainstream school. The primary unit has staffing of 0.5 wte SLT, two specialist teachers for language impairment and two LSAs. This unit serves 13 children.

Budgets for SEN support are devolved to head teachers. However, there is a central LEA learning support service consisting of 12 teachers who offer specialist advice across the LEA. Typically each teacher would be responsible for approximately 16 schools. These teachers also have a lead role in monitoring provision in place for children with special educational needs who are receiving additional support. As part of this monitoring role, they carry out an annual audit in each school following which the amount of resource allocated to the support of an individual child can be adjusted to take account of current need. This service includes two specialist teachers for language impairment. LEA Metropolitan also has special schools/units for children with autistic spectrum disorders, physical disabilities, learning disabilities, hearing impairment and emotional and behavioural difficulties.

LEA Metropolitan has developed a system which allows additional funds to be allocated to children at Stage 3 of the Code of Practice for Special Educational Needs. This is a finite budget which Head Teachers can apply for in order to provide additional support for a child at Stage 3. Many of the children supported in this way have been identified as having specific speech, language and communication needs. However, due to their relatively good skills in other areas of learning, these are children who might not meet the criteria for statutory assessment. Alongside this system of Stage 3 support, Head Teachers in the LEA have agreed to a top-slicing of their budgets in order for the LEA to fund two wte SLT posts to implement programmes of support for children at Stages 1-3 of the Code of Practice. The development of these posts was a collaborative venture between the LEA and SLT service. Health Authority Metropolitan was approached to contribute to this funding but this bid was not successful.

Trust Metropolitan is a single unit NHS Trust which provides both acute and community services. Consequently, resources within Trust Metropolitan can be diverted to acute services in times of extreme need.

Table 8.4   Profile of SLT service within Trust Metropolitan

Children aged 0-16			SLT Children's services staffing		Ratios	
Total population (0-16)	Ongoing SLT caseload	SLT waiting list	SLTs	SLT assistants	SLT wte per capita population	Ongoing caseload per SLT
40,000	945	302	11.4	1.4	1:3509	1:83

Percentage of population age 0-16 known to SLT service = 3.1%

As outlined above, 2 wte. SLT posts are funded by Head Teachers in LEA Metropolitan via a top-slicing arrangement from their budget. The organisational relationship between Trust Metropolitan's SLT service and LEA Metropolitan is represented in Figure 8.2 below. The highlighted relationships indicate reciprocal sites which were involved in the interviews at Phase 2.

Figure 8.2 Education and Health relationships for LEA Metropolitan
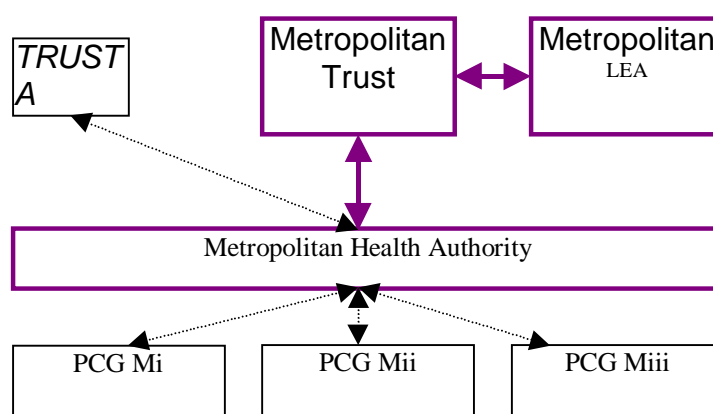
8.3.1 Model of SLT service delivery

The SLT service for children with a Statement of SEN is funded from health monies. However, SLTs, EPs and LEA officers responsible for special educational needs have devised a jointly agreed protocol of management levels. This protocol involves five levels of SLT management being defined for children at Stage 5 of the Code of Practice:

- Level 5 - two visits by the SLT to the school per week
- Level 4 - one visit by the SLT to the school per week
- Level 3 - two visits per half term
- Level 2 - up to three visits per term
- Level 1 - one visit per year for Annual Review.

There are criteria for each of the levels and each child's level is reviewed on a termly basis. Further to this, the LEA monitors a sample of children across the LEA to ensure equity in how the levels are being interpreted between schools.

At the time of this survey, 76 children were being supported in this way by SLTs from Trust Metropolitan. Although working from a clinic base, approximately 2.8 wte. SLTs were engaged in this support as part of their post. However, no single SLT was working

entirely with this caseload therefore several SLTs were involved in delivering this support.

The SLTs funded by the LEA to support children at Stages 1-3 of the Code of Practice are physically based with the specialist teachers for the LEA. These posts are still relatively new and the first task for the SLTs has been a comprehensive audit of need. This has indicated a further shortfall in SLT support required in schools. The remit for these posts is to provide training and support to schools around language and communication needs. It is not envisaged that these SLTs will spend significant amounts of time in direct intervention with children. However, the audit has uncovered a group of children who are at Stage 3 or below in Code of Practice terms, but who have speech, language and communication needs equivalent to some children with Statements of SEN who could be receiving management level 4 (see above). These children can be offered a clinic based service, but it has been recognised that this is not ideal.

8.3.2 Key issues

(a) LEA funding of SLT service for Stages 1-3 of the Code of Practice
(b) Agreed management levels for children with statements of SEN
(c) Direct SLT input vs. a consultative model - especially parental perception of this issue

8.3.2 (a) LEA funding of SLT service for Stages 1-3 of the Code of Practice

Commissioner

- The health commissioner interviewed expressed the view that no more funds could currently be allocated to SLT by the Health Authority
- Bids had been received in respect of matched funding for the development of the service for children at Stages 1-3 of the Code of Practice, however, SLT was not a current priority for additional funding

Manager

- The LEA managers had been hoping for matched funding from the Health Authority and were disappointed that this had not been forthcoming
- Head Teachers accepted the option of having their budgets 'top-sliced'- in order to fund the service
- The LEA managers acknowledged the potential anomaly with a child at Stage 3 of the Code of Practice potentially having speech, language and communication needs which were similar to a child who was at Stage 5 due to their overall learning needs. This was a driver in establishing the SLT service for children at Stages 1-3 of the Code of Practice
- The SLT manager expressed very similar views to the LEA managers - this was true across all themes and appears to reflect a high level of collaboration
- The SLT manager also expressed concern that the high caseload levels for the two wte. SLTs providing the service to children at Stages 1-3 (102 schools : 2 SLTs) was forcing a highly consultative model to the extent that the impact of the service might be in jeopardy

Practitioner

- Specialist teachers interviewed had a monitoring role in relation to the additional funding provided by the LEA for children at Stage 3 of the Code of Practice
- These teachers expressed positive views of the SLTs providing the new service to children at Stages 1-3
- The teachers appreciated the enormity of the task for the SLTs
- They were keen to develop joint training packages
- The SLTs providing this new service were optimistic about the development of the service
- They reported that being based with the specialist teaching service was an advantage in terms of liaison
- They also reported much closer contact with the EPs than colleagues based in clinics
- Anxieties were expressed regarding the enormity of their task - 1000 children were put forward by schools
- A group of children at Stage 3 had been identified whose needs could not be met by the service for children at Stages 1-3
- They were also concerned that due to their resource being stretched that their effectiveness would be undermined

Parents

- Parents interviewed were not aware of the additional resource available at Stage 3 of the Code of Practice or of the SLT service for this group of children
- In part, this had been because the SLT service had wanted to get the provision right before publicising it

8.3.2 (b) Agreed management levels for children with statements of SEN

Commissioner
• The health commissioner was aware of and supportive of the management levels for children at Stage 5
• This commissioner had been involved in the initial redistribution of SLT resources from clinics to schools in order to provide the service
• He was also aware of an estimated shortfall in the provision available for children at Stage 5 but reported not being 'wholly convinced' of the accuracy of the scale of the shortfall
• The commissioner stated that a well argued case from the LEA would help secure additional funds

Manager
• LEA managers reported having led the way in the evolution of the agreed management levels
• Initially these discussions had taken place with the Health Authority as the previous SLT manager had been reluctant to develop this system
• The LEA managers reported that the change in SLT manager had been instrumental in moving this forward
• The LEA managers continue to be frustrated by their responsibility for ensuring SLT provision whilst not being able to influence funding
• The SLT manager viewed the process of establishing the agreed management levels as having been important in developing collaboration
• The SLT manager regretted the lack of additional funds from the Health Authority and expressed the view that this posed a potential threat to collaboration
• The SLT manager was also aware of the impact of service to clinics in that funds had been redirected from clinics to schools rather than additional funds being identified

Practitioner
• Teachers were supportive of the levels of management
• Concerns were expressed by the education-based SLTs that the therapists based in clinics who wrote statutory advice sometimes did so without being able to do a school visit to see the child in context
• The use of management levels appeared to be partly resource driven in that SLT practitioners reported there being some children they would like to have put on Level 5 (highest) but that this recommendation was not made, as the input could not be provided from within existing resources
• The SLT practitioners were pleased that SLT provision in terms of management levels was usually under 'non-educational' provision in the statement of SEN, as they felt this allowed them to review the management level termly, whereas they feared that if it were under 'educational' provision, the level could only be reviewed at Annual Review.

Parents
• Parents of children with a Statement of SEN commented that although SLT appears in the Statement it is under non-educational provision which they felt was not ideal
• They reported that contact with the SLT was limited and insufficient
• They were also concerned that the support described (management levels) did not ensure direct input from an SLT

8.3.2 (c) Direct SLT input vs. a consultative model - especially parental perception of this issue

Commissioner
• The health commissioner expressed the view that there was evidence that intervention through care-givers/schools was more effective than 1:1 SLT input
• He was therefore supportive of a model which included indirect support from the SLT service

Manager
• SLT and LEA managers were of one view on this subject
• They felt that there needs to be a range of provisions available to meet varying levels of need
• Schools should be directly involved in deciding how SLT support can be used most effectively
• They viewed direct and indirect intervention as appropriate at different times and for different children

Practitioner
• Specialist teachers interviewed were very familiar with an indirect or advisory role as that is the model which they operate
• SLT practitioners reported that where language aims were incorporated into IEP targets this worked well
• Where the SLTs did offer direct 1:1 intervention for a child, it was always with the additional aim of training a member of school staff to be able to follow-up on the tasks
• SLTs expressed the view that they perceived many classroom teachers still expected 1:1 withdrawal from the classroom

Parents
• Parents expressed concerns that there was not enough input from the SLT service
• They also expressed concerns regarding the amount of liaison between the SLT and the SENCO
• They felt that there should be a member of school staff with specialist knowledge about speech, language and communication needs
• Two of the parents interviewed were accessing independent SLT for direct intervention

8.4   Case Study 3: A Welsh LEA and partner NHS Trust

Case study 3 focuses on an LEA in Wales. This LEA is responsible for educational provision in an area of Wales which includes a significant proportion of schools using Welsh as the language of the classroom. SLT services for LEA Wales are provided by Trust Wales, with the exception of the provision to the LEA's language units (see below).

Table 8.5   Profile of special educational need relative to schools in LEA Wales

Number of schools		Number or percentage of children on Code of Practice Stages			Percentage of children with Statement of SEN	Number of children with SLT needs identified in Statements of SEN
Primary	Secondary	Stages 1/2	Stage 3	Stage 4		
96	8	2982	1073	33	4.05%	67 as a primary need

There are two primary language units. These primary units are staffed by two wte. specialist teachers and four LSAs. SLT provision to these units is purchased by LEA Wales from Trust O. Trust O neighbours Trust Wales, which is the Trust in the focal relationship for this case study. LEA Wales has no other interactions with Trust O apart from this contract for the language units.

Trust Wales is a Community NHS Trust. LEA Wales currently funds 0.5 wte SLT posts. However, following comments made by OFSTED in its inspection of the LEA, monies have been identified to fund an additional 2 wte. SLT posts to develop the service to children in mainstream schools. Recruitment of Welsh speaking SLTs is a particular issue for Trust Wales. The SLT service did include one Welsh speaking SLT until recently. This SLT moved to a neighbouring Trust in order to achieve promotion.

Table 8.6   Profile of SLT service within Trust Wales

Children aged 0-16			SLT Children's services staffing		Ratios	
Total population (0-16)	Ongoing SLT caseload	SLT waiting list	SLTs	SLT assistants	SLT wte per capita population	Ongoing caseload per SLT
24,874	1034	120	6.0	0.0	1:4146	1:172

Percentage of population age 0-16 known to SLT service = 4.6%

The organisational relationship between Trust Wales' SLT service and LEA Wales is represented in Figure 8.3 below.

Figure 8.3 Education and Health relationships for LEA Wales
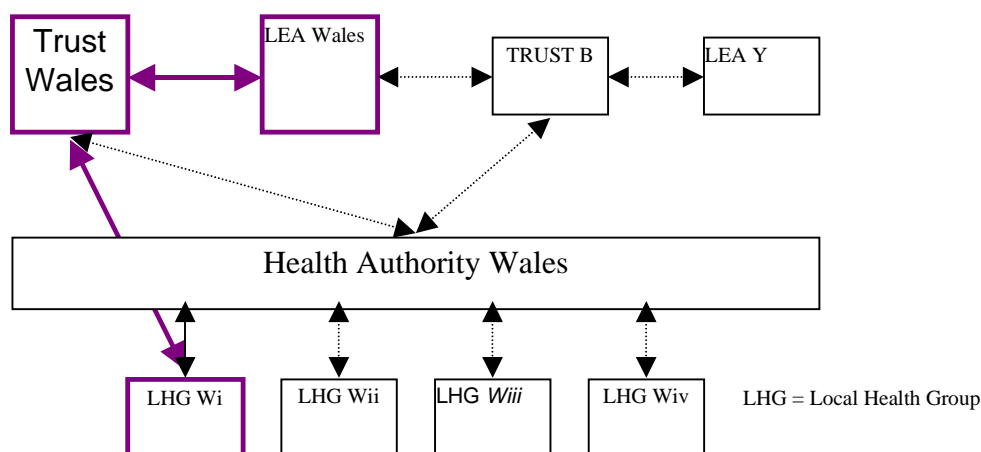
Local Health Groups in Wales are similar to Primary Care Groups in England. The commissioner for SLT services in Trust Wales is the general manager of LHG 7i as represented in figure 3. She describes the LHG as a sub-committee of the Health Authority which appears to be a slightly more direct relationship than for PCGs in England.

8.4.1 Model of SLT service delivery

Currently, SLTs are clinic based but offer designated support for children in mainstream schools from that base. This support is described as consultative, in that therapists visit school in order to set up a programme of activities which is then implemented by an LSA. The caseload numbers for SLTs in this service are such that visits are not as frequent as would be desirable.

The additional funding equivalent to 2 wte. SLT posts which LEA Wales is providing to Trust Wales is expected to allow the development of a more strategic model of working in mainstream schools. The intention is that schools will identify a member of school staff, either a teacher or LSA, who can be released to work alongside the SLT for 6-8 weeks. Following this period, the SLT will move on to set up a similar programme with the next school. The member of school staff will continue the intervention with gradually decreased amounts of support from the SLT. It is hoped that once such a rolling programme of support is in place, the effectiveness of the consultative model of support offered from the clinics will increase as school staff will have increased knowledge and confidence in delivering support for speech, language and communication needs.

8.4.2 Key issues

(a)   Lack of Welsh speaking SLTs
(b)   LEA funding of SLT posts arising from OFSTED inspection

8.4.2 (a) Lack of Welsh-speaking SLTs

Commissioner
• The health commissioner interviewed did not comment specifically on this issue

Manager
• The LEA mangers interviewed commented on the need for Welsh speaking SLTs for schools in the north of the LEA where the curriculum is delivered in Welsh
• The manager from LEA Wales commented on how useful it had been to have access to a Welsh-speaking therapist, and was sorry she had moved to another Trust
• The LEA manager perceived the reasons for this as being linked with career development opportunities
• The SLT manager also recognised the need for Welsh speaking SLTs
• The Welsh speaking SLT who had previously worked in Trust Wales was able to secure a more highly graded post in another Trust. The grading was such that Trust Wales could not match it.
• However, recruitment was generally an issue even without the additional requirement of Welsh skills and therefore she was not optimistic about resolving this situation
• Contingency measures such as working through assistants and teachers in Welsh speaking schools were being considered

Practitioner
• Teachers interviewed did not raise this as a specific issue but may not have been representative of the Welsh speaking schools
• Non-Welsh speaking SLT practitioners who cover Welsh speaking schools felt at a significant disadvantage in working within those schools
• Some reported that they perceived a mild hostility to them when they had to say that they did not speak Welsh
• SLT practitioners also commented on the lack of clarity as to what was a given child's first language. Many of the children attending Welsh speaking schools were not Welsh speaking in the home and therefore the SLTs felt that the issue was perhaps exaggerated for those children

Parents
• Parents expressed the view that English speaking SLTs were at a disadvantage in supporting Welsh speaking children in school and that this situation was not satisfactory

8.4.2 (b) LEA funding of SLT posts arising from OFSTED inspection

Commissioner
• The health commissioner interviewed was sympathetic to the pressures on the SLT service, however was also clear that SLT provision is not a current priority for spending in the context of other health needs
• The commissioner was encouraged by the funds identified by the LEA, however felt that one wte. post was 'picking at the surface' of the needs in schools

Manager
• LEA managers acknowledged the large caseloads of the current SLT service and were optimistic that the additional funding would go some way to alleviate this situation
• The post was going to be managed within the SLT service but the LEA was looking at ways of being involved in the management of the SLTs funded in this way given their financial commitment
• The longer term aim was to develop a service which would increase skills levels within schools as well as meeting the needs of individual children
• The SLT manager hoped that the new SLT post would allow a consistent training programme to be developed to bring about a situation where a member of staff in each school would have on the job training in supporting children with speech, language and communication needs

Practitioner
• Teachers interviewed perceived that the current SLT service consisted of only assessment and no intervention
• The teachers were aware of recruitment and retention issues for SLT
• They felt that training of LSAs was a positive way forward in supporting children with speech, language and communication needs
• SLT practitioners described their service as being consultative but more than assessment as they provided programmes of advice for schools
• SLTs perceived that when on a school visit the teachers' expectations were that they should remove the child and work 1:1 with them
• SLTs also felt that training of LSAs was a good strategy for the future
• However, they also expressed the view that they were significantly understaffed and that their caseload size did not allow them to be effective

Parents
• Parents expressed the view that SLT support should be school based
• They were not opposed to LSAs implementing programmes but felt that there were issues about training
• Parents were clear that there is currently insufficient SLT provision and therefore the additional post will be viewed positively

8.5   Case Study 4: A Shire LEA and partner NHS Trust

Case study 4 outlines the situation in a large shire authority. LEA Shire has 2 nursery language units/bases, 10 primary language units/bases and 4 secondary language units/bases. The LEA employs 19 wte. specialist teachers within these language units/bases and a further 19.2 wte. specialist teachers form the peripatetic Learning and Language Support Service. One of the peripatetic team is a specialist in speech and language needs. In addition to this provision, the LEA contributes £400,000 per annum towards SLT services across the county. This funding is divided between Trusts C, D, E, F, G and Trust Shire but there are anomalies regarding the equity of the distribution of this funding.

Table 8.7   Profile of special educational need relative to schools in LEA Shire

Number of schools		Number or percentage of children on Code of Practice Stages			Percentage of children with Statement of SEN	Number of children with SLT needs identified in Statements of SEN
Primary	Secondary	Stages 1/2	Stage 3	Stage 4		
437	54	Not available	686	Not available	3.8%	906

Trust Shire is a Community NHS Trust. Table 8.8 gives a profile of the SLT service relative to the population which it serves. These data are representative of Trust Shire's activity across its area of responsibility which includes LEA Shire and LEA X as represented in Figure 4 below. Trust Shire is expected to reconfigure by 2002 with the sector of LEA Shire currently provided for by Trust Shire leaving Trust Shire and joining Trust G. In the interim, the SLTs providing the SLT service to LEA Shire are being encouraged to work as a 'locality', and a colleague for the SLT manager interviewed will be taking over responsibility for leading this team.

Table 8.8   Profile of SLT service within Trust Shire

Children aged 0-16			SLT Children's services staffing		Ratios	
Total population (0-16)	Ongoing SLT caseload	SLT waiting list	SLTs	SLT assistants	SLT wte per capita population	Ongoing caseload per SLT
54,700	1750	Not available	21.2	0.8	1:2580	1:83

Percentage of total population age 0-16 known to SLT service = 3.2%

Figure 8.4 shows a diagrammatic representation of LEA Shire's interactions with NHS Trusts in which the provider speech and language therapy services are based. The highlighted relationships indicate reciprocal sites which were involved in the interviews at Phase 2.

Figure 8.4 Education and Health relationships for LEA Shire
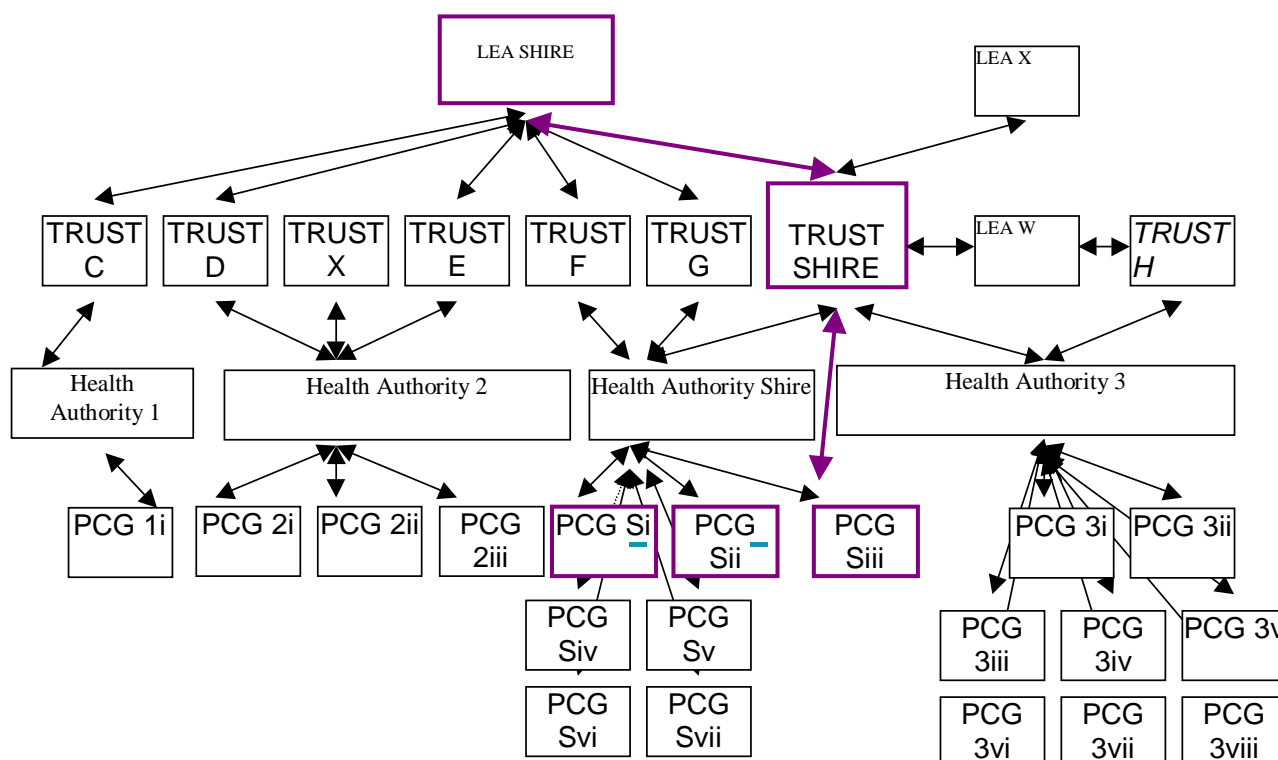
The complexity of the relationships between LEA Shire and its relevant NHS Trusts is evident from Figure 8.4. Complex relationships such as this were found to be a feature of shire authorities which were surveyed. However, LEA Shire reports a high level of collaboration with all its NHS Trust partners and this is reciprocated. Therefore, whilst lack of co-terminous boundaries is clearly not ideal, it does not in itself account for a lack of successful collaboration between an LEA and NHS Trust. [NB. Trust X does not have a relationship with LEA Shire as it is a specialist Trust for Mental Health and Adult Learning Disability services and therefore does not typically have clients in the 0 - 16 age range.]

LEA Shire and its NHS Trust partners have employed active strategies to overcome the challenges presented by their complex structural relationships. The SLT managers from Trusts C, D, E, F, G and Trust Shire meet on a regular basis to work on joint projects. Reorganisation of LEA management structure has changed the pattern of meetings between SLT managers and the LEA. Prior to the reorganisation, SLT managers met with the Assistant Director, whereas now they meet with a number of LEA managers who all have particular responsibilities within special educational needs provision. This change was felt to have both positive and negative aspects. It resulted in a number of working parties being established. However, this in turn has resulted in the SLT managers across the six trusts being represented on a working party by two of their group. This factor, whilst obviously a practical necessity, is felt to have contributed to frustrations for the LEA in terms of the speed of decision making possible. The SLT managers not in attendance on the working parties also experience the frustration of feeling distanced from the decision making process.

LEA Shire interacts with NHS Trusts that are commissioned by four Health Authorities. However the establishment of Primary Care Groups (PCGs) has already resulted in some changes in commissioning of SLT services. Services for Trust Shire and Trust G

are commissioned by a PCG acting as a Lead Commissioner on behalf of three PCGs in the northern part of the county covered by LEA Shire. The interviews in this study focussed on the relationships relating to LEA Shire and Trust Shire. Consequently, detailed information regarding the commissioning arrangements for Trusts C, D, E and F is not available. However, based on data available regarding the PCGs in place relative to the Health Authorities covering the Shire County for which LEA Shire provides, it appears that there are potentially 12 PCGs who could have a commissioning interest in SLT services across the county.

The inclusion of children with speech, language and communication needs into mainstream settings is reported to be a priority for LEA Shire and a joint strategy regarding this issue is currently being developed with its NHS Trust partners. Within the LEA, learning support services have been reorganised to form a Learning and Language Support Service which has a staffing establishment of 19.2 wte. specialist support teachers as outlined above. One of these teachers has a specific specialism in the area of speech and language. The rest of the team has recently completed a course on speech, language and communication which is accredited by a local University. The SLT manager of Trust D made a significant contribution to the content and delivery of this course.

8.5.1 Model of SLT service delivery

The model of service delivery in mainstream schools is largely consultative based on contributing language targets to Individual Education Plans (IEPs) with a learning support assistant (LSA) implementing the recommended strategies/activities. No specific system was reported for the allocation of SLT input to mainstream schools. In an academic year, some schools could receive several visits whilst others would not receive any. This decision making was based on need and the demand from schools. Some short courses of group intervention were reported to be offered on an *ad hoc* basis. Speech and language therapy is also offered in clinics for children with disorders of speech including phonological difficulties and stammering. In addition to the service to mainstream schools, Trust Shire provides input to language units and special schools.

Prioritisation by the SLT service in Trust Shire was reported to be based on severity of need as the primary criterion followed by age of the child. However, a project is currently underway across LEA Shire involving all six Trusts which aims to develop a system of allocating children to four quadrants of a grid based on parameters of severity and potential for progress in response to intervention. It is anticipated that this system of assessment and profiling will help resolve some of the concerns regarding the equity of provision across LEA Shire. Ultimately there will be agreement that a child placed in a given quadrant will receive a particular programme of support regardless of which SLT service is providing the service. This model would also include intervention by the Learning and Language Support Service as a potential alternative or as a complement to SLT input for children in a given quadrant.

Trust Shire also uses its commitment to training of student speech and language therapists to support the work of the service to mainstream schools. Teams of student speech and language therapists work in pairs to deliver group intervention in schools.

8.5.2 Key issues

(a) Lack of co-terminosity
(b) Equity of SLT support across the LEA
(c) Development of the Learning and Language Service
(d) Direct SLT input vs. a consultative model - especially parental perception of this issue

8.5.2 (a) Lack of co-terminosity

Commissioner
• Lack of co-terminosity has traditionally been the norm for many, if not most health commissioning bodies in that HAs have typically purchased services from a range of NHS Trusts.
• However, the Lead Commissioner for the consortium of PCGs in the north west of this shire county did have issues regarding the differences in service model between Trust Shire and Trust G.
• The PCGs were addressing this issue via a reorganisation of management structures and the appointment of a Head of Therapy Services across Trusts G and the relevant part of Trust Shire. It is not absolutely clear from the data, but this appointment may have been part of the strategy towards the reconfiguration of Trust Shire reported by the SLT manager.
• Shire Health Authority continued to have a strategic role despite devolution of commissioning to PCGs

Manager
• LEA managers expressed high level of frustration at having to liaise with six SLT services.
• They would have preferred a single LEA wide SLT service with a common model of service delivery.
• In LEA Shire, a manager interviewed expressed the view that the SLT support for schools should be managed by one agency that was not at Trust level.
• Trust Shire SLT manager had to maintain links with the five other SLT services serving LEA Shire.
• This manager also had to liaise with LEA X and to a lesser extent (the amount is unclear and in a state of flux currently) with LEA W.
• From 2002, Trust Shire will no longer provide a service to LEA Shire.

Practitioner
• LEA practitioner (specialist teacher) had a countywide remit. Lack of consistency in models of SLT service delivery across the county was viewed as unhelpful.
• There was a perception that the SLT services of Trusts C, D, E, F, G and Trust Shire differed qualitatively. This is may have had an impact on the success of working relationships between support teachers and SLTs.
• SLT practitioners tended to have a specific site or geographically bound caseload. Therefore the majority were not affected on a day to basis by the lack of co-terminosity as their own work centred in either LEA Shire or LEA X.
• The few that did provide a service to both LEAs commented on qualitative differences in their interactions in each LEA. However, these comments were typically at a school level and therefore cannot be specifically attributed to LEA differences.

Parents
• Parental views on co-terminosity were based on equity of service as a child could transfer from one school to another school within LEA Shire and yet cross SLT service boundaries and receive a different model of support.

8.5.2 (b) Equity of SLT support across the LEA

Commissioner
• The commissioner concerns re: equity were limited to equity between SLT services provided by Trust Shire and Trust G.
• The move from Health Authority (HA) to PCG commissioning was viewed as positive by the commissioner interviewed, in that it would offer the opportunity for more qualitative monitoring of contracts rather than monitoring by number of contacts made by SLTs with children.

Manager
• LEA managers expressed the need for school based as opposed to clinic based SLT support for children throughout LEA Shire.
• They reported that the quantity and quality of school based support available varies between Trusts C, D, E, F, G and Trust Shire and this inequity was a cause for concern in the LEA.
• The adoption of a common assessment and profiling protocol across the LEA in conjunction with all six SLT services was seen as a positive step towards consistency for the future.
• One LEA manager described an additional benefit of the protocol in facilitating the exploration of roles and responsibilities between SLT staff and learning and language support teachers.
• Equity across LEA Shire was also an important issue for the SLT manager of Trust Shire in that LEA Shire contributed in excess of £400,000 towards SLT services across the LEA but the distribution of these funds was perceived as inequitable relative to need.
• It was hoped that the common assessment and profiling protocol may highlight such inequities and facilitate redistribution of resources controlled by the LEA.

Practitioner
• At a practitioner level, the equity issues were broadly similar to those around lack of co-terminosity.
• LEA practitioners reported that SLT services operating clinic-based models were felt to be less equitable for children whose families had difficulty keeping appointments.

Parents
• For parents, the issues were again linked to the co-terminosity issues.
• Parents whose children have been subject to the assessment and profiling protocol were positive about it.

8.5.2 (c) Development of the Learning and Language Service

Commissioner
• The health commissioner interviewed made no comment on this. It appeared from the interview data that his level of interaction with the LEA would not involve discussion of such operational matters.

Manager
• LEA managers were extremely positive about the reorganisation of their learning support services.
• They clearly valued their specialist teacher for language impairment and her expertise. They also appeared very committed to the training of the rest of the Learning and Language Support Service in matters relating to speech, language and communication needs.
• The course which the support teachers had recently completed was viewed by the LEA managers as giving the teachers a high level of skill in the area of speech and language needs.
• The SLT manager for Trust Shire did not comment specifically on the Learning and Language Support Service, but did express a view that one LEA manager might be of the opinion that increasing the number of Language Support Teachers could be a viable alternative to SLT input.

Practitioner
• The specialist teacher for language impairment interviewed expressed positive views about the reconfiguration of the learning support service.
• The teachers from the Learning and Language Support Service were often the first point of contact for schools in relation to children with speech, language and communication needs.
• Her view of the accredited course which her colleagues had completed was that it had given them a level of knowledge to be able to more appropriately make use of her specialist skills in the area. Also, that it would enable these teachers to provide training within mainstream schools in relation to language and communication needs.
• However, she made a point of stressing the expertise which lay with the SLT services that was over and above the expertise of the learning and language support service.
• SLT practitioners from Trust Shire appeared to know little about their colleagues in the Learning and Language Support Service.
• Individual teachers were known where there had been collaboration around specific pupils.
• The SLT practitioners did not perceive that the accredited course for the learning support teachers was more than an introductory level.
• Some tensions were described around roles. For example, a learning support teacher who expressed the view to an SLT that the teacher should deal with children with language difficulties and the SLT deal with children with speech difficulties. Working more closely together was felt to be useful in order to address these issues.

Parents
• Parents did not appear to have any specific views on the developments in the learning support service

8.5.2 (d) Direct SLT input vs. a consultative model - especially parental perception of this issue

Commissioner
• The commissioner interviewed did not express any particular views in relation to parents of children with speech, language and communication needs.
• He did, however, comment that in general changes in commissioning patterns are perceived as potential cuts even when this is not the intention.

Manager
• LEA managers commented that parents generally were of the view that direct 'hands-on' therapy with a SLT is the best support for their child. If the SLT service provided by one of Trusts C, D, E, F, G and Trust Shire recommended a more consultative approach, parents often got advice from an independent SLT which would recommend direct contact with an SLT. This posed difficulties for the LEA where individual cases reached the SEN Tribunal.
• A further related issue for LEA Shire in particular was the presence of a high number of independent special provisions for children with speech, language and communication needs within their geographical area of responsibility.
• At a school level, LEA managers reported some instances of dissatisfaction from Head Teachers with a consultative model of SLT support which only provided one or two visits per term. This concern extended to physiotherapy and occupational therapy also. The concept of a consultative model was supported by this LEA manager but with a linked concern that the support for the Learning Support Assistant (LSA) who would be responsible for delivering the support on a daily to day basis was adequate.
• The SLT manager for Trust Shire did not express any specific views on parental views of a consultative model.
• However, she stated that the purely consultative model which has evolved in Trust Shire's SLT provision to LEA Shire had been resource driven and not philosophically driven. Furthermore, she expressed the view that there was a lack of understanding on the part of LEA managers about the clinical decision making process which an SLT would apply to an individual child.
• Comments were made in respect of the difficulties of maintaining contact with parents when working consultatively through schools.
• The variability of LSAs carrying out SLT programmes was also an area of concern.

Practitioner
• The specialist teacher did not comment directly on the consultative model of SLT intervention.
• She did state that her view of the role of the Learning and Language Support Service teachers was to interpret SLT recommendations for schools in terms of the curriculum.
• She also appreciated the caseload pressures on the SLT service and the impact that this had on their operational models of working.

Parents
• Parents were skeptical about the consultative model of SLT support.
• The variability in LSA support added to these concerns.

8.6 Case study 5: A Unitary LEA and partner NHS Trust

Case study 5 examines a unitary authority. All SLT services to pupils attending schools under the responsibility of LEA Unitary are provided by the SLT service from Trust Unitary. LEA Unitary provides two infant language resources and one primary language resource within mainstream schools. Each resource has places for 14 children. The infant resources are each staffed by a specialist teacher and a learning support assistant whilst the junior resource is staffed by two specialist teachers and two learning support assistants. These teachers have an LEA-wide role in terms of outreach and support for teachers in mainstream schools. The philosophy of LEA Unitary is for maximum delegation to schools of budgets for supporting children with special educational needs. Consequently there is no centrally located support service.

Table 8.9   Profile of special educational need relative to schools in LEA Unitary

Number of schools		Number or percentage of children on Code of Practice Stages			Percentage of children with Statement of SEN	Number of children with SLT needs identified in Statements of SEN
Primary	Secondary	Stages 1/2	Stage 3	Stage 4		
53	10	6297	2034	98	2.9%	86 as a primary need

Trust Unitary is a Community NHS Trust. Table 8.10 gives a profile of the SLT service relative to the population which it serves. These data are representative of Trust Unitary's activity across its area of responsibility which includes LEA Unitary and LEA V as represented in Figure 5 below. LEA V is an LEA shire responsible for the educational provision in the county of which LEA Unitary is a part. Relationships with health services in relation to LEA V are of a similar complexity to LEA Shire as outlined in Case Study 4.

Table 8.10 Profile of SLT service within Trust Unitary

Children aged 0-16			SLT Children's services staffing		Ratios	
Total population (0-16)	Ongoing SLT caseload	SLT waiting list	SLTs	SLT assistants	SLT wte per capita population	Ongoing caseload per SLT
115,000	3,500	Not available	28.6	0.5	1:4021	1:122

Percentage of population age 0-16 known to SLT service = 3.0%

The only body commissioning health services for Trust Unitary has been Unitary Health Authority. However, there are four PCGs within the boundaries of Unitary Health Authority and commissioning arrangements will change in the future. LEA Unitary funds 0.2 wte. SLT posts within Trust Unitary's SLT service. The organisational relationship between Trust Unitary's SLT service and LEA Unitary is represented in Figure 8.5 below. The highlighted relationships indicate reciprocal sites which were involved in the interviews at Phase 2.

Figure 8.5 Education and Health relationships for LEA Unitary
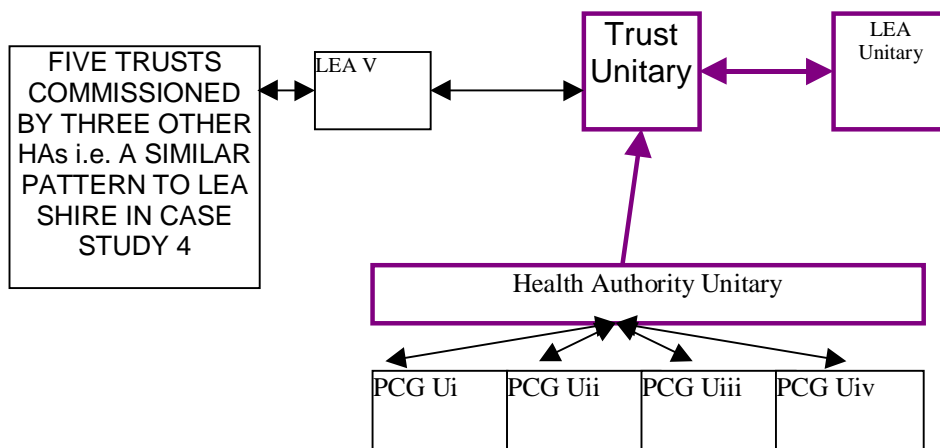
8.6.1 Model of SLT service delivery

The SLT service within Trust Unitary does not report having a designated service for children in mainstream schools. SLTs are based in community clinics, language resources and special schools. However, in practice, SLTs do visit schools in relation to their clinic caseloads. Examples given include a termly visit where a meeting takes place with the SENCO and all the children known to the SLT service in that school are reviewed. Programmes are put in place and SLTs visit schools in order to model activities if appropriate. LSAs are a key feature in the carry over of these programmes. Qualitatively, the description of school support by clinic based SLTs in Trust Unitary is similar to those of services described by other Trusts reviewed in this study as a designated mainstream support service.

The SLT service from Trust Unitary has taken part in a pilot study working with a cluster of schools. The SLTs became school-based and worked with SENCOs to develop joint targets and teaching strategies. Alongside this pilot, another collaborative project involved the development of a training package for LSAs which was jointly planned and delivered by the EPs and SLT service.

8.6.2 Key issues

(a)   Lack of co-terminosity of Trust Unitary with LEA Unitary
(b)   Designated mainstream school SLT service

8.6.2 (a) Lack of co-terminosity of Trust Unitary with LEA Unitary

Commissioner
• SLT services for Trust Unitary were commissioned via the Children's Services Plan, which in turn is a collaboratively developed plan involving the Health Authority, LEA, Social Services
• Four PCGs were in place in this Health Authority area - based on current plans they will evolve into 3 PCTs and one NHS Trust
• The health commissioner interviewed expressed the view that the move to PCG commissioning was advantageous from a service perspective as the commissioning priorities could be more closely allied with local needs
• However, SLT as a specific case was not a current priority for health commissioning

Manager
• The LEA manager reported that they were fortunate in that they were co-terminous with the SLT service
• However, an impact was perceived of the fact that Trust Unitary also provides SLT provision to LEA V
• LEA manager was aware that the SLT manager had always to consider the whole service when discussing service delivery and not just the portion relating to LEA Unitary
• The SLT manager commented on the challenges of liaising, not only with two LEAs but also that LEA V in turn liaised with so many other Trusts
• This could lead to difficulties where, for example, LEA V wanted to implement a system for SLT based on a model in another Trust and expected Trust Unitary to follow this system. However, Trust Unitary also had to be aware of models of service delivery emerging in conjunction with LEA Unitary
• The SLT manager also expressed concerns that with the emergence of PCTs, SLT services should not be fragmented across the PCTs.
• The SLT manager was clear in her recommendation that SLT services should be placed within one PCT or organisation in order to avoid fragmentation and to allow the economies of scale which maintain specialist posts

Practitioner
• SLT practitioners were aware of differences arising between work in LEA Unitary schools and LEA V schools
• The EPs of the two LEAs were thought to be a particular difference, with EPs in LEA V appearing to 'take over' the SLT role on occasions
• SLT practitioners mainly commented on differences at the level of the school which affected their input
• They felt that an agreed protocol for work between specialist teachers, SLTs and schools would be useful to avoid confusion

Parents
• Parents interviewed all had children attending LEA Unitary schools and therefore were not directly affected by the co-terminosity issue

8.6.2 (b) Development of a designated mainstream school SLT service

Commissioner
• The health commissioner interviewed did not comment at the level of operational models of service delivery

Manager
• The LEA manager had been instrumental in setting up the two pilot projects with the SLT service
• The LEA would have liked to move towards a designated SLT service in mainstream schools which was not clinic based
• The SLT manager was supportive of the view that SLT support should be incorporated into curriculum support
• However, prioritisation systems remained clinically based

Practitioner
• LEA practitioners would have welcomed more school based SLT support and training for LSAs
• SLT Practitioners welcomed the opportunity to take part in 'outreach' projects and training packages for LSAs
• SLTs would have also welcome a consistent approach across schools that was agreed at an LEA level

Parents
• Parents interviewed were particularly keen to see a designated SLT service for mainstream schools
• They reported that SLTs often monitored programmes by phone and were 'elusive'
• Parents also felt that training of LSAs was crucial as the skills of LSAs were highly variable and often unsatisfactory
• Most positive reports were from parents whose children had accessed nursery provision with a SLT visiting regularly to carry out direct intervention

8.7 Points of interest across Case Studies 1-5

8.7.1 Funding

- Health Commissioners report difficulties in allocating additional resources for SLT services in schools for a number of reasons including:
  - Other health priorities, for example, care of the elderly, mental health services, and National Service Framework targets.
  - In some cases a reluctance to fund educational support where the model of SLT service delivery is perceived to be educational to the extent of having few proven health outcomes.
- LEAs are dissatisfied with the situation where they have the responsibility for ensuring that SLT services are provided but do not have the funding to ensure provision of these services
- Head Teachers are becoming increasingly powerful stakeholders. As budgets are devolved further to Head Teachers they will also have the potential to commission services as seen in LEA Metropolitan.
- The tension between LEA managers and Health Commissioners regarding funding responsibilities may in fact be masking the possibility that neither agency is adequately resourced for the provision of SLT services to schools.

8.7.2 Co-terminosity

- The complex relationships in large Shire LEAs is a significant issue (c.f. Case Study 4)
- LEAs who are co-terminous with a single SLT provider may still be negatively affected by the boundary issue, in that the SLT provider may have draws upon its resources across a wider area including other LEAs (c.f. Case Studies 1 and 3)
- The changes in the structure of the health service towards commissioning by increasingly smaller units such as PCGs in England and LHGs in Wales will add to the lack of co-terminosity in terms of funding.
- The further development of PCGs into Primary Care Trusts which will also be service providers could potentially lead to the breaking down of SLT provider units into even smaller units of provision.
- LEAs would prefer one model of SLT service delivery across the LEA.
- SLT services also prefer to have consistency in being able to work with in a common model. Liaison with more than one LEA is therefore not ideal from the SLT perspective either.

8.7.3 Equity

Equity issues are reported by all stakeholders.
- Commissioners
  - Equity between SLT needs vs. other health needs
- Managers
  - Equity between services and across boundaries
- Practitioners
  - Equity from school to school in terms of collaboration and from child to

child in terms of allocated provision

- Parents:
  - Equity from one SLT service to another, from one part of the SLT service to another (e.g. across primary and secondary phases)
  - Equity from one school to another
  - Equity from one LSA to another

8.7.4 Joint systems for addressing the needs of children with speech, language and communication needs

Case studies 1, 2 and 4 all illustrate models which have been developed through collaboration between the LEA and health services. Although different in their essence, there are some common features of these models.
They all include:

- A range of management levels or packages based on clinical and learning needs
- Flexibility regarding which professionals are best placed to meet the needs of different children with different levels and type of need
- Training of LSAs, central to all the models outlined
- An understanding at the level of LEA/Trust of the value of an indirect model of intervention

8.7.5 Models of service delivery

Models of service delivery varied across the case study sites. The model of service delivery in place was in most cases influenced by resources and staff in post. Caseload sizes varied significantly from 37 per wte SLT in Trust London to 172 per wte. SLT in Trust Wales. The impact of caseload size on service delivery is obvious. However, it seems that in many cases, the overwhelming pressures are preventing strategic thinking around developing an optimal model of service delivery. However, moving towards optimal caseload size in order to provide a desirable service has costs for an under-resourced service as can be seen by the waiting lists in Trust London.

Services which have begun a more strategic approach in collaboration with LEAs and commissioners, appear to favour a mixed model which allows for some direct intervention from a SLT alongside a range of other options.

Indirect intervention appears to have become synonymous to some with a poor service. However, all five case studies report some indirect intervention in the form of SLT targets and programmes left with schools for implementation, usually by LSAs.

8.7.6 Recruitment and retention of SLTs

This issue came up in different ways across the case studies and is recognised to be a professional issue at present. The impact on Trust Wales in being unable to recruit a Welsh speaking SLT was considerable.

Trust Shire and Trust London use their commitment to student training in a creative way, in that they both offer appropriate training opportunities for student SLTs and provide an additional service to schools in their LEA. It remains to be seen what the long-term impact will be on recruitment to posts in SLT services to schools. However, it is likely that student SLTs who have had experience of school based work will be able

to enter the workforce with a higher level of skill in this area than has previously been the case.

Chapter 9 - Research into Practice

9.1   Introduction

This 'research into practice' phase of the project aimed to explore the potential of assemblies of individuals (representing parent and professional groups) to generate innovative and practical ideas, which would capitalise on the impetus for change stimulated thus far through the project, and facilitate future collaboration between the agencies of Health and Education. A summary of the results of Phases 1 and 2 was presented during the workshops, which was an essential basis for full contribution during the discussion sessions which followed.

Delegates were issued with badges identifying their professional or parent status, but without personal names or site identification. This enabled both delegates and research team members to attribute the professional scope of issues raised during the discussions; at the same time it preserved individual confidentiality in line with established principles of research, for as participants were made aware, this was a research phase of the project. Chapter 2 outlines the methodology and structure of the days.

Following the morning presentation, participants were assigned in groups of ten to discuss pre-set questions, a list of which is included in Appendix III[62]. After this discussion period, the plenary session reconvened so that the issues raised by each group, and recorded on acetates, could be shared. The same pattern of activities was followed in the afternoon.

The Bristol workshop attracted more participants from Wales than was the case at the other venues, and these delegates formed a separate discussion group. They were given the opportunity to select questions for discussion that they regarded as particularly relevant to Wales, as regional difference was an issue highlighted by interviewees in Phase 2 of the project. The point is underlined by the fact that these delegates headed their acetate for presentation to the plenary session: *"Welsh Group".*

Issues raised, and proposals made for improved collaboration appertained to four levels: DH/DfEE/Welsh Assembly level, LEA/Health Trust/Health Authority level, clinical/educational practitioner level, and parent level, and the following analysis has preserved this arrangement.

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[62]   Questions were adjusted slightly for Bristol and London (in the light of experience gained from the first three workshops). The aim was to clarify questions and to encourage participants to put forward specific examples of effective practice.

9.2 DH-DfEE-NAfW level

Delegates emphasised:

- The lack of national (and local) knowledge of resources needed for, and monies spent on, speech and language provision.

- The need for equal support from the DH and the DfEE (and, in Wales, the Welsh Assembly) for change initiatives, backed up with joint funding.

- The lack of awareness of the impact of national policy initiatives at practitioner level.

Delegates proposed:

- A national audit of needs and resources.

- Joint clarification of the roles and responsibilities of each agency.

- A plan of national criteria and standards for entitlement.

- Legislation and guidance on the above in the Code of Practice.

- Joined-up practice to review the impact of national policy initiatives at practitioner level.

9.2.1 Responsibility, funding and equity

Overwhelmingly, delegates felt that the responsibilities for the funding and delivery of SLT services in schools, as between Education and Health, should be clearly set out by government. The view of all parties was that the current situation was unclear.

The government's philosophy and programme for promoting inclusion at all levels of society, and in Health and Education in particular, focuses attention on the extent of the need for services to children with speech, language and communication needs. Many delegates expressed the view that the levels of need and resource, nationally, were extremely unclear. Such knowledge was perceived to underpin the effective development of an equitable policy for access to provision.

A proposal to address this issue, made by several groups, was a national audit of current needs and projected needs, with attendant costs. Such an audit of needs was seen as a necessary basis for establishing the extent and nature of any (widely cited) resource deficiency in the system, and as a basis for moving towards a system of provision which protects resources for individuals more effectively. In the absence of such knowledge, there is an overriding belief among parents (and others) in the statement of needs as the sole means of safeguarding speech and language provision for individual children.

A number of participants at the workshops proposed that a joint audit would include parents and support groups. Their involvement, as well as making a valued contribution to identifying needs and specifying existing resources and shortfall, would be an important step in securing their support for decisions taken in the light of the audit

exercise. Delegates emphasised that the proposed audit would need to be repeated on an annual basis, to avoid the danger of future action planning based on snapshot (and outdated) information. Delegates from Wales reported that the Welsh Assembly has undertaken a complete study of the deployment of speech and language provision across Wales.

The results of such an audit would have clear implications for children's services planning and for other planning measures, both nationally and at local levels. For example, this audit information would facilitate agreement between the DfEE and DH about the pre-school agenda, to include planning for early identification of need, and matching need with appropriate intervention programmes. It seems clear too, that such an agreement at national level would entail a more structured approach to collaboration at LEA/Trust level, with some "must do's" for collaboration, perhaps enshrined in a protocol arrangement.

One group detailed a four-step initiative at government level with a view to creating a context in which NHS/LEA providers can take account of each other's agenda in joint strategic planning: firstly, as described above: clarification of the money available in the system in terms of how much is available, its location, and to which agencies it is available; secondly, clarification of the roles and responsibilities of each agency relating to the use of this money; thirdly, a plan of national criteria and standards for entitlement, based on the newly defined resources and roles; and fourthly, legislation and guidance in the Code of Practice to reflect this model.

9.2.2 National Curriculum

Several delegates suggested that the linguistic demands of the National Curriculum are not necessarily realistic for children with speech and language difficulties, proposing that adjustments for this group could bring the Curriculum more into line with what is achievable for them. Another group proposed that, in order to accommodate the need for more emphasis on language and communication at Key Stage 1, the National Literacy Strategy should be reviewed, with a view to expansion to cover speech and language, as well as reading and writing. Alternatively, a new initiative (taking the National Literacy Strategy as its model) should take forward its emphasis on language and communication at Key Stage 1.

9.2.3 Measuring practitioner activity

The phrase "joined up thinking at national level" was used by a number of groups as a pre-requisite for improved collaboration between Health and Education at subordinate levels. Of concern in this context was the impact which "Best Value" policy, as an element of the Government's raising achievement agenda, has at practitioner level. Workshop attendees were concerned that in measuring "time in contact", (therapists'/teachers' face to face contact with a child), as the basis for Best Value, much highly valuable non-contact work could be disregarded. It was felt that time to liaise should be built into Best Value measures.

9.2.4 Common data sets

Several groups stressed the need for a reliable and accessible database: "*We need to identify the data everyone needs, and first everyone needs to know what they need to collect.*" (Ed Psych). Delegates indicated that the parameters of such a database need

to be decided at national level to ensure that the required degree of collaboration between Health and Education is forthcoming. Workers at local level in the LEA and in SLT can then have confidence in collecting, analysing and sharing relevant and accurate audit data, which can be used to plan services and describe need.

9.2.5 Standing group

Delegates emphasised that initiatives for change from either the DfEE or the DH need the support of both agencies (LEA and Trust) to secure maximum and sustained impact "in the field", for it is *"easy to cascade information down, much more difficult to influence strategic planning from below."* One group of delegates proposed that a joint officer standing group would be a good way to link the activities of the national agencies. This would entail a permanent review meeting with officers from both agencies to monitor outcomes. The "Welsh group" indicated that the relative paucity of civil servants in the Welsh Assembly has meant that feeding back information to ministers has become difficult, e.g. *"the Therapies Group has not met for over a year."*

Attendees emphasised that initiatives need to be backed up accordingly with resources to the appropriate agencies to ensure full implementation. Delegates felt that short term funding for pilots should lead to longer term, and sustainable, funding for coherent, integrated services.

9.3   LEA/Health Trust/Health Authority/Primary Care Group/ Local Health Group Level

Delegates emphasised:

- The need for better communication between different levels within agencies.

- The need for strategy groups to have an overview of children's issues, informed by service managers.

- That organisational variation between areas tests levels of common understanding.

- Concerns with the perceived negative impact of Primary Care Groups (PCGs), Primary Care Trusts (PCTs) and Local Health Groups (LHGs) on SLT priorities.

Delegates proposed:

- Sharing of data by stakeholders in regional vertical groupings.

- That strategic planning groups at high levels include those with "hands-on" experience.

- Retaining SureStart/OnTrack as providers of models of good practice.

- SLT representation on PCGs/LHGs.

9.3.1 Multi-level collaboration

One theme emerging from the workshops, and the discussions of the many proposals put forward, was that effective collaboration required activity and contact at a number of levels: at the national level; at the strategic level between Health Trusts, Health Authorities and LEAs; at the operational level between LEA managers, Head Teachers

and SLT managers; and at the level of the individual professional, between teachers and therapists.

9.3.2 Strategic planning

One group proposed the need for strategic planning groups at a high level; these groups would produce a national strategic plan, with a view to neutralizing the vested interested of all stakeholders in how resources are allocated. Delegates stressed the need for members of such strategic groups to have "hands-on" knowledge, for it was pointed out that the professional expertise of those who direct funding is very different from that of providers, whether in the NHS or LEA. The result is felt to be that the "balance of service" is in the hands of those whose perception of how things operate in practice is limited.

At Health Trust/Health Authority/LEA level, delegates emphasised that a "strategy" group should be able to demonstrate that it has consulted, and also is informed by, service managers, for example the principal EP, the SLT service manager and LEA support service manager. This should ensure that the group has a strategic overview of all relevant initiatives and plans which relate to children, including behaviour support plans, children's services plans and education development plans. Delegates stressed, too, that members of the strategy group should consist of those in each agency responsible for strategic planning and budget holding, rather than being responsible solely for service delivery.

Workshop participants suggested that stakeholders might be brought together in regional vertical groupings to share data. It was felt that improved linkage with central government targets are likely to draw stakeholders together, encouraging a context in which different perspectives and agenda can be shared. Delegates perceived a need for providers' terminology to be discussed at officer level; it was felt that there are differences between agencies which can usefully be preserved, and where there is a good understanding, "tolerance" of differences is more likely to evolve. The importance of rapport and good relationship building between individuals is an issue in this context.

Comments from a number of groups indicate that there are problems of communication between different levels of agencies, creating difficulties for strategic planning across levels. The internal hierarchy of each agency is not always transparent to the others. The view was expressed that a joint management protocol is needed, *"to set out Health/Education members to schools, to outline roles and state clearly who is managing whom"*.

In particular, attendees commented upon the need for a common understanding of organisational structures and processes, and indeed, organisational variation between areas was repeatedly highlighted by delegates. Differences reflect both the evolution of organisations in a range of geographic and demographic areas, and the influence of idiosyncratic philosophies from individuals in decision making posts. On the one hand this variation offers a raft of initiatives which can be drawn upon for examples of efficacy which can provide models for practice at local level; on the other hand such variation makes for difficulties in preserving the best of existing practice while homogenising and codifying practice in the interests of maximising resources and supporting equity of provision.

9.3.3 Commissioning

A number of attendees expressed the view that commissioning should be centrally administered. The increased responsibility at Trust level entailed by devolved commissioning to PCTs (requiring additional financial management, with correspondingly increasing numbers of employees at director level), was perceived as a drawback. Such devolution was felt to increase claims on economic resources, at the same time bringing in new layers of management with whom effective collaborative dialogue must be initiated and maintained. Many delegates also felt that devolution of funds for SLT to Head Teachers was not desirable, because of the many competing claims which can be made on the funds, once available in school for allocation.

All the participants in several groups agreed that if the Head Teacher held the budget, this was a '*dangerous route*' for equity of provision, creating *'problems with ring fencing.'* At the very least, delegates felt that Head Teachers should be required to be explicit about how their SEN budget is spent.

The advent of PCGs, PCTs and LHGs was perceived by many participants to have negative implications for SLT provision. The status of SLT is an important factor in this reorganisation, and there were fears among delegates (expressed too during Phase 2 of the project) that the dominant GP's agenda, and acute service issues, will compromise the position of SLT in the priority stakes. Local priorities which favour needs other than SLT, and allocate resources accordingly, can result in battles at local level for a share of the funding "cake".

Many delegates noted the absence of SLT representation on PCGs, PCT boards and LHGs, and proposed that this should be remedied. This would provide an effective voice for SLT issues within local strategic planning bodies, identifying SLT as a high priority need in the face of the many competing claims on resources.

One group proposed setting up a cross-departmental Children's Services Agency as a funding agency responsible for children from age 0 upwards, closing the gap which now exists in many areas between pre-school and school.

In another LEA, a four-year business plan had been devised, in which money had been earmarked from both the LEA and HA for paediatric SLT mainstream school provision. There was an operations group and a communications group. Longer term funding was, however, proving problematic; to date the plan had been supported by 'stealth' funding.

9.3.4 Shared criteria and data

Workshop discussion groups regarded joint prioritisation and agreement on intervention levels, prior to planning "packages of intervention", as essential to maintaining the best model of intervention for each child. As a precondition of a move towards joint agreement on priorities, however, many delegates highlighted a need for uniform, agreed standards of data collection, using IT packages which are compatible service and nation-wide.

9.3.5 Pilot funding

In the context of discussions about the role of pilot funding, Sure Start received praise from delegates as *"an important tool for getting the ball rolling"* (SLT manager). Other

attendees felt that Sure Start and OnTrack provided models for similar initiatives, in yielding good examples of pre-school preventative models which can work against the need for statutory assessment. Such initiatives won praise too for the opportunities they offer for joint planning and resourcing of services. In a similar vein, the focus within Education's new 'Foundation Stage' on goals for speaking and listening was commended for effectively raising the profile of SLT issues. However, while noting the potential of such initiatives as drivers for change at local level, delegates observed the danger of an ethos of short-termism, which seeks to maximise benefit for the duration of a funding initiative, losing the momentum for change as this funding opportunity draws to a close. A related problem is that of co-ordinating services because of the conflicting demands of different funding bodies. The Welsh group pointed out that the GEST initiative operates differently from the Standards Fund in England, and suggested that research could illuminate which system is proving to be more effective for developing services.

9.4   Practitioner level

Delegates emphasised:

- Early identification of need and intervention as elements of good practice.

- Tensions in balancing cohort/individual needs in the context of a school-based/clinic-based debate.

- Models of good practice, and flexibility of patterns of provision.

- Current inadequacies of training for teachers.

- Importance of training for LSAs, particularly relevant in the context of a consultancy model of SLT provision.

- Clear definition of roles.

Delegates proposed:

- Collaborative, multi-professional assessment.

- Research on the cost/benefit of provision in education and health settings.

- Wide dissemination of models of good practice and research data.

- A menu of provision possibilities in various settings, which facilitates transfer between settings.

- That special needs receive focus at the induction stage of initial teacher training.

- A dual Health/Education training approach which gives both SLTs and teaching staff joint opportunities for sharing knowledge and informal networking.

- Clear top/down management structures with well-defined lines of communication.

9.4.1 Identification

SLTs and teachers shared a view (also with parents) that identification of need and early intervention is an important element of good practice, and an ideal system would

identify likely need by the beginning of KS1. However, a challenge would be to develop a system sufficiently robust to diagnose needs accurately by this age, bearing in mind the diversity of presenting difficulties and the disparate developmental paths taken by individual children. Delegates commended collaborative assessment involving EP, SLT, teacher; this would take as its model the diagnostic assessment process used for autism, and would help to ensure that parents receive a consistent message from professionals: consistent because of its shared input and ownership by professionals concerned. Collaboration in producing IEPs was highlighted as important for avoiding duplication of roles by one group. One group proposed speech and language screening for all children, which would facilitate clear identification of need by the end of the foundation year.

9.4.2 Models of service delivery

At present, a diversity of service models is in operation in various areas of the country. Comments from delegates confirm wide variations in provision from area to area, e.g.: "*If a child has no statement, therapy will be in a clinic; if he or she does have a statement, therapy will be in school.*" (advisory teacher). "*It's the other way round in my area.*" (SLT).

An example of good inter-agency collaboration over the issue was given by a SENCO, who reported that in one Welsh authority a system had been created whereby children on Language Unit waiting lists were put into a Stage 3+ category, allocated jointly by a SLT, EP and teacher. Children with similar difficulties were clustered together and received support teaching in school. The success of this initiative was accredited to its central funding.

Overall, the clinic/school debate involves consideration of balancing the interests of individual children with those of the cohort of children needing therapy, and an issue here is the perception of conflict between effectiveness and resource allocation. The clinic/school-based dichotomy was characterised by one participant as "*a tension of efficiency vs. community and school-based model.*"

Delegates in one group saw school-based therapy as more effective for a child's overall development, but pointed out that this is heavily resourced, allowing perhaps four children to receive therapy in a day, as compared with around ten in a clinic setting. The same group felt that clinic-based therapy, while isolating the child in the clinic, tends to "*perpetuate isolation of the child in society.*" Other delegates too, expressed the view that "*children with developmental speech and language difficulties should have speech and language provision in school*".

By contrast, however, in other discussion groups, SLTs felt that work in clinic is preferable: *"in spite of LEAs' attempts to push* (us) *towards doing therapy in schools".* The comment of an EP, taking the viewpoint of the head teacher, and the rejoinder of an SLT manager illustrate the tension surrounding this issue: *"How can I deliver a National Curriculum when children are going off to clinic?" "How can I justify sending one member of staff to one school, for one child?"*

There was concern among some SLTs that access to parents should not be put at risk by school-based therapy provision: their emphasis on the value of contact with parents reflects views expressed in Phase 2; delegates pointed out that the attitude of Head

Teachers and class teachers is crucial in allowing contact opportunities for SLTs with parents, and indeed with teachers themselves.

9.4.3 Research

Nearly all attendees were in agreement, however, that there is a need for research on the cost/benefit of provision in education and health settings. One group referred to a *"desperate need to evaluate efficacy of school based intervention"*. Above all, delegates emphasised the need for the results of research projects, and examples of good practice, to be disseminated more widely.

With regard to the clinical aspects of models of care, delegates stated that research has focused largely on outcomes in clinics, rather than on the outcomes of therapy which takes place in schools. Such evaluation could be an important step towards universally accepted understanding of what effective therapy is, and in what form it should ideally be provided in education and health settings. Delegates expressed the need for future research, therefore, to be carefully targeted from government level, involving close collaboration between the DH, the DfEE and the Welsh Assembly to agree a research agenda. In the absence of research evidence on efficacy, moves towards either a consultative or a hands-on model of therapy are premature, unless provision is to be openly resource driven.

Such collaboration will rely on a philosophical convergence of views between the two agencies; in addition, however, it will require those funding to adopt a sympathetic understanding of the research methodology which can be used to explore issues of intervention, in the absence of any mechanism for identifying a control group against which to measure the results of intervention programmes.

9.4.4 Flexibility of provision

"Flexibility" was a word frequently used by workshop attendees, with the comment that a single pattern of provision would not be suitable for every child. One group favoured maintaining flexibility of provision as a school based, clinic based, or consultative model, but proposed that protocols of transparent criteria should be applied, which would mirror contracts of care currently in operation. Preservation of this pattern of flexible provision would offer responsiveness to the individual needs of children, whether these are best met in a clinic or school setting. This group proposed offering parents a menu of provision possibilities in various settings, though the scope of this choice would be based on resource as well as needs related criteria. Delegates in another group agreed: *"[there is a] need for a range of models of provision which link both to the disorder of the child and to jointly agreed criteria for access"*.

An SLT manager described an example of flexible provision in practice in her area: provision is in two language units with eight children in each class, served by a teacher trained in speech and language modules, and a nursery nurse. Speech and language therapy is based on site, and the arrangement offers a gradual process of re-integration into mainstream schooling. Schools are also served by therapists from a community base.

Another example of practice which allows an adaptable approach to therapy provision involved the creation of an SLT post concerned exclusively with liaison, without clinic

responsibilities, which had been successful in promoting greater flexibility within the local SLT team.

One group discussed the potential of IT for facilitating flexible and innovative therapy provision. In one county, for example, I-CAN has set up a video conferencing scheme with primary units and a school, enabling SLT and teachers to work together. The local authority has now taken over funding responsibility for this scheme.

A flexible approach to the employment of speech and language therapists was proposed by one group, depending on need, provision and placement; following this model an SLT might be employed by Health; by a school; by the LEA (this would facilitate joint funding/training of LSAs from SLT and LEA/school budgets); or by the LEA and Health for INSET.

9.4.5 Training and continuing professional development

Training is an issue on which many practitioners expressed views. In particular, attendees criticised the brief attention given to special needs on the curriculum for initial teacher training (ITT). In view of the condensed nature of ITT overall, it was proposed that special needs (and more specifically speech and language issues, to cover communication difficulties and appropriate classroom approaches) could most usefully be given higher profile at the school induction stage of the course. The need was perceived for the initial training of SLTs, as well as of teachers, to prepare them for joint working and understanding of perspectives.

A number of SLTs praised the dual role of "link" specialist teachers, who while working in partnership, for example, with an SLT, also offer a valuable source of advice upon which other professionals can draw. One group proposed that peripatetic "link" teachers should have recognised specialist training, possibly National Standards accredited training, and the potential exists too to use a similar model to train LSAs. Many SLT practitioners at the workshops felt that the need is for teachers to have language knowledge, rather than for SLTs to deliver a daily language programme. Overall, there was much support for a joint training strategy between the LEA and the SLT service, and delegates noted that joint training should incorporate time for informal networking.

An advisory teacher, who reported having had much experience of working with SLTs on site in schools, commented that teachers and LSAs need a dual training input from Education and from Health, to reflect the importance of speaking and listening, and the development of language. This teacher recommended as a model two courses:

The first of these courses is for experienced teachers to become specialist teachers in speech and language, with university accreditation. The three course modules comprise: 'development of language', to remedy the omission of early years development from initial teacher training (very many workshop attendees mentioned this omission); 'delay and disorders of language'; and thirdly, 'assessment of children and programmes of intervention' (a practical module). Subsequently two additional modules have been developed, also accredited as an advanced diploma; these are: 'autistic disorders', since many teachers are unaware of presenting difficulties and how to deal with them, and secondly, a research module.

The second course this teacher described is a ten-week, practically oriented course for LSAs, focusing on good practice, IEPs and targets, activities for intervening and modelling. This teacher's assertion that *"there is no understanding among them* (LSAs) *of speech and language issues"* was echoed by the comments of many other workshop attendees (and by interviewees in Phase 2). Both courses are jointly taught by "educators" and therapists.

Training for support staff received wide support from workshop delegates, who felt this is essential if the consultative model is to operate. One group suggested that there should there be SLT assistants for all schools, noting, however, the disparity between LSA and SLT assistant pay scales. A number of delegates valued specialist support assistants, particularly for secondary age students.

At SLT level, an SLT manager was arranging for her therapists to do a two-day course on negotiating with parents. A key feature of this course is a recognition that *"to deliver what is possible"* is contingent upon both resources available and the development of the individual child; both of these factors can change over time, and can be the subject of a process of negotiation with parents.

A number of delegates indicated the importance of CPD in underpinning both professional "expert" knowledge, and in building in individuals a confident knowledge of both the boundaries of their own and others' roles in relation to SLT, and the complementary nature of these roles. Such confidence can facilitate communication with other professionals, negotiation and joint planning. Barriers to this pattern of communication and negotiation can be confusion about the "contract" which exists between a teacher and a therapist working with a child: who is responsible for assessing what needs? How should reports be presented, and to whom? Who is responsible for what aspects of intervention? In sum, there needs to be clarity from the profession about the role of its practitioners, and what good practice is for therapists.

9.4.6 Shared protocols

A proposal in this context was for collaborative working protocols to be established between the SLT, teacher, support service and EP. Use of these firm procedural agreements, currently more prevalent in Health than Education, could be expanded to implement a procedural process binding upon both agencies. This would offer an opportunity to draw up a regularised action framework against which individual practitioners could work, and the process of its formulation would involve an input of debate and planning which would in itself aid the collaborative agenda. At a practical level, therapists indicated that work within schools sometimes means moving outside a "comfort zone" for SLTs. In this context, protocols for working within schools focusing, for example, upon liaison with teaching staff, good joint planning, and the training contract, should go some way towards minimising the uneasiness of SLTs in this situation.

An SLT Manager described the successful working of joint working protocols for Speech and Language Support Service teachers, SLTs, EPs and school staff at a particular primary school. This school houses speech and language units for KS1 and KS2, and an outreach Speech and Language Support Service for pupils and schools in other parts of the area. Joint reports are written for annual reviews, and a significant training element is included in the work of the professionals, delivered collaboratively.

Discussions held within the LEA's Communication Continuum group, consisting of professionals from a variety of agencies, parents, national and local organisations including AFASIC and the local Autistic Society, as well as local schools, have stimulated and supported collaboration.

A number of participants suggested that a clear overall top-down management structure, giving well-defined lines of communication, would assist practitioners in avoiding duplication of roles, as well as providing an environment which nurtures and facilitates productive professional dialogue. In this respect, a number of groups viewed the role of the Head Teacher as particularly important.

9.5 Parent Level

Delegates emphasised:

- Inequities of provision arising from lack of resources.

- Inequities arising from reliance on the statement as a guarantee of provision.

- Prevalence of the notion that "who shouts loudest gets".

- Parental misconceptions about the nature of speech and language therapy.

- Professional concern for a relationship of trust to develop between parents and professionals.

- Parental need for a named contact to advise/liaise.

Delegates proposed:

- A menu of provision (as mentioned above).

- Attention to resource mechanisms to explore the feasibility of discontinuing the statementing process.

- Nationally agreed criteria for needs assessment.

- The need to keep parents informed.

- The need for transparency in the decision making process surrounding assessment and provision.

- The need to involve parents as 'partners', with consideration given to training them in "professional knowledge", enabling parental assumptions that "more (therapy) is best" to be challenged.

- Appointment of a key worker to follow through liaison with individual cases.

9.5.1 Trust

The greatest consensus of views in discussions relating to "managing parents' expectations" and "maintaining their co-operation" centred on the need for building trust among parents. This means trust for individual professionals involved in their children's assessment and therapy, and perhaps more elusively, trust for the agencies in totem -

for it is noteworthy that the LEA or Health as an organisation may be "tarred with the same brush" following the negative experience of a parent with some key figure. More positively, parents have reported engagement with an individual in Health or Education who has taken their case forward, and from this experience parents have gained a favourable perception of inter-agency collaboration. Moreover, some of the parents interviewed in Phase 2 of the project had experienced problem-free access to therapy, and supportive relationships with the professionals involved in assessment and provision.

While individual professionals are concerned to foster trust, however, barriers to this are considerable: firstly, as highlighted in Phase 2 of the project, there may be initial reluctance on the part of some professionals to take early worries about a child's development seriously; this is followed for many parents by a long assessment process, characterised by some as a "struggle", a "fight".

In some cases, parents perceive that they have been let down by the absence, or withdrawal, of provision which in their view their child needs: a view which may have received professional support elsewhere. Denial or withdrawal of therapy might be due to lack of resources, or the reason for this might be simply a professional judgement that the child's needs would not be best served by therapy; nevertheless, parents are likely to question the sincerity of a needs-based decision which has been made in the context of sparse resources. While the phrase "who shouts loudest gets" has credence among parents and practitioners alike (Phases 2 and 3), it is easy to understand the suspicion of some parents that they are being cynically manipulated into compliance. For such parents, failure to "shout loudest" will be tantamount to failing a child, for forbearance will mean simply that a more forceful parent "gets". Moreover, lack of transparency surrounding the assessment process itself, and criteria applied to therapy provision, is likely to exacerbate this situation.

9.5.2 Transparency

Transparency was highlighted as a key issue by a number of groups at the workshops, relating in concrete terms to the way decisions are reached, statements of needs are written, and resources allocated, and relating in conceptual terms to general honesty, clarity and keeping parents informed. In the words of one group, such concerns amount to building *"an ethical framework (which is) transparent"*. These barriers, hindering a relationship of trust, were also identified by many of the delegates who attended the workshops as professionals, one of whom acknowledged that *"the parent may feel they are the only voice for the child".*

Delegates from Health and from Education suggested that trust will only be built up if all professionals give a similar message, and indeed parent representatives, and parents themselves (Phases 2 and 3) have highlighted conflicting information as a source of discontent. Many delegates from both agencies proposed that joint assessment would eliminate problems created for parents by conflicting information, as well as reducing the time in completing the assessment process.

Parents highlighted the need to have a named contact to whom they could turn for information or advice at all stages of the assessment process and beyond. One LEA represented at the workshops reported a multi-professional consultation group, consisting of SLT, EP, specialist teacher and SENCO, as a mechanism for parents to

air problems, providing a concentrated resource which helps parents to avoid a feeling of being "passed from pillar to post" in the search for information. Delegates perceived a need, however, to ensure that role boundaries do not preclude an ongoing line of communication with the parent after assessment; there should be a key worker through whom follow-up after assessment can be arranged, and who will help the parent, for example with a date for review. The role of the Parent Partnership Officer as a key link with professionals was highlighted by parents, and many individual officers received praise (Phase 2) for their role as informants/advisers/liaison contacts.

While welcoming the role of AFASIC and other charitable organisations in supporting parents, a number of professional delegates were less enthusiastic about their perceived influence in encouraging parents to proceed with tribunal hearings. The proliferation of tribunal hearings was held by professionals to be a factor in exacerbating inequitable provision.

9.5.3 Partnership

A number of delegates referred to an ideal concept of parents as "partners", both in decisions taken about therapy provision, and possibly in implementing a therapy programme, and phrases such as *"parental opinion to be given equal weight", "engage with parents and seek view actively"* were used by workshop participants. In support of the partnership concept, delegates felt that parents should be actively engaged as early as possible regarding shared assessment and intervention *"to result in shared identification and understanding of child's strengths and needs".* One group proposed the involvement of parents in negotiating an action plan for their child as a means of achieving a shared view of realistic intervention aims. Another group suggested parents being given a *"formal voice"* at strategic level.

These are all measures which delegates hope will go towards remedying a current lack of transparency, giving parents access to information which they can use as part of the decision making process for their child's development: information which will include knowledge about resources available, as well as about the choice of programme. Professionals hope, in a context of partnership relationships to be able to *"challenge parental assumptions that more is necessarily best"* (SLT). Success in this should have implications, too, for the way that statements are written, decreasing the perceived need to include vaguely worded descriptions of provision which lead to confusion and disappointment.

Nevertheless, while inequity of provision persists, there are clear tensions in adopting such a policy. It remains unclear whether professionals would always wish to be "transparent" where denial of provision is in fact resource, rather than need driven, for such honesty would rely on parents' acceptance of alternative arrangements which they might rightly regard as "second best" for their child. Delegates suggested that a "menu" of provision (as discussed above) would offer parents sufficient choice of provision to accommodate their child's needs.

A number of workshop groups suggested that statementing should ideally be discontinued, though there was general agreement that funding mechanisms will influence whether creative alternatives can be found. As a precursor to this, there is a perceived need for the LEA to monitor the allocation of resources for special needs. One group suggested that as an alternative to statutory assessment a group of

professionals, say, academics, LEA and SLT practitioners, should be brought together to define specific provision according to level of need, in the context of robust criteria for intervention identified at national level.

"Managing parents' expectations" clearly includes expectations of provision, but also role expectations: the role of SLTs, teachers and LSAs. Following from this is a need, expressed by a number of delegates, for clearer definitions of roles and responsibilities for the professionals involved, as discussed elsewhere. At the same time, professionals will need clear definitions of parental involvement, whether or not they are to be active partners in implementing therapy programmes. A teacher at one of the workshops spoke of "*acknowledgement of parents' knowledge and skills and limitations*", a phrase which appears to underline the distinction between professional knowledge and a parent's knowledge of their child, and suggests a need for parent training. Such training, while helping parents to find a balance between hope and realism, should enable them to make their contribution to an informed decision in respect of their own child's needs.

Overall, delegates expressed the view that parents' expectations can usually be successfully managed, so long as clear information is honestly and sympathetically given from the beginning of their involvement with the professional concerned. The need for this is emphasised in the current climate of scarce resources and inequitable provision.

Chapter 10 - Thematic analysis and recommendations

This chapter develops the analysis in the preceding chapters by looking across the three phases of the study and pulling out thirteen key themes which have recurred in the data.

The themes are:
1. Funding;
2. The need for common data sets;
3. The identification process;
4. Co-terminosity between LEAs and Health Trusts;
5. Collaboration between LEAs and Health Trusts;
6. Models of provision for supporting children with speech and language needs;
7. The size and changing nature of caseloads of children with speech and language needs;
8. Prioritisation systems;
9. The recruitment and retention of speech and language therapists;
10. Education, training and continuing professional development;
11. Expectations of colleagues and parents;
12. The role played by parents and carers;
13. Issues related to Welsh and English as an additional language.

Throughout the discussion reference will be made to sections in the preceding chapters. This is then followed by a discussion of the interrelationships between some of the themes. A set of numbered recommendations is included at the end of the chapter. Where appropriate, explicit reference is made to a parallel set of recommendations that is to be reported simultaneously by the Speech and Language Therapy Working Group.

10.1 Funding

From the discussion with both LEA and SLT managers, it is clear that one of the key issues is that of funding. There is the general issue of the funding of *services for children with speech and language needs* overall, and the more specific issue (that first alluded to in Chapter 1) of the funding of *speech and language therapy services* related to children within educational provision. These can be further divided into three key issues:
1. the level of funding for services to children with speech and language needs;
2. the way in which funding to children with speech and language is allocated; and
3. one way in which these issues can best be taken forward at a local level.

10.1.1 The level of funding for services to children with speech and language needs

There was a sense from the discussions with both LEA and Trust representatives that, once one embraces the joint concepts of inclusion and equity, services are often spread too thinly to provide effective input. This was expressed by SLT managers as a shortfall in speech and language therapists (an issue to which we return below), but it is also an issue of the general level of support within education, and the appropriate skill mix of those supporting children with speech and language needs. Clearly, to obtain an

effective service, consideration also needs to be given to the training and supply of teaching assistants and the general level of knowledge amongst teaching staff.

It is important to recognise that no respondent was simply making the case for more resources. Nor was it simply considered a question of shifting funding from one service to another, from Health to Education or vice versa. Neither party has a sufficient budget under the current funding arrangements. This is particularly true for mainstream provision (3.3.3). All contributors indicated that additional resources would only be useful if the correct mechanisms were in place for deploying them appropriately given the issues arising out of the themes identified below.

10.1.2 The way in which funding to children with speech and language needs is allocated

Finance for speech and language therapy/educational provision for children with speech, language and communication needs should be co-ordinated, and there is a clear demand for a system of resource allocation which is transparent to both practitioners and users of the service. It is not the case that the present diversity of provision, including the variation in relative funding and staffing by LEAs and Health Trusts, reflects locally determined rationales based on need. Central government and local services need to work together to create the most appropriate model. The former should set the overall agenda, including a move towards more inclusive provision and the determination of appropriate standards (to avoid 'postcode lottery' complaints). The latter should determine the precise deployment of services according to local need. Central government must play a key role in setting the parameters around funding, while detailed determination of action is best undertaken at local level.

In the light of the discussion above we would suggest that a new funding stream be created that runs from Central Government and the DfEE to LEAs, specifically to meet the needs of these children. We suggest the DfEE as the source of funding for three main reasons:

a) children's speech and language therapy services are outside the spending priorities for DH and health commissioners, as defined by the National Service Frameworks and National Priorities Guidance[63] [64] (5.5.5) (and, as such, new funds to health commissioners could not be guaranteed to be hypothecated for speech and language provision);

b) by the same token, the driving force for change in both the funding and provision of services for children with speech, language and communication needs comes more from LEAs than from HAs or PCGs; and

c) we perceive that any new funding should be directed not just at the delivery of speech and language therapy *per se*, but at the provision LEAs themselves are able to make for children with these needs, in terms of accommodation, specialist teachers and LSAs, and training for staff.

However, in order to reflect the bi-partite interests of Education and Health, the funding stream should be co-ordinated by both the DfEE and the DH, and should be

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[63] Department of Health (1998) *Modernising Health and Social Services: National Priorities Guidance 1999/00 – 2001/02*

[64] Department of Health (1999) *Modernising Health and Social Services: National Priorities Guidance 2000/01 – 2002/03*

hypothecated for services to children with speech, language and communication needs. We would expect a parallel system to operate in Wales.

We did not encounter a strong case for LEAs acting as providers of SLT services. Rather we would suggest that LEAs act as the lead commissioner of services, commissioning from local SLT providers to meet the needs designated at a local level. In order to maintain equity, the budget should be held centrally by the LEA and not devolved to Head Teachers. In this way LEA managers would be able to have a say as to how services were deployed, and SLT practitioners would be meshed into the existing LEA system and accord with local policy on inclusion and other educational priorities. We recognise that a funding stream directed from central government to LEAs could be perceived as giving Education managers more influence in determining spending priorities than SLT managers (5.7.4). However we envisage that equity in strategic decision-making will be served by the formation in each area of an inter-agency board(s), where SLT managers should be at liberty to negotiate the strategy, and the resulting contract, in a professionally justifiable manner (5.2.1, 10.1.3). Training and professional support, development and management would come from within the health system. Obviously this would create a need to formulate local service level agreements (SLAs).

Such an agreement would be based on a local needs assessment exercise carried out by LEA and SLT services operating together. With a policy of moving towards inclusive education, this is likely to mean an increasingly mainstream-based allocation of resources. This process would require local decision-making, which must include the LEA and Trust(s) at senior officer level. We would also urge the involvement of parents in this strategic planning. Regional or cross-LEA discussions would also be required in some cases and would be able to take into consideration issues that arise from the extent to which LEAs and NHS Trusts/PCTs/LHGs map on to one another.

If the LEA had determined the level of need within its service, it would then be in a position to influence the level of provision, and would not find that it was competing with other NHS priorities, a problem which we encountered throughout the project.

10.1.3 One way in which these issues can be taken forward at a local level

Of particular interest is how to key NHS and LEA funding in to one another. One possible solution is the opportunity that arises from the "new flexibilities" to encourage inter-agency working under the 1999 Health Act[65]. In such cases a joint board including Speech and Language Therapy service providers, the LEA and parents would be set up. An agreed amount of money from Education and Health would be pooled and then managed by the board under specific terms of reference. The priorities, designated management, clinical governance etc. would then be organised by the board, which would effectively act as a governing body. This possibility offers real opportunities to exploit a national initiative to manage acceptable provision at a local level. The great advantage of this approach is that the board would provide a means of auditing the effectiveness of the collaboration and of including local parents at a strategic level in the decision making process.

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[65] Available at http://www.legislation.hmso.gov.uk/acts/acts1999/19990008.htm

10.2   The need for common data sets

It was evident that few, if any, authorities shared data sets. There is a striking need for the collection of common data sets at both local and national levels. Indeed it is difficult to see how the issue of equity of service provision can properly be addressed without such data sets. On a number of occasions in the Phase 1 data collection, authorities simply were not able to provide the figures requested in the questionnaire. For example, at the simplest level some Trusts were not able to provide the figures for their caseloads (3.2.1). Only one third of SLT managers were able to report the number of children on their caseloads who had a statement (3.2.11). LEAs were much clearer about this, but the issue is particularly important for SLTs because of the proportion of children without statements that they saw (63-71% depending on whether they were estimates or based on actual data). This is an important issue if the presence of a statement is employed as a principal criterion for resource allocation for one group (LEA), but not the other (SLT). This lack of data was also evident in the inability of four Welsh LEAs to indicate how many children with speech and language difficulties were monolingual Welsh (3.5.1). Understandably these unilateral gaps make it very difficult to plan services at the level of the Trust or LEA.

There is a need, then, for central government to discuss and determine a key set of information which would then be collected and used at a local level. This should include routine data on caseloads; number of children on different stages of the code of practice specifically with speech/language needs; level of resourcing of services and skill mix; individual outcome data for children derived from speech and language assessment and IEP target attainment; and process data e.g. on the number of times children are seen, and possibly related to the service as a whole, e.g. level of contact between professionals.

Given that the current government policy is to reduce burdens on schools and Local Authorities, any requests for new data should have a clear purpose. It is envisaged that these data could be fed into joint strategic planning in general, and in particular, a local assessment of need. It is felt essential that joint needs assessments are carried out by the LEA/Trust partners, with agreed case definitions and ways of calculating need, and at agreed age points. Without these data, it is difficult to see how workforce planning can be more than reactive and this probably increases the risk of litigation, forcing authorities to provide resources for children in an *ad hoc* fashion. The down side of the needs assessment is that it is very likely that the perceived need is not as high as the real need, which, in turn, may be closer to the prevalence figures reported in Chapter 1. As a consequence, the audit procedure may result in heavier demands on the service (5.15.4). But if services are serious about addressing the issue of the equity of provision, there is little choice but to improve the joint collection of data.

At a practical level there would also be considerable potential for enhancing collaboration by means of shared IT systems between health and education (5.2). While this is critical at a local level, it is also a national issue, with so much non-comparable data already being collected by both the DfEE and the DH. For example, the LEA/DfEE collect data on the number of children with statements annually, whereas the Trust/DH collect data on initial patient contacts with 0-15 year olds.

A number of authorities do share data sets but there is no agreed format in England. By contrast, there is a standard data set for Wales and this is provided in Figure 10.1 as an

initial indication of the type of data that it would be appropriate to collect. This list could be supplemented with a reciprocal set of indicators for Education. For example there is a case for including audit data about the outcomes of the annual review of the statement and the IEP process.

Figure 10.1 Welsh Core Indicators relating to speech and language therapy

> - % of time spent on all patient related activity by speech therapists with children
> - % of children waiting for their first speech therapy appointment and assessment on the last day of the quarter who had waited over 6 weeks
> - % of children waiting for their first agreed speech therapy treatment on the last day of the quarter who had waited over 6 weeks
> - Number of referrals during the quarter for speech therapy assessment
> - Number of first speech therapy assessments during the quarter
> - Number of speech therapy patients discharged from treatment during the quarter
>
> Speech therapy for children with statements of special educational needs (SEN):
>
> - % of requests for speech therapy advice received by the Health Authority from an LEA which were processed within the 6 week time limit (under Section 323 of the Education Act 1996).
> - % of children where the agreed speech therapy has been met within 2 weeks

10.3 The identification process

Many children with significant speech and language needs are identified before compulsory school age and have speech and language therapy involvement during the pre-school period. This may be in a clinic, or in a range of early years settings. The National Baseline Assessment arrangements require that all children are assessed by schools using a scheme accredited by the Qualifications and Curriculum Authority (QCA) within the first seven weeks of their school careers (i.e. at about 4-5 years of age). The schemes include language and literacy assessments and so provide the basis for a systematic screening programme for children's speech and language needs at school entry. While schools report a high level of satisfaction with their chosen scheme, including its use for identifying special educational needs, the evidence base for most of the 91 accredited schemes is limited. Consequently, the use of baseline assessment for screening must be undertaken cautiously[66]. Nevertheless, consultations between SLT and reception teacher based on baseline assessment results have the potential to provide a means for using this method as a first stage screen and could also feed into the type of shared audit process discussed in 10.2 above. This could be followed up by consultation with parents and more detailed assessment for children identified.

The concept of integrating a general screen for speech and language difficulties with assessments which occur at critical points in a child's school career (e.g. National Curriculum Assessment tests) could be extended to facilitate identification of those children whose difficulties surface later than in Reception year. Naturally, this would have to be accompanied by training for school staff to ensure the appropriate identification of children.

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[66] Lindsay G, Lewis A, Phillips E (2000) *Evaluation of the accredited baseline assessment schemes* London: QCA

10.4 Co-terminosity between LEAs and Health Trusts

Detailed descriptions of the interactions between health and education systems is provided in Chapter 8. From this discussion it is clear that issues around co-terminosity are common to most Trust/LEA pairs and to Health Authorities. Indeed, the degree that boundaries overlap was found to be a more significant issue than whether the LEA was classified as Shire, Metropolitan, etc. Given that, of those responding, only nine of 66 had co-terminous boundaries, this is a very important issue. Although the patterns of linkage that emerge look to be very complex, it is important to reiterate the comment from Chapter 8 that this need not necessarily be a problem when there are active strategies implemented to address the matters that arise from it. But it is very easy for issues around boundaries to come to the fore, and those involved may have to work extremely hard to overcome differences. These differences have been exacerbated in some areas where LEAs have opted to buy different services from different Health Trusts (3.3.6). This is a throw-back to an earlier "purchasing" model which prevailed in the NHS in the late 1980s and early 1990s, but clearly there is some rationalisation needed here.

Finally the introduction of the Primary Care Trust in the NHS introduces a new layer into the collaborative process between health and education services. It is unclear how these will map onto current LEA populations but it is likely that they will result in a greater number of boundaries to negotiate. To the extent that they will be responsible for commissioning SLT services this may prove problematic, a concern that permeated many of the Phase 2 interviews and is discussed in greater detail in 10.5.3 below.

10.5 Collaboration between LEAs and Health Trusts

This section integrates the sense of the collaboration data recorded in Phase 1 of the study (see Chapter 4) with comments made about collaboration in Phases 2 and 3. Relatively few of the contributors commented on collaboration at a national level and most, even strategic managers, tended to concentrate on local issues. Almost all respondents accepted the need for collaboration and recognised the historical difficulties that many services have experienced in striking an appropriate balance. There was a recognition of the need for joint working, but an uncertainty as to how to put it into place. Where good collaboration was in place, this had often come about through a local process of choosing to work together and a gradual build up of trust between the parties concerned. Whereas the role played by individual 'chemistry' was recognised to be critical, many commented that there was a need to put structures in place to prevent collaboration depending on personalities. It was not simply a process of getting practitioners to discuss the needs of children with whom they were working, but a need for collaboration to be built into the system in a formal manner. Although there are discrepancies between LEA and Trusts in provision, and some differences identified between collaboration described in Phases 1 and 2, there is generally a high degree of commonality in the opinions expressed.

10.5.1 Assessing collaboration

The obstacles to collaboration have been well documented and will not be comprehensively reviewed again (1.3). How one measures the effectiveness of collaboration is less well established. The system adopted in this study and reported in Chapter 4 is a first stage, and these findings can be cross-checked against the interview data from the fifteen sites visited in Phase 2 of the project. While there was a

considerable degree of consensus around collaboration between those involved within LEAs and Trusts (suggesting the validity of the collaboration scale), there were some differences. An interesting case in point would be the pattern which appears to be emerging of the LEAs rating the process of collaboration and their satisfaction with the provision made more highly than the speech and language therapy managers (4.2, 4.3). Another example of inconsistency occurred between the Phase 1 and Phase 2 data. In Phase 1, the LEAs commonly reported that they had input into the strategic management of therapy services (particularly with regard to inclusion), but it was clear in Phase 2 that, even in highly collaborative authorities, this was seldom the case (5.2.1). One approach that would be interesting to pursue would be to rate the respective partner and then share that information with them. Another possibility would be the further development of existing audit procedures such as the Index for Inclusion[67], which has been designed precisely to highlight key issues around inclusion for all schools. There are some items related to communication in the existing index and these could be extended.

10.5.2 Key issues in collaboration

There are a number of specific cultural issues which explain the different approaches and which need to be highlighted. At the root of collaboration is a shared vision. Without it there is little chance of practical mechanisms falling into place. This joint vision appears to come through more readily at a practitioner level, especially where teachers and therapists work together on the same premises (for example, where they work in a language resource base and discuss the increasing integration of individual children in their care into mainstream classes).

In our Phase 2 sites, collaboration at practitioner level was generally reported to be changing for the better. However, at strategic levels, there remain a number of issues around collaboration which need to be closely monitored. There is a case for doing this at a national level, thereby ensuring consistency across the country, with an agreed standard of collaboration which parents could reasonably expect local services to maintain. Appropriate methods for measuring collaboration and outcomes would be established. For example, there is still a question as to how much SLT services are involved in the SEN process as far as the LEA is concerned. The fact that only a third of SLT services are involved in the SEN placements panel, given that where they are involved, their contribution is rated very highly, may be an indication of this (4.6).

Measuring outcomes and evaluating services is a cornerstone of health provision, a point made by one of the health commissioners interviewed. The IEP system used by LEAs tends to favour examining the process of change and data are rarely collected on specific outcomes. There are some LEAs where IEP outcome data are collected but these are relatively uncommon. National Curriculum tests and task results are also available, as are the 'P (performance) scales' which were designed for whole school target setting. None of these offers an easy solution. If Health is to be actively involved with Education in the provision of speech and language services, this issue needs to be reconciled.

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[67] Black-Hawkins K, Vaughn M, Shaw L (2000) *Index for inclusion: developing learning and participation in schools* Bristol: Centre for Studies on Inclusive Education

10.5.3 Managing collaboration

It is apparent that even when there are meetings set up for discussion of strategic matters, those who attend those meetings are not necessarily of the same level of seniority and may be unable to make the same level of decision for example around the deployment of budgets (*Figure 5.1*). It can be frustrating, for example, for a manager to make a decision with their Education or Health Service counterpart, but then find this person has to negotiate separately with a senior member of their organisation before being able to commit to the decision. This can happen in either direction, but is a more common frustration for LEA managers. One particular problem that has been reported is that senior medical staff (who may be at the same management level as senior LEA officers) attend meetings which discuss speech and language therapy, but effectively know very little about the service in question. It may be that there will be more opportunities, under increased staffing flexibilities currently being introduced in the NHS, for speech and language therapists to become involved within senior management within a Trust.

The future changes in the commissioning of both health and education services are likely to have an impact on the way SLT services are funded. The trend is for smaller units – the school and Head Teacher and the Primary Care Trust and General Practitioner – but this is unlikely to provide the optimal solution for a relatively small service such as SLT, and will tend to result in a decrease in the equity of distribution of services, making it impossible for speech and language therapists to develop specialisms[68]. While it would be feasible for the funding to come up from individual schools (or more likely from clusters of schools), the co-ordination would need to be at a much higher level to ensure efficient and effective provision of services and the professional development of SLTs. It is quite possible that the co-ordination of services at a PCT level would not allow for sufficient sized departments and it might be necessary to transfer it to the HA or NHS Regional tier. It is important that the co-ordination and funding of services need not be at the same level. The point here is that there is a need to consider the most effective operational unit in terms of service provision for all those responsible for the provision for children with speech and language needs

10.5.4 Collaboration at a practitioner level

Negotiation of roles is a key issue for some authorities where there are a number of different practitioners involved. There needs to be a mechanism for allocating a key worker with whom the parent relates directly to avoid confusion. This could be the SENCO, a specialist teacher or a speech and language therapist. Some of the most irksome issues for LEA managers and practitioners were simple operational matters. For example, there was concern expressed about terms and conditions of SLTs which usually do not match those of teachers (6.2.2) and that effective collaboration often meant something as simple as joint working arrangements and formal processes for sharing time (5.13, 6.2.2). The contractual arrangements for speech and language therapists working in Education also need to be clarified between Health service providers and LEAs/schools. LEA practitioners complained that recruitment/retention issues were often made worse by the fact that, even when there was a Speech and Language Therapist available, their contract allowed them to go on leave during term

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[68] Hillery A (2000) Primary care: challenges and concerns *Bulletin of the Royal College of Speech and Language Therapists* 580 10-11

time. Clearly there are issues that affect collaboration which need to be addressed at strategic, operational and practitioner levels.

10.6   Models of provision for supporting children with speech & language needs

Not surprisingly, given their willingness to be involved in the study, all those who responded in all three phases of the project had strong views as to how children's needs should best be met. In some cases this involved a recognition of the value of the contributions of other professionals. In other cases there was criticism of other professionals because they did not work in a given way. Clearly there was a strong demand from LEA representatives for speech and language therapy services to provide extensive input to mainstream schools and, to a great extent, SLT managers concurred.

SLT providers with a designated service to mainstream schools[69] allocated an average of two therapists per week to this type of provision. Where there is no designated mainstream school service, SLT departments used the equivalent of one therapist a week from clinic time to provide input to schools (3.2.5). This indicates a widespread recognition of the need for this type of work. So schools are effectively pushing at an open door wanting speech and language therapists to provide them with a service. Yet this level of input is bound to be inadequate whichever method one uses for interpreting the prevalence and referral figures. The figures for input of SLT services to specialist (i.e. not mainstream) provision are much higher, but that only serves to emphasise the point (3.2.8). The number of children with speech and language needs, if not the severity of difficulties they experience, is likely to be higher in mainstream schools. As the inclusion agenda is implemented and children move from specialist provision to mainstream the number of children with more severe difficulties in mainstream schools is likely to increase.

There is a benefit in maintaining a clear professional association between SLTs, which is probably best facilitated by their being within one service locally, rather than a small number of SLTs being employed by the LEA separate from the Trust's SLT service. The latter need not necessarily be problematic provided that a clear linking of such SLTs with the main service is set up; however, we consider that, in practice, such arrangements are more difficult to maintain effectively. There is also a benefit in the flexibility that comes from a Health Trust level service, e.g. to cover maternity leave and illness, and allow for professional development. There is a concern that Primary Care Trusts may well have a detrimental effect here (by virtue of their small size), because they may militate against flexibility and professional development and detrimentally affect recruitment. Similarly, employment of therapists by Head Teachers with devolved budgets could threaten the integrity of services. A clear steer about the most appropriate level for the co-ordination of SLT services would be welcomed for LEAs and Trusts from government departments, in order to protect the critical mass of a service, provided that flexibility remained at local level.

10.6.1 The need for common terminology

There are a number of different ways of delivering a speech and language therapy service to schools and it is possible to characterise these in terms of a number of parameters (1.2). Ideally a menu of options and the choice of approach will be

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[69]   i.e. where sessions are devoted exclusively to working in mainstream settings, as opposed to clinic settings

discussed with the class teacher (6.6), but, at present, there is often a lack of clarity about what the approaches themselves entail. Joint training for therapists and teachers would be of great benefit in this respect (10.10). The terminology associated with interventions needs clarification and a mutual understanding by both parties, at both operational and strategic levels. For example, it was apparent that some LEA contributors were conflating the concepts "school-based" and "consultative". Although the literature review referred to in Chapter 1 suggested that indirect work could be as effective as direct work, these data are derived from studies examining the effect of working through parents. However, almost all the approaches referred to by those involved in this study include indirect work through teachers and LSAs. The key word here is "flexibility", a term which emerged repeatedly in the interviews. A needs-based service will be characterised by a number of different approaches ranging from direct work by the therapist to indirect work through other professionals.

10.6.2 Support services

LEA managers were very positive about the use of teaching assistants (TAs) (5.16), but SLT managers were more circumspect on the basis of their experience of what can be a rather erratic service in terms of availability and knowledge base. Too little is known about the value of such intervention to recommend it as the only solution, and it is clear that speech and language therapy managers and practitioners are unhappy about assuming that this is necessarily the best way forward. There is also a concern about the availability of such resources. As we saw in Chapter 3, the numbers of peripatetic teachers and LSAs with specialist skills in this area is very low (3.3.2), with 83-92% of LEAs reporting that they had no designated peripatetic teachers to work with this client group. We will be returning to this issue under the topic of continuing professional development below. Realistically, if there are not enough appropriately skilled LSAs in place, it is unlikely that speech and language therapists will be able to function effectively in the educational context. If they are not able to rely on LSAs to implement programmes, either they will continue to support the children themselves, working directly rather than indirectly, or the children will receive no service at all.

10.6.3 The consultative model

The so-called "consultative model" to which reference has been made throughout the report presupposes that the speech and language therapist is in a position to function as a consultant. To pursue the medical analogy, the consultant is a senior member of clinical staff who has an excellent knowledge and experience of intervention before he or she starts to be consulted. This then inspires the confidence of the staff and the patient. It also implies that the consultant continues to practise "hands-on" themselves, so maintaining and developing their knowledge and skills. It is this type of consultant therapist model that is proposed in the 2000 NHS Plan[70]. The problem we have to face is that for many speech and language therapists, the job within the education service is one that they are likely to take on at a relatively early stage of their career. If they have not had the time to develop the skills of observation, assessment and intervention themselves, it is probably not appropriate for them to be functioning in a purely consultative fashion. The maintenance of credibility requires expertise and does not simply follow on from a statement of preferred practice. Experienced teachers want experienced therapists to support them.

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[70] Department of Health (2000) *The NHS Plan – A plan for investment, A plan for reform* London DH.

For speech and language therapy services, the term "consultant" is not confined to indirect work via another party. For example, it may be very appropriate for the therapist to spend time specifically modelling techniques to an LSA. Similarly the assessment process may, in some cases, be particularly complex and this may require the therapist to take the lead in direct assessment. Equally it is important to emphasise that while the consultant model may predominate, it is not the only element of the mainstream service. There may be a range of specialist and generalist therapists available in a given speech and language therapy establishment, some of whom may function more readily as consultants. There needs to be specialist recognition for SLTs who are very experienced in working in educational settings, but it would be wrong to suggest that only experienced therapists can work in schools. There is a case for skill mix within teams, and this requires teams of sufficient size for a range of different grades to be supported. Thus less experienced SLTs may be doing more direct work with children and, as they become more experienced, they may act in a more indirect fashion.

This pattern of moving from "hands-on" practitioner to consultant is a route followed some years ago by educational psychologists and is one which needs to be negotiated carefully. In addition to the intervention itself it is evident that SLT services place considerable emphasis on their involvement in child development centres and assessment units (3.2.8). Whatever the model of intervention adopted, assessment will take up a substantial part of the speech and language therapist's workload simply because, by definition, many of these children have very complex needs and take time to assess properly. Of course there is another side to this coin and one which has the potential to bring many benefits to all concerned. Good collaboration can aid and streamline the assessment process if, for example, the SENCO has collected information and classroom observations about the child before involving the SLT.

Another area about which we did not specifically collect numerical data, but which does come out of the Phase 2 reports, is the time allocated for liaison. This can be considerable and needs to be written into IEPs/statements etc. if it is not to become marginalised as the pressures to apply the consultative model increase. SLT services are also extensively involved in training LEA staff. Some 94% of Trusts are involved in this activity (4.7) representing a significant input which is not directly client related. Liaison, training, continuing professional development and assessment are all key features of the service provided by speech and language therapists irrespective of the specific approach to intervention adopted. They all take time and need to be part of the "package of care" on offer. Likewise these features need to be written into the work of the LSA. Thus it may be appropriate to indicate that while the greater part of the LSA's work may be in the classroom, there may be situations where it is more appropriate for the LSA to work outside the classroom alongside the SLT. It is important to note that the standard data collection method used in the NHS pertains to number of face-to-face contacts and would not, as it stands, reflect accurately the process of consultation as it is envisaged here. In some authorities, the transparency issue addressed in 9.4 has only effectively been resolved by formalising types of input in terms of time allocated. For example the "management levels" model described in 8.3.1 may be the only way of ensuring that the LEA is confident about what is on offer.

10.7   The size and changing nature of caseloads of children with speech & language needs

The data in Chapter 3 indicated that there was a considerable range in the caseloads of

speech and language therapy services across England and Wales. From an education perspective, the speech and language therapy services were often perceived to be difficult to access, in part because they were very busy. Of course, many SLTs working in mainstream provision are peripatetic and have to cover a great many schools and individual children, whereas this was not the case for most support staff within schools. There were a number of different pressures on staff in terms of which children should be identified as on a given caseload, and how they should be prioritised within that caseload. From the SLT point of view, the caseload question was often focused on children who needed input but did not receive it (e.g. children without statements, secondary schools, EBD facilities). From the LEA perspective, it was often more an issue of whether those whom they had identified were receiving enough input.

Planning services must start with an accurate interpretation of the level of need, and monitoring that need is probably the only really effective method of ensuring equity. Prevalence data based on pre-set levels on standardised tests suggest a figure of around 10% of the child population as being potential cases. But the caseloads reported in 3.2.1 suggest that the figures actually being referred and seen are much lower than this. Size of caseload was positively correlated with both the size of the base rate population and the number of therapists available in the service. However, it is not possible to deduce the direction of causality. It begs the question as to whether more therapists are employed because there are more referrals, or more referrals occur because there are more SLTs available to meet their needs.

10.7.1 The size of caseload

It is necessary to address directly the issue of how big a caseload one can reasonably expect a speech and language therapist to carry, maximising coverage while maintaining quality. Certainly, parents are very suspicious that the current emphasis placed on the consultancy model is being driven by financial expediency rather than clinical judgement. It is difficult to gainsay this unless services have a good rationale for the size of caseloads that therapists are expected to manage. The following provides one such rationale, but it should be stressed that this is an exemplar of the kind of process that should reasonably be carried out as a part of the strategic decision making which we would recommend needs to be undertaken by each LEA/Trust pair.

It has been suggested that the optimum number of clients per therapist is of the order of 40. This figure can be derived from first principles, in that it represents the number of cases that a SLT can provide an effective service to. By "effective", we mean at least as good as that which is currently available in a well managed clinic. But more demanding than this are the four goals identified in Chapter 2. To be effective a service must be equitable, inclusive, comprehensive and pervasive. The interpretation of what it means to be effective may change depending on the needs of a given clinical population and the recommended caseload size may vary accordingly For example, it may be lower for client groups requiring very specialised input (such as children using AAC), higher for client groups which may require more generic input (such as children with delayed language development). Similarly the figure would be lower where a high level of direct involvement was deemed appropriate, and correspondingly higher where the capacity for an effective indirect model was in place. If we look at the figures quoted for the five sites described in Chapter 8 these range from 37 to 172 (median 83, mean 99).

Some independent corroboration for caseload figures of the order of 40 can be

obtained from documentation aiming to establish notional caseloads for speech and language therapists. For example, a national survey suggested that 75% of managers considered 40-100 cases to be an appropriate notional caseload[71], while 41% considered loads of 40-60 cases to be appropriate. In preparing the prioritisation system which was commended by the Harrow judgement (discussed in Luscombe and Shaw[72]), the managers of the service in question based their model of service delivery on a caseload of 40. In terms of the number of schools that can reasonably be covered by a single speech and language therapist, some corroboration comes from a study carried out in Canterbury and Thanet, which recommended caseloads of between 40 and 60 children[73]. A more comprehensive appraisal of appropriate caseload levels has been produced by the North Thames Region Speech and Language Therapy managers[74]. This suggests that it is possible to provide optimum caseloads for different client groups according to whether they are being seen in special schools, special units, resource bases/schools or mainstream schools, at both primary and secondary level. The figures range from therapist/child ratios of 1:15 for severe specific speech and language impaired children in a primary level resource base/school, to 1:70 for children in special schools for the visually impaired. In all cases, the notional caseload is higher for children in secondary school than it is for children in primary school. For mainstream schools, the report recommends a ratio of 1:20 for what is termed a "client-based" service, to 1:30 for a "clinic-based" service. For a school service, a caseload of one SLT to five schools is recommended. This, of course, would depend on practical considerations, such as the proximity of the schools to one another. It is important that the concept of notional caseloads is intended as a way of identifying the number of cases that can be worked with most effectively. For a manager introducing such a system, it may mean restricting caseloads in the knowledge of the cost associated with lengthening waiting lists.

Corroboration of a different nature can be taken from the National Outcomes Measurement Systems [NOMS] project carried out by the American Speech and Hearing Association[75]. The data suggest that more flexible models of working in which SLT are able to modify their practice according to the need of the child are more sustainable with caseloads of 40 or less. Caseloads of above 40 children effectively imposed a model of group working on those providing the SLT services. That is, all provision was likely to be made to children in groups effectively eliminating a more flexible way of working which would allow for the possibility of providing individual support. The data do not address directly the issue of whether this level of caseload affects the extent to which the therapist is able to work directly or indirectly with the

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[71] Hughes A (1984) Analysis of notional caseload study West Berkshire Health Authority. Referred to in Speech and Language therapy Department (1985) *Survey of Speech Therapy referrals from primary schools* Unpublished report, Bristol and Weston Health Authority

[72] Luscombe M and Shaw L (1996) Agreeing priorities for a school service *Bulletin of the Royal College of Speech and Language Therapists* December

[73] Johnson M, Thomas J (1995) *The Canterbury and Thanet Mainstream School Project*. Unpublished report available from Speech and Language Therapy Department, Kent and Canterbury Hospital, Ethelbert Road, Canterbury Kent CT1 3NG

[74] North Thames Region Speech and Language Therapy Managers Group (1998) *Position statement on speech and language therapy service delivery to children in mainstream primary schools* Available from Diana Moir, SLT Services, First Floor, East Wing, St Pancras Hospital, 4 St Pancras Way, London NW1

[75] Boswell S, (2000) Crushed by growing caseloads The ASJA Leader 5, 18 p 1 and 6 See also www.asha.org/nctecd/treatment_outcomes.htm

child.

If we accept this figure of 40, we then have to ask the question of how many schools that would allow such a therapist to cover. The prevalence figure quoted in Chapter 1 suggests the relatively high proportion of 10% of all children. The referral rates are much more conservative, and would suggest a figure of the order of 3%. In fact, in the five case studies identified in Chapter 8, this figure ranged from 2.8 to 4.6% (median 3.2, mean 3.4). It is possible that a comprehensive needs assessment would raise this figure, but a figure of 3% in a typical primary school of 200 children would give six children with speech and language needs. This would suggest an optimum number of 7 schools per therapist. Again, this can be approached from first principles, in that it is possible to determine the level of SLT input which would provide a reasonable presence in the school to allow effective collaboration, but the amount of time spent in each school would vary. If a reasonable presence could be construed as at least one visit every two weeks, and if each visit for the six children constituted a day's work, then the total number of schools that a single SLT could reasonably contribute to would be ten.

It is difficult, in the absence of nationally, or indeed locally, collected outcome data, to comment on the relative effectiveness of the different phase 2 sites relative to the level of provision. Is the intervention more effective with a caseload of 40 than 172? The ASHA data referred to above (Boswell (2000) suggests that it is possible to determine a difference in outcome for groups of children with difficulties of speech sound production. These data indicate that 87% of children from caseloads of 40 or less made measurable progress compared to 63.9% of children from caseloads of more than 60 children. Of course this question takes us back to what we mean by effective. At one level, sites with large numbers of children on the caseload of each therapist may provide a more equitable service, because perhaps they opt to assess all children with potential need as specified by parents and schools. The downside of this is that comprehensive assessment may effectively mean no intervention at all, or a consultative model which guarantees one visit a year. In one such authority, the manager indicated that "caseload numbers are such that visits are not as frequent as would be desirable". It may be a management decision to follow this course, but it is clear that the decision to follow it needs to be taken between Health and LEA managers, and with input from parents.

10.7.2 Specific gaps in provision

With regard to gaps in the provision, the lower numbers of children with speech and language needs in secondary school are particularly interesting (3.2.1, 3.2.6, 3.3.2). It is possible, of course, that children's difficulties and SLT support gradually reduce over the primary stage and, hence, that the apparent cliff effect at secondary transfer is an artefact of the way the data were collected. However, while many children improve their speech and language abilities over the early years and primary period, prospective studies suggest that significant difficulties may remain, and that children continue to experience these problems (especially with literacy), and that these may persist into secondary school[76] [77].

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[76] Johnson CJ, Beitchman JH, Young A, Escobar M, Atkinson L, Wilson B, Brownnlie EB, Douglas L, Taback N, Lam I, Wang M (1999) Fourteen year follow-up of children with and without speech/language impairments: speech/language stability and outcomes *Journal of Speech, Language and Hearing Research* 42 744-761

What possible explanations could there be for this drop in numbers? This could reflect a true reduction in need, at least for SLT services. The changes could simply be a function of the reduced numbers of speech and language therapists working in secondary school. There is also the issue of the number of children who are supported in mainstream schools who transfer into special schools at secondary level – not because of a change in severity of need but because the support is not available in mainstream secondary school. This is likely to interact with the difference in the way SEN services are organised. Although the impairment may still be present, there may be a reduction in need associated with maturity. But it is equally important to recognise that the transition from primary to secondary schools is a challenge for all children. The less structured format in secondary schools could be particularly difficult for children who may have difficulties understanding written and spoken information, and who may find it difficult to enquire about location, arrangements, etc. Subject teachers at secondary level have even less experience of identifying these sorts of problems than their colleagues in primary schools. Another important gap is the level of services to children in EBD and pupil referral units (3.2.8). Given what is known about the relationship between communication and behavioural difficulties, it is likely that there will be a strong relationship here that is simply being overlooked[78][79].

10.8   Prioritisation systems

Prioritisation is effectively a balance between need in the individual child and the abilities of those around the child to do something about that need once it is identified. At the heart of this issue are three key elements:
1. The definition of which children are truly "cases", in the sense that they stand to benefit from intervention.
2. The competencies that SLTs, other specialists and TAs bring to the intervention process.
3. The available resources.

It was clear from the discussions in Phase 2 of the study that there was variation in the criteria used for prioritisation, both within and between professional groups. One of the critical differences is the extent to which the statement of educational need should be seen as a key feature of prioritisation. A second is the extent to which SLT services in clinics may be seen to prioritise against children who fail to attend. But there may be some fundamental differences in the way prioritisation is construed between health and education models.

The health model presupposes a system of prioritisation, which is not routinely a part of the way education services are provided (1.3). Nevertheless, scarcity of resources related to SEN inevitably means that, in practice, prioritisation systems are in operation. The process of providing statements of educational need is effectively a system for prioritisation. Likewise, the deployment of a scarce resource such as a peripatetic

[77] Stothard SE, Snowling MJ, Bishop DVM, Chipchase BB, Kaplan CA (1998) Language impaired pre-schoolers: A follow-up into adolescence *Journal of Speech, Language and Hearing Disorders* 41, 407-418

[78] Botting N, Conti-Ramsden G (2000) Social and behavioural difficulties in children with language impairment *Child language Teaching and Therapy* 16, 2 105-120

[79] Lindsay G, Dockrell J (in press) The behaviour and self esteem of children with specific speech and language difficulties *British Journal of Educational Psychology*

service of specialist teachers must mean that some children do receive services and others do not. 87% of speech and language therapy services indicated that they ranked children on a variety of criteria, of which severity was the most common. It is interesting that SLT services and LEAs do not appear, in the majority of cases, to have reached their system of prioritisation together (3.2.13). This point is linked to that of the joint collection of audit data. Shared criteria mean shared thinking. Without it misunderstandings are almost inevitable. Indeed Dockrell and Lindsay's work has suggested that this lack of shared understanding is the norm rather than the exception. In a study of 133 children with speech and language needs in year three, they found that "surprisingly there were very few double identifications (between teacher, SLT and EP). Only two children in LEA B were identified by more than one professional, whereas in LEA A one child was identified by three professionals and two professionals identified 20 children".[80]

There may also be a potential conflict in need determined by the statement or Stage on the Code of Practice, and need determined by the SLT practitioner. In an ideal world these would be the same, allowing for the length of time that the child had been identified. In practice this was not the case, and SLTs interviewed maintained that there were a number of children who did not have statements but had an equivalent level of need. Although therapists might choose to work with this latter group, they were often forced by the consultative model to work with those who were most likely to have been allocated an LSA (i.e. in turn, those most likely to have a statement) (6.7).

10.9   The recruitment and retention of speech and language therapists

The concept of equity is closely linked to there being "enough" practitioners to meet the children's needs. Of course, this relates to the size of SLT services and those of other professional groups. But it also relates to the simple availability of potential staff. It was clear from our discussions that this is a major issue. 80% of LEA managers perceived difficulties with recruitment and retention of SLTs, compared to half of the Trust managers (3.2.4, 3.3.7). This reflects recent concerns in the professional literature, which suggested that some 50% of advertised posts were not recruiting[81]. With such a scarce resource as SLT, this is clearly a substantial issue and one which will need to be addressed.

In part the issue is one of salary progression. To a certain extent this has been addressed by recent modifications to the pay spine at the higher end of the salary scale. It remains to be seen what, if any, effect this will have on retention. In the short term, at least, these changes may be unlikely to enhance service provision in the mid-range of grades, because these grades will not be affected by the changes to the career structure.

But there is also a more specific issue about career development for those working in Education. The speech and language therapy profession has a number of specialisms, but these are defined by client group (stroke, geriatrics, autism, dysphagia) rather than the workplace. The nearest parallel of a specialism built up around a location rather

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[80]   Dockrell J, Lindsay G (2000) Meeting the needs of children with specific speech and language difficulties *European Journal of Special Educational Needs* 15, 1, 24-41

[81]   Rossiter D (2000) Recruitment and retention: the black and white picture *Bulletin of the Royal College of Speech and Language therapists* July pp12-14

than a client group would be that of working in Child Development Centres addressing the needs of a broad range of children with developmental delays. Work in education settings is not currently well recognised as a professional specialism and there is, therefore, a need to develop further the expertise and status of speech and language therapy practice within education. Our data would suggest that there is a perceived benefit in the development of this expertise but that there are anxieties over loss of professional autonomy (one of the defining characteristics of professional specialisation). A further concern, one raised by SLT managers, was that LEA contracts were often not very appealing because they were commonly short-term (5.7.4) and were not associated with the same terms and conditions as teachers.

Recruitment also depends on there being a pool of practitioners looking for employment. Current workforce planning in the NHS suggests that this pool probably does not exist. Too few speech and language practitioners are being qualified. This issue is currently being addressed to the extent that a real effort is being made by the DH to achieve good workforce planning, and there is a new drive to recruit 6,500 more therapy staff for the NHS[5], but this is currently without input from the DfEE or LEAs. Undergraduate, pre-registration education for speech and language therapists is co-ordinated and directed by health consortia which respond to demand from those contributing to them. As it stands, LEAs are not represented on these consortia and until they are, this issue cannot be addressed effectively.

10.10 Education, training and continuing professional development

Throughout the interviews it was clear that there were concerns on the part of both parties (Education and Health) about the level of understanding of a range of different issues. This is a critical issue, because practitioners are not likely to be able to collaborate if they do not respect the knowledge base of their colleagues. In some cases individuals identified their own gaps, in other cases those of others. There seemed to be a better understanding of joint terminology and respective roles when staff had collaborated for some time and had attended training programmes with one another. Training and, in particular, joint training have a real contribution to make in this area. Particularly successful are programmes of training that had been planned and executed across services.

One area of particular importance is the input to pre-registration training of speech and language therapists and teachers. To date this has been monitored by the Royal College of Speech and Language Therapists and the Teacher Training Agency respectively. Recently the speech and language therapy profession has moved into the Council for Professions Supplementary to Medicine which, in turn, is to be subsumed under the new Health Professions Council (HPC) in 2001. The significance of these changes is that the HPC will take over the monitoring of higher education institutions providing pre- registration training for speech and language therapists. This process will make it possible to impose standards on university departments in terms of the different components of the courses. The courses will then have to demonstrate that they provide sufficient training in a given area. The HPC, as the name suggests, is primarily "health" orientated, but this organisation will be responsible for specifically monitoring the nature of the education component to these courses. The HPC will need advice as to what are the appropriate standards.

Currently there is a considerable amount of workplace training going on, although it

would be fair to say that there is far more training going from Speech and Language Therapy services to Education than the other way around (4.7). In general this appears to be taking place on an *ad hoc* basis.

As budgets are devolved downwards it may be appropriate for clusters of schools to organise their own packages of training and to have speech and language therapy services involved in providing these as appropriate (within some county-wide or nation-wide standard). It is appropriate to look at training in terms of appropriate skill-mix. For example, it is almost certainly inappropriate to provide TA training without first training classroom teachers. An illustration is reported in Chapter 6 regarding a package of training arranged in four stages – SENCO, class teacher, LSA and then advanced section for teachers with a specialist interest. Examples of the content of this type of training are provided in 9.4.

For teachers, training "on the job" was also perceived as CPD. They often found it easier to learn from training which related to children in their class. This is an important issue as regards the organisation of speech and language therapy services, because it requires extensive commitment in terms of time and needs to be written into the statement of educational need. Process targets around this issue need to be seen as legitimate outcome measurements as far as SLTs and teachers are concerned.

Parents also expressed an interest in more information to help them with their decisions. It is appropriate for courses to be run aimed at the needs of parents. These could readily be run using the networks set up by the Parent Partnership Officers, but should be a part of the joint programme of training provided by health and education services.

The following areas of need were identified:

Teachers need
- a clear emphasis on language and child development in their basic training;
- more basic information about SEN (9.3) through their basic training as determined by the TTA;
- a better understanding of the identification and description of children with language difficulties;
- a clearer idea of the link between language and literacy (6.9);
- more information on how language development links to curriculum demands;
- a clearer idea of the potential role of the speech and language therapist. For example, it was apparent from the practitioners' interviews that many teachers perceived that language could be taught as a curriculum subject separate from what routinely happens in the classroom (6.2.2).

Head teachers (especially those with units or resource bases) need
- on site access to CPD, perhaps through a dedicated website.

SLT and LEA Managers need
- a mandatory level of management training to empower them to plan and negotiate joint strategy and contracts.

Speech and Language Therapists need
- a better understanding of the classroom culture;

- greater knowledge of the application of the curriculum (5.9.3);
- sufficient opportunities for the development of hands-on skills to become effective consultants;
- a pathway into specialising in education;
- updating opportunities for those wishing to return to the profession.

Learning Support Assistants need
- a comprehensive accredited programme of relevant training to enable them to promote speech and language development effectively. This should be in line with the TTA specialist standards;
- an understanding of how language development relates to the curriculum;
- an understanding of the role of the speech and language therapist.

Teachers with a specialist interest in language development need
- appropriate postgraduate courses to enable them to develop their expertise regarding language development;
- a comprehensive understanding of language disorders;
- a comprehensive understanding of appropriate methods of intervention;
- support groups to facilitate dissemination of good practice.

Parents need
- information about the range of disorders that exist, and appropriate interventions associated with them;
- the opportunity to learn the appropriate skills to negotiate with the LEA/Trust about their child's needs.

There is also a higher level of training which needs consideration. Even when the professional groups are better informed and have more relevant experience, there remains the issue of how to get those involved to work in partnership to continue to foster and develop their skills. To some extent there are already moves towards a more integrated framework for developing professional skills in this area. The DfEE has recently taken the important step of offering grant support to the charity I-CAN to produce a Joint Professional Development Framework to promote joint training for teachers and speech and language therapists.

10.11 Expectations of colleagues and parents

Although differences of knowledge can be addressed through modifications to initial education and training, and through joint training post-qualification, there were also some fairly fundamental differences in understanding. These may not be just a matter of training, but may emerge from unacknowledged differences in orientation between those working in education and health services, and equally from parents. The practitioner interviews made it apparent that there may be a very different understanding between therapists and teachers concerning the objectives of intervention. This is partly a product of initial education and professional culture, but it is also a product of the experiences of the practitioners concerned. For example a number of different approaches to intervention have been identified[82]. Norwich suggests that it is possible to draw a distinction between different levels of need, namely individual

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[82] Norwich B (1996) Special needs education or education for all – connective specialisation or ideological impurity *British Journal of Special Education* 23, 100-109

need (specific to that child only), exceptional need (specific to a group of children) and common need (equally relevant to all children regardless of any individual or exceptional needs). For practitioners to work closely together they must be aware of the level at which the intervention is pitched.

One of the key aspects of the intervention of the speech and language therapist is what might be termed "impairment-focused" therapy, aimed at effectively remediating a perceived deficit in an individual child's abilities. This may be extended to a group of children, but would presuppose that all the children had a comparable difficulty. Such an approach might be characterised as "medical", and successful remediation would be seen as a key health outcome. The intervention data quoted in Chapter 1 (1.2) suggest that for young children at least, this can be very effective. We simply do not know how effective it is for school children, but it remains one priority for most therapists and, in the early years at least, a major goal for most parents.

By contrast the education model aims more at compensation (6.3.2), at accepting the impairment but removing the obstacles that the child is facing, for example in accessing the curriculum. Interestingly, that environment can be construed in different ways. To many teachers the environment is the classroom, while to therapists the environment includes the home and the family. This is not to say that educationalists are not also concerned with remediation (e.g. in programmes to "catch up on" literacy attainment), but there is always the second aim of enhancing curricular access. This approach may pay less attention to the developmental stage of the child and more to how the child fits into the age peer group. This probably explains why some teachers interviewed expressed concern about the low level of the language input provided by the speech and language therapist to the language impaired child. In such cases, the therapists might target the child's level of verbal comprehension (being more influenced by developmental norms for speech and language), whereas the teacher might aim to facilitate the child's understanding of the level of input to the class as a whole (being more influenced by the progression dictated by the curriculum). Evidently there is a fundamentally different understanding of child development in operation here. Having polarised the different approaches in this way, it is also important to say that many therapists would choose to work in the classroom looking at strategies for helping the child to compensate for their difficulties, or helping the class teacher to remove obstacles to effective inclusion. Similarly there are specialist teachers who would focus on the child's individual needs, and would argue that their task would be to remove the impairment by teaching the child missing skills.

Parents often have a high expectation that speech and language therapy should be offered in a direct one-to-one manner. This view was supported by some classroom teachers, who retained a relatively traditional view of the role of the speech and language therapist. LEA managers and, to a certain extent, speech and language therapy managers do not agree with this. One LEA manager spoke of speech and language therapy being "velcro-ed" on top of existing services in an artificial fashion (5.10). A number of references were made to "managing parental expectations", and persuading parents that the consultative model was a) more appropriate and b) as effective. While the former may well be true, the same cannot necessarily be said of the latter, and this may explain why parents do not readily accept this alternative model. There is a need to demonstrate to parents the relative effectiveness of the consultative model.

Therapists have an expectation that they will have contact with parents and a number felt a high level of dissatisfaction that the consultative model within the school system all too often meant giving up their work with parents. But this is also a matter of professional standards for the speech and language therapist. Communicating Quality[83], the handbook of professional standards for the profession, indicates "Following assessment, a management decision will be made in conjunction with and following full discussion with carers and education staff" (p.55). Therapists are also required to take a full case history and include a record of the carer's observations in their evaluation (p.172-3). Clearly, parent contact needs to be retained as a key part of the consultative model. There is no reason why this type of activity should not take place within a school, but it is unlikely to take place within the classroom.

10.12 The role played by parents and carers

As discussed in Chapter 7, this study specifically targeted parents and their views. These were supplemented by what was learned from professionals regarding the involvement of parents and by the often very forthright views of parents in our "research into practice" days. There was little doubt that many were very keen to be actively involved in the education process, but had come to construe it as a battle ground, where the statement of educational needs had become the 'holy grail' of provision. Of course, these views do not tend to include those of parents who were either not asked to be involved, or who chose not to be. Similarly, they did not seem to represent those for whom the process of getting their child's needs met had been a smooth journey. For those that did become involved in the study, the principal area of concern was their own child's access to services. Although much is heard about parental choice, "Partnership with Parents"[84], and the parents' role in directing service development, in fact, most managers readily admitted that parents had no input at a strategic level.

The type of model of intervention at an individual level is, in part, determined by the relationship with the parent and what is considered to be the most appropriate location to work with the parent. Naturally schools tend to see their own premises as the best place to meet the child's educational needs, and it is clear that in the majority of cases the therapy services would agree with this. But there is also a concern that this need not necessarily be the case (3.2.9, 5.15.4) and that therapists need to retain the possibility to consult with parents in a clinical facility or in the child's home as appropriate.

As much of the discussion in Chapter 7 indicates, parents frequently express intense frustration in accessing services initially and in obtaining on-going support. Indeed many find the whole experience "isolating and alienating" (7.2.2). The process only seemed to work when they had an advocate – a "champion" fighting for them from within the system. Given this, it is reassuring that once they receive those services, they generally hold them in high regard (7.4). This is very significant, given the often negative initial experiences they may have had.

One of the potentially most interesting findings is that parents perceive there to be no collaboration between health and education services when they are dissatisfied with the

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[83]   Van der Gaag (ed) (1996) Communicating Quality 2: *Professional standards for speech and language therapists* London: Royal College of Speech and Language Therapists

[84]   NASEN (2000) *Policy Document on Partnership with Parents* Tamworth: NASEN Publications

way in which their needs are being addressed (7.2.2). It may be that it is appropriate to see the principal role of the parent in the collaboration process as one of closing the audit loop, having the final word on whether the process is functioning effectively. This requires practitioners to inform parents of how they are working collaboratively. There is also a possibility here to allow parents to become more involved at a structural level in the provision of speech and language needs. As indicated above, a recommendation will be made that Trusts and LEAs look into joint funding arrangements managed by local boards. The role of a parent with a casting vote on such boards provides a possibility for meaningful involvement of parents in monitoring collaboration.

10.13 Issues related to Welsh and to English as an additional language

Many of the issues described above are as common to services providing for children with speech and language needs in Wales as they are to those in England. In general we found more similarities than differences between issues in the two countries. Nevertheless there is a good case for arguing that, while bilingualism is of generic significance to the development of any services in the UK, it has particular ramifications for services for individuals with speech and language needs and there are a number of specific issues which need to be drawn out.

The number of therapists and other support staff able to work bilingually is small. Our data suggest that while the position may be rather better for the Welsh populations (3.4.3) than it is for other bilingual groups, there are simply too few therapists and specialist support workers with an expert knowledge of the languages concerned. Even when they are available, there is a lack of appropriate literature, materials and assessments for them to use (6.7). Resourcing constraints are amplified for peripatetic services operating in rural communities, an issue which we found to be particularly pressing for many Welsh services. Speech and language therapy services operating across a number of school sites are likely to be expensive and this should be reflected in the level of provision made.. Increased travel time means less time for client contact. There is a good case for developing peripatetic specialist teacher services alongside those of speech and language therapists. There may also be some merit in pursuing the video-conferencing model of therapy currently being explored by the charity I-CAN. It is also true that too little is known about the impact of speech and language difficulties on bilingual language acquisition and the ensuing development of literacy. Finally some concern was expressed that elements of the funding mechanism operate differently in England and Wales. The Standards Fund operates differently from the GEST system in Wales. It is not clear which is most effective for developing services.

10.14 Drawing together the thematic analysis

Although the above themes are presented in a linear fashion it is clear that many are closely interdependent *(Fig. 10.2)*.

One of the pivotal issues is the level of caseload. Inevitably, this is determined by the level of **resources** and the way in which the **caseload** for each individual is managed. If the number is too high, this puts pressure on staff because they are unable to manage their work, but this also affects the ability to collaborate because too little time may be available for professional discussion. Alternatively if the caseloads are manageable, but the overall **resources** and level of staffing is inadequate, this is likely to impact on the number of children with needs for whom support is available. This is likely to lead to an increase in t waiting lists, thus affecting **equity** of access to services.

The **level of caseload** also has an impact on the **models of provision** and may influence the **opportunities to collaborate** available to SLT services. If the caseload of each therapist is high, there may be no choice but to maximise numbers by working in a consultative fashion. Unless carefully monitored, this pressure to maintain equity in terms of coverage may result in low levels of support per child, with a resulting lack of effectiveness and resultant dissatisfaction on the part of parents. It also has a knock-on effect on therapist job satisfaction, because they recognise that little can be achieved by spreading services too thinly.

What we have termed **"staff well being"** is also affected by a number of factors identified throughout this report namely: terms and **conditions** of service, length of **contracts** and the availability of appropriate **training** Positive weighting here will lead to staff **recruitment and retention**, negative weighting will lead to loss of staff and, in turn, gaps in the service. The same negative weighting will also be achieved if the **supply of staffing** is inadequate. The **level of service provision** has a direct bearing on both **parental satisfaction** and **school satisfaction**. Equally it is likely to have, a bearing on the proportion of those returning to the profession. They are more likely not to leave in the first place and to return after a career break if they perceive the demands to be made on them to be manageable and the working conditions to be good. This last point is, of course, a much wider issue and is not confined to speech and language therapists working in education.

Parental satisfaction is likely to be higher for those who are able to engage with professionals, and therefore understand the rationale for, and contribute to, decisions taken. Those that do not are more likely to resort to **litigation**, which in turn imbalances service provision and is likely to affect **equity**. The important point to take from this discussion is that these factors are closely connected and that decisions which impact at one level will almost certainly affect others.

Figure 10.2 The interdependence of factors in the provision of services to children with speech and language needs
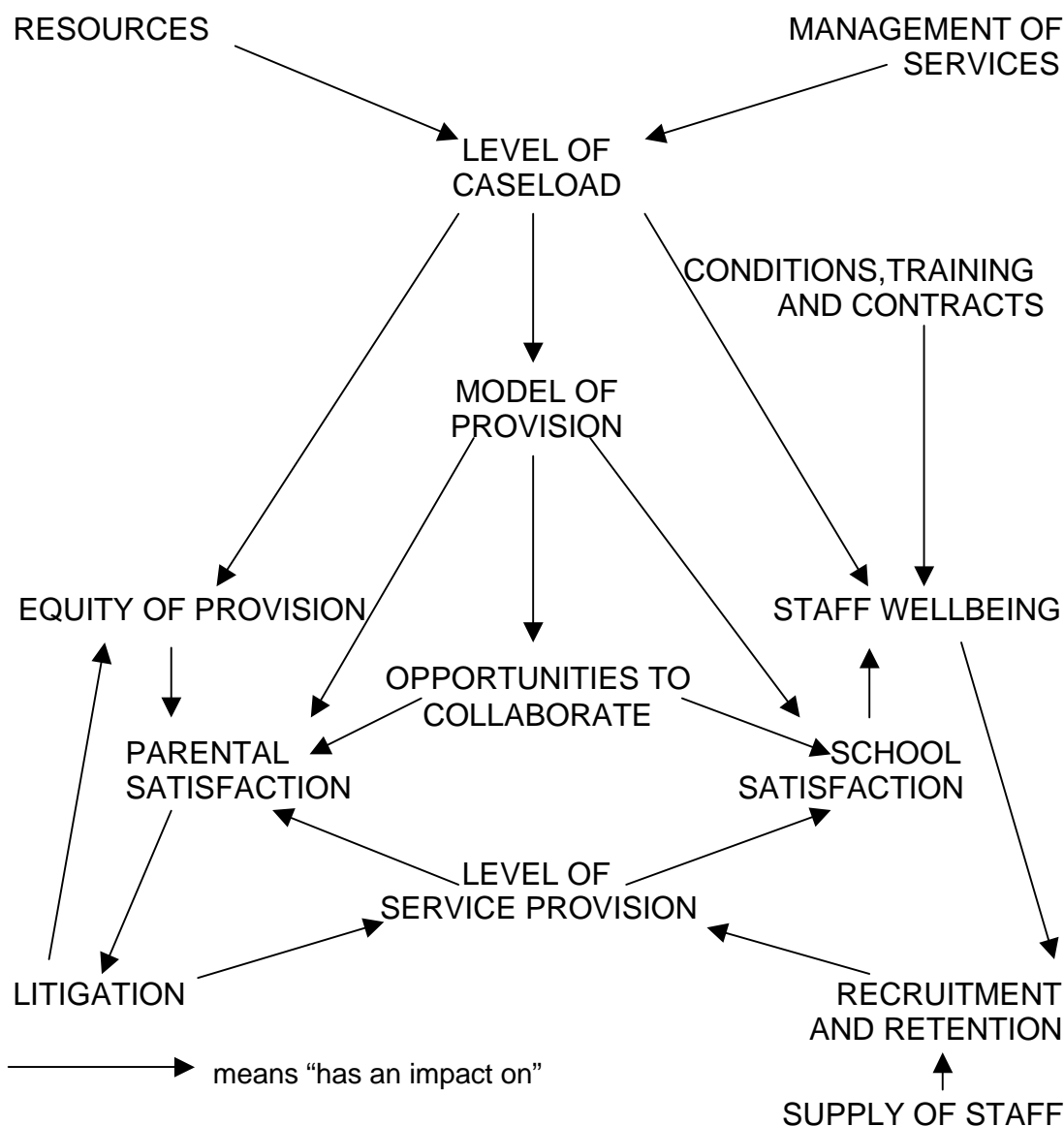
10.15 Key recommendations

It is suggested that each recommendation be seen as functioning at a national and a local level. The move towards effective provision will only come about if each party makes the decision to address the issues concerned. Where possible, the different national and local contributions are identified.[85]

10.15.1   The role of speech and language

The evidence suggests that there is a need for a better understanding of the importance of speech and language development in the educational and social well being of the child.

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[85] Recommendations which coincide with those from the Speech and Language Therapy Working Group report are marked *.

Recommendation 1* - That there be a renewed emphasis on the role that speech and language plays in mediating all the child's experiences in school and at home.
Examples of initiatives here should be:-
- That a National Oracy Strategy or National Speaking Strategy be implemented across England and Wales;
- That the initial training of teachers contain sufficient detail on the development of speech, language and communication;
- That there be a re-emphasis on language development in the school curriculum, to complement that currently placed on literacy and numeracy.

Recommendation to be implemented by: DfEE, DH, Welsh Assembly, TTA, Independent/voluntary sector, Head Teachers and SLT departments.

10.15.2   The role played by speech and language therapists

There is a widespread recognition that the majority of the provision for school-aged children with speech and language needs should be provided within the context of the National Curriculum and the inclusion agenda.

Recommendation 2* - That the greater part of the provision for school-aged children with speech and language needs should be embedded within the curriculum and take the child's educational context into consideration.
The local implementation of this recommendation would need to take into consideration:-
- Local agreements regarding optimum models of service delivery;
- The need for elements of the provision to be made outside the classroom, e.g. assessment, parent liaison and appropriate demonstration of intervention targets and intervention techniques to TAs.

Recommendation to be implemented by: Head Teaches, SLT training establishments, SLT departments and LEAs.

10.15.3   Equity

Evidence suggests that widely disparate systems of provision are in operation both across the country and within local systems. These inequities arise because of a combination of a number of forces.

Recommendation 3 - That services work together to appraise the level and type of inequities in existence, and put appropriate mechanisms in place to address these inequities.
Specific issues to address include:-
- Disparities between primary and secondary school provision;
- Disparities between specialist language unit and mainstream provision, and specialist provision for children with emotional and behavioural difficulties;
- Disparities in provision for children with and without statements of educational need;
- The under-emphasis on the involvement of specialist SLT services in LEA early years provision.

Recommendation to be implemented by: LEAs, Head Teachers and Health Authority/Trust/LHG/SLT management.

10.15.4   Funding

Evidence suggests that there is a need for greater clarity at a national level with respect for the funding stream associated with children with speech and language needs, and the way in which those services are commissioned.

Recommendation 4 - That a funding stream be explored that runs from Central Government (the DfEE/Welsh Assembly) to LEAs (co-ordinated by both DfEE and DH in the case of England), for the commissioning of services to children with speech and language needs within educational contexts.

Recommendation 5 - That LEAs act as lead commissioners through local NHS providers of speech and language therapy services for children in educational contexts.

Recommendation 6 - That SLT managers offering services for children with speech and language needs should be in a position to negotiate appropriate models of service delivery.

Recommendation 7 - That the new joint partnership flexibilities be exploited to provide pooled designated budgets for services for children with speech and language needs.
To facilitate this
- Health Trusts should recognise the priority set on this provision by LEA colleagues and support such funding arrangements;
- The DfEE/Welsh Assembly should encourage LEA/Trust pairs to make use of partnership flexibilities via current Standards Fund/GEST arrangements.

Recommendation 8 - That the level of funding in general be considered in the light of the apparent shortfall between reasonable levels of provision and what is currently available.
To enable this:
- Current levels of need and provision need to be audited and shortfalls identified.

Recommendation 9 - That specific funding needs to be ear marked for areas of unmet need, namely:
- developing support services in secondary schools;
- developing support services for children with emotional and behavioural difficulties, and for those dealing with youth crime;
- developing services for additional support to those for whom English is an additional language

Recommendation 10 That specific funds be allocated to addressing a number of issues arising out of this study.
Examples of specific tasks which should be funded are
- an audit of local need;
- setting up systems for annual collection of data for central Government, and to provide local data for service planning;
- supporting the development of a joint strategic plan;
- setting up of local frameworks for monitoring collaboration and reporting on designated outcomes;
- helping all stakeholders fully understand the various models of support possible for children with speech, language and communication needs, including the

consultancy model;
- Promoting the effective inclusion of children with speech and language needs;
- Promoting the differentiation of language in the classroom relevant to all children;
- commissioning research;
- supporting innovative projects and joint bids for funding for innovative projects;
- promoting and delivering a substantial input to training, to ensure that sufficient teachers and teaching assistants are in a position to integrate children with speech and language needs into the classroom.

Funding recommendations to be implemented by: DfEE, DoH, Welsh Assembly, Health Authority/Trust/LHG/SLT management and LEA

10.15.5   The level at which services are organised

Evidence suggests that there are considerable concerns about the level of service organisation that is required to offer an adequate service. The prevailing trend suggests that the devolution of budgets is likely to lead to a fragmentation of services, with a resulting loss of specialisation and a corresponding detrimental effect on recruitment and retention.

Recommendation 11 - That SLT departments should continue to be organised at a level sufficient to provide for appropriate specialist management and professional development.
In the event of a series of smaller Primary Care Trusts replacing a current Health Trust, SLT services should be deployed by a lead organisation of sufficient size. This could be a large PCT, but it would also be appropriate to consider setting up Specialist Therapies Trusts or the New Care Trusts identified in the recent NHS Plan[86].

Recommendation to be implemented by: NHS Executive and Trusts/PCGs/PCTs/LHGs, in collaboration with speech and language therapy departments.

10.15.6   Strategic planning

Evidence suggests that, in many areas, there is often little sense of joint strategy between Health and Education in the planning and delivery of services for children with speech and language needs. Where interagency (LEA/SLT) strategic planning groups do exist, a high degree of successful collaboration is reported (5.2.1).

Recommendation 12 - That structures be put in place to enable joint strategic planning across Trust and LEA.
Such structures could include
- At a national level:
  - The implementation of needs assessment based on shared criteria. (There is a case for making this at a uniform age nationally and linking it into baseline assessment);
  - The collection of nationally agreed data sets including both individual and process outcomes.
- At a local level:
  - Collaboration, through standing inter-agency boards involving LEAs, SLTs and

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[86] Department of Health (2000) *The NHS Plan – A plan for investment, A plan for reform* London DH.

parents, aimed at exploiting opportunities for pooled budgets and the new flexibilities regarding shared services designed to meet local needs;

- An audit of existing local provision relative to the level of unmet need;
- Formal discussion of the implications of differing geographical boundaries;
- Agreed level of skill mix for different levels of service provision;
- Agreement on local prioritisation systems;
- Agreement on most appropriate models of service delivery (consultancy, direct intervention, etc.);
- Identification of most appropriate ways of making "best value" comparison of services.

Recommendation to be implemented by: DfEE, DH and Welsh Assembly, Trust/PCG/PCT/LHG and SLT departments and LEA

10.15.7   Operational planning

Evidence suggests that many practitioner teams build up extensive collective experience over long periods of time and come to collaborate very effectively, but this is essentially an *ad hoc* process and could usefully benefit from active facilitation by managers.

Recommendation 13 - That Trusts and LEAs jointly review the implementation of process to improve practitioner level collaboration.
At a national level, an example might be:
- That the distinction between educational and non-educational provision of speech and language therapy be dropped: Speech and language therapy to be stated as an educational provision in Part 3 of the statement.
At local level, examples might include:
- The active involvement of Speech and Language Therapists in the local SEN panel. Where possible they should also be empowered to represent their own services at a strategic level;
- A clear delineation of the roles of teachers with a specialist interest in language impairment and speech and language therapists. It may be appropriate to allocate one member of staff as the "lead person" for a given child, dependent upon the child's key needs;
- Schools to facilitate the integration of speech and language therapists;
- Shared office space;
- Equivalent contracts (annual leave constraints, etc);
Time is a critical feature of the liaison process. Reduced flexibility on the part of both therapist and teacher reduces the possibility for shared time. In order to compensate for this, liaison time needs to be written into the IEP as a performance target, and into the statement.

Recommendation to be implemented by: DfEE, DH and Welsh Assembly, Trusts/LHGs/SLT departments and LEA management and Head Teachers.

10.15.8   Monitoring collaboration

Evidence suggests that there is no system currently available for monitoring the effectiveness of collaboration between education and health services.

Recommendation 14 - That national and local mechanisms be put in place to monitor the level of collaboration and disseminate effective collaboration.
At a national level this could include:
- Joint inspection from the Audit Commission, the Commission for Health Improvement and the DfEE using the "best value" system;
- The government setting up an appropriate mechanism through the Royal College of Speech and Language Therapists and appropriate independent sector organisations;
- A standing committee of comparable status to the Speech and Language Therapy Working Group to run in the first instance for five years.

At a local level this could include
- A body specifically set up for this purpose combining LEA and Trust representation;
- Monitoring through the boards of joint funding initiatives;
- Funding local initiatives and employing specific staff to monitor collaboration.

Recommendation to be implemented by: DfEE/DH/Welsh Assembly at a national level, local boards set up to monitor relevant joint funding.

10.15.9   Recruitment and retention

Evidence suggests that demand for speech and language therapists exceeds supply, especially when the level of retention is taken into consideration.

Recommendation 15* - That both Trusts and LEAs take the joint issues of recruitment and retention seriously in planning services.
This might include:
- LEAs being represented on NHS consortia responsible for commissioning undergraduate education of speech and language therapists;
- appropriate grading and career structure being introduced to promote specialisation amongst senior staff.

Recruitment to initial training should recognise that:
- there is a high demand for speech and language therapists able to function in a language other than English. This is particularly true of community languages such as Welsh. Health Consortia currently funding speech and language therapy educational courses are in a position to address this issue by requiring that recruitment to these courses effectively reflects a given population;
- this may not be simply a matter of an admissions policy, but may require an active approach to recruitment amongst bilingual populations.

Working in a given area should be made particularly attractive for potential applicants by providing:
- scholarships in initial training;
- favourable terms for educational debt repayments;
- term time contracts on full salaries;
- permanent rather than short-term and fixed-term contracts;
- affordable housing;
- suitable career progression;
- appropriate training packages for returners, who should be actively recruited.

Recommendation to be implemented by: DfEE/DH/Welsh Assembly (through releasing

funding for national educational/training schemes), NMET Consortia, University departments, Speech and language therapy managers/LEA managers.

10.15.10 Initial professional education and continuing professional development

Evidence suggests that there may be considerable gaps in the basic understanding of reciprocal issues amongst education and health professionals. These gaps may be perpetuated throughout the system.

Recommendation 16* - That the curricula of initial training and education courses for speech and language therapists and teachers prepare the different professional groups to work effectively within the education system with children with speech, language and communication needs.
Initial course content issues include:
- appropriate input for speech and language therapists on matters related to SEN and the delivery of the curriculum in schools;
- appropriate input for teachers regarding SEN in general, and speech and language difficulties in particular;
- appropriate monitoring of course content by
- the TTA, to ensure that teachers have a good working knowledge of language development;
- The Royal College of Speech and Language Therapists, to ensure that speech and language therapists have a good working knowledge of practice in schools.

The courses providing education for speech and language therapists need to address the issue of their course content related to bilingual and culturally diverse students. This needs to be closely monitored through the system of quinquennial reviews which courses currently undergo from the Royal College of Speech and Language Therapists and, in the future, the Health Professions Council.

Recommendation to be implemented by: University departments, RCSLT, TTA

Recommendation 17* - That there be a comprehensive accredited system of educational and training opportunities for all staff working with children with speech and language needs.
These should:
- deal with communication (normal and disordered) across the age span;
- address the issue of terminology in relation to professional expectations developing out of initial training;
- be organised so that individuals may achieve accreditation from individual short courses through to masters level and beyond;
- consider the need to develop a specific 'education' specialism for speech and language therapists;
- be appropriate for parents wishing either to know more about the system or who want to become more actively involved in it;
- take advantage of "pump-priming" opportunities offered by the DfEE Standards Fund/Welsh Assembly GEST fund;
- exploit IT opportunities where appropriate.

Recommendation to be implemented by: DfEE/DH joint funded initiatives, Welsh Assembly, Independent/ voluntary sector, local collaboration between LEA and SLT

departments.

10.15.11   Further research

There is a need for good quality research evidence. There is now a review centre focusing on the best quality education research comparable to the Cochrane Collaboration or the NHS Centre for Reviews and Dissemination at the University of York in the UK[87].

Recommendation 18 - That a programme of research be jointly commissioned between the DH and the DfEE and/or the Welsh Assembly, following the model laid down by the NHS Health Technology Assessment programme, to address directly a number of the evidence gaps identified in this study.
The commissioning of research might include:
- A systematic review to examine the best quality evidence of good practice in integrating children with SEN in general, and SLT in particular, into mainstream provision. This would then flag up the evidence gap which needs to be filled;
- LEA-based research projects to evaluate the efficacy of different systems of service delivery, e.g.
  - Evaluations of the work of LSAs and support teachers. Which is the most effective model of intervention?
  - The "clinic" model needs to be properly evaluated relative to the inclusion model. Such a project should be co-ordinated with both health and education systems, so that a full range of measurable outcomes can be identified;
  - Most effective methods of collaborating – a comparison between the efficacy of LSA/teacher collaboration models would be appropriate in the first instance.
- Evaluating the effectiveness of different funding mechanisms. For example there is a case for examining the relative effects of the different mechanisms in England (Standards Fund) and Wales (GEST);
- Evaluating the most appropriate levels of management for SEN and SLT services – especially in the light of the move to PCTs.

Recommendation to be implemented by: DfEE/DH, Welsh Assembly, Regional Health Authorities/Trusts/LEAs, Independent/voluntary sector initiatives.

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[87] The organisation is the Campbell Collaboration based at the University of Pennsylvania (http://campbell.gse.upenn.edu/intro.html)

Appendix I - LEAs sampled in Phase 1

English LEAs were organised in ascending order of proportion of children on roll who had a statement, on the basis of Statistical First Release: SEN in England: January 1999. Alternate LEAs (in grey) were sampled from the resulting list (below) to produce a 50% sample.

LEA	% on roll with statement	LEA	% on roll with statement
Nottinghamshire	1.1	Sandwell	2.6
City of London	1.4	Bury	2.7
City of Nottingham	1.4	North Lincolnshire	2.7
Oldham	1.6	Calderdale	2.7
Solihull	1.6	Rutland	2.7
Redbridge	1.8	Warwickshire	2.7
Isles of Scilly	1.9	Birmingham	2.7
Redcar & Cleveland	2.1	Coventry	2.7
Trafford	2.1	Walsall	2.7
Dudley	2.1	Wolverhampton	2.7
Thurrock	2.1	Kingston-upon-Thames	2.7
Croydon	2.2	York	2.8
Salford	2.3	Leicestershire	2.8
Essex	2.3	Northamptonshire	2.8
Enfield	2.3	Luton	2.8
East Riding of Yorkshire	2.4	Southend-on-Sea	2.8
City of Kingston-Upon-Hull	2.4	Hertfordshire	2.8
Kensington & Chelsea	2.4	Barking & Dagenham	2.8
Barnet	2.4	Havering	2.8
Southampton	2.4	East Sussex	2.8
Wiltshire	2.4	Oxfordshire	2.8
Hartlepool	2.5	Dorset	2.8
Rochdale	2.5	Somerset	2.8
Ealing	2.5	Stockport	2.9
Bexley	2.5	Tameside	2.9
Hampshire	2.5	Sefton	2.9
Haringey	2.6	Newham	2.9
Gateshead	2.6	Hounslow	2.9
Newcastle upon Tyne	2.6	Sutton	2.9
North East Lincolnshire	2.6	Portsmouth	2.9
North Yorkshire	2.6	Bournemouth	2.9
Bradford	2.6	Gloucestershire	2.9

LEA	% on roll with statement	LEA	% on roll with statement
Middlesbrough	3.0		
Northumberland	3.0	Cumbria	3.5
South Tyneside	3.0	Bedfordshire	3.5
Manchester	3.0	Norfolk	3.5
Wakefield	3.0	Southwark	3.5
Worcestershire	3.0	Bromley	3.5
Westminster	3.0	Hillingdon	3.5
Harrow	3.0	Slough	3.5
Richmond-upon-Thames	3.0	Kent	3.5
Bracknell Forest	3.0	Wirral	3.6
Windsor & Maidenhead	3.0	Derby	3.6
Bolton	3.1	Staffordshire	3.6
Liverpool	3.1	Hackney	3.6
Barnsley	3.1	Wokingham	3.6
Sheffield	3.1	Torbay	3.6
Stoke-on-Trent	3.1	Devon	3.6
Buckinghamshire	3.1	Knowsley	3.7
South Gloucestershire	3.1	Camden	3.7
Warrington	3.2	Waltham Forest	3.7
Cheshire	3.2	Surrey	3.8
Rotherham	3.2	Durham	3.9
Lincolnshire	3.2	Islington	3.9
Herefordshire	3.2	Lancashire	4.0
Suffolk	3.2	Shropshire	4.0
Merton	3.2	Tower Hamlets	4.0
West Sussex	3.2	Milton Keynes	4.1
Poole	3.2	Hammersmith and Fulham	4.2
Stockton-on-Tees	3.3	Lambeth	4.2
North Tyneside	3.3	Wandsworth	4.2
Cambridgeshire	3.3	Greenwich	4.2
Brent	3.3	Halton	4.3
Reading	3.3	Wigan	4.3
Bath and NE Somerset	3.3	Kirklees	4.3
North Somerset	3.3	Leicester City	4.3
City of Plymouth	3.3	West Berkshire	4.4
Swindon	3.3	Isle of Wight	4.4
Darlington	3.4	Doncaster	4.5
Leeds	3.4	Cornwall	4.5
Derbyshire	3.4	St. Helens	4.6
City of Perborough	3.4	Brighton and Hove	4.6
Lewisham	3.4	Blackburn with Darwen	4.7
Medway	3.4	Blackpool	4.7
Sunderland	3.5	City of Bristol	4.7
		Telford and Wrekin	4.9

Welsh LEAs were selected in a similar manner, using data relating to the number of pupils with statements of SEN per 10,000, from January 1998. The results of this selection have not been reported, in order to protect the anonymity of the Welsh sites selected for participation in Phase 2.

Appendix II - Purposive sampling of the Phase 2 case study sites

Phase 1 questionnaire data used
The questions eliciting the quantitative data which acted as a measure of collaboration were as follows:

Section A – Joint Planning between SLT and Education Inclusion

A1. Do you meet with the LEA manager with responsibility for SEN/Speech and Language Therapy Service manager to develop a joint approach for SLT provision to Education?[88]

A2. Please indicate if meetings take place monthly/termly/yearly/other.

A3. Do the outcomes of these meetings contribute to any formal Development Plan within the LEA?

A5[89].Do the outcomes of these meetings contribute to the SLT Service Development Plan?

A6. How effective are these meetings?

A7. Is the inclusion of children with speech, language and/or communication needs into mainstream settings a priority for this LEA?

A8. Are you developing a joint strategy with the SLT service/LEA with regard to this particular issue?[1]

A10. How effective are these arrangements?

Section B – Service Development at Practitioner Level

B1. Do speech and language therapists and key education staff (e.g. educational psychologists, learning support services) take part in joint meetings/working groups e.g. to discuss policy, develop criteria, etc?

B2. Please indicate if meetings take place termly/yearly/ad hoc/other.

B3. How effective are these meetings?

Section C – Operational Issues

Quality assurance mechanisms

C1. Are quality assurance mechanisms in place for the review and monitoring of the impact of SLT provision to children in educational settings (e.g. SLT outcome measures, progress with IEP targets, movement up/down the SEN **register?)**

C3. How effective are these procedures?

SEN Placements Panel

C4. Is the SLT service represented on the SEN placements panel (or equivalent)?

C5. How effective are these arrangements?

Section D – Continuing Professional Development (CPD)

D1. Do SLTs and education personnel <u>receive</u> joint training on issues of common interest, e.g. IEPs, Literacy hour, etc?

D2. How often does this joint training take place?

D3. Do SLTs contribute to the planning and/or delivery of CPD provided to education staff (e.g. teachers, classroom assistants, learning support assistants)?

D4. Do education staff (e.g. educational psychologists, specialist teachers, etc.)

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[88] Questions were phrased so as to be relevant to each of the two types of recipient.

[89] Questions eliciting quantitative data only are reported here, hence non-consecutive numbering.

contribute to CPD provided to SLTs?

D5. How effective do you find these training and CPD activities in terms of promoting inter-service collaboration?

Section E – Adequacy of provision
E1. In your opinion, to what extent does the available SLT provision meet the needs of the children identified by the LEA through statutory assessment? (LEAs only)

E2. In your opinion, to what extent does the available SLT provision meet the needs of the children placed by schools on the SEN register? (LEAs only)

E1. In your opinion, to what extent does the available LEA provision meet the needs of the children whose primary disability lies in the area of speech/language and/or communication? (SLTs only)

Purposive sampling criteria

The procedure for the purposive sampling of the case study sites based on the collaboration data from Part 1 of the questionnaire (Chapter 4) is given below. The procedure for England is followed by that for Wales.

Definitions
Indicator score: Indicated the number of collaborative procedures in place, i.e. the sum of responses to Qs A1, A3, A5, A8, B1, C1, C4, D1, D3, D4.
[Yes = 2, No/Don't know = 1, Range: 10 - 20]
Effectiveness score: Indicated the effectiveness of the collaborative procedures in place, i.e. the sum of responses to Qs A6, A10, B3, C3, C5, D5, E1, E2*
[1 = not effective, 5 = very effective, LEA range: 0 - 40, SLT range: 0 – 35]
(*LEAs only)
Composite score: A composite of indicator and effectiveness scores from both partners in a collaborative relationship, using the following algorithm:

(LEA indicator score + SLT indicator score - 20) x 4) + LEA effectiveness score + SLT effectiveness score

This gave a final figure by which all cases were ranked according to the number and effectiveness of collaborative procedures in place.

Selection of sites reporting higher collaboration – England
Rationale
Nine sites needed to be chosen on the basis of both LEA and SLT respondents having indicator scores and composite indicator/effectiveness scores of a specified minimum cut-off (basal) value (i.e. ≥ 16 and ≥ 100 [approx. 75th percentile[90]], respectively). At least one site had to come from each council-type (Metropolitan, London Borough, Unitary, Shire) and, if possible, there should be representation from all of the regions of the NHS National Executive. The tenth site was to come from Wales.

Methodology
1) Those cases where both LEA and SLT respondents had returned the questionnaire were identified, and a composite score calculated for each.

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[90] Composite scores did not fall exactly on the 25th and 75th percentiles, therefore the values falling at the cumulative percentiles just below the 25th and 75th percentiles were chosen.

2)   There were data points missing for the effectiveness score in 33 of a possible 179 'effectiveness' responses (i.e. where the respondent had indicated the presence of a collaborative procedure, but had not evaluated its effectiveness). In these cases, the mean of the other effectiveness responses for each case was calculated.

3)   The percentile rank of the mean effectiveness score thus generated was determined [Tables 3 & 4]. The case in question was then assigned an effectiveness score based on the value of the equivalent percentile rank derived from the distribution of the actual effectiveness scores [Tables 1 & 2], e.g. if LEA mean effectiveness score = 3.13, then percentile rank = 80.6; Nearest LEA actual effectiveness score percentile rank = 80.6, therefore equivalent effectiveness score = 25. This value was then used to calculate a composite score for the cases where there were missing data points.

4)   Those cases where both respondents reported an indicator score of ≥16 were identified.

5)   Of these, those cases where the composite score ≥100, (range: 35 - 137) were selected [Table 5].

6)   The resulting pool of cases was then grouped according to council-type, i.e. Metropolitan, Unitary, Shire, London Borough.

7)   The two cases with the highest composite scores from each group were then selected, giving eight out of the nine English cases. [NB. Once a single LEA/SLT case had been selected by this method, any further cases involving the LEA or SLT service in question were treated as reserve sites.]

8)   The final case was selected by balancing composite score and NHS Executive Region; The selected case had a lower composite score than the case which would have been chosen by the ranking system (i.e. 100 vs. 107), but the South & West region had already been represented, whereas Anglia & Oxford had not.

9)   All other cases in the sample remaining at point (5) of the methodology were retained as reserve cases, plus those with a composite score of 90 – 100.

10) All cases selected had given qualitative information in question F1 of the questionnaire regarding examples of collaboration between the LEA and SLT services.

Selection of sites reporting lower levels of collaboration - England
Rationale
Four sites needed to be chosen on the basis of both LEA and SLT respondents having indicator scores and composite indicator/effectiveness scores of a specified maximum cut-off (ceiling) value (i.e. ≤15 and ≤71 [approx. 25th percentile[91]], respectively). At least one site had to come from London, and there would have to be representation from as many of the regions of the NHS National Executive as possible. The fifth site was to come from Wales.

The selection of these sites proved more difficult for the following reasons:
a)   A greater number of respondents reporting poor collaboration had 'collaborative' partners who had not returned the questionnaire.
b)   Some respondents did not seem to be aware of who their collaborative partners should be, i.e. one partner would report liaising with a particular service, yet that service would make no mention of the other.

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[91]   Composite scores did not fall exactly on the 25th and 75th percentiles, therefore the values falling at the cumulative percentiles just below the 25th and 75th percentiles were chosen.

c)   In some cases, one partner would evaluate the collaboration taking place as being highly effective, while the other would report the opposite.

The last two were thought to be of interest when considering factors inhibiting effective collaboration; it was therefore decided that the cases selected should include a 'non-reciprocated' case (i.e. reflecting the situation described in [b] above) and an 'opposite' case (as described in [c] above).

Methodology for selection of those cases reporting reciprocally limited collaboration
1)   Those cases where both LEA and SLT respondents had returned the questionnaire were identified and a composite score calculated for each.
2)   There were data points missing for the effectiveness score in 33 of a possible 179 'effectiveness' responses (i.e. where the respondent had indicated the presence of a collaborative procedure, but had not evaluated its effectiveness). In these cases, the mean of the other effectiveness responses for each case was calculated.
3)   The percentile rank of the mean effectiveness score thus generated was determined [Tables 3 & 4]. The case in question was then assigned an effectiveness score based on the value of the equivalent percentile rank derived from the distribution of the actual effectiveness scores [Tables 1 & 2], as described in (3) above. This value was then used to calculate a composite score for the cases where there were missing data points.
4)   Those cases where both respondents reported an indicator score of ≤15 were identified.
5)   Of these, those cases where the composite score ≤71 (approx. 25th percentile, range: 35 - 137) were selected, the cases with the lowest composite scores being the sites of first choice, the other cases being retained as reserves.

Methodology for selection of non-reciprocated case
The one London Borough that had reported very limited collaboration (of the five returns from London) was not named as a potential collaborative partner by its reciprocal Trust. It was therefore selected as an example of a 'non-reciprocated' case, as described above.

Methodology for selection of 'opposite' case
The most extreme case of 'opposite' reporting was selected, i.e. where both indicator and effectiveness scores were above the 75th percentile for one partner, and below the 25th percentile for the other.

Selection of sites in Wales
The selection of the Welsh sites also presented some challenges:
a)   The response rate for Wales was lower than for England, with 54.5% of LEAs returning and 66.7% of SLT services.
b)   There were only seven cases where both collaborative partners had returned the questionnaire (or promised a return) and these included two SLT pilot sites.
c)   Of these, only one satisfied the criteria in the methodology for selection of the least collaborative sites described above, and was thus selected.
d)   In the five cases which had already sent a return, the LEA partners mostly reported that collaborative practices were in place and that they were effective. The SLT partners of these same LEAs did not report as many collaborative practices or as much effectiveness, their scores in many cases placing them at

the opposite end of the spectrum.

It was therefore decided to select a case where the LEA had reported indicator and effectiveness scores above the 75th percentile and the SLT service had reported the highest scores among the SLT returns (albeit not quite above the 75th percentile).

Appendix III - Phase 3 discussion questions

Conferences 1-3
1. How should the LEA, Head Teachers and SLT services agree systems of resource allocation while maintaining the best model of intervention for each child?
2. How can we move towards a system where NHS and LEA providers take account of each other's agendas in joint strategic planning (e.g. sharing audit data?)
3. How do we ascertain what is the optimum balance between provision in education and health settings from speech and language therapy?
4. How should practitioners avoid duplication of roles?
5. How do we square the parents' perception of the needs of their child with what services define as the most appropriate provision? Is it just a case of managing expectations or might they be right?

Conferences 4 & 5
1. The data illustrate a desire for clarity a governmental level. What specific proposals (or examples) can you put forward to achieve this clarity?
2. What experience do you have of joint models of resourcing of services for children with speech, language and communication needs? Give specific examples of what you perceive to be effective practice.
3. How can we move towards a system where NHS/LEA providers take account of each other's agendas in joint strategic planning? What specific proposals (or examples) can you put forward to achieve this?
4. How can the LEA, Head Teachers and SLT services implement systems of joint resource allocation? What specific proposals (or examples) can you put forward to achieve this?
5. How do we ascertain the optimum balance between provision in education and health settings for children with speech and language needs? What specific proposals (or examples) can you put forward to achieve this optimum balance?
6. How do we square the parents' perception of the needs of their child with what services define as the most appropriate provision? Is it just a case of managing expectations or might they be right?
7. What collaborative mechanisms work effectively to establish and maintain the co-operation of parents of school-aged children?
8. What are the alternatives to statutory assessment for children with speech and language needs?

Appendix IV - DfEE-DH SLT Working Group & Project Steering Group Members

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Appendix V - Glossary, abbreviations and references

Glossary and list of abbreviations

AFASIC	Association For All Speech Impaired Children. A voluntary body representing the rights of children with speech, language and communication needs and their parents.
Annual review	The yearly re-evaluation of a statement of special educational need.
Articulation	The physical movements of the mouth and throat involved in making the different speech sounds.
Audiologist	A professional who measures hearing loss.
Autism	A pervasive developmental disorder characterised by impairment in social interaction and communication, and restricted, repetitive behaviour.[92] Associated terms: Autistic spectrum disorder, autistic continuum, autistic tendencies, autistic features.
Cerebral palsy	A persistent disorder of movement and/or posture due to injury during brain development.
Clinical psychologist	A professional, usually employed by the NHS Trust, who specialises in assessing cognitive (mental) skills.
Code of Practice (CoP)	Gives practical guidance to LEAs and the governing bodies of all maintained schools on their responsibilities towards all children with SEN. It covers school-based stages of assessment and provision; statutory assessments of special educational needs; statements of special educational needs; assessments and statements for under fives; and annual reviews.

Stages within the Code of Practice:

Stage 1	The class teacher gathers information about the child's needs and differentiates (adapts) the child's normal classroom work. The SENCO places the child on the school's Special Needs Register.
Stage 2	The SENCO co-ordinates the child's special educational provision and marshals relevant information (including that sourced from outside the school). The SENCO and the class teacher together write an IEP.
Stage 3	Specialists from outside the school (e.g. EP, SLT, Learning Support Service) become involved in order to help the child make progress. IEPs are written. The SENCO maintains the co-ordinating role.
Stage 4	Where the school thinks it cannot meet the child's needs from within its own resources, it may request a statutory assessment of the child's needs by the LEA. The LEA's responsibility is to consider whether statutory assessment is necessary, and if so, to conduct it. The child is placed on Stage 4 while this process is being undertaken.
Stage 5	The child has a statement of special educational need.
Communication	Any aspect of interpersonal interaction, including speech, language, non-verbal communication and pragmatic and social skills.
Dysphagia	Disorder of swallowing.
Dyspraxia	A disorder of co-ordination of movement, which can affect overall co-ordination, or specific aspects, such as co-ordination of the articulators for speech.
Dyspraxic	Relating to the condition 'dyspraxia'.
Early learning goals	Establish expectations for most children to reach by the end of the foundation stage. They include personal, social and emotional development; communication, language and literacy; mathematical development; knowledge and understanding of the world; physical development; and creative development.
Early Years	Nurseries (LEA, Social Services and private) and Reception classes.
Educational Psychologist (EP/Ed Psych)	

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[92] World Health Organisation (1994) *International Classification of Diseases*

	A professional, usually employed by the LEA, who specialises in the assessment of children's learning skills, and particularly in identifying and advising on children with special educational needs.
Fair Funding	A collective term used to describe the methodology adopted by LEAs in delegating money into individual school budget shares.
Foundation Stage	A new stage of education (from September 2000) for children aged from three to the end of the reception year.
GEST	Grants for Education Support and Training, the Welsh counterpart to the Standards Fund. The aims of the GEST programme include raising standards and the expectations of schools, teachers and pupils; getting better leadership and support for teachers; improving performance through the use of information and communications technology; broadening the range of qualifications to include vocational qualifications for school age children; promoting the wider social inclusion agenda; and spending money wisely.
Grammar	The part of linguistic knowledge concerning grammatical structures. Also known as syntax.
Hanen	A programme aimed at helping parents encourage their children's communication.
Health Authority (HA)	Responsible for assessing the health needs of the local population, drawing up plans for meeting those needs in the form of a Health Improvement Programme, determining local targets and standards to improve quality and efficiency, supporting the development of Primary Care Groups, allocating resources to them and monitoring their performance. Formerly the 'purchaser' in the 'purchaser/provider split' within the Health Service, but now gradually handing over the health commissioning role to PCGs/PCTs/LHGs.
Health Improvement Programme (HImP)	
	An action programme to improve health and health care locally, led by the local Health Authority. HImPs will involve Health Authorities, Trusts and Primary Care Groups working in partnership with the local authority, the Community Health Councils, the voluntary sector and local public. They offer the opportunity to remove the artificial barriers between health and social care, so that the patient experiences 'seamless care'.
Hearing impairment	Any degree of deafness.
I-CAN	A national educational charity providing services for children, from pre-school to school leaving age, with speech and language impairment.
Inclusion	The process of educating all children in their local mainstream school, regardless of disability or special educational need.
Individual education plan (IEP)	
	A document usually prepared termly by school staff, detailing the learning objectives and outcomes for a child.
Key Stage 1/2	Years 1-2 and 3-6 respectively, usually corresponding to the primary phase of education.
Key Stage 3/4	Years 7-9 and 10-11 respectively, usually corresponding to the secondary phase of education.
Learning difficulty/disability	
	Generalised reduction in cognitive (mental) abilities, which usually impacts on language development. Can be classified as moderate (MLD), severe (SLD) or profound and multiple (PMLD).
Learning Support Assistant (LSA)	
	A person employed by an LEA or by a school to assist the teacher in supporting children in their learning, on a one-to-one basis, or in small groups.
Local Health Group (LHG)	
	The counterpart in Wales to Primary Care Groups in England.
Locality	A sub-division of an NHS Trust in which different services serving the same geographical area are grouped together administratively.
Makaton	A widely-used signing system, based on the vocabulary of British Sign Language.

Median	The central value of a set of scores, which has as many scores above it as below it.
Mode	The most frequently occurring value in a set of scores.
Moderate learning difficulty/disability	
	See 'learning difficulty/disability'.
Narrative	The linkage of sentences to produce coherent and cohesive written or spoken discourse.
National Service Frameworks	Priorities set out by the DH targeting specific aspects of service delivery, e.g. coronary care, mental health, cancer.
Natural history	The progress of a condition over time (usually meaning in the absence of intervention).
Neurologist	A doctor who specialises in diseases of the brain and the nervous system.
NHS Trusts	Providers of most NHS services, through contracts with HAs and PCGs. The 'provider' in the 'purchaser/provider split' within the Health Service. Many NHS Trusts will cease to exist where PCTs take on the responsibility for providing health services.
NNEB	A qualified nursery nurse.
Non-verbal communication	
	Communication which occurs through means other than the spoken word, e.g. eye contact, gesture, facial expression.
Paediatrician	A doctor who specialises in child development and diseases.
Parent Partnership Officer	
	A professional who offers parents independent information and advice about SEN procedures, school based provision, support available for their child and additional sources of help and information, such as voluntary organisations and childcare information services. LEAs are required to ensure parents have access to this person, and are responsible for their recruitment and training.
Part 3	The section of the statement describing a child's educational needs. Also known as 'Section 3'.
Part 5	The section of the statement describing a child's non-educational needs. Also known as 'Section 5'.
Perinatal	Relating to the time around childbirth.
Phonological delay	A delay in the development of phonological skills.
Phonology	The part of linguistic knowledge concerning speech sounds and their combinations.
Pragmatics	The part of linguistic knowledge concerning use of language in social situations and the interpretation of communication contexts.
Primary Care Group (PCG)	
	Responsible for improving the health of the community and developing primary and community health services. Have started to take over from HAs as the main commissioners of health services.
Primary Care Trust (PCT)	At present, most PCGs are still located within the HA. However, there are options for PCGs to become Primary Care Trusts (PCTs), freestanding bodies which are accountable to the HA for *commissioning* services, and which in some cases also *provide* health services.
Primary speech and language delay/difficulties	
	Speech and language difficulties which occur in the absence of other developmental conditions. Also known as 'specific speech and language difficulties'.
Psychiatrist	A doctor who specialises in the diagnosis, treatment and prevention of mental and emotional disorders.
Royal College of Speech and Language Therapists (RCSLT)	
	The professional body for SLTs and SLTAs.
Scope	The national disability organisation whose focus is people with cerebral palsy.
Section 3	See 'Part 3'.
Section 5	See 'Part 5'.
Semantics	The part of linguistic knowledge concerning the meaning of words and phrases.

SEN Placements Panel   A body within the LEA which considers which provision will appropriately meet the needs of each child with SEN. NB. Not all LEAs term this process 'the SEN Placements Panel'.

Service Level Agreement (SLA)
    A written arrangement between two parties specifying the terms under which the agreement between them will operate.

Session   A term used by SLTs, meaning 'half a day' (am or pm).

Severe learning difficulty/disability
    See 'learning difficulty/disability'.

Special Educational Needs Co-ordinator (SENCO)
    The member of school staff responsible for co-ordinating support for children registered at Stages 1-5 of the CoP.

Specific learning difficulty (SpLD)
    Difficulty with reading and/or spelling in the absence of other learning difficulties.

Speech   The physical production of spoken language. See also 'articulation'.

Speech and language delay/difficulties
    Broad descriptive term for speech and language abilities which are considered to be below that expected for a child's age, while still following the expected developmental sequence. Often qualified as mild, moderate or severe.

Speech and language disorder
    Broad descriptive term for speech and language abilities which are considered to be developing in a manner distinct from the usual developmental sequence. May be further qualified by noting those aspects of speech and language most affected: semantics, pragmatics, phonology, syntax.

Speech and language impairment
    General term for a speech and language problem, whether this is diagnosed as a delay or a disorder.

Speech and language therapist (SLT)
    A professional, usually employed by the NHS Trust, who specialises in assessment and intervention for people with disorders of speech, language and communication. A sub-group of SLTs also specialises in feeding and swallowing difficulties.

Speech and language therapy assistant (SLTA)
    A person employed (usually) by the NHS Trust to assist the SLT in the delivery of speech and language therapy intervention.

Stammer/stutter   Term used for hesitation, repetition or other disruptions in speech, which are considered to be outside the normal range of speech fluency. (American English usage: stuttering; British English usage: stammering).

Standards Fund   A collection of specific grants which enables schools and LEAs to achieve improvement in education standards set out in agreed targets, particularly for literacy, numeracy, social inclusion and GCSE.

Statement   A legal document produced by the LEA describing a child's special educational needs and the provision required to meet them. A child with a statement is on Stage 5 of the SEN Code of Practice.

Statutory assessment   The assessment of a child's special educational needs by the LEA, who gather advice (evidence) from all parties involved with the child, e.g. class teacher, parents, EP, SLT, Social Services, Child Health, etc., with a view to issuing a statement. NB. Statutory assessment does not guarantee that a statement will be issued. Also known as 'Stage 4' of the CoP.

Sure Start   A cross-government initiative involving agencies at local and national level working together in new ways to improve services for young children under four and their families in areas of disadvantage. The aims of the strategy are: to prevent social exclusion; raise educational standards; and reduce health inequalities and improve life chances for young children in areas of disadvantage.

Systematic review   An evaluation of the research literature about a particular topic.

Teaching Assistant (TA)   The official term for persons employed by an LEA or school to assist the teacher in supporting children in their learning.

Total Communication	A philosophy which accepts any method of communication as valid, e.g. speech, signing.
Trailblazers	The districts involved in the first phase of Sure Start provision.
Tribunal	An appeal at which the child's level of SEN provision can be contested.
Trust	See 'NHS Trust'.
Vocabulary	Words understood and/or used by an individual.
WILSTAAR	A programme of language screening and intervention for infants in their first year (Ward, 1999)[93].

World Health Organisation definitions

Impairment	Dysfunction resulting from pathological changes in a system.
Disability	Consequence of impairment in terms of functional performance (i.e. disturbance at the level of the person).
Handicap	Disadvantages experienced by the individual as a result of impairment and disabilities. This reflects the adaptation to the individual's surroundings.

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[93] Ward, S (1999) An investigation into the effectiveness of an early intervention method for delayed language development in young children. *International Journal of Language and Communication Disorders* 34, 243-264.

Abbreviations

AFASIC	Association For All Speech Impaired Children
ALD	Adult Learning Disability
BSL	British Sign Language
CoP	Code of Practice
CPD	Continuing Professional Development
DfEE	Department for Education and Employment
DH	Department of Health
EBD	Emotional/behavioural difficulty
EP/Ed Psych	Educational Psychologist
FE	Further Education
fte	full time equivalent
GEST	Grants for Education Support and Training
HA	Health Authority
HimP	Health Improvement Programme
IEP	Individual Education Plan
INSET	In-service Training
ITT	Initial teacher training
KS	Key Stage
LEA	Local Education Authority
LSA	Learning Support Assistant
LHG	Local Health Group
LRB	Language Resource Base
LU	Language Unit
MLD	Moderate learning difficulty/disability
NHS	National Health Service
NNEB	National Nursery Examination Board Nursery Nurse
OT	Occupational Therapy/Therapist
PCG	Primary Care Group
PCT	Primary Care Trust
PMLD	Profound and multiple learning difficulty/disability
PPO	Parent Partnership Officer
PRU	Pupil Referral Unit
RCSLT	Royal College of Speech and Language Therapists
SEN	Special Educational Needs
SENCO	Special Educational Needs Co-ordinator
SLA	Service Level Agreement
SLD	Severe learning difficulty/disability
SLT	Speech and Language Therapy/Therapist
SLTA	Speech and Language Therapy Assistant
TTA	Teacher Training Agency
wte	whole time equivalent

References

Definitions have been sourced from:

- Websites at the Department of Health, Department for Education and the Health of Wales Information Service (http://www.wales.nhs.uk/org.cfm);
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- Communicating Quality 2: Professional Standards for Speech and Language Therapists;
- Members of the project team.