



The Bercow Report

A Review of Services for Children and Young People (0–19) with Speech, Language and Communication Needs

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Foreword



Since I was elected to Parliament in 1997, I have always sought to assist any constituent who has a child with special needs to obtain the necessary help, but for a long time I had no direct experience of, or personal attachment to the subject. All that changed just over two years ago. Motivated by circumstances in my own family, I developed an intense interest in Special Educational Needs policy in general and services for those with communication difficulties in particular. To be able to communicate is a precious commodity. To be unable to do so can be a profoundly damaging disability. The challenge in a civilised society is to support those for whom communication is more difficult.

Last summer, after fifteen months in which I raised in Parliament the issue of speech, language and communication over twenty times, the Secretary of State for Health, Alan Johnson, and the Secretary of State for Children, Schools and Families, Ed Balls, asked me if I would be willing to lead a review of provision and to suggest a way forward. Subject only to the caveats that I wanted to obtain the agreement of my party, to be an unpaid volunteer, and to publish my findings, I said that I would be happy to proceed. Alan Johnson and Ed Balls accepted the conditions and I accepted the task.

We agreed that I would concentrate on three key issues:

- The range and composition of services required to meet the diverse needs of children and young people from 0 to 19 in an affordable way.
- How planning and performance management arrangements, together with better cooperation nationally and locally between health and education services, can spur beneficial early intervention.
- What examples of best practice could be identified as templates for the wider roll-out of services across the country.

I agreed to submit an interim report to Ed Balls and Alan Johnson in March 2008. This would be followed by a final report to both Secretaries of State in July 2008.

Over the last ten months our work has fallen into two distinct phases – the gathering of evidence and the formulation of recommendations. It is worth saying something about each.

The evidence we gathered was encapsulated in the interim report, published in March 2008, which set out what we learned, what we saw as the main challenges and what we believed to be the principal issues for further consideration. My colleagues and I have gathered evidence in four ways:

- we issued a consultation questionnaire in October 2007 to which we received over 2,000 responses;

- we have staged a series of consultation groups to hear views about, for example, young offenders' communication difficulties and the plight of those who need Alternative and Augmentative Communication aids to express themselves. In addition, we listened in further consultation groups to the voices of parents, children and young people in locations across the country;
- we visited Children's Centres, nurseries, primary schools and secondary schools from London to Sussex, from Buckinghamshire to Kent, from Leicester to Manchester, from Oxford to Nottingham, from Essex to Salford and from Newcastle to Norwich to Plymouth. In the process, we have met speech and language therapists, teachers, special needs coordinators, classroom assistants, pupils, together with staff of Primary Care Trusts and local authorities, to discuss the issues; and
- we commissioned research by leading academics in the field of speech, language and communication needs – Geoff Lindsay, Martin Desforges, Julie Dockrell, James Law and Nick Peacey. This research explored the efficiency and effectiveness in six case study areas of the provision for children and young people with speech, language and communication difficulties. It further assessed the feasibility of conducting a cost-benefit analysis of investment in services for this group.

Since March, our focus has been on formulating recommendations and consulting people who would implement them, be affected by them or have a view on them. Commissioners, workforce organisations, regulators, professional practitioners and voluntary bodies have all told us what they think. In formulating recommendations, I have had two overriding considerations in mind. First, we should do as much as we can for as many people to make our reform the most sustainable we can devise. Secondly, we should eschew any temptation to start from year zero with an ideological grand plan or unaffordable wish lists. Instead, my colleagues and I have concentrated on practical proposals which will improve services soon, together with measures to embed speech, language and communication in wider policy frameworks for the future.

I am privileged to have been asked to lead this Review which for me has been the most stimulating endeavour of my parliamentary life. I hope that we can make a difference for the benefit of our children and young people by setting the direction of travel of public policy for the months and years ahead. For all that is good in our report, the Review Team deserves the credit. For whatever shortcomings it contains, I accept full responsibility.

John Bercow MP

Advisory Group

The Review's Advisory Group members are:

Virginia Beardshaw, Chief Executive of I CAN

Trevor Daniels, Head of Special Educational Needs, South Gloucestershire Council

Kamini Gadhok, Chief Executive of the Royal College of Speech and Language Therapists

Brian Lamb, Chair of the Special Educational Consortium and Executive Director of Communication, Royal National Institute for Deaf People

Linda Lascelles, Chief Executive of Afasic

Norbert Lieckfeldt, Chief Executive of The British Stammering Association

Michelle Morris, Head of Speech and Language Therapy, Salford Primary Care Trust and professional advisor on speech and language therapy to the Department of Health

Alice Sluckin, Chair of the Selective Mutism Information and Research Association

Associate members:

Dr Gillian Baird, Consultant Developmental Paediatrician and Honorary Professor in Neurodisability at Guy's Hospital, London

Dr Vicky Slonims, Clinical Lead Speech and Language Therapist and Honorary Lecturer at Kings College, London

Executive Summary

This report makes recommendations to Government about the steps it should take to transform provision for and the experiences of children and young people with speech, language and communication needs (SLCN) and their families. These recommendations are the culmination of ten months of extensive evidence gathering and analysis, as well as consultation with a wide range of stakeholders.

During the Review we identified five key themes – issues that need to be addressed for real change and improvement to happen. Our recommendations are gathered under these five themes:

- Communication is crucial;
- Early identification and intervention are essential;
- A continuum of services designed around the family is needed;
- Joint working is critical; and
- The current system is characterised by high variability and a lack of equity.

How to improve understanding that communication is crucial

The ability to communicate is an essential life skill for all children and young people and it underpins a child's social, emotional and educational development. Evidence illustrates that there is insufficient understanding of the centrality of speech, language and communication among policy makers and commissioners nationally and locally, professionals and service providers, and sometimes parents and families themselves. It follows that insufficient priority is attached to addressing SLCN.

To raise the national profile of speech language and communication and all forms of SLCN:

We recommend that the Government creates a Communication Council to monitor and support implementation of this Review's recommendations. [Recommendation 1]

We recommend that the Government creates the post of a Communication Champion to lead on awareness raising and best practice dissemination elements of the Communication Council's work. [Recommendation 2]

We further recommend that the Government commissions a *National Year of Speech, Language and Communication* to be led by the Communication Champion.

[Recommendation 3]

To increase understanding of speech, language and communication among all families and provide information, advice and support to families of children and young people with SLCN:

We recommend that all parents receive information which emphasises the importance of speech, language and communication to all children through the Child Health Promotion Programme. [Recommendation 4]

Once a child's SLCN has been identified, **we recommend that a range of information, advice and support should be readily available to families, particularly at key stages and transition points in a child's life.** [Recommendation 5]

We further recommend that the Government considers the case for funding national, regional and local support services for parents. [Recommendation 6]

To ensure that it is clear to all parents what provision is available in their local area, **we recommend that the Government reminds local authorities of their current duties to provide information to families, including about publicly funded provision.** [Recommendation 7]

How to ensure that early identification and intervention are recognised as essential

Early identification means recognising a child's difficulty quickly: both as early as possible in his or her life and as soon as possible after the difficulty becomes apparent. Early intervention means making a prompt intervention to support the child and family. In addressing SLCN, there is strong clinical opinion about the value of early intervention and the danger of its absence. If a child receives the right help early on, he or she has a better chance of tackling problems, communicating well and making progress. If a child does not benefit from early intervention, there are multiple risks – of lower educational attainment, of behavioural problems, of emotional and psychological difficulties, of poorer employment prospects, challenges to mental health and, in some cases, of a descent into criminality.

To ensure a robust system for early identification of children and young people with SLCN:

We recommend that PCTs and local authorities work together to undertake surveillance and monitoring of children and young people to identify potential SLCN across the age range, and particularly at key transition points. [Recommendation 8]

For children up to the age of five, **we recommend that surveillance and monitoring is delivered through PCTs adopting the recently updated Child Health Promotion Programme and, in particular, implementing the child and family health and development reviews, including the review of speech and language development.**

[Recommendation 9]

We recommend that the Government considers a review of the 'red book' (the Personal Child Health Record), to ensure that families and professionals have a clear record of a child's speech and language development at key ages and stages. [Recommendation 10]

To help ensure that where a SLCN is identified, appropriate provision is available to intervene promptly, **we recommend that speech, language and communication is prioritised by all Children's Centres and that it is a primary focus for measuring every child's progress.**

[Recommendation 11]

We recommend that the Department for Children, Schools and Families (DCSF) asks Sir Jim Rose to examine how to strengthen the focus on speech, language and communication in the primary curriculum and that the Department be ready to act on his advice. [Recommendation 12]

To deliver early identification and intervention for older children and young people with SLCN **we recommend that the DCSF reinforces its inclusive approach to SEN in the revised secondary curriculum by preparing and disseminating widely exemplifications of the effective removal of barriers for pupils with SLCN, in line with the principles of the National Curriculum inclusion statement.** [Recommendation 13]

We further recommend that, when issuing guidance to local authorities and schools on the use of funding, including that for personalised learning, the DCSF emphasises the importance of meeting the needs of all children and young people with SLCN.

[Recommendation 14]

How to design a continuum of services around the family

The requirements of children and young people with SLCN and their families will be met when, and only when, appropriate services to support them, across the age range and spectrum of need, are designed and delivered in a way that is accessible to them. This will require a broad and varied continuum of universal, targeted and specialist services, delivered by an appropriately skilled and supported workforce.

To ensure effective joint commissioning of services for children and young people with SLCN:

We recommend that, as part of the work on *World Class Commissioning*, the Government produces a joint framework for commissioners, including Children's Trusts and schools, on the commissioning of a continuum of universal, targeted and specialist services for children and young people with SLCN across the age range 0-19. [Recommendation 15]

We recommend that the commissioning framework is developed through a programme of pathfinders, funded and supported by the Government, to identify best practice and evidence of effective interventions for children and young people with different types of SLCN and to show how joint working and commissioning works well in a range of local areas. [Recommendation 16]

To support commissioners further and embed incentives to commission services for children and young people with SLCN **we recommend that the Department of Health creates a speech, language and communication annex to Standard 8 of the Children's National Service Framework: Disabled Children and Young People and those with Complex Health Needs.**

[Recommendation 17]

In recognition of the fact that greater delegation of funding to schools and their increasing role as commissioners has further complicated the commissioning challenge, **we recommend that the current DCSF review of the Dedicated Schools Grant should take account of how the school funding system supports the delivery of universal, targeted and specialist services for children and young people with special educational needs.** [Recommendation 18]

To ensure that strategic commissioning is successfully supported by the workforce:

We recommend that the commissioning framework includes advice on:

- **how to assess the range of skills in local children’s workforces;**
- **how to identify the right skills and capacity mix required in the children’s workforce to deliver services and agreed outcomes, including staff with specialist skills able effectively to assess and support children and young people with SLCN;**
- **how to develop the workforce by identifying and addressing skills or capacity ‘gaps’; and**
- **how to develop effective collaborative practice between different services and members of the workforce.** [Recommendation 19]

To support further the workforce to deliver **we recommend professionals from across the children’s and young people’s workforce undertake pre-qualification training in collaborative and multidisciplinary working, alongside professionals from other backgrounds.** [Recommendation 20]

To improve the training and continuous professional development related to speech, language and communication and SLCN which is available to the workforce:

We recommend that the Children’s Workforce Development Council, in collaboration with the Children’s Workforce Network, ensures that speech, language and communication and SLCN are a core requirement or unit at the appropriate level in all qualifications for the children’s workforce as part of the emerging Integrated Qualifications Framework.

[Recommendation 21]

We further recommend that the standards for Qualified Teacher Status ensure that students develop a better understanding of children and young people’s SLCN and of how to address those needs. [Recommendation 22]

We recommend that DCSF includes speech, language and communication, both as a core requirement and as an elective module, in the new Masters in Teaching and Learning.

[Recommendation 23]

We recommend that the Government ensures that good quality training, such as that provided through the Inclusion Development Programme (IDP), is available to everyone in the children’s workforce, including health and education professionals, to develop their skills in relation to speech, language and communication. This should include training for staff wishing to specialise in working with children and young people with more severe and complex SLCN. In ensuring that training is available, the Government should consider how it should best be provided, including consideration of whether training should be an entitlement and the circumstances in which it would be appropriate to fund the ‘backfilling’ of posts in order to enable staff to undertake training. [Recommendation 24]

To provide more information to local areas on the workforce resources required to meet needs, **we recommend that the Government, working with other partners, undertakes a modelling exercise to help Strategic Health Authorities and Primary Care Trusts, in**

partnership with their local authorities, to estimate the workforce that they will require to deliver appropriate services for children and young people with SLCN. [Recommendation 25]

To improve understanding of what support and interventions work for children and young people with SLCN **we recommend that the Government considers a programme of research to enhance the evidence base and inform delivery of better outcomes for children and young people.** [Recommendation 26]

In this report, we examine the difficulties faced by groups with particularly severe or on-going needs that are not currently being met. To address the needs of children and young people who use Assistive and Augmentative Communication aids (AAC) **we recommend that the Government develops a 'hub and spoke' model of regional provision, coordinated by a national organisation. Moreover, we recommend that on appointment the Communication Champion should immediately evaluate the effectiveness of local areas' AAC provision, and report findings to the Communication Council.** [Recommendation 27]

To strengthen support in one of the most acute examples of on-going SLCN, **we recommend that the Government's forthcoming Youth Crime Action Plan and the follow-up work on young offenders' health should consider how best to address the SLCN of young people in the criminal justice system, including those in custody.** [Recommendation 28]

To ensure that families and others get the opportunity they deserve to have their voices heard where closure of language units is being proposed, **we recommend that the DCSF reminds local authorities of their statutory responsibilities and parents of their rights regarding consultation procedures.** [Recommendation 29]

How to promote more and better joint working

In planning, commissioning and delivering universal, targeted and specialist provision, it is critical that health services and children's services, including schools, work together in support of children and young people with SLCN. No single agency can deliver any one of the five *Every Child Matters* outcomes for children and young people by working in isolation. Operating in separate silos produces misunderstandings, causes divisions and can be bewildering or infuriating to parents.

To increase the effectiveness of Children's Trust arrangements to facilitate joint working, the priority afforded to SLCN by Children's Trusts and hence the impact on provision and outcomes for children and young people with SLCN, **we recommend that each Children's Trust appoints an appropriate senior member of its governing board to lead on speech, language and communication in the local area. This leadership role should include overseeing a drive to improve outcomes.** [Recommendation 30]

To avoid confusion in joint commissioning of provision for children and young people with SLCN, the commissioning framework should make clear who the responsible commissioner is in complex cases. Where a lack of clarity about the responsible commissioner is identified, **we recommend that the Government considers amending regulations and associated guidance.** [Recommendation 31]

In 2009 the Government will introduce a new Comprehensive Area Assessment (CAA) of outcomes delivered by local authorities, both independently and in partnership with others. To

help ensure that Children's Trusts fulfil their responsibilities for children and young people with SLCN, **we recommend that the new CAA takes account of the effectiveness of Children's Trusts in facilitating joint working and effective commissioning to deliver improved outcomes for children and young people with SLCN.** [Recommendation 32]

We welcome the discussion paper on strengthening Children's Trusts recently launched by the Government. **We recommend that during the debate following this paper the Government considers whether sufficient numbers of Children's Trusts are functioning effectively in terms of improving outcomes for children and young people with SLCN, and takes account of the evidence and recommendations of this Review in any plans to strengthen Children's Trust arrangements, including by further legislation.** [Recommendation 33]

In response to a report by the former Education and Skills Select Committee¹, the DCSF has commissioned Ofsted to carry out a detailed review of progress on Special Educational Needs (SEN) in 2009-10. Given the prevalence of SLCN within the SEN population and the fundamental importance of supporting children and young people with SLCN, **we recommend that the forthcoming Ofsted review takes full account of the need for the joint provision of services for children and young people with SLCN.** [Recommendation 34]

In particular, we believe the Ofsted review should consider:

- the effectiveness of joint working arrangements between schools, local authorities and health services in addressing SLCN;
- the contribution of community child health services commissioned by the PCT;
- the effectiveness of local authorities' support to schools on improving outcomes for children and young people with SLCN;
- the effectiveness of School Action, School Action Plus and statements of SEN in improving outcomes for children and young people with SLCN; and
- how Ofsted itself might strengthen its contribution to raising standards for children and young people with SLCN, including what training may be required for Ofsted Inspectors in this area.

How to ensure greater consistency and equity for families

The current system for providing support to children and young people with SLCN is routinely described by families as a 'postcode lottery', particularly in the context of their access to speech and language therapy (SLT). Despite the hard work and commitment of many professionals in health and children's services, the needs of many children and young people are still not being met.

Local leaders, particularly senior managers, are crucial to setting priorities and leading development of services that will improve outcomes for children and young people. To support the strengthening of the local leadership role, DCSF has published a national professional development framework in its document *Leading and Managing Children's Services in England* (April 2008)². **We recommend that the DCSF work closely with its central and local**

1 Now Children, Schools and Families Select Committee.

2 Available at www.dfes.gov.uk/publications/childrensplan/implement.shtml

government partners to promote the framework to local leaders, setting out in the 2009 Departmental Annual Report the steps taken and the progress made. [Recommendation 35]

In line with the focus on leadership development within Lord Darzi's report of his NHS Next Stage Review, **we recommend that the Department of Health supports the development of appropriately skilled and experienced clinical leaders who can interpret policy and research to support the delivery of evidence-based practice for children and young people with SLCN.** [Recommendation 36]

To improve performance monitoring at a national level, **we recommend that the Government considers retaining national early years targets beyond 2011. We further recommend that the Government considers introducing a national indicator specifically for SLCN to underpin a relevant Public Service Agreement from 2011.** [Recommendation 37]

Whilst national targets will bring some external performance monitoring to certain aspects of provision, it will be essential for Children's Trusts to maintain a comprehensive view of local performance. Trusts must be able to identify where satisfactory progress is being made and where it is not so that resources can be appropriately targeted. A continual cycle of self-evaluation is required in order to improve outcomes. **We recommend, therefore, that the joint framework on commissioning emphasises the need for local agencies to monitor performance and publish their findings in forms accessible to children, young people, parents and professionals.** [Recommendation 38]

We further recommend that the Government makes as much data as possible available about the educational attainment of children and young people with SLCN to allow it to be accountable for progress and to encourage improvement in provision [Recommendation 39]. Data should be readily understandable and accessible to all stakeholders with an interest in the outcomes for children and young people with SLCN.

To support all the above recommendations to strengthen improvement and performance management at all levels of the system, **we recommend that progress on implementing the recommendations of this review is assessed through an independent progress check conducted in 18 months' time.** [Recommendation 40]

Introduction

What are speech, language and communication needs?

The term speech, language and communication needs (SLCN) encompasses a wide range of difficulties related to all aspects of communication in children and young people. These can include difficulties with fluency, forming sounds and words, formulating sentences, understanding what others say, and using language socially.

Approximately 50% of children and young people in some socio-economically disadvantaged populations have speech and language skills that are significantly lower than those of other children of the same age. These children need access to early years provision which is specifically designed to meet their language learning needs and they may also benefit from specific targeted intervention at key points in their development.

Approximately 7% of five year olds entering school in England – nearly 40,000 children in 2007 – have significant difficulties with speech and/or language. These children are likely to need specialist and/or targeted intervention at key points in their development.

Approximately 1% of five year olds entering school in England – more than 5,500 children in 2007 – have the most severe and complex SLCN. They may not understand much of what is said to them, they may have very little spoken language and they are likely to be completely unintelligible when they start school. These children often need to use alternative and augmentative means of communication. This group is likely to have a long-term need for specialist help, in school and beyond.

SLCN may be a child's primary educational need. Primary SLCN include specific difficulties of which there is often no obvious cause.

A significant proportion of children and young people in both primary and secondary school with special educational needs have SLCN as their primary need.

In contrast, secondary SLCN are associated with other difficulties that the child may be experiencing such as autism, cerebral palsy, hearing loss or more general learning difficulties. The number of children and young people with secondary SLCN is almost impossible to quantify separately from the primary SLCN group. However, meeting their SLCN should be considered as part of their overall package of care.

When are SLCN apparent in children and young people?

The majority of SLCN are identifiable from the second year of life and can persist through school and into adulthood. Some may become apparent only as the school curriculum becomes more demanding, for example at secondary school.

Impact on children and young people

Children and young people who have SLCN commonly have difficulties with reading and writing and accessing the curriculum. They also often have poor behaviour and may find it hard to socialise with their peers.

The transition from compulsory education for children and young people with SLCN and the longer-term implications in adulthood are not well understood. However, it is clear that all children and young people with SLCN are potentially “at risk”.

Just to recap...

For the benefit of those who did not read our interim report of March 2008 it is as well to recap on the evidence that we found and the themes that we identified. This will establish a context for the remainder of this final report which, as appropriate, draws directly from that earlier report.

Based on questionnaire responses, consultation groups and visits across England, the central findings of our interim report were stark. Although there are some skilled professionals and good facilities, the overall position in terms of speech, language and communication services is highly unsatisfactory. Access to information and services is often poor, services themselves are very mixed, continuity across the age range is lacking, effective joint working between the health and education services is rare and there is something of a postcode lottery across the country. Above all, local commissioners attach a low priority to the subject and we believe that this must change.

On the strength of what we learned, we identified five key themes which would define the parameters of our final report and the basis for its recommendations. These themes are set out below:

- **Communication is crucial.** Communication is a fundamental human right. Communication is a key life skill. Communication is at the core of all social interaction. For some children and young people, acquiring the ability to communicate is a difficult and ongoing challenge. Just as the nature and severity of their needs will vary, so will the type and extent of the help required to address them.
- **Early identification and intervention are essential.** In addressing delay and disorders, the most important principle is the value of early intervention and the danger of its absence. If a child receives the right help early on, he or she has a better chance of tackling problems, communicating adequately and making progress. If a child does not benefit from early intervention there are multiple risks, which may become apparent over a number of years – of lower educational attainment, of behavioural problems, of emotional and psychological difficulties, of poorer employment prospects, of challenges to mental health and, in some cases, of a descent into criminality.

- **Continuum of services designed around the family.** Universal, targeted and specialist services are required to meet the range of needs and, as the Government envisages in its recent Children's Plan, children, young people and their families must be at their heart. Support for SLCN is essential in the early years of a child's life. However, whilst this is often the crucial stage at which to intervene, older children and young people can also require support.
- **Joint working is critical.** In planning, commissioning and delivering universal, targeted and specialist provision, it is critical that health services and children's services, including schools, work together in support of children and young people with SLCN. No single agency can deliver any one of the five *Every Child Matters* outcomes for children and young people by working in isolation. Separate silos produce misunderstandings, cause divisions and can be bewildering or infuriating to parents for whose children services are delayed or denied as a result.
- **The current system is characterised by high variability and a lack of equity.** The current system is routinely described by families as a 'postcode lottery', particularly in the context of their access to speech and language therapy (SLT). Despite the hard work and commitment of many professionals in health and children's services, the SLCN of too many children and young people are still not being met.

Throughout the pages that follow, we seek to keep in the forefront of our minds what we are about in undertaking this review. The rationale for it is twofold. We are determined that this country should do better in providing help for every child or young person with SLCN because it is right in itself to help people in need who will otherwise be vulnerable, marginalised and at risk of exclusion from the opportunities which society can offer them. We are also determined that this country should do better by such people because it is in the national interest to do so. Improving educational outcomes, promoting public health, tackling anti-social behaviour, reducing the numbers of young people who go through the revolving doors of the criminal justice system, bolstering the skills of the workforce, drawing on the talents and energies of all of our citizens and increasing the competitiveness of the country in the global market place are all vital objectives and speech, language and communication services must play their part in helping to deliver those objectives. This report attempts to chart a course to enable them to do so.

Chapter One: Communication is crucial

The issue

*“Speech, language and communication is the most important thing in all our children ...
It’s their key to life”*

Parent of a five year old child

- 1.1** The ability to communicate is an essential life skill for all children and young people in the twenty-first century. It is at the core of all social interaction. With effective communication skills, children can engage and thrive. Without them, children will struggle to learn, achieve, make friends and interact with the world around them. The centrality of communication is not simply a personal statement of value. It is a formal, public and multilateral declaration by UNICEF, UNESCO and the World Health Organization, which lists communication as one of the ten core life skills. Communication is a fundamental human right.
- 1.2** Many children and young people face a significant struggle to acquire the ability to communicate. For some their needs will be challenging but short-lived; some will lag behind their peers on account of social or environmental factors; a proportion may have disabilities that will be on-going throughout their lives. Difficulties vary because speech, language and communications needs (SLCN) can be associated with a wide range of factors including social and environmental causes, neuro-developmental difficulties or sensory impairment. Some children and young people will have complex needs resulting from more than one of these causes, for example delayed speech development combined with a specific language impairment (SLI).
- 1.3** It is important to be able to identify the diverse needs of children and young people with SLCN and to provide appropriate support for them to interact socially, to participate fully in education and to lead safe, healthy lives.

What we found

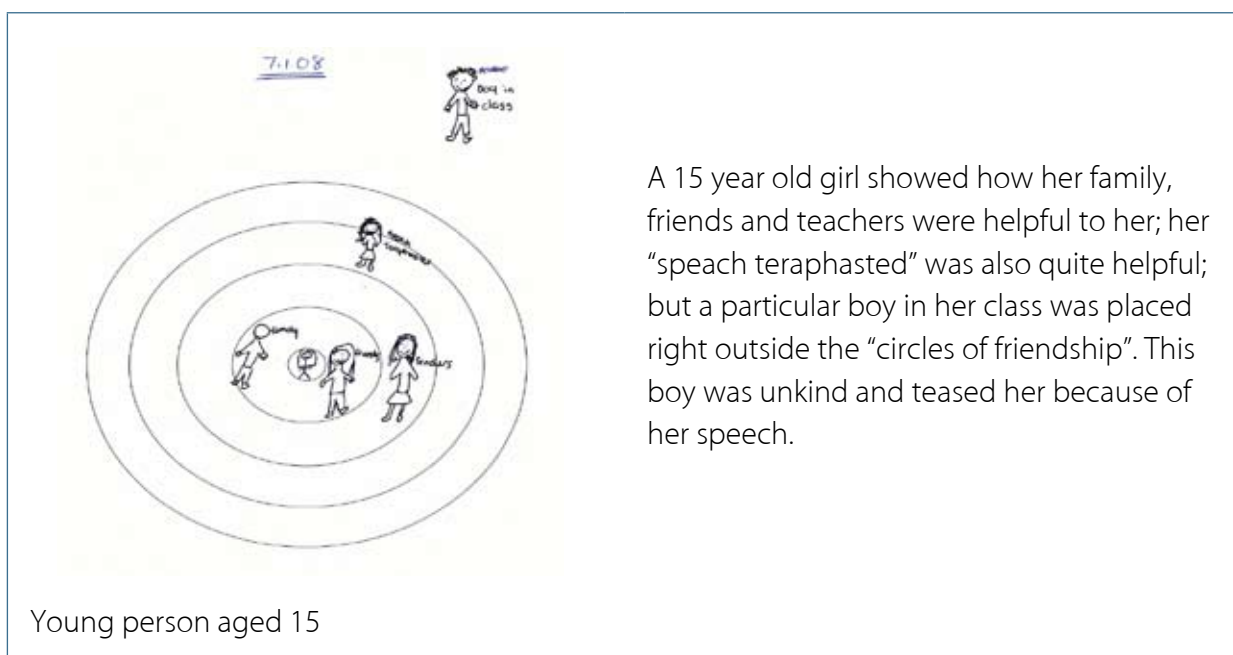
- 1.4** *Every Child Matters*³ – the Government’s flagship programme for children and young people – aspires for all children and young people to achieve five outcomes: to be healthy; to stay safe; to enjoy and achieve; to make a positive contribution; and to achieve economic well-being. These were the five vital outcomes identified by children and young people themselves. Speech, language and communication underpin achievement of every one of these outcomes. There is evidence that an inability to communicate effectively can put children and young people at risk of poorer outcomes in a number of respects.

- 1.5** Children and young people with SLCN are more likely to be bullied than other children⁴, affecting their ability to make friends and, potentially, their safety. In a report on children, young people and parents' views commissioned by this Review⁵, children and young people with SLCN reported feeling isolated and excluded because of their communication difficulties.

'When I was in year 4 I used to get stuck and people would start laughing at me and they wouldn't let me play with them.'

Child aged 10

- 1.6** The children and young people were asked to draw pictures of familiar people and places. Their pictures illustrated some of the social difficulties they faced as a result of their SLCN.



- 1.7** Children and young people who struggle to communicate will often also struggle to engage in and enjoy education. Almost all aspects of school life are language based. In his report on the teaching of early reading⁶, Sir Jim Rose made a clear connection between strong speaking and listening skills and children’s ability to learn to read. Educational achievement statistics show a significant gap between the achievement of children and young people with SLCN and their peers.

4 Knox, E. and Conti-Ramsden, G. (2003) Bullying Risks of 11 Year Old Children with Specific Language Impairment (SLI); Does school placement matter? *Journal of Language and Communication Disorders* 38 (1) 1-12
Lindsay, G., Dockrell, J., and Mackie, C., (2008) Vulnerability to bullying and impaired social relationships in children with specific speech and language difficulties. *European Journal of Special Needs Education* 23, 1-16
5 Roulstone, S and Ayre, A (March 2008): *Services for children and young people with speech, language and communication needs: evidence from parents and children*
6 www.standards.dfes.gov.uk/phonics/report.pdf

Educational outcomes for children and young people with SLCN at School Action Plus and with a Statement of Special Educational Needs are considerably lower than for their peers⁷.

At the end of primary school, although nearly 80% of all children achieve the expected level in English, just 25% of children with SLCN reach that level – a gap of almost 55%. The gap in Maths is 46% and in science it is 41%.

At the end of Key Stage 4, the gaps are similar: just 15% achieve 5 GCSE A*-C or equivalent compared to 57% of all young people.

- 1.8** Furthermore, research indicates that the result of an inability to interact with others and to access the curriculum can, in some cases, lead to behavioural problems in children and young people with SLCN⁸. Children with primary language difficulties are at higher risk of developing behavioural, emotional and social difficulties (BESD)⁹. This increases the risk of their exclusion from school and, in the most extreme cases, can lead to young people entering the criminal justice system.
- 1.9** Unmet needs limit children’s and young people’s ability to develop the range of life skills that enable them fully to participate in and contribute to society, both socially and economically. This can adversely affect not only the outcomes of that individual child, but also his or her family, peers and teachers at school, not to mention the detrimental impact upon communities and society as a whole¹⁰. Some children and young people, including those with SLI, will have an ongoing need which constitutes a disability and will require specific support including at transition in to secondary education, adult services, as well as access to appropriate further education, training and employment.
- 1.10** From our visits around the country and submissions made to the Review, it is clear that there is grossly inadequate recognition across society of the importance of communication development, let alone of the active steps needed to facilitate it. It is a skill which has to be taught, honed and nurtured. Yet parents in the consultation groups¹¹ expressed concern that their children’s ability to communicate, to speak and to understand was taken for granted. They discussed the lack of understanding of their children’s SLCN: their children often looked like any “normal” child and yet behaved differently.

7 Data from the National Pupil Database

8 Brownlie, E.B., Beitchman, J.H., Escobar, M., Young, A., Atkinson, L., Johnson, C., Wilson, B. and Douglas L. (2004) Early Language Impairment and Young Adult Delinquent and Aggressive Behaviour *Journal of Abnormal Child Psychology* 32 453-467

9 (Lindsay, Dockrell & Strand, 2007) Longitudinal patterns of behaviour problems in children with specific speech and language difficulties: Child and contextual factors *British Journal of Educational Psychology*, 77, 811-828.

10 www.ican.org.uk/upload/publications/the%20cost%20to%20the%20nation%20of%20children's%20poor%20communication%20report.pdf

11 Roulstone, S and Ayre, A (March 2008): *Services for children and young people with speech, language and communication needs: evidence from parents and children*

"They don't think quickly and they can't express themselves quickly, but they look as if they can manage. All my children stare at people because they are looking for cues, and that causes fights."

Parent of four children with SLCN

"When I go to [a place for additional teaching], the teacher says "hurry up, hurry up!" and when she says that I get more nervous and [it's] more hard for me."

Child aged 10

- 1.11** Where SLCN was a priority, parents and professionals often reported that this was as the result of an individual with a special interest, rather than a product of the system. In response to our online consultation¹², only 15% of respondents said speech, language and communication issues were a high priority in their area.

'While it seems that practitioners at ground level are very concerned about the level of speech and language difficulties, at a higher level it is given little priority.'

Respondent to the consultation

- 1.12** Current Government policy encourages local communities to set their own priorities based on a thorough assessment of local need. The strong impression of the Review team, however, was that lack of prioritisation of SLCN was not the result of a thorough assessment which concluded that there was no need. Rather, the inertia resulted from a lack of awareness and understanding of what that need might be and how to assess and deliver appropriate provision to meet it.
- 1.13** It is important to see this picture within the context of all the pressures on local commissioners. Our meetings with commissioners from local authorities, schools and PCTs highlighted the challenges they face in prioritising and meeting, with finite resources, the needs of a large number of competing groups.

'We have identified 92 current priorities in our area. It is not that commissioners don't care about these children. It's that there are a lot of competing demands upon them. If commissioners are to prioritise this area they need to see a compelling, evidence based case for doing so and be given the right support.'

London PCT commissioner

The central role of families

- 1.14** Ensuring that parents and families have a good understanding of the importance of speech, language and communication and the information and advice to support their child's development is vitally important in improving outcomes for children and young people with SLCN. In consultation groups, many parents commented that they did not know enough about typical speech and language development. They wanted to see information and guidance about

¹² See annex D(ii) for an analysis of the responses to the online consultation

speech, language and communication development given to all parents and the issue raised to the top of the agenda.

- 1.15** If parents do identify or suspect a problem they do not always know where to go for advice and support. Many parents said that they knew nothing about the issue of SLCN until their child was identified with a problem and the issue was poorly understood by society at large. They felt that they needed more information to recognise when their children required help and to know how to help them. Once a child's SLCN had been identified, parents said they needed clear sign-posting to where they might find help and consistent advice from the professionals working with their child.

Good practice: information to families

A lot of information exists about SLCN, including many government and voluntary organisation leaflets and websites.

Talking Point website

Launched in 2003 by Afasic, the Royal College of Speech and Language Therapists (RCSLT) and I CAN. It provides a comprehensive source of information on all aspects of children's communication development, including up to date, expert information for families and the children's workforce.

Early Support Programme

Early Support is the Government programme to achieve better co-ordinated, family focused services for young disabled children and their families. It's a national programme that is used in local authorities, hospitals and community-based health services across England.

Early Support includes a wide range of materials for parents including *Background Information* booklets on services, a *Family File* to help with co-ordinating services and joint planning, booklets describing particular conditions or factors that affect young children's development including SLCN and *Developmental Journals* which help families track, record and celebrate their child's progress through the early years.

- 1.16** However, many families told us that information was not getting to them when they needed it. In response to our consultation 77% of families said that the information they needed to support their child was either not easily available or not available at all.

Parents had variable experiences of the information and advice available

There is a lot of information out there but it's hard to find what I need. I am still struggling to find out exactly what a LA statement is and what it means to my family.'

Parent

'We were given good, detailed written information about the service offered by speech and language therapy. We were also able to speak to a speech and language therapist during parents' evening. In addition, Stockport has a fantastic disability database. We were visited at home by their staff, who again provided us with good information about the speech and language service.'

Parent

'Quality of information varies enormously...Even where some information is given, there is often an essential level of complexity that is not given in the leaflet and takes some time to find and more to understand.'

Parent

- 1.17** Respondents mentioned a number of particular problems that they had experienced in obtaining information: these included the absence of a formal or coordinated system to provide parents with information and the difficulty of locating the right person or department to contact. Some parents reported that health and education services' staff were apprehensive in providing information because to do so would add to the demand on their time and resource. Others reported that staff lacked sufficient knowledge to be able to help them. Several parents said that other parents, support groups and independent organisations had been most helpful in giving them the information that they needed.

How to improve understanding that communication is crucial

- 1.18** This Review is evidence that the Government has recognised the importance of speech, language and communication to all children and young people and the priority that this issue deserves. To prevent poor outcomes for children and young people with SLCN we need to raise the profile and understanding of speech, language and communication among all policy makers, commissioners and service providers nationally and locally, as well as among professionals working with children and young people in mainstream, targeted and specialist services. For all the above groups, their working life is already awash with competing priorities. If we want and expect them to ensure that children and young people with SLCN get the right support at the right time, it is essential that they understand the fundamental nature and importance of communication. To develop and maintain speech, language and communication issues as a genuine priority at a national and local level, the system needs effective leadership from the centre.
- 1.19 We recommend that the Government raises the national profile of speech, language and communication and all forms of SLCN by creating a Communication Council to monitor and support implementation of this Review's recommendations.** The Council should be chaired jointly by Ministers from the Department for Children, Schools and Families (DCSF) and the Department of Health (DH) and its members should be drawn from key stakeholder groups.

Parents and young people should be represented on the Council. The Council should have a well resourced secretariat to secure a joined-up Government approach to speech, language and communication issues.

- 1.20** This Council should be responsible for promoting the importance of speech, language and communication, monitoring national progress in improving services and outcomes for children and young people with all forms of SLCN, making recommendations for improvements to Ministers and identifying and sharing effective practice. It should be established initially for three years, after which time its status and purpose should be reviewed.
- 1.21** In addition **we recommend that the Government creates the post of a Communication Champion.** The Champion should be a member of the Communication Council and should promote change and improvement. He or she should lead on the awareness raising and best practice dissemination elements of the Communication Council's work. This should be in two phases. The first should focus attention on encouraging and supporting local policy makers and commissioners to enhance the quality and capacity of provision for children and young people with all kinds of SLCN. The second should include management of a *National Year of Speech, Language and Communication* (see below) and should have a broader target audience, including the wider children's workforce and children, young people and families themselves. The Champion should liaise with speech, language and communication leads in Children's Trusts to support the local facilitation and delivery of change.
- 1.22 We recommend that the Government commissions a *National Year of Speech, Language and Communication*** to be led by the Communication Champion as set out above. The National Year should:
- raise awareness of how crucial speech language and communication is for all areas of all children's development and stress the need for appropriate services to identify and support children and young people with all forms of SLCN;
 - particularly raise awareness and understanding of groups likely to have high levels of need: for example, children and young people in areas with high levels of deprivation, children and young people with specific language impairments (SLI) or those who use communication aids;
 - share effective strategies for stimulating and strengthening language among all children and young people, highlighting the sort of activities which encourage, sharpen and sustain language, particularly to professionals and families;
 - engage stakeholders both nationally and locally; and
 - leave, as its legacy, meaningful, long-term benefits.
- 1.23** This Review has identified a lack of understanding of speech, language and communication issues and believes it is important to raise the profile of these issues promptly. However, a year of this kind will require significant preparation time. It is also important that the other recommendations of this review have adequate time to take hold prior to an awareness raising campaign, so that increased awareness and expectation among families are met with accessible, high quality services. **We recommend, therefore, that the National Year should take place within the next three years.**

- 1.24** Families are central to improving outcomes for children and young people, so the right information and advice at the right time is vital. In disadvantaged areas of the country, where there may be larger numbers of children and young people with language delay due to social factors, more support for families will be particularly important. **We recommend that, as part of the Child Health Promotion Programme¹³, all parents receive information at an appropriate time which emphasises the importance of speech, language and communication to all children and young people.** The information should identify the key milestones in a child's speech, language and communication development, it should provide guidance on how to recognise any potential SLCN and it should signpost sources of help if a SLCN is identified or suspected. This guidance should seek not merely to raise awareness and understanding of speech, language and communication, but also to help parents interact directly with their children so as to intensify opportunities for speaking and listening, enlarge their vocabulary and bolster children's confidence in speaking for themselves. Information and advice should be developed using a variety of innovative formats and media which will meet the needs of a local population. Consideration should be given to how information on speech, language and communication can be integrated into material that families already receive. Maximum use should be made of opportunities to provide information and advice to parents directly – for example, through parenting courses or informal guidance from Children's Centre staff or health visitors.
- 1.25** Once a child's SLCN has been identified, **we recommend that a range of information, advice and support should be readily available to families, particularly at key stages in a child's life**, including in the early years, at the time of a diagnosis, when starting nursery, primary and secondary school and as young people move on to further education, employment or training. This should recognise and build on what already exists. A key element of delivering appropriate, relevant information and advice to families in an accessible way will be a workforce trained and supported to understand SLCN. Recommendations to address this need are set out in Chapter Three.
- 1.26** To ensure that it is clear to all parents what provision is available in their local area, **we recommend that the Government reminds local authorities of their current duties to provide information to families, including about publicly funded provision.** This information should be presented in a way that is meaningful to parents and the Government should also encourage areas to publicise local voluntary organisations and parents' groups which could provide support.
- 1.27** Recognising that there will be circumstances in which some parents will need advice beyond what might be provided through written information, **we further recommend that the Government considers the case for funding national, regional and local support services for parents, building on current best practice, including from the voluntary sector.**

¹³ The Child Health Promotion Programme is the early intervention and prevention public health programme that lies at the heart of all universal health services for children and families.

Chapter 2: Early identification and intervention are essential

The issue

- 2.1** Early identification means recognising a child's difficulty quickly, both as early as possible in his or her life and as soon as possible after the difficulty becomes apparent. Early intervention means making a prompt intervention to support the child and family alike.
- 2.2** As we set out in Chapter One, speech, language and communication are crucial to all children and young people. Children and young people with SLCN are particularly at risk of poor outcomes. For these children, early identification is important to ensure that they receive the support they need to fulfil their potential. In addressing SLCN, there is strong clinical opinion about the value of early intervention and the danger of its absence. If a child receives the right help early on, he or she has a better chance of tackling problems, communicating well and making progress. If a child does not benefit from early intervention, there are multiple risks which may become evident over a period of years – of lower educational attainment, of behavioural problems, of emotional and psychological difficulties, of poorer employment prospects, of challenges to mental health and, in some cases, of a descent into criminality.
- 2.3** When designing services for children and young people with SLCN, commissioners need to understand the importance of prompt identification and appropriate intervention to support children in the early years.

What we found

- 2.4** Government policy places a strong focus on the importance of early identification to ensure that all children get the best start possible in the vital early years. This is based on the rationale that early identification will allow early intervention and that this in turn will result in the child's difficulties being prevented, overcome or at least ameliorated. A range of professionals in universal, targeted and specialist settings can be involved in the identification of children and young people with SLCN and subsequent intervention to support them.
- 2.5** The wide variation in trajectories of children's early development does raise challenges in the early identification of children with SLCN. Despite these challenges, there is increasing evidence that early intervention has a positive impact on the outcomes of children and young people with SLCN. A number of studies have examined the efficacy of interventions to support children with SLCN and reported positive results¹⁴.

14 For example a 2005 article on a RCT of early intervention in stammering in the British Medical Journal has shown that 'The Lidcombe programme, an early intervention for stuttering, is significantly and clinically more efficacious than no formal programme in treating stuttering in preschool children' (www.bmj.com/cgi/reprint/331/7518/659) Herder, Howard, Nye, & Vanryckeghem, 2006; Law, Garrett & Nye, 2003; Morgan, Vogel, 2007; Morgan, Vogel, 2007); (Barnett, Escobar, & Ravsten, 1988; Eiserman, McConn, & Escobar, 1990); (Weiss, & Heublein, 1981); and (Boyle, McCartney, Forbes, & O'Hare, 2007)

- 2.6** 65% of respondents to the Review's consultation agreed that resources should be directed towards early intervention and preventative work to ensure better outcomes for children and young people.

'Early intervention has been shown to benefit children with communication needs enormously, and we are now seeing this in the population coming through. The resources need to be allocated so that therapists can work with pre-school age children.'

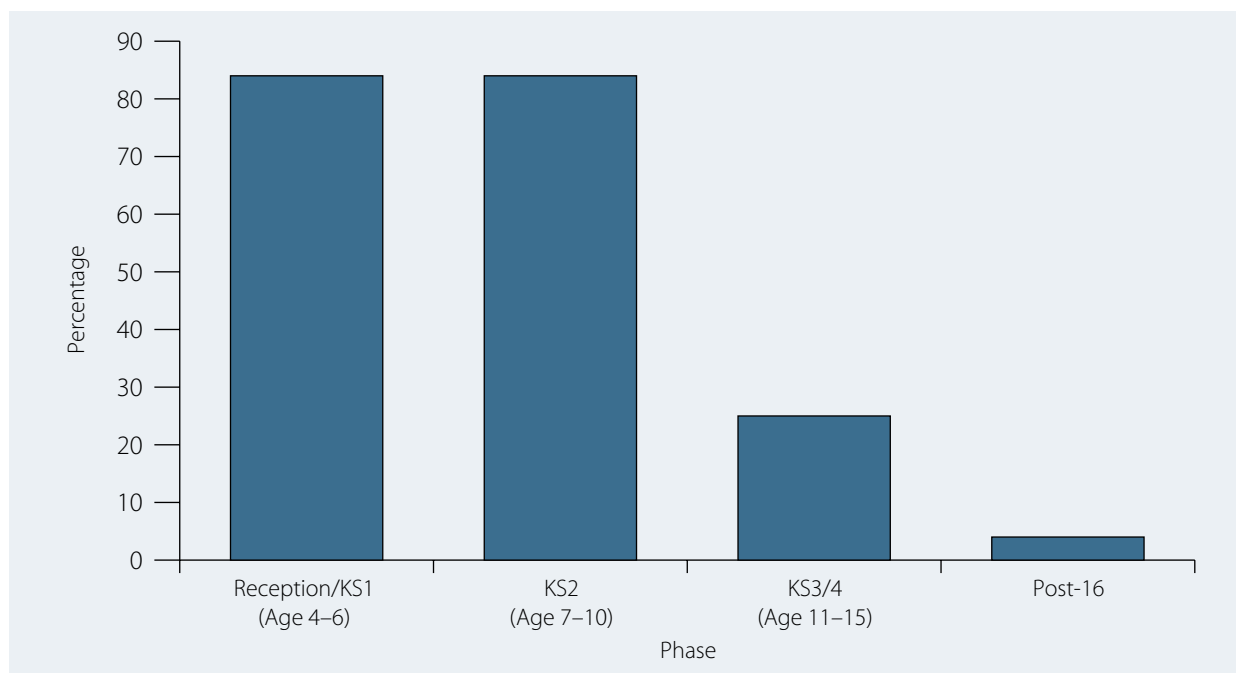
School teacher

'My son has Down's syndrome...it's well known that with the condition goes significant speech and language/communication delay...We were very lucky...from eight months my son started until he went to school and he had weekly speech and language therapy with a brilliant speech and language therapist...it has made the world of difference to him and his ability to communicate.'

Parent

- 2.7** The focus on early intervention is illustrated in the distribution of resources across the age range. The majority of respondents to our online consultation identified early years provision as currently the recipient of the largest level of resources for SLCN in their area. Research¹⁵ found a similar picture in the percentage of areas making specialist provision in mainstream and specialist integrated resources for children and young people with primary SLCN at different ages. There is also evidence in the distribution of speech and language therapists (SLTs) across the age range that services for younger children receive the bulk of the resource, as demonstrated in the figure below.

Figure 1: Proportion of SLTs providing services by phase



¹⁵ Lindsay et al: "The effective and efficient use of resources in services for children and young people with speech, language and communication needs" (July 2008). Research commissioned by this Review (funded by DCSF).

- 2.8** On our visits around the country, we learned of excellent work in early identification of SLCN. For example, in Kent, we witnessed the use of a light touch assessment technique to establish the existence of speech or language difficulty. Similarly, in North Tyneside PCT, Northumberland Care Trust and Middlesbrough, Redcar & Cleveland Community Services, there is a striking focus on early identification. More widely, we saw in the North East significant investment in a range of services, a determination to upskill further the children’s workforce and emerging evidence of schools’ increasing satisfaction with the SLT service.
- 2.9** There are noteworthy practical illustrations of what appear to be beneficial early identification and intervention elsewhere in the country. For example,

NCH Furness Children's Centres, Barrow In Furness, Cumbria

NCH run four Furness Children's Centres where they have implemented a number of specific strategies to support children with SLCN which appear to have improved the language skills of two year olds over recent years:

Average word count:	% of children putting two words together:
2000 – 18 words	2000 – 74%
2007 – 26 words	2007 – 94%

The Centres use a range of approaches which have specific, language-related learning outcomes. The core outcomes identified for all activities are:

- Increased confidence of parent/carer.
- Greater awareness of how they [parent/carer] communicate.
- More realistic expectations of their child's language and behaviour.
- Changes in children's communication and behaviour.
- Families enjoy time together.

NCH's participant reports indicate that these outcomes are being met.

- 2.10** Despite the concentration of resources in early years, parents reported variable experiences in the identification or diagnosis of their child’s SLCN. In some cases, the process goes very smoothly but, for many parents, it was not so straightforward. Often they were the first to recognise that something was wrong but they were frustrated that the professionals whom they approached for help, including health visitors and GPs, did not always take their concerns seriously.

Parents' experience of early identification

'My overall experience has been excellent. But I feel that this is because she was referred early. My speech therapist provides home visits, family support, advice, liaison with other agencies and practical family led advice.'

Parent

'I wish that my son had had constructive support on entering school at age four as this is when the condition became obvious and when it was easiest to treat. Lack of diagnosis followed by lack of support led to his condition deteriorating.'

Parent

'I did initially go to my health visitor and got told that 'speech can develop when they're 3 or 4, don't worry she'll gradually catch up'.'

Parent

- 2.11** Research¹⁶ carried out for the Review identified a wide range of often inconsistent practices in identifying children and young people with SLCN. Across six case study areas, some local areas gave very clear and detailed guidelines, as well as the degree of need required to access different levels of funding. Others left it to the clinical judgements of involved professionals, including teachers, SLTs and educational psychologists (EPs).
- 2.12** Concern was also expressed by families that SLI is not always distinguished from the far more prevalent speech and language delays, with the result either that no early intervention took place or that the wrong help was provided. This is a particular challenge where SLI occurs among children and young people from socially disadvantaged backgrounds or among children whose first language is not English as this increases the challenge in identification.
- 2.13** Professionals commented on the gap left by the changed role of health visitors and school health advisers in many areas which has resulted in a trend of children with significant SLCN not being identified and referred to specialist services until later because universal surveillance¹⁷ is no longer present. Some parents of young children talked about their experiences of 'fighting' to secure an appropriate assessment for their child and then having to fight again for adequate support to help to address his or her needs. They reported an often lengthy wait between identification and any provision being available to their child, especially in the case of speech and language therapy (SLT). This caused considerable levels of anxiety for families who knew that there was a problem but that nothing was being done.
- 2.14** We did see evidence that Children's Centres have played an important role in early identification and intervention for children with SLCN. Both parents and professionals stressed the difference which they have made.

¹⁶ *ibid.*

¹⁷ Hall, D.M.B. and Elliman, D. (7 September 2006) Health for ALL Children

'The investment via Sure Start and Children's Centres is very welcome and has provided excellent preventative work and Early Years support.'

Respondent to the consultation

2.15 The *Sure Start Journey – summary of evidence*¹⁸ published by the Department for Children, Schools and Families (March 2008) found that some good work is taking place in relation to development of children's language through Sure Start Local Programmes and praised the work of SLTs within them. However, it also identified scope for greater efforts on two fronts. First, to ensure that all staff and parents realise the importance of the language environment in children's early development. Second, to provide those staff and parents with the necessary support so that children are exposed to high-quality stimulation and interaction to develop their communication skills and the right support is given to children with complex or specific needs.

How to ensure that early identification and intervention are recognised as essential

2.16 The Government has recognised the importance of the early years to all children, the necessity of identifying any problems as soon as possible and the responsibility to provide prompt support to tackle such problems. This is illustrated in the *Every Child Matters* agenda, Sure Start and the more recent Children's Plan, though, as ever, there is a difference between recognising a need and ensuring that it is met in hundreds of areas across the country.

2.17 Also reflected in a range of areas of Government policy is an increased focus on the importance to very young children of speech, language and communication and the need to monitor children's development to identify any SLCN.

2.18 The Child Health Promotion Programme (CHPP) is the early intervention and prevention public health programme that lies at the heart of all universal services for children and families. The Department of Health (DH) published an update of the CHPP in March 2008. This update highlights a child's speech and language development as one of eight priority topics for health and development reviews of children. The reviews provide the opportunity to assess the strengths and needs of individual children and families.

2.19 From September 2008, the Early Years Foundation Stage (EYFS) will set out a single framework for learning, development and care for children in all registered early years settings and schools from birth to the end of the reception class. EYFS includes communication, language and literacy as one of the six, equally important, areas of learning and development.

2.20 Sir Jim Rose's review of the Teaching of Early Reading called for speaking and listening to receive much greater priority as attributes in their own right and as essential skills for the acquisition of literacy. All principles underpinning this review's recommendations have been incorporated into the revised Primary Framework for literacy and the new EYFS. Minor changes¹⁹ have also been made to the National Curriculum at Key Stage 1 to underpin the recommendations.

18 www.surestart.gov.uk/_doc/P0002533.pdf

19 www.standards.dfes.gov.uk/phonics/curriculumchanges/

- 2.21** However, there still needs to be a more systematic approach to ensure that all children and young people with SLCN are identified as early as possible so that appropriate provision and support can be delivered promptly. **We recommend that PCTs and local authorities work together to undertake surveillance and monitoring of children and young people to identify potential SLCN across the age range, and particularly at key transition points.**
- 2.22** For children up to the age of five, **we recommend that this is delivered through PCTs adopting the updated CHPP and, in particular, implementing the child and family health and development reviews, including undertaking a direct review of a child’s speech and language development.** To help ensure families and professionals have a clear record and understanding of the identification and monitoring process, **we recommend that the Government considers a review of the ‘red book’ (the Personal Child Health Record)²⁰, to ensure that a child’s speech and language development is recorded at key ages and stages.** Government should also explore the feasibility and value of including speech and language as a component of a universal indicator of a child’s development at age two and a half.
- 2.23** Early intervention to support children with identified SLCN will be possible only if appropriate provision is available. **We recommend that speech, language and communication is prioritised by all Sure Start Children’s Centres and that it is a primary focus for measuring every child’s progress.** We recommend that this is implemented locally by:
- a. spreading best practice via delivery agents Together for Children;
 - b. supporting centres to develop the speech, language and communication skills of staff; and
 - c. giving clear messages via guidance to the Children’s Centres manager network about the importance of prioritising speech, language and communication and providing appropriate support to children with SLCN.
- 2.24** Early identification and intervention are important and valuable across the age range and appropriate action to make sure that they happen must continue as a child enters and progresses through school. This must include embedding speech, language and communication in the curricula and supporting staff both to identify children and young people who have difficulties and to take the effective action to support them. **We recommend that the DCSF asks Sir Jim Rose to examine how to strengthen the focus on speech, language and communication in the primary curriculum and that the Department be ready to act on his advice.**
- 2.25** To maintain early identification and intervention for older children and young people with SLCN **we recommend that the Government reinforces its inclusive approach to SEN in the revised secondary curriculum by preparing and disseminating widely exemplifications of the effective removal of barriers for pupils with SLCN, in line with the principles of the National Curriculum inclusion statement.**

20 www.dfes.gov.uk/publications/childrensplan/downloads/The_Childrens_Plan.pdf

- 2.26 We further recommend that, when issuing guidance to local authorities and schools on the use of funding, including that for personalised learning,²¹ DCSF emphasises the importance of meeting the needs of all children and young people with SLCN.** Government should draw on lessons learned in person-centred planning in social care and ensure a holistic approach to supporting children and young people to enable them to fulfil their potential.
- 2.27** Ensuring that the right provision is available to support children and young people who are identified as having SLCN will also need to be done through effective joint commissioning, an issue we address in Chapter Three.

21 The Children's Plan, page 65, para 3.59.
www.dfes.gov.uk/publications/childrensplan/downloads/The_Childrens_Plan.pdf

Chapter Three: Continuum of services designed around the family

The issue

- 3.1** Raising the profile and understanding of speech, language and communication, recognising its importance to children and young people's development and identifying early those who have difficulties are all essential. However, they are necessary but not sufficient conditions for change. The requirements of those who would otherwise be vulnerable will be met when, and only when, appropriate services to support them, across the age range and spectrum of need, are designed and delivered in a way that is accessible to children, young people and their families.
- 3.2** To meet the full range of need, this continuum of services needs to be broad and varied, with robust mechanisms for identifying and diagnosing children and young people's difficulties and providing appropriate support. It should include:
- universal services to support the speech, language and communication development of all children and young people;
 - supportive services for children and young people who are struggling or who have delayed communication development but are expected to 'catch up';
 - targeted and specialist services to support children and young people with difficulties including those with SLI and complex or multiple conditions in which speech, language and communication is affected;
 - individually tailored provision for a small but important group of individuals who have SLCN arising from acquired conditions such as head injury, childhood stroke and cancer; and
 - services for children and young people with problems associated with SLCN, for example feeding and swallowing difficulties.
- 3.3** Planning and commissioning universal, targeted and specialist services for children and young people, including for children and young people with SLCN, is a complex process. It requires organisations to work with service users and professionals to:
- assess the current and future needs of the local population;
 - agree desired outcomes, priorities and resources;

- design and commission services around these needs;
- ensure that the right skills and capacity are developed to deliver the services and agreed outcomes; and
- monitor and review processes and services.

What we found

3.4 Although we saw isolated examples of excellent service provision for children and young people with SLCN, areas with a continuum of universal, targeted and specialist services designed around the needs of families are not at all common. We saw a highly varied picture of what provision is available.

Where services are provided

3.5 In the early years, evidence shows that less than 10% of local authorities make provision for children with SLCN through designated nursery schools for pre-school children, but specialist units in mainstream settings are more common: provided by a third of local authorities²². For school age children and young people with SLCN, provision can include mainstream schools, a resourced unit in a mainstream school or a special school, which may be dedicated to children and young people with SLCN or be one for a range of children and young people, such as those with moderate learning difficulties.

A resourced unit in a mainstream school

Churchill Gardens Community Primary School is situated in central London. It serves a disadvantaged community in which over 75% of children are learning English as an additional language and 55%²³ of pupils are eligible for free school meals, which is much higher than found in most schools.

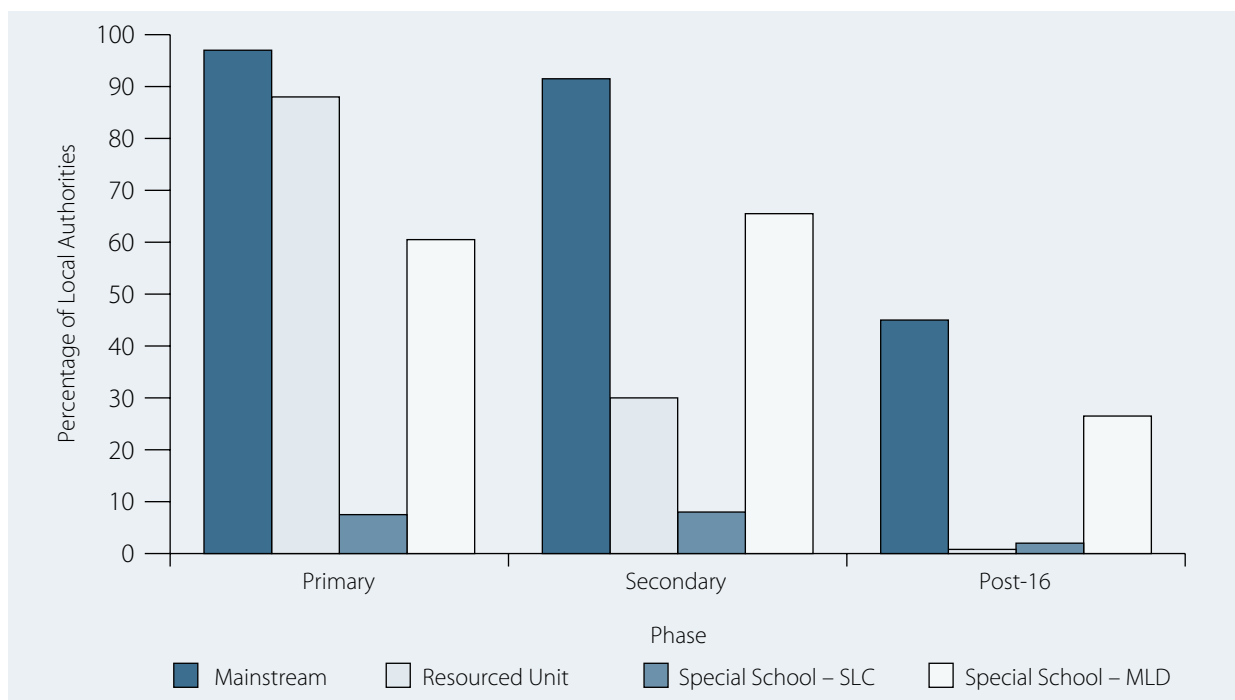
Under the Head Teacher's leadership, the resourced unit provision is strongly entrenched, a language rich environment is serving children and there is a powerful focus on communication throughout the school. It was apparent why the school is often held up as Westminster's flagship provision for children with SLCN.

3.6 The research evidence²⁴ available does provide an overall picture of the types of provision available.

22 Lindsay, Dockrell, Mackie and Letchford, *Local education authorities' approaches to provision for children with specific speech and language difficulties in England and Wales*, (August 2005), *European Journal of Special Needs Education* Vol.20 No.3.

23 This is more than three times higher than the 15.9% of pupils in maintained primary schools in England. See DCSF publication "Schools and Pupils in England", January 2007.

24 Ibid.

Figure 2: Education provision for children and young people with SLCN

3.7 Research²⁵ in six case study areas also showed a number of trends in provision.

Trends in provision of services for children and young people with SLCN in six local areas across England

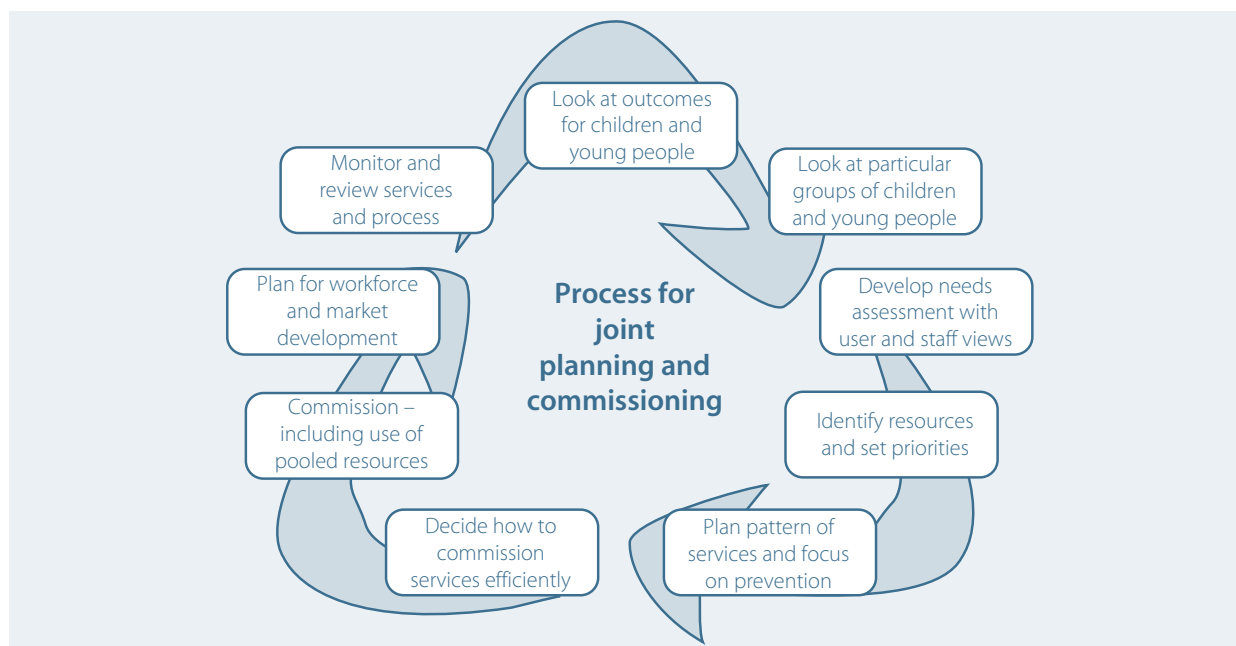
- Provision in integrated resources for pupils with SLCN as a primary need exists in all authorities, with some wanting to reduce and others to increase this provision.
- Many authorities are trying to increase the outreach role of special schools so that they spend more time supporting integrated resources and mainstream schools to increase the numbers of children and young people with SEN included in mainstream, and to help them include a wider range of needs.
- In all case study areas the trend is towards reduction in the number of pupils in special schools. An important factor in managing this change in provision towards inclusion has been use of banded funding where amount of money depends on the nature and extent of need of the individual pupil.
- Once placed in specialist provision, both integrated resources and special schools, pupils usually remain there until the next age related transition. Movement back to mainstream does not often happen.
- Many of the specialist provisions, both integrated resources and special schools, have places for both those with SLCN and those with autistic spectrum disorders (ASD). In some areas the proportion of pupils with ASD in these facilities is increasing, with fewer places for pupils with SLCN as their primary need.

25 *ibid.*

- 3.8** In the course of the Review, we have received a number of representations from around the country that local language units have faced the threat of summary closure, without a proper opportunity for parents and others to make their voices heard about such proposals. We have no detailed knowledge of individual cases and cannot therefore judge the merits of the representations made to us. However, there are established consultation procedures and these should be followed. **We therefore recommend that DCSF reminds local authorities of their statutory responsibilities and parents of their rights.**

Commissioning

- 3.9** As we set out at the start of this chapter, effective commissioning requires a joined up approach to assessing need, agreeing desired outcomes, planning appropriate provision and developing and supporting the workforce to deliver.
- 3.10** The *Every Child Matters* framework aims to help local planners and commissioners jointly design a unified system in each local area. This should create a clear picture of what children and young people need, make the best use of resources, and join up services so that partners provide better outcomes than they can merely operating on their own. To address areas of inequality all commissioners need to take a longer term view of population needs and changing requirements. The framework is designed for people working in all sectors of children, young people and maternity services, including political leaders, senior management, planners, commissioners, providers, corporate procurement, finance, legal and other support staff, and central and regional government officials. It is underpinned by the duty in the Children Act 2004 on local agencies to cooperate. This framework sits alongside the DH Joint Commissioning Framework for Health and Well-being, the ODPM Best Value Guidance 2 and World Class Commissioning. In encouraging key agencies to work strategically together to meet the needs of children and young people with SLCN and their families, the Government has provided guidance, including the framework for commissioning set out in the box below.

Figure 3: Joint planning and commissioning for children's services²⁶

- 3.11** On our visits around the country, we saw pockets of excellent practice in commissioning. However, our strong impression is that, despite Government guidance, coherent commissioning strategies for children and young people using a joint commissioning framework and consistent plans are the exception, not the rule, a judgement supported by our commissioned research of six case study areas²⁷.
- 3.12** A national evaluation²⁸ of Children's Trusts' joint planning, joint commissioning and budget pooling showed that from the sample of 35 Children's Trust Pathfinders, social care and health services were more likely to be jointly commissioned than education services with a total of 16 social care, 15 health and only 7 education services being identified. This has a significant impact on the way in which speech, language and communication services can be delivered when children's and health services commission separately, motivated by different understandings, choosing different priorities and using different processes.
- 3.13** Current examples of the joint planning and commissioning process are often limited to specific services such as child and adolescent mental health services and youth offending teams. Many frontline professionals, including teachers, SLTs and managers commented that, although in many areas there is good integrated working in direct service provision for children and young people with SLCN, joint working across children's services breaks down at the level of strategic commissioning across agencies. Where strategic inter-agency governance arrangements are not in place, and some PCTs still commission children and young people's services independently, this can result in poor integration of frontline delivery.
- 3.14** The need for, and discernible lack of, strategic planning at a local level for children and young people's speech, language and communication services has been a recurring feature of evidence

²⁶ *Joint planning and commissioning framework for children, young people and maternity services*, March 2006, HM Government.

²⁷ *ibid.*

²⁸ *National evaluation of children's trusts*, April 2006, University of East Anglia in association with the National Children's Bureau, commissioned by the Department for Education and Skills and Department of Health.

presented to the Review. In one area visited by the Review, senior health and local authority commissioners, who met each other for the first time when giving evidence, commented on the lack of formal arrangements for joint working. In particular, they noted the lack of an overall commissioning strategy, based on sound data and a needs assessment, for services for children and young people with SLCN. By contrast, in Hackney, considerable progress had been made and a range of innovations introduced to make speech, language and communication services more responsive and accessible to local families.

- 3.15** A submission to the Review on commissioning incentives by Scope, the Royal College of Speech and Language Therapists (RCSLT), Communication Matters and Afasic, supported by a wide range of other voluntary organisations, highlighted the lack of incentives to commission services for SLCN within the current system. It highlighted the relative absence of references to SLCN within key agendas and programmes such as *Every Child Matters*, Aiming High for Disabled Children and the Children’s National Service Framework. This submission, and the research commissioned for this Review, also pointed to the lack of effective use of good quality data to inform policy making and commissioning at a local level.
- 3.16** An example is in the working practices of SLT services in six case study areas. Research²⁹ found that relatively few areas are collecting data on efficacy of therapeutic interventions. It raised a further concern about how SLT services can provide data about the range of activities they carry out, and the outcomes of these activities, in a way that fits both health and education data collection and analysis requirements.
- 3.17** We do not under-estimate the challenge of commissioning services to deliver outcomes, such as improvements in the communication skills of those in universal early years and school settings or developing the confidence and self-esteem of those with severe SLCN. However, we found little evidence that services were outcomes-focused or commissioned with outcomes in mind. In some areas, activity data and other output measures, such as numbers of children and young people seen and waiting times, were used but there was little evidence that these were set with a shared understanding of what constitutes good performance.

There is insufficient clarity in relation to how commissioners can gauge the performance of the service. This is especially so in relation to the achievement in school of children with SLCN. The development of the child’s language may be more easily charted by the service than its effect on overall school achievement.’

Respondent to the consultation

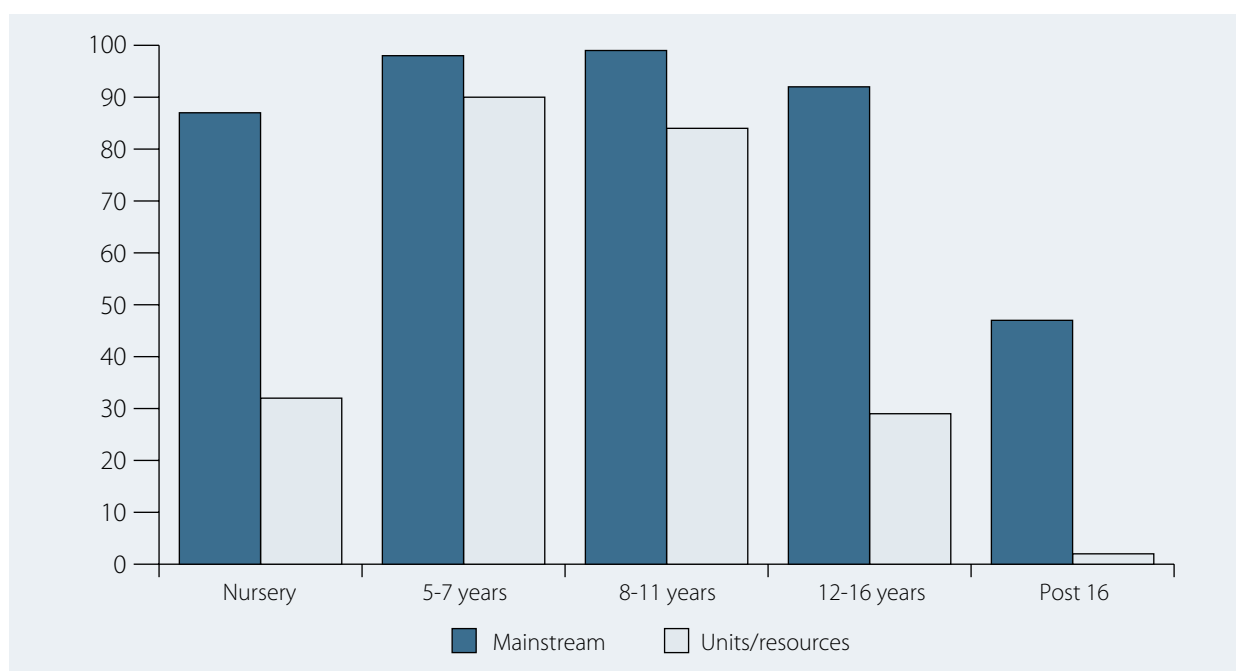
- 3.18** In consultation groups, parents reported a range of experiences of the continuum of services available to them. Some parents said that they were able to access quality support for their children relatively smoothly. Others talked about how they struggled or were still struggling to access adequate support, leading in some cases to deterioration in their child’s condition.
- 3.19** As we set out in Chapter Two, resources for SLCN provision tend to be concentrated in the early years. Effective provision for children in the early years is vital. However, there will inevitably be some children and young people who have continuing SLCN. This may be because their difficulties were not identified at an early age, or because their needs are severe, or both.

29 *ibid.*

Furthermore, some children and young people's needs will change over time: for example, earlier concern about oral language may become secondary as these abilities improve but the child continues to have major challenges developing literacy, which become the primary need. Evidence³⁰ tells us that some children and young people may manage reasonably well in primary education, but that their difficulties become more apparent when they reach the more language challenging environments of secondary school. It is vital to recognise the importance of prompt intervention when a child's SLCN is identified, whatever his or her chronological age.

3.20 Many parents reported that services tended to 'disappear' over time, especially at entry to primary school or on transfer to secondary school. Indeed, we found minimal evidence of services for young people at secondary school and beyond. Again there was little evidence that this was a decision based on a rigorous needs assessment. For example, a survey in 2005 of 200 young people in an inner city secondary school found that 75% of them had communication difficulties that hampered relationships, behaviour and learning³¹. The figure below demonstrates this trend.

Figure 4: Percentage of local authorities making specialist provision in mainstream and specialist integrated resources for children and young people with primary SLCN



30 Nippold M (2004) Research on Later Language Development: International perspectives. In R.A Berman (Ed) Language Development across Childhood and Adolescence, Amsterdam: John Benjamins Publishing Company

31 Sage, R (2005) Communicating with Students Who Have Learning and Behaviour Difficulties: A Continuing Professional Development Programme *Emotional and Behavioural Difficulties*, 10, 4, 281-297

- 3.21** In one of the case study areas examined for this Review, researchers found that at secondary level the criteria for being identified as having SLCN included that pupils came into school with an SEN record of SLCN. It was very rare that pupils would be assessed for the first time at secondary level and be categorised as having SLCN. In the case study area, a special school which made provision for children with behavioural, emotional and social difficulties (BESD) indicated that many of the problems of its pupils arose out of speech, language and communication difficulties and the school considered that the issue of distinguishing between a pupil's primary or secondary SEN was problematic.
- 3.22** Parents frequently raised continuity as an issue during consultation groups: both in terms of having contact with the same SLT and of having that contact on a regular basis. Parents described the benefits of good continuity of care, as well as the feelings of being 'deserted' or left 'in mid-air' or 'in limbo' when this did not happen.

Parents' experience of continuity of support:

'When our son was small he attended a special needs playgroup where interaction with speech and language therapy was once a month. When he moved to mainstream primary it dwindled to once a term.'

Parent

'My son had limited, but good speech and language therapy input at the Child Development Unit and his special primary school. He then moved to a mainstream secondary school. We were informed that no service was available in this setting. After a battle, some very limited support was made available. He has just moved to college and at 20 years of age we have again been told no help is available despite him having a communication aid.'

Parent

- 3.23** Parents also recognised that each child would benefit from services personalised to meet his or her needs. Whilst very many children and young people's needs are likely to be met by effective universal services, such as nurseries and schools, some children and young people will need an appropriate and personalised mix of universal, targeted and specialist services.
- 3.24** Parents asked for more specialist expertise in order to support children and young people with more complex SLCN. They identified the need for tailored packages giving the right care for every child, training for schools about the development of children and young people's speech, language and communication skills, and more SLTs developing specialisms.

Statements of Special Educational Need

- 3.25** Most parents who contributed to the online questionnaire had children with statements of SEN. Although not typical of the majority of parents of children and young people with SLCN (who do not have statements), their comments explain why so many parents regard securing a statement as essential in order to access services. Their comments also reflect the fact that most parents do not find the statementing process easy or pleasant.
- 3.26** Many parents felt that their children's statements were vague, in some cases because statements were considered to be resource led, with local authorities more concerned to manage resources

rather than to identify how best to meet the needs of the child. Some parents reported having to 'fight' to get statements that included SLT in part three of the statement and in a way that specified clearly what support would be provided. Responses suggested that, even with services specified in part three of the statement, delivery of those services was not guaranteed.

Parents' views on statements

The provision by the NHS up to when we applied for a statement was appalling. Speech and language provision was hit and miss, agencies failed to notify each other of his needs and we went for a year without adequate support. The statement has been very worthwhile. We have had excellent results since obtaining ten hours of speech and language support and the whole statement process was well handled.'

Parent

'Although his statement stated that he would get regular speech therapy, this was only once a term in school. We considered this appalling for a child with NO SPEECH AT ALL. When the speech therapist did come, she did not speak to my child at all, just left work for him in the Head's office, which unfortunately stayed there, my son saw none of it in school.'

Parent

'I was advised by the Deaf Children's Society to ask for it to be put in part 3. The local authority doesn't put it there but in part 6. For a deaf child it is a VITAL part of education needs and should be in part 3.'

Parent

3.27 This Review warmly supports the on-going Lamb Inquiry into parental confidence in the SEN assessment process and looks forward to its report and recommendations.

Responsibility for providing SLT

3.28 A recurrent theme in our Review has been the frequent tensions between local authorities and PCTs and the limited evidence of effective joint working between them. Although SLT services are the prime responsibility of the NHS, the SEN Code of Practice makes clear that where the NHS fails to provide the service, "ultimate responsibility" for securing and funding SLT for pupils with statements of SEN falls to the local authority. Local authorities regard this as unfair. Two suggested solutions are that SLT should either be viewed as medical provision, duly provided and funded by the NHS, or as an educational matter, with local authorities holding the resources with which to commission these services.

3.29 We have listened to a range of representations and concluded that neither of the changes suggested above is desirable. Although a need for SLT can be medically driven, the requirement for the service is frequently essential to meeting the educational needs of the child and this principle has been recognised in statutory guidance and case law for many years. To depart from this principle now would be wrong for three reasons: first, a case has not been made that the need is predominantly medical; secondly, a change would represent a great upheaval with no obvious benefit for children and young people; and thirdly, it would be resented and feared by parents who believe that they have acquired some hard won rights over the years which such a structural change would undermine. In short, the present framework provides certainty to

parents, with the machinery of SENDIST to which they can appeal, and this must outweigh the concerns of service providers. As for the idea of handing responsibility, power and resources to local authorities for all SLT, this would ignore the medical dimension of SLTs' work and the reality that most therapists work by choice for the NHS and not the education service.

- 3.30** In truth, speech, language and communication services necessarily involve education and health providers alike. The challenge of joint working arises precisely because they are both legitimate and necessary participants on the field of children's services. For this reason, therefore, it is sensible to focus not on single agency control, but on effective joint commissioning in the interests of children and young people. Both local authorities and Primary Care Trusts must commit to such commissioning. Both must devote resources to it. Both must work to identify outcomes and the means to deliver them.

Services provided by schools – delegated funding for SEN

- 3.31** Concern was expressed about delegated funding to schools and the fact that, as this is not ring fenced, schools are able to spend it on any number of things unrelated to SEN. The Government is committed to the policy of delegating funding to schools to provide services to meet the SEN of children and young people. It argues that passing resources directly to schools bypasses bureaucracy and allows them to address more quickly the individual needs of pupils. In short, on this argument, delegated funding spurs early intervention to the benefit of pupils who urgently need help. The counter-argument is that to delegate funds without ring fencing them runs the risk that those funds will be siphoned off, perhaps on a utilitarian motivation, to pay for the mass of pupils without SEN. The risk that funds might be diverted is compounded as delegation is not accompanied by oversight or monitoring by the local authority. As a result, there appears to be a deficit of accountability.
- 3.32** In 2006, the then Education and Skills Select Committee shared the concern about what might be called 'unconditional delegation' and recommended that the policy should not be extended until other necessary conditions and improved school expenditure had been established. Specifically, it called for a clearer national framework linked to minimum standards, a broad range of suitable provision, and a workforce able to identify and meet the needs of children and young people with SEN. In the absence of such conditions, the Committee was concerned that further delegation of funding was 'a high risk approach particularly in light of evidence from Ofsted that some delegated funding to schools is not being spent on SEN'. Delegated funding can yield benefits in practice, but there are legitimate concerns about how it is operating. How such a policy can provide local flexibility, safeguard the interests of children and young people with SLCN, including those with low incidence needs³², and be subject to proper accountability, will be a continuing challenge.

Communication Aids

- 3.33** Children and young people who require alternative or augmentative communication aids (AAC) face a particular struggle to have their needs met under the current commissioning arrangements. In 2007, the average cost of a high tech communication aid was £5,800. This cost remains prohibitively expensive for many families with disabled children who are unable

³² See annex A(ii) for case studies of provision for children and young people with 'low incidence, high needs'.

to obtain statutory funding for communication equipment. In addition to the high cost of purchasing equipment, many families had to meet the extra burdens of repair, insurance and warranty. Around 40% of respondents to the Scope Communication Aids Survey 2007 had received equipment which did not come with a warranty or guarantee and half did not have any form of insurance. Inevitably, this leaves many children and young people at risk of being without the means to communicate if their equipment breaks down or is stolen.

3.34 In 2002, the Communication Aids Project (CAP) was established by the then Department for Education and Skills. CAP provided £5 million each year for expert assessment, communication equipment and training for *school-aged* children and young people as a complement to local provision. Equipment was provided to more than 4,100 children and young people whose needs had not been met locally. The CAP project closed in 2005-06. While CAP provided ring-fenced funding over the lifetime of the project, it was always designed as a short-term programme. It did not address, or even purport to address, the need for a sustainable model or commissioning incentives to deliver AAC on a universal basis.

3.35 The ending of the CAP funding highlighted the problems associated with devolving responsibility for funding high-cost equipment for low incidence groups to local authorities and PCTs. The low incidence of people of all ages with complex SLCN and the high-cost of providing expert assessment, costly equipment and on-going support, means that local agencies often do not prioritise the needs of this group of disabled people.

3.36 Unfortunately, although some authorities enhanced provision on the basis of the impetus provided by CAP, many local authorities did not take this opportunity to create a viable local or regional model of provision. Consequently, the infrastructure was not in place when CAP closed and little capacity was built up locally. Invaluable expertise, partnerships and infrastructure were developed during CAP and those children and young people who have received equipment through it have had their expectations and life chances significantly increased. Sadly, withdrawing CAP funding and not replacing it with a broader all age initiative undermined the very positive achievements that the project had made.

Young Offenders

3.37 An example of the potential impact of SLCN is represented by the 7,000 children and young people aged under eighteen passing through young offender institutions (YOI) each year, of whom at least 60% are estimated³³ to have difficulties with speech, language and communication that are sufficient to affect their ability to communicate with staff on a day-to-day basis, to prevent them from benefiting from verbally mediated interventions such as education and offender behaviour work and, if not addressed, to contribute to re-offending³⁴. The former HM Chief Inspector of Prisons, Lord Ramsbotham, has observed that:

*'In all the years I have been looking at prisons and the treatment of offenders, I have never found anything so capable of doing so much for so many people at so little cost as the work that speech and language therapists carry out.'*³⁵

33 Bryan, *Speech and language therapy for young people in prison* (2004) submitted to HM Prison Service and Helen Hamlyn Trust as quoted in Hansard HC Deb 13 December 2007, column 915W

34 Ward and Stewart (2003), *Psychology, Crime and Law*

35 Hansard HL Deb 27 October 2006 vol. 685, column 1447

- 3.38** Current figures estimate that 210,000 children and young people pass through the Criminal Justice System each year³⁶, who may benefit from preventative approaches which ensure early identification and support for children who are recognised as vulnerable or at risk of offending.
- 3.39** Research³⁷ has been cited which found that offenders gaining oral communication skills qualifications were 50% less likely to re-offend in the year after release than the national average. Vulnerable young people with communication problems may be unable to express themselves effectively, resulting in disruptive and aggressive behaviour. Although a two year trial was undertaken in two YOIs until 2005, earning praise from the Prison Health Service and Government alike, its results have yet to be translated into wider policy. The Government's position is that speech and language provision is already available in the young offender estate because when a problem is identified, a referral is made and therapy can then be provided³⁸. Unfortunately, the Review's strong impression is that, in most cases, a young offender's problem is not identified, a referral is not made and SLT is not provided.
- 3.40** In December 2005, the then Department for Education and Skills published a document entitled *Reducing Re-offending Through Skills and Employment* which made no reference to the importance of speech, language and communication skills in equipping young offenders with the tools to lead law abiding and fulfilling lives.

Workforce

Who makes up the workforce?

In recognising that communication is a fundamental life skill and the bedrock for children and young people's learning and social and emotional well being, it is essential that the right workforce with the right competencies is available to enhance children and young people's communication skills. For all children and young people, this includes:

- early years practitioners – child minders, playgroup workers, crèche workers, nursery nurses and Children's Centre staff;
- school staff – including teachers, special educational needs coordinators (SENCOs) and classroom assistants; and
- health professionals – such as health visitors, GPs, school health advisors; and
- other specialist staff who have regular contact with children and young people as part of universal services.

The majority of children and young people will access universal services only. Children and young people with SLCN may themselves also benefit from such services. However, they will also require targeted or specialist provision. Input for this provision will come from a range of specialists, including SLTs, specialist teachers, SENCOs, educational psychologists, occupational therapists and paediatricians.

36 Figure provided by the Ministry of Justice

37 Moseley et al, *The impact of ESB oral communication courses in HM Prisons – an independent evaluation in Developing oral communication and productive thinking skills in HM Prisons* (2006), Learning and Skills Research Centre

38 Hansard HL Deb 27 October 2006 vol. 685, column 1457

- 3.41** On our visits around the country we met many skilled, committed professionals working with children and young people with SLCN. Many parents also reported that the professionals who worked directly with them had been invaluable in supporting them and their child and helping them navigate the system. However, almost a third of respondents to our consultation felt that there was a shortage of SLTs, which meant there was limited access to these staff. Many parents also reported that they encountered professionals who didn't understand SLCN or have the time, training or resource to meet their child's needs. This slowed down the process of identification and hindered them from accessing support quickly. Some parents lamented the lack of time spent with them by professionals in supporting their understanding of the implications of an identification or diagnosis of SLCN and in helping them to address its emotional impact.

Families' experience of the workforce:

'Our speech and language therapist has been excellent in offering help in times of difficulties.'

Parent respondent to consultation

'Teachers do not have enough expertise to recognise needs, particularly when related to receptive language and therefore understanding. The pressure of the National Curriculum does not encourage or allow them to spend time trying to unpick why a particular child may be struggling with learning.'

Parent respondent to consultation

'Most depressing aspect is that your child is treated as a 'case' or 'object of analysis' and you need to hang on to the concept that this is a family member/trainee adult you are nurturing. Everything is focused on the speech issues, rather than the 'whole child' or even 'whole family' aspect.'

Parent respondent to the consultation

- 3.42** Although SLTs are moving towards a more consultative way of working through others in the children's workforce, we saw little evidence of areas systematically considering the skills which these people would need or how they would acquire them. Respondents to our consultation continually returned to the issue of training for the *whole* of the children's workforce, including health and education professionals in the full range of settings and services, as a key component of any attempt to improve families' experiences. Almost half of respondents thought that, in their local area, the expertise of school staff and others in the children's workforce to identify and deal with children and young people's SLCN was in need of significant improvement. Half thought that access to speech and language training for the same group was also in need of significant improvement.
- 3.43** During visits, professionals and service leaders raised three key barriers to increasing the SLCN skills of the workforce: resources to pay for training; difficulty in releasing staff from work to attend courses; and limited availability of high-quality, accessible training of this kind. The research in six case study areas showed that most were providing some training for staff working with children and young people with SLCN as a primary need. Some was on the job training through joint working with a SLT and an experienced teacher, some was through short training courses provided by SLTs. Some local authorities had financed training for specific packages or had negotiated tailor made packages delivered jointly by staff from a local university, SLTs

and EPs. Once in post, however, there is little opportunity for secondments to study for longer courses. Any teachers registered for higher degrees were studying part-time, and paying fees themselves.

Case study: Impact of workforce training

[Local area]³⁹ has offered specific SLCN training for workers in pre-school and nursery settings in the authority since 2004, and in 2007 an independent evaluation of this intervention was undertaken. The consequent report examined numbers trained and the cost, and the monitoring of the long term impact of the training: 371 early years practitioners from around half the early years settings in the authority were trained during the time covered by the report. The major outcome seems to be an increase in the early identification of children going into reception classes. It is hoped that this will lead to a decrease in referrals of children of school age, and monitoring is continuing to see if this is the case.

- 3.44** As well as formal training sessions, collaborative working was seen as leading to skill sharing and professional development of staff. Managers in all areas talked of their desire to improve training and continuous professional development (CDP) across the workforce but they also highlighted problems and challenges.

Challenges in developing the whole children’s workforce to meet the needs of children and young people with SLCN

‘We want to move from fire-fighting all the time, dealing with individual referrals of failing pupils, to deliver a preventative service by improving the skills of teachers and teaching assistants in mainstream to work productively with a greater range of language development needs.’

SEN manager

‘Training and SLTs working through those caring for the child is not seen as important. Enhancing support to help the child function in a school environment by training and supporting teachers and others is not well received.’

SLT manager

‘We are looking at the heroic quest of getting equity of provision across the authority. Some clusters feel they are doing brilliantly, but it goes from basic awareness to high levels of provision. A big issue is training overload – so many initiatives being pushed into schools and it is impossible to react to each one.’

SEN manager

- 3.45** Research⁴⁰ further found that although both SLTs and EPs are trained in research skills as part of their professional training courses, there were few examples of research projects helping to develop evidence based practice, or to evaluate interventions and provision for children and young people with SLCN. This is a significant wasted opportunity. Parents also raised concerns

³⁹ Case studies and research commissioned by the Review were undertaken on the basis of anonymity and locations are therefore not identified.

⁴⁰ *ibid.*

about the accessibility of 'specialist' SLTs and the opportunities available for new SLTs to gain specialist knowledge and skills.

'My son used to receive speech therapy from an experienced therapist who worked with children with learning difficulties. After restructuring his therapist was an inexperienced general therapist who was out of her depth. My son needs more specialist provision than this.'

Parent respondent to the consultation

- 3.46** The RCSLT considers that the development of clinical expertise is essential in order to ensure that clinical practice is developed and delivered on the basis of evidence of efficacy. Specialist SLTs are responsible for the appropriate clinical support, education and training to more junior SLTs, as well as to the wider children's workforce, including in schools. These clinical leaders also provide the 'back up expertise' which, amongst other roles, enables them to be directly involved in complex cases. It is essential to maintain specialist SLTs in the workforce skills mix in order to ensure long term sustainability of wider workforce development.
- 3.47** Other specialist professionals are also a vital resource to train colleagues and deliver collaborative working to improve outcomes for children and young people. For example, staff working in special schools will have specialist expertise that could be very usefully shared in their local area to support colleagues working with children and young people with SLCN in other settings.
- 3.48** In recognition of the fact that language skills need to be supported and developed with and through the full range of people interacting with the child, the 'team around the child' was cited consistently by professionals and families as an effective way to bring together the individuals and expertise required to meet a child's needs. Importantly, parents saw themselves as members of the team and welcomed the increasing recognition from professionals of their vital role.
- 3.49** On visits, it was evident that there were significant variations in the combination of expertise in multidisciplinary teams and, therefore, in the subsequent model of service delivery. In addition to SLTs, the range of professionals in teams included specialist teachers, EPs, paediatricians, occupational therapists and, for some children and young people, clinical psychologists, child and adolescent psychiatrists or other child and adolescent mental health services (CAMHS) staff, portage teams, physiotherapists and arts and music therapists.

How to design a continuum of services around the family

- 3.50** As we set out earlier in this chapter, Government policy and guidance, including the *Every Child Matters* framework, already encourages strategic commissioning and workforce planning. However, the evidence set out above suggests that, for children and young people with SLCN at least, this is not consistently happening to meet their needs. There are examples of more recent programmes and initiatives, the effects of which are yet to be seen, intended to address these issues across children's services.
- 3.51** The DH's World Class Commissioning programme is intended to transform the way in which local areas commission services. Its purpose is to place an increased emphasis on commissioning for outcomes, on clear information about the competencies which World Class Commissioners will need, and on more support for commissioners to access the tools which they require to

drive improvements. This will be done either by sharing services and good practice, developing internal resources, or buying in external expertise.

- 3.52** The Children’s Workforce Development Council (CWDC) was set up in 2005 to support the implementation of *Every Child Matters*. In partnership with other workforce organisations forming the Children’s Workforce Network, it is currently developing the Integrated Qualifications Framework (IQF)⁴¹. This will be a set of approved qualifications allowing progression, CPD and mobility across the children and young people’s workforce.
- 3.53** To deliver a full continuum of services, consideration of how to meet the needs of children and young people with SLCN must be mainstreamed into all relevant Government policy. For example, in DCSF’s strategy for young people not in employment, education or training⁴² (NEET), there is clear opportunity to address SLCN as part of the ‘personalised support and guidance’ offered to young people to overcome barriers to entering education or employment.
- 3.54** In recognition of the fact that some children and young people with SLCN are disabled, Government policies relating to disabled children and young people must take full account of their needs. Aiming High for Disabled Children⁴³ (AHDC) is the Government’s transformation programme for services for disabled children, young people and their families. The programme sets out in its ‘core offer’ a national expectation of how services will be delivered locally. The programme pays particular attention to short breaks for families with disabled children and young people, establishes pilots for improving accessibility of childcare, backs improved support at key transitions and encourages better use of data, as well as introducing the first national indicator to measure parental experience of services for disabled children and young people. The needs of disabled children and young people with SLCN, including those with severe, complex and persistent needs associated with SLI, should be emphasised throughout the relevant aspects of this programme.

Commissioning

- 3.55** In addition to those initiatives set out above, the joint DH and DCSF Child Health Strategy should consider how commissioning for children’s health services can be more closely aligned between different local bodies which are commissioning services. However, commissioners told us that they would welcome help to navigate the complex process of commissioning for children and young people with SLCN and their families.
- 3.56** **We recommend that, as part of the work on *World Class Commissioning*, the Government produces a joint framework for commissioners, including Children’s Trusts and schools, on the commissioning of a continuum of universal, targeted and specialist services for children and young people with SLCN across the age range 0-19.**
- 3.57** The framework should:
- set out the benefits of better commissioning of provision for children and young people with SLCN;

41 www.cwdcouncil.org.uk/iqf

42 www.dcsf.gov.uk/14-19/documents/neet_strategy_0803.pdf

43 www.ecm.gov.uk/ahdc

- include a checklist that will help commissioners design, plan and implement their local commissioning for SLCN;
- propose an audit tool to help commissioners assess the range of needs to be met by universal, targeted and specialist services in their area;
- give examples of the outcomes for children and young people that services should deliver, showing the inputs, including investment, needed to achieve outcomes. In time, key case studies should be added from a growing evidence base; and
- examples provided of evidenced interventions both in terms of efficacy and of cost effectiveness.

3.58 The framework should acknowledge that schools are increasingly fulfilling the role of commissioners in this area and provide guidance to them in doing so. It should sign-post schools to relevant support and guidance, including the Audit Commission and National Strategies' *SEN Value for Money Resource Pack for Schools*⁴⁴.

3.59 In addition to that set out above, we recommend that the framework should take full account of the need to commission services for particular groups within the SLCN population:

- children and young people with 'low incidence-high need' conditions;
- older children and young people, including those of secondary school age, those in post-16 settings; and
- children and young people in contact with (or at risk of coming into contact with) the Youth Justice System.

3.60 It should further highlight to commissioners the needs of children and young people with SLI. While we are not seeking to elevate one condition over another, it is important to recognise that children and young people with SLI frequently go undetected because their disability is often hidden and they are at risk of misdiagnosis, for example as having behavioural, emotional and social difficulties.

3.61 The framework should emphasise the value of providing information, advice and support to families and involving them in the design and delivery of services. It should include sign-posts to the support materials on how to implement locally the Aiming High for Disabled Children 'core offer', launched in May 2008⁴⁵.

3.62 **We recommend that the commissioning framework is developed through a programme of pathfinders, funded and supported by both Departments, to identify best practice and evidence of effective interventions for children and young people with different types of SLCN and to show how joint working and commissioning works well in a range of local areas.** Following a thorough needs assessment in their area and strategic planning of services, pathfinders, should set out for other local areas what an evidence based core offer of provision across universal, targeted and specialist services from 0-19 should look like.

44 sen-aen.audit-commission.gov.uk

45 www.ecm.gov.uk/ahdc/coreoffer

- 3.63** A number of pilots on the commissioning of services for children and young people with SLCN have been completed in Wales and their evaluation is in progress. In planning and implementing pathfinders, national and local Government should learn from their experience.
- 3.64** To support commissioners and to embed further incentives to commission services for children and young people with SLCN **we recommend that DH creates a speech, language and communication annex to Standard 8 of the Children’s National Service Framework: Disabled Children and Young People and those with Complex Health Needs.** This annex should be supported by a set of exemplars and care pathways.
- 3.65** We recognise that the commissioning challenge is increasingly complex, not least because the increased delegation of funding to schools has caused them, in ever greater numbers, to become commissioners in their own right. **We recommend that the current DCSF review of the Dedicated Schools Grant should take account of how the school funding system supports the delivery of universal, targeted and specialist services for children and young people with SEN.**

Workforce development

- 3.66** To ensure strategic commissioning is successfully supported by the workforce, **we further recommend that the commissioning framework includes advice on:**
- **how to assess the range of skills in local children’s workforces;**
 - **how to identify the right skills and capacity mix required in the children and young people’s workforce to deliver services and agreed outcomes, including staff with specialist skills able to assess effectively and support children and young people with SLCN;**
 - **how to develop the workforce by identifying and addressing skills or capacity ‘gaps’; and**
 - **how to develop effective collaborative practice between different services and members of the workforce.**
- 3.67** This advice should be tailored to be relevant to situations in which the commissioner and the provider are the same agency, and to those in which they are not. It should include guidance on funding CPD, supporting SLTs to develop specialisms and increasing the number of teachers, specialist teachers, learning support assistants, youth workers, EPs and other professionals with specialist skills relevant to SLCN.
- 3.68** To address families’ concerns about the understanding and experience of SLCN among the children’s workforce, it is important to examine the initial training and CPD available to this workforce. Core training would be enhanced by appropriate bespoke specialist training. This would ensure that professionals have the skills to support a personalised programme of support for individual children and young people with SLCN. This can then be monitored through the Common Assessment Framework. This training needs to equip the workforce to meet the needs of children and young people at different ages and stages to support a continuum of service delivery.

- 3.69** To support further the workforce to deliver **we recommend professionals from across the children's and young people's workforce undertake pre-qualification training in collaborative and multidisciplinary working, alongside professionals from other backgrounds.**
- 3.70** **We recommend that the CWDC, in collaboration with the Children's Workforce Network, ensures that speech, language and communication and SLCN are a core requirement or unit at the appropriate level in all qualifications for the children and young people's workforce (0-19)⁴⁶ as part of the emerging Integrated Qualifications Framework.**
- 3.71** We welcome the new specialist SEN units in initial teacher training. **We further recommend that the standards for Qualified Teacher Status ensure that students develop a better understanding of children and young people's SLCN and of how to address those needs.**
- 3.72** In March 2008, the Secretary of State for Children, Schools and Families announced the new Masters in Teaching and Learning, a qualification which it is intended, over time, will be open to all teachers. **We recommend that DCSF includes speech, language and communication, both as a core requirement and as an elective module, in the new Masters in Teaching and Learning.**
- 3.73** The first round of the Inclusion Development Programme (IDP) has focussed on SLCN, alongside dyslexia. **We recommend that the Government ensures that good quality training, such as that provided through the IDP, is available to everyone in the children's workforce, including health and education professionals, to develop their skills in relation to speech, language and communication. This should include training for staff wishing to specialise in working with children and young people with more severe and complex SLCN. In ensuring that training is available, the Government should consider how it should best be provided, including consideration of whether training should be an entitlement and the circumstances in which it would be appropriate to fund the 'backfilling' of posts in order to enable staff to undertake training.**
- 3.74** Some organisations have argued that there should be a clear national specification for the level of SLT services to be funded by each PCT. Whilst this may not be feasible, there is a case for providing more information on the resources required to meet needs. **We therefore recommend that the Government, working with other partners, undertakes a national modelling exercise to help Strategic Health Authorities and PCTs in partnership with their local authorities, to estimate the workforce that they will require to deliver appropriate services for children and young people with SLCN.** This will be based on a comprehensive needs assessment. It will look at skill mix issues and identify the number of SLTs, specialist teachers and others required to deliver the agenda nationally. This should also include the wider children and young people's workforce. Consideration should also be given to how SLTs and other professionals work to ensure the most effective collaboration to improve outcomes for children and young people with SLCN.
- 3.75** The Government's Child Health Strategy, due in the autumn of 2008, should address the requirement for a continuum of services to meet the needs of the full range of children and young people with SLCN at every age and stage. It should particularly take account of the needs

46 www.cwdcouncil.org.uk/iqf

of children and young people with SLCN in its approach to commissioning and workforce development to promote child health. In developing its strategy, the Government should take account of the evidence presented by this Review both in this report and in our interim report.

Strengthening the evidence base

3.76 In this report we have highlighted the importance of designing and planning provision around a clear set of outcomes for children and young people. It is also important that provision is based on sound evidence of what works. We have highlighted the need for a stronger evidence base and the challenges of gathering evidence in this area.

3.77 We recommend that the Government considers a programme of research to enhance the evidence base and inform delivery of better outcomes for children and young people with SLCN. The main focus should be a study of interventions, including examination of the following key issues:

- locational (eg special school, integrated resource, mainstream, clinic or hospital);
- pedagogic (eg specific programmes for specific needs);
- organisational (eg nature and deployment of support services, use of data informed developments);
- models of intervention and delivery (eg use of consultancy model v direct teaching/therapy); and
- cost effectiveness and efficiency of different interventions and models of collaboration.

3.78 There is a benefit in developing a research agenda that utilises the combined expertise of practitioners such as EPs and SLTs in collaboration with researchers, many of whom will also be qualified as practitioners.

3.79 Research also needs to deliver an examination of the range of working practices in integrated/inclusive resources for children and young people with SCLN. This is a prerequisite for the development of advice about good practice and relevant training in this field.

Communication Aids

3.80 The CAP Project was popular and reflected many aspects of good practice. For example, equipment was personal to the child and went with him or her on changing school or moving to another area. Its demise has left a gap. It needs to be replaced if vulnerable children and young people for whom the ability to communicate should be a fundamental human right are not to continue to be denied the support which they require. Simply to leave the matter exclusively to the discretion of local commissioners is not a credible option. That is the status quo and it is failing. We have learned the damaging effects of such an approach both from written submissions to the Review and from visits made around the country. Various models have been proposed to address the weakness of current arrangements and to secure access to AAC services for those who need them. One approach canvassed with us is a 'hub and spoke' model of regional provision.

3.81 Longer term sustainable funding needs to be established for the provision of equipment which is a life need for the children and young people who use it. It is recommended that appropriate

commissioning, guidance and inspection arrangements should be in place by April 2010 with funding streams identified and mandated across Government, including DH and DCSF. These funds need to be managed by a national organisation responsible for purchasing (probably via the DH National Commissioning Body), monitoring and measuring the supply of equipment and effective services. These funds will cover provision of:

- Equipment – including devices, access solutions, software, mounting, insurance, warranties and other integrated electronic assistive technologies for independent living, self care and quality of life;
- regional loan banks of assessment equipment in each regional centre; and
- replacement equipment in case of breakdown.

3.82 In the short term, until sustainable funding is agreed, it is imperative urgently to establish dedicated funding with an immediate injection of capital for purchasing, monitoring and measuring the supply of equipment and services.

3.83 It is also important that the regional centres are stabilised as the current financial situation makes their future unclear. An immediate short term injection of revenue is needed to avoid the imminent closure of both the Ace Centres (DCSF) and to support the on-going services of NHS centres (DH) to avoid the loss of highly experienced practitioners. This will mean that all regional centres will be expected to develop and support local services whilst a sustainable long term solution is established.

3.84 We recommend that the Government develops a ‘hub and spoke’ model of regional provision, coordinated by a national organisation to meet the needs of children and young people who use AAC. The national organisation should establish and oversee the delivery of standards for AAC services in regional centres, which will in turn be required to support developing AAC expertise in all areas in England. In the long term, sustainable funding for this model should come through a budget pooling arrangement between education, health and social services.

3.85 Moreover, we recommend that on appointment the Communication Champion should immediately evaluate the effectiveness of local areas’ AAC provision, and report findings to the Communication Council.

Young Offenders

3.86 We recommend that the Government’s forthcoming Youth Crime Action Plan, and the strategy for the health needs of children and young people subject to the Criminal Justice System due in late 2008, should consider how best to address the SLCN of young people in the criminal justice system, including those in custody.

3.87 The Government’s Child Health Strategy, due to be published in the Autumn, and implementation of the recommendations in Lord Darzi’s final report of the NHS Next Stage Review provide a great opportunity to consider the issues raised by this Review in a broader context. We suggest that both should examine the evidence we have gathered and the recommendations we have made and take account of the needs of children and young people with SLCN.

Chapter Four: Joint working is critical

The issue

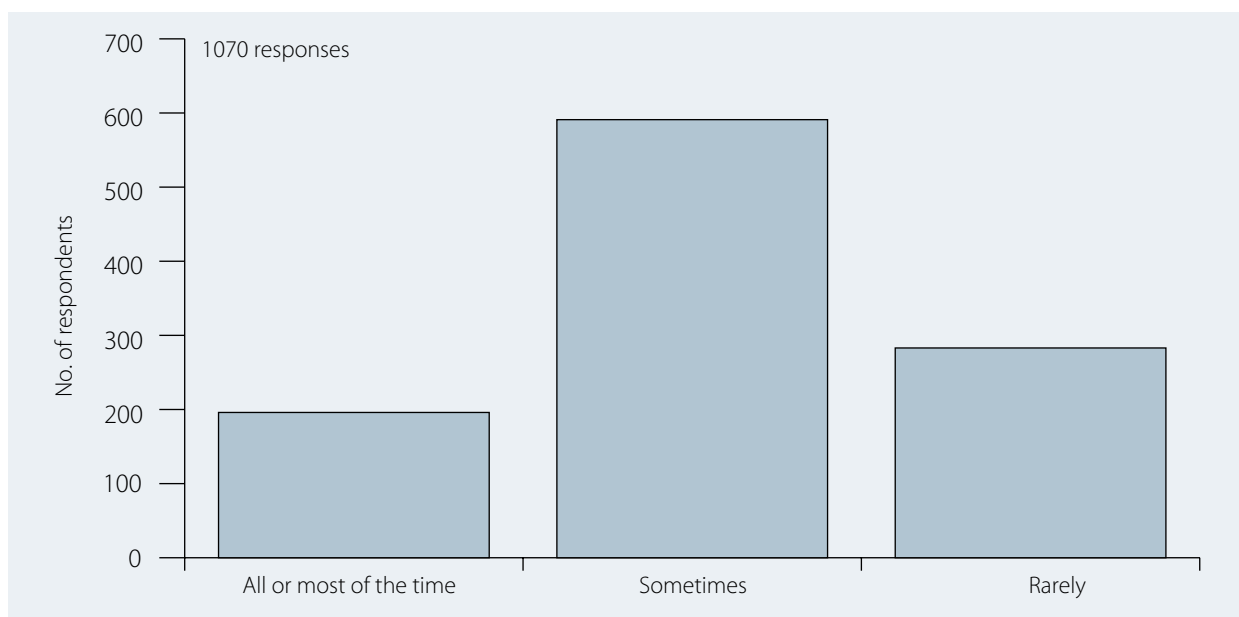
4.1 In planning, commissioning and delivering universal, targeted and specialist provision, it is critical that health services and children’s services, including schools, work together in support of children and young people with SLCN. No single agency can deliver any one of the five *Every Child Matters* outcomes for children and young people by working in isolation. Operating in separate silos produces misunderstandings, causes divisions and can be bewildering or infuriating to parents.

What we found

4.2 Parents expressed concern about the lack of clarity over the respective responsibilities of health and education services. Parents often felt that they and their child were ‘caught in the crossfire’ between the two. Families wanted to see effective joint working both between services and between professionals and families.

4.3 However, the impression we gained from our visits around the country was that coherent strategies for children and young people using a joint commissioning framework, shared goals and integrated service delivery were rare. Responses to the call for evidence reinforced this view.

Figure 5: Do health and education services work together?



4.4 Research commissioned for the review found in six cases study areas that structures and processes to facilitate cooperation across PCT and local authority services were at an early stage of development; cooperation and joint working between SLT services and education range from complete integration of services in one to minimal contact in another; cooperation in all local

authorities seemed to be at its best in early years provision with close working relationships between different professional groups⁴⁷.

- 4.5** Many frontline professionals, including early years staff, teachers and SLTs, commented that, although in many areas there is good integrated working in direct service provision for children and young people with SLCN, joint working across children's services breaks down at the strategic level. Where strategic inter-agency governance arrangements are not in place, and with some local authorities and PCTs still commissioning services independently, poor integration of frontline delivery is usually evident.

'At ground level, practitioners do their best to work together within the resources they have available and manage to provide a service to children. However, at a strategic level, the two services do not communicate well and there are significant barriers to service provision.'

Children's Centre professional

- 4.6** In addition, with the advent of extended schools and the increasing devolution of SEN budgets, schools now have a much more important role to play in service provision. In turn, the need for them to work closely with local authorities and PCTs becomes all the more vital. Where joint working between all the partners is not effective, it is children, young people and their families who suffer.

'Trying to get the support she needs from a speech and language therapist and teacher of the deaf within her schooling to help her communicate is proving difficult and traumatic for my sister and her children. We have a catalogue of examples that show the way in which health and education departments do not work together.'

Aunt of a child with SLCN

- 4.7** The current situation is not satisfactory for parents. They sensed a lack of leadership from local authorities and the NHS. There was consensus amongst the submissions made to the Review, and mirrored in the evidence gathered from visits and consultation groups, that strategic leadership at local level needs to be clearer and more unified than at present. What was lacking was a joint vision of the roles of strategic leaders across all children's services in order to provide services that are equitable, efficient and effective.
- 4.8** During several of our visits to local areas, professionals indicated that strengthening and formalising local joint strategic leadership through Children's Trusts would result in more effective integrated working across health, social care and education services at the level of the individual child. In response to a question on strategic leadership, 30% of respondents to the call for evidence questionnaire considered that steps were being taken to integrate services and to promote joint working between health and education. However, it was acknowledged that, in most instances, this was in its early stages and that much more work was required.

⁴⁷ *ibid.*

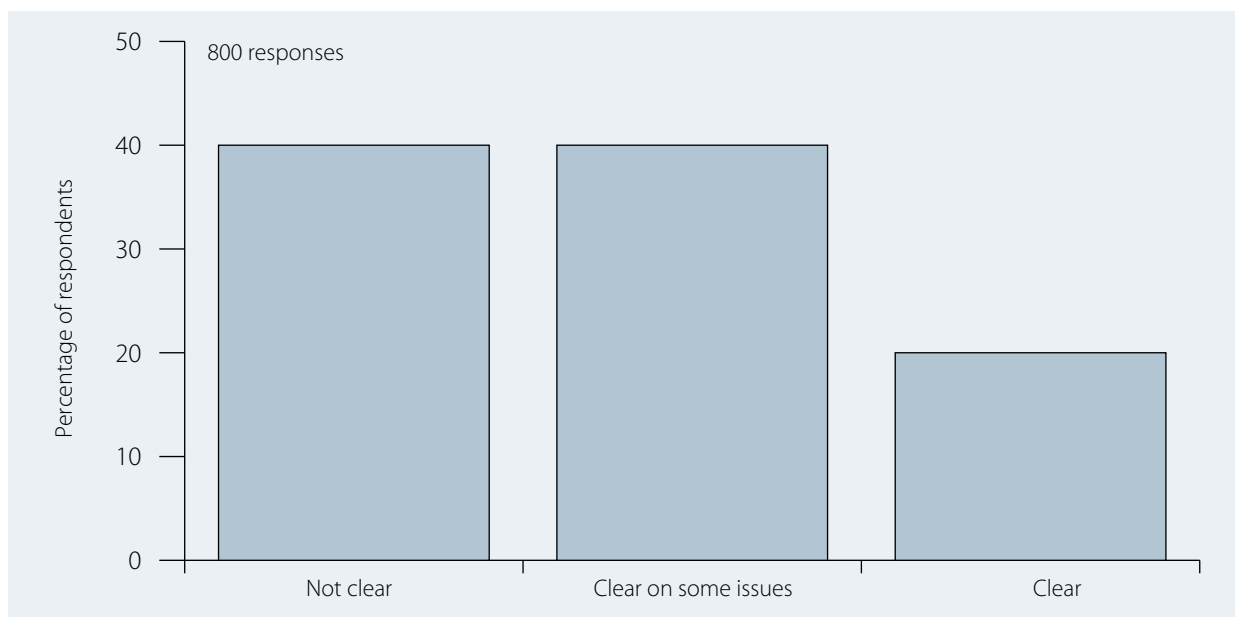
- 4.9** Strategic local authority and PCT leaders whom we met on visits confirmed that they considered speech, language and communication to be an important issue. The strategic measures that these leaders were taking to promote speech, language and communication and to address needs were not always evident, but we did find pockets of good practice, including through the research we commissioned for the Review⁴⁸.

Case study: inner London borough

Since 2005, the borough has had a completely integrated SLT service across health and education for the 0-19 age group. This integrated service is funded by the PCT, the local authority and by schools buying in additional SLT time from their own budgets. The time allocated to universal, targeted and specialist work is transparent. Time is allocated to mainstream and special schools based on age phase (Children's Centres, nurseries, primary and secondary), size of school, size of caseload, and complexity of need. The borough's Children and Young People's Plan demonstrates the role which the integrated service has in contributing to the *Every Child Matters* outcomes for local children and young people.

- 4.10** In many areas we visited, however, we found that frontline professionals did not always feel that sufficient priority was given to addressing the needs of children and young people with SLCN. In turn, the low priority did not promote effective joint working but served to prevent it. It was rare to find local authority and PCT services with shared objectives; for example, only a very small number of local Children and Young People's Plans (CYPP) made any reference to improving outcomes for children and young people with SLCN. We did not see any CYPPs that set meaningful objectives or targets in relation to these children and young people.
- 4.11** In addition, there was a concern expressed that there were few incentives for strategic leaders to work jointly to address SLCN, not least because it appeared difficult to hold them to account for improving children and young people's outcomes. Often the allocation of responsibilities and lines of accountability were not clear, joint strategic objectives were not set and performance was not monitored. Responses to the call for evidence questionnaire showed:

48 *ibid.*

Figure 6: In my area, lines of accountability in all services are:

- 4.12** Commissioners reported as a challenge identifying who the relevant commissioners to engage with in their areas were. In many cases, local authorities and PCTs have different geographical boundaries. They also have different arrangements for identifying the population for which they are responsible. For example, a local authority will be responsible for a looked after child placed at a school in a different authority, while the PCT responsible will be determined through that child's GP, which may be in that child's school or home authority. In addition, an increase in the budget delegated directly to schools has led to increasing numbers of head teachers also acting as commissioners.
- 4.13** Lack of clarity about the level of resources that are in health and education budgets for provision for children and young people with SLCN was reported as a further difficulty in joint working arrangements. The Association of Directors of Children's Services (ADCS) raised in their submission to the Review's call for evidence that some local authorities have historically been concerned about committing their own resources to SLT services as this may facilitate cuts in NHS support for SLT in schools.
- 4.14** The ADCS submission further raised the issue of responsibility for providing SLT as a sticking point in joint working, which we have considered in Chapter Three. Whilst historically SLT has been within the health service, case law⁴⁹ has established that the local authority has ultimate responsibility for securing the provision of therapy in the case of children and young people where SLT is specified in Part Three of their statement. Local authorities believe that having to use their budgets to provide services which they regard as the prime responsibility of PCTs is the cause of disputes. Families can then become caught up in arguments about who is responsible.
- 4.15** For both SLT and other speech, language and communication services, the Review found little evidence of mechanisms by which local leaders could be held to account. Generally, performance management appeared weak with, for example, little or no mention of performance measures for SLCN in Local Area Agreements.

49 www.ipsea.org.uk/caselaw.htm#LancashireJudgement

4.16 It is apparent that local strategic leaders must work more closely in order to improve services and outcomes for children and young people with SLCN in their area. The challenge is for local authority and health service senior managers to work in collaboration through Children's Trusts. It is by such an approach that they will create the best conditions in which joint universal, targeted and specialist services can provide support to children and young people with SLCN and their families.

How to promote more and better joint working

4.17 The Government's *Every Child Matters* programme has placed a strong emphasis on improving outcomes for children and young people through better joint working between services, including sharing objectives, pooling budgets and developing integrated service delivery.

4.18 In particular, the Government has taken steps to promote and support joint working at both strategic and operational levels through the concept of Children's Trusts and joint training opportunities through the Joint Professional Development Framework.

4.19 Children's Trusts, underpinned by the Children Act 2004 duty to cooperate, bring together all services for children and young people in an area in order to focus on improving outcomes. The vision is for professionals to work in effective multi-disciplinary teams, to be trained jointly and to be co-located, often in extended schools or Children's Centres. Joint working is supported by integrated processes, such as the Common Assessment Framework.

4.20 Whilst integrated delivery can be fostered in many ways, and at many levels, making sure the system overall is meeting the right needs for the right children and young people requires effective strategies led jointly by senior managers.

4.21 However, we found that although Children's Trusts should bring many benefits for children and young people, in practice they did not appear to be having any significant impact on provision and outcomes for children and young people with SLCN.

4.22 It is clear, therefore, that senior leaders working through Children's Trust arrangements do not usually afford speech, language and communication the priority which it deserves. This is presumably because they are not sufficiently aware of its importance for all children and young people in their area and they do not appreciate fully the unwelcome consequences of failing to support those children and young people with SLCN. In addition to prioritisation, there is a practical problem arising from the different approaches of health commissioners compared with those of education services, including schools. The former are working to a payment by results system that tags each individual by a diagnosis. This approach is at odds with the long-standing approach in education, namely to avoid the need for and use of diagnoses but to focus on needs.

4.23 In order to address this issue, **we recommend that each Children's Trust appoints an appropriate senior member of its governing board to lead on speech, language and communication in the local area. This leadership role should include overseeing a drive to improve outcomes.**

4.24 The speech, language and communication lead, taking advice from suitably qualified and experienced experts, should oversee work with partners, including commissioners, providers of services and the voluntary, community and private sectors, to ensure:

- that a proper joint assessment of children and young people's SLCN is carried out;
- that there are shared decisions on priorities;
- that all available resources are identified; and
- that joint plans to deploy resources are drawn up and agreed.

- 4.25** In addition, the speech, language and communication lead should oversee a joint reflection on progress, including joint scrutiny of feedback from children, young people and parents in the local area.
- 4.26** The process to draw up the commissioning framework and to establish the pathfinders recommended in Chapter Three of this report should be used to develop the role of the speech, language and communication lead further, with a view to disseminating guidance on and examples of effective practice to all Children's Trusts.
- 4.27** During this Review, local commissioners identified two challenges to effective joint working:
- confusion over which PCT is responsible for commissioning in cases, for example, where a child might live in one area, go to school in another and have a GP in a third; and
 - a lack of clarity over respective responsibilities of local authorities and PCTs for commissioning and funding of services.
- 4.28** Such uncertainties apply not just to provision for children and young people with SLCN, but across the range of children's services and these challenges should be addressed through the forthcoming Child Health Strategy. To avoid confusion in joint commissioning of provision for children and young people with SLCN, the commissioning framework should make clear who the responsible commissioner is in complex cases. Where a lack of clarity about the responsible commissioner is identified, **we recommend that the Government considers amending regulations and associated guidance.**
- 4.29** In addition, the new NHS Standard Contracts for Mental Health and Learning Disabilities and for Community Services should be drawn up in local areas in close consultation with children's services.
- 4.30** As discussed above, the evidence presented to the Review demonstrated that there is little by way of performance monitoring at a strategic level in local areas and this makes holding leaders to account all the more difficult. However, a move to more effective commissioning arrangements should bring about significant improvements as continuous monitoring and management of performance are integral to success.
- 4.31** In 2009 Government will introduce a new Comprehensive Area Assessment (CAA) of outcomes delivered by local authorities, both independently and in partnership with others. To help ensure that Children's Trusts fulfil their responsibilities for children and young people with SLCN, **we recommend that the new CAA takes account of the effectiveness of Children's Trusts in facilitating joint working and effective commissioning to deliver improved outcomes for children and young people with SLCN.**
- 4.32** We welcome the discussion paper on strengthening Children's Trusts recently launched by the Government. **We recommend that during the debate following this paper the Government**

considers whether sufficient numbers of Children’s Trusts are functioning effectively in terms of improving outcomes for children and young people with SLCN, and takes account of the evidence and recommendations of this Review in any plans to strengthen Children’s Trust arrangements, including by further legislation.

- 4.33** In response to a report by the former Education and Skills Select Committee⁵⁰, DCSF has commissioned Ofsted to carry out a detailed review of progress on special educational needs (SEN) in 2009-10. The Ofsted review provides a timely opportunity to consider the effectiveness of joint working arrangements between partners at both strategic and operational levels.
- 4.34** Given the prevalence of SLCN within the SEN population and the fundamental importance of supporting children and young people with SLCN, **we recommend that the forthcoming Ofsted review takes full account of the need for the joint provision of services for children and young people with SLCN.**
- 4.35** In particular, we believe that the Ofsted review should consider:
- the effectiveness of joint working arrangements between schools, local authorities and health services in addressing SLCN;
 - the contribution of community child health services commissioned by the PCT;
 - the effectiveness of local authorities’ support to schools on improving outcomes for children and young people with SLCN;
 - the effectiveness of School Action, School Action Plus and statements of SEN in improving outcomes for children and young people with SLCN; and
 - how Ofsted itself might strengthen its contribution to raising standards for children and young people with SLCN, including what training may be required for Ofsted Inspectors in this area.
- 4.36** The review should also take full account of evidence from children and young people and their families.
- 4.37** Through the recommendations made in this chapter to strengthen leadership, to assess current practice and to improve accountability, local authorities and PCTs will be better placed to work more effectively together in the way that children and young people with SLCN and their families manifestly desire.
- 4.38** The forthcoming Child Health Strategy should build on all these recommendations by considering further how joint working between local agencies dealing with child health can be promoted, in particular between agencies dealing with SLCN.

50 Now Children, Schools and Families Select Committee.

Chapter Five: The current system is characterised by high variability and a lack of equity

The issue

- 5.1 The current system for providing support to children and young people with SLCN is routinely described by families as a 'postcode lottery', particularly in the context of their access to speech and language therapy (SLT). Despite the hard work and commitment of many professionals in health and children's services, the needs of many children and young people are still not being met.

What we found

- 5.2 Whilst some families had had positive experiences, parents who contributed evidence to the Review were generally concerned about the difficulty of access to services, shortages across services and inadequate services.
- 5.3 We found inconsistency in the way areas commission and deliver the similar levels of services to children and young people with SLCN and this disparity rankled with families. Parents often found it difficult to understand why there was inadequate support for their child and considered it unfair that their needs were not given a higher priority.

Parents' experience of service variability:

'The shortage of SLT on the NHS means there is a postcode lottery in place. When living in Bucks we had regular fortnightly visits from the time of diagnosis and having moved to [urban area], we waited a year before my daughter saw a SLT.'

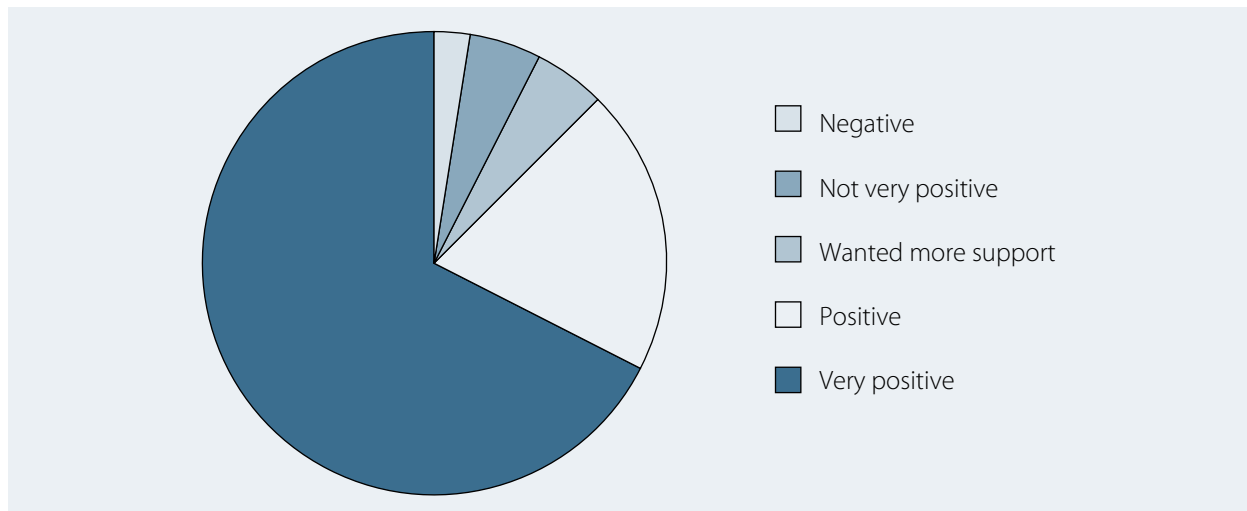
Parent

'The conditions of service should be equal to all and published so parents know what they are entitled to and what they should demand as their right. This DOES NOT happen.'

Parent

- 5.4 In addition, research⁵¹ shows that, when it is provided, most young people with SLCN have a positive experience of the additional support which they receive at school.

51 Dockrell and Lindsay, "Inclusion versus specialist provision: ideology versus evidence based practice for children" in "Understanding developmental language disorders in children: From theory to practice", Editors: Norbury C, Tomblin B, Bishop D, London: Psychology Press

Figure 7: Young People with SLCN views of support recent

Don't knows and views not stated removed.

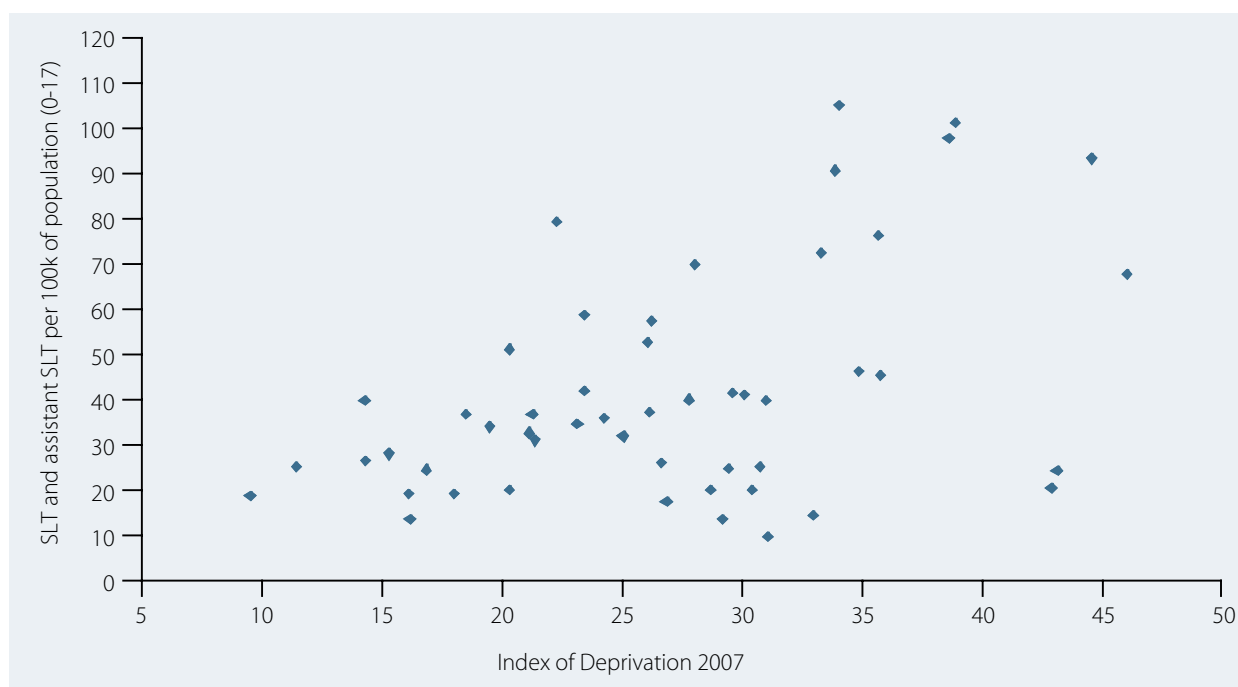
- 5.5** Recalling the type of support received in primary school, nearly half cited teaching assistant support in the classroom and SLT, with a fifth citing small group work outside the class and a small number citing 1 to 1 work with a teaching assistant outside the classroom. In secondary school, teaching assistant support in the classroom was cited by around 60% of young people, homework and coursework clubs by over a fifth and work with SLTs and small group work outside the classroom by just under a fifth. The research also asked young people about the type of support which they found most helpful. Support from personal tutors, head teachers and teaching assistants was cited as the most helpful formal support, by between 20% and 30% of young people, with less than 10% of young people singling out SLTs. When asked what more support they would have liked, many young people did not know, but more teaching assistant support was the most frequent cited (a quarter of respondents).
- 5.6** The Review has also commissioned its own research⁵² in to the effective and efficient use of resources. This work – which took the form of case studies of local authority and PCT provision in six local areas – has identified a wide variation in approaches and service provision between the six areas. The case studies show that there are considerable differences between the approach to criteria and definitions of SLCN. For example:
- there are differences in the way ASD is categorised – some local authorities categorise it as a subset of SLCN, others as a separate category;
 - there are also differences in the provision of integrated resources for children and young people with SLCN, with some local authorities considering reducing such provision and others looking to increase it; and

52 *ibid.*

- there is variation in joint working and cooperation between SLT services and education. Examples range from complete integration of services to minimal contacts. Some areas have teams of SLTs, educational psychologists and specialist teachers working across groups of schools, whilst others still operate a culture of separate working for the different professionals. The degree to which schools and local authorities funded SLTs to work in early years provision and in schools varied widely between the six areas.

5.7 The national figures on SLTs mask significant local variations in numbers. The DH/Durham University Child Health Mapping Project provides the number of whole-time equivalent SLTs and assistant SLTs per 100 thousand of the 0-17 years old population for PCTs. A better comparison is to look at the range for similar areas because we would expect those areas serving more disadvantaged communities to have a greater need for SLT. The chart below shows the number of SLTs and assistant SLTs per 100 thousand of the 0-17 years old population by the index of deprivation for the 51 PCTs on which there are complete data. Areas with similar levels of deprivation have significantly different numbers of SLTs.

Figure 8: SLT and Assistant SLT per 100k of population and area deprivation



5.8 Our conclusion is that there is a wide variation in the level, type and quality of provision across the country. Variation is both inevitable and desirable between different areas as commissioners commission services to meet the needs of their different local populations. However, the evidence considered by this Review suggests that proper needs assessments and a focus on outcomes generally play little part in the commissioning and provision of services for children and young people with SLCN. Variability in services appears to be due to the priority given to SLCN by each school, local authority and PCT. Putting the research evidence alongside other evidence presented to the Review, leads us to the conclusion that it would not be unreasonable to assume that there is a wide variation in the level, type and quality of provision across the country. Where insufficient priority is afforded to addressing SLCN, parents understandably perceive a lack of equity for their children.

How to ensure greater consistency and equity for families

- 5.9** The previous chapters to this report set out a series of steps that the Review has concluded need to be taken in order to improve outcomes for children and young people with SLCN. In large part, implementation of our recommendations will lead to a more equitable system for children, young people and their families.
- 5.10** However, if variability is a result of local prioritising, we must look at who is responsible for setting priorities, the factors that influence their priority setting and how they are accountable both for identifying the right priorities and for delivering against them.
- 5.11** Local leaders, particularly senior managers, are crucial to setting priorities and all that ensues. To support the strengthening of the local leadership role, DCSF has published a national professional development framework in its document *Leading and Managing Children's Services in England* (April 2008)⁵³. **We recommend that DCSF work closely with its central and local government partners to promote the framework to local leaders, setting out in the 2009 Departmental Annual Report the steps taken and the progress made.**
- 5.12** In line with the focus on leadership development within the Darzi Review, **we recommend that DH supports the development of appropriately skilled and experienced clinical leaders who can interpret policy and research to support the delivery of evidence-based practice for children and young people with SLCN.**
- 5.13** The Government has taken a number of steps to help ensure that local leaders prioritise speech, language and communication for all children and young people. For example:

The Early Years Foundation Stage (EYFS)

The EYFS framework will come into force in September 2008. It will be the new statutory framework for the provision of learning, development and care for children between birth and the academic year in which they turn five. It will apply to children in early years settings, such as nursery schools and private, voluntary and independent settings, including playgroups, as well as to children in the reception year in maintained and independent schools.

One of the EYFS's six areas of learning will be "Communication, Language and Literacy". At the end of the EYFS, when most children will be five, professionals will assess through observation each child's ability to speak about events, listen to a story, listen to sounds and link to letters, read simple words, write his or her name and simple words.

- 5.14** The Government has set national targets related to the EYFS, so that by 2011, local authorities must ensure that a greater proportion of children achieve the expected standard; and they must improve the average performance of those children with the lowest levels of achievement. These targets contribute to the basket of key indicators which will measure progress towards the overarching Public Service Agreements. Those Agreements have two overriding purposes. First, to raise the educational achievements of all children and young people. Secondly, and

53 Available at www.dfes.gov.uk/publications/childrensplan/implement.shtml

crucially, to narrow the gap in educational achievement between children from low income and disadvantaged backgrounds and their peers.

- 5.15** Given that setting such national expectations is very likely to motivate local leaders when it comes to setting priorities for commissioning and service provision, **we recommend that the Government considers retaining national early years targets beyond 2011. We further recommend that the Government considers introducing a national indicator specifically for SLCN to underpin a relevant Public Service Agreement from 2011.**
- 5.16** Identifying the feasibility of a national indicator for SLCN should be a function for the Communication Council working closely with the Communication Champion and other key partners, including families. In addition, any future indicators must take account of the potential of children and young people with SLIs and complex needs and be devised in a way that seeks to maximise that potential.
- 5.17** Whilst national targets will bring some external performance monitoring to certain aspects of provision, it will be essential for Children’s Trusts to maintain a comprehensive view of local performance. Trusts must be able to identify where satisfactory progress is being made and where it is not so that resources can be appropriately targeted. A continual cycle of self-evaluation is required in order to improve outcomes. **We recommend, therefore, that the joint framework on commissioning emphasises the need for local agencies to monitor performance and publish their findings in forms accessible to children, young people, parents and professionals.**
- 5.18** The framework should provide guidance on establishing robust performance monitoring arrangements and examples of effective practice. In doing this, the framework should promote the systematic collection and interrogation of data across services and the development of integrated data and information systems in order to evaluate provision and outcomes. For this task to be undertaken effectively, professionals in pathfinder areas will need to agree shared definitions of data so that they know what they are collecting and why. In addition, the framework should highlight the role of Local Area Agreements and local Children and Young People’s Plans in setting out the ambitions for children and young people with SLCN.
- 5.19** **We further recommend that the Government makes as much data as possible available about the educational attainment of children and young people with SLCN to allow it to be held accountable for progress and to encourage improvement in service providers.** Data should be readily understandable and accessible to all stakeholders with an interest in the outcomes for children and young people with SLCN.
- 5.20** Together, incentives, such as national targets, and effective performance monitoring will help to raise services for children and young people with SLCN as a local priority. In turn, this will lead to improved service provision: ensuring less variability between local areas and a more equitable access to services for children, young people and their families.

Conclusion

Over the last ten months, my colleagues and I on the Review team have been privileged to conduct the first review of speech, language and communication services for seven years. In doing so, we have striven to consult by a variety of means and as widely as possible. An online questionnaire, meetings with parents, children and young people, visits to facilities across the country and detailed discussions with professionals have all helped to shape our understanding of the issues. Thousands of people have given us their perspective on what is working, what is not and what is needed. We have witnessed shining examples of good practice, but not enough for comfort. Our experience has been fascinating, disturbing and challenging. None of us is likely to forget the more harrowing testimonies from parents seared by bad experiences or professionals frustrated that insufficient resources, lack of training or present working arrangements prevent them meeting the needs of children and young people with SLCN as comprehensively as they wish. Yet, for all that we encountered intense dissatisfaction that resources were inadequate, systems deficient and the priority attached to speech, language and communication too low, the mood of respondents and of the Review team has been not of weary resignation, but of unbreakable determination to seize the opportunity that this Review offers to help some of our most vulnerable children and young people.

Listening to many such children, young people and families has been sobering and instructive. Our witnesses were not slow to offer fulsome praise for quality professionals or services that they had met or experienced. Yet their verdict has been blunt and, for some, perhaps uncomfortable. They do not believe that their children are a priority for policy makers or providers of public services. Too often they have to struggle too much in order to obtain too little. Information is hard to find, services frequently hard to access. They are told about what is available rather than about what their children need. Agencies do not work together effectively for their children and often do not even share a common language. The mantra of early intervention is lost as agencies bicker with parents, argue with each other and lose precious time to help children and young people.

Accessing the right service sometimes just does not happen. When it does, maintaining continuity of support is an uphill struggle. Professionals do their best but face pressures on their time and resources. Non-specialist members of the children's workforce want to help but need the training to do so. Some parents see their children struggle in silence and are angry that they are treated as an afterthought.

Let us be blunt. The status quo is unacceptable. Unacceptable to suffering parents. Unacceptable to dedicated professionals. Unacceptable to all who believe that the country has a moral obligation and a practical need to do better for and with all of its citizens. Our purpose is to keep the best and improve the rest. There is a challenge to deliver change for the better. That challenge embraces five main themes:

- Communication is crucial. Recognising that is right in terms of equity for those in need and right in the national interest as we all wish to cut the costs of failure and to increase the productiveness of our country.
- Early identification and intervention are essential to avoid poor social and economic outcomes in later life. The evidence that early intervention brings benefits and its absence incurs costs is there for all to see. The task is to act on that evidence systematically in delivering policy and allocating resources.
- A continuum of services, designed around the family, is needed. Thought must be given to what is the best possible service to each individual child or young person at all stages of development. Crucially, services must be personalised to meet the needs of the individual.
- Joint working is critical. We have seen abundant evidence of the damage that is done when professionals operate in isolation from each other and the result is anything but splendid. We are resolved that the joint working recommended in a panoply of legislation, policy and guidance should now take root at national and local levels alike.
- The current system is characterised by high variability and a lack of equity. This is the most damning indictment of current arrangements and it has applied under governments of both colours for too long. We are committed to tackling the 'postcode lottery' and to ensuring that, while encouraging local innovation, proper standards are established and a strong core offer is made to all children and young people with SLCN.

Our recommendations have naturally been framed around the key themes which we have identified. We believe that communication is crucial but in a political market place in which a plethora of issues competes for ministerial attention and resources for improvements, the subject struggles to get, let alone stay, on the Government's radar. It is time to drag the issue from the back of minds, thrust it to the front and keep it there. Establishing a Communication Council, appointing a Communication Champion and organising a National Year of Speech, Language and Communication can help to obtain the focus which is the prerequisite of necessary and sustainable change.

We believe that early identification and intervention are essential. Converting that principle into practice demands that we do not fight shy of discovering the scale of the challenge which we face. Surveillance and monitoring of children's communication development is necessary to the promotion of public health. Equally, placing speech, language and communication at the heart of the school curriculum ensures that the subject is not an optional extra, but a mainstream feature of education policy.

We believe that a continuum of services is needed. Those services do not just happen. They have to be commissioned. That requires a structure. It is not the exclusive responsibility of the NHS or the education system. Both are involved and services should be jointly commissioned, yet at present they rarely are. The challenge is to convert joint commissioning from the gleam in the eye of the policy makers into the standard practice of those responsible for children's services. The pathfinder projects will rigorously assess need, plan services accordingly, identify the skills required to deliver them and ensure that the team is in place to do so. In the process of this pioneering work, the pathfinders can help to devise a national template of a core offer to children and young people with SLCN in whichever part of England they happen to live.

It is almost impossible to overstate the premium that should be placed on training and deploying the necessary workforce. From therapists to specialist teachers, to SENCOs, to classroom assistants, we need the right people in the right place to offer the right service. Professionals need to be trained themselves and to train others with the resources required for both purposes.

We believe that joint working is critical but, at the level of strategic planning and priority setting, it is honoured more often in the breach than in the observance. With monotonous regularity, we found either that no Children's Trust existed or that we could not identify who served on it, what responsibilities people held or how they were accountable. Someone must take the lead and performance should be independently assessed. Above all, Ofsted should scrutinise what local leaders are doing, are not doing and should be doing.

We believe that the current system of support for people with SLCN is highly variable and thereby inequitable. Bringing about change will require local leaders who can support and promote sound services which are driven by the most up to date evidence. To incentivise best practice and a single-minded focus on outcomes, we need carefully chosen targets for early years to continue and a national indicator of the improvement which we seek in speech, language and communication.

Ironically, there are two recommendations which rival in significance any of the others we make, even though neither is a proposal for a specific policy. One calls for a programme of research into the effectiveness of different interventions in raising standards of speech, language and communication. This is long overdue. We do not expect to achieve utopia. Making progress for those with SLCN is not about staging a Big Bang event, but rather about embarking on a continuous process. We need constantly to research what is best, to refine policy accordingly and to work with communities to roll out such policy in a fashion which fully reflects local needs. The other is the suggestion that progress on implementing the recommendations of the Review be independently checked at the beginning of 2010. This is a democratic safety valve. If Ministers accept the need for external scrutiny of the record of delivery to a demanding timetable, that should be an antidote to those who distrust all politicians.

Let us finish this report where we started. This Review is driven not by a desire for equity alone, but by a concept of national self-interest. Tackling this country's speech, language and communication problem is right on so many fronts – it is right for the sake of fairness, right for educational progress, right for social inclusion, right for employment generation, right for safeguarding mental health, right for reducing offending and right for our commercial advantage in an age in which a job for life is a relic of the past and the importance of communication skills in today's knowledge economy is greater than ever.

Improving speech, language and communication requires a relentless drive to place the subject centre stage in a raft of domestic policies. Just as importantly, it requires every interested party to recognise that we are all in this together. Government at all levels, practitioners, the voluntary sector and parents must drive progress on the ground so that promise is replaced by performance, failure by success. It is time to call a halt to the sequence of low priority, neglect and poor performance. People with SLCN don't want to be kept waiting, left floundering and forced to struggle. They don't want sympathy. They want empathy, understanding and action. For far too long communication has been elbowed aside by policy makers focussed on other parts of the child development agenda. Yet speech, language and communication is inextricably bound up with that wider agenda of aspiration, opportunity and social harmony. The ability to communicate is a vital piece of equipment for citizenship, fundamental to our humanity and central to the quest to improve life chances in the 21st century.

Annex A: Commissioning

(i): Commissioning for outcomes

In this report we highlighted the importance of outcome focused services for children with SLCN.

Commissioners should develop a pattern of services which are based on a clear rationale to improve outcomes for children and young people. Commissioning plans should be based on needs assessment and an understanding of what outcomes are being met.

Some areas use joint outcome measures very successfully to help monitor and plan services, but there is also great confusion about outcomes and outcome measures.

In the first part of this annex, we set out developing work on an outcomes framework for services; in the second part, case studies of low incidence services, and in the third part a report on commissioning provision for users of AAC.

Towards outcomes for commissioning services for children and young people with SLCN

When considering outcomes for children and young people with SLCN we need to take the 5 Every Child Matters outcomes and then drill down. They are:

1. Be healthy
2. Stay safe
3. Enjoy and achieve
4. Make a positive contribution
5. Achieve economic well-being

1. Be Healthy (Eating and drinking)

Outcomes

- Eat and swallow safely
- Adequate nutrition and hydration from food and drink

Indicators

- Child's weight and growth
- GP interventions for aspiration infection
- School attendance
- Increased awareness of others about communication interventions and management

Qualitative indicators

- Improved participation in family mealtimes
- Reduction in harm or distress caused to the child and/or family by eating and drinking difficulties
- Parental/carer confidence in providing safe techniques for eating and drinking

1. Be Healthy (Mental health)

Outcomes

- Developing positive self-esteem, confidence

Indicators

- Lack of participation in class activities
- Reduction in incidence of bullying
- Included and part of a peer group during play activities
- Attendance at school
- Managing anxiety to prevent social withdrawal
- Reduction of the impact of the speech, language and communication disorder on the individual's functioning
- Increased awareness of others about communication interventions and management
- Improved communication environment
- Tracking of conditions and numbers accessing mental health services

Qualitative indicators

- Child and family identify strong social relationships with peers
- Child and family identify strong social relationships with adults

- Child and family identify an increase in participation in family activities

2. Stay Safe

Outcomes

- Developing emotional maturity

Indicators

- Reduction of the impact of the speech, language and communication disorder on the individual's functioning
- Increased awareness of others about communication interventions and management
- Improved communication environment

Qualitative indicators

- Understanding issues re: safety and risk
- Participation in age appropriate activities for daily living

3. Enjoy and achieve

Outcomes

- Increased educational attainment
- Fulfilling potential

Indicators

- School readiness
- Baseline assessment on school entry
- Participation in learning
- Reduction of the impact of the speech, language and communication disorder on the individual's functioning
- Increased awareness of others about communication interventions and management
- Improved communication environment
- Level of SATs achievements
- Child's ability to read and write in line within the nationally accepted range
- Improvement in communication and listening in the classroom
- Ability to problem solve within the normative range
- The wider workforce is knowledgeable and informed in managing children with SLCN
- Reduction in NEET figures

Qualitative indicators

- Child and family report educational progress which is acceptable to them
- Teachers and other professionals report of educational progress
- Child demonstrates enjoyment of curricular and extra curricular activities

4. Make a positive contribution

Outcomes

- Contributing to positive social interactions with the following
 - Peers
 - Family
 - Community
 - Society

Indicators

- Decreased anti-social behaviour
- Interaction and effective communication within a peer group
- Engaging in family activities
- Engaging in both school and wider community
- Reduced risk of anti-social behaviour
- Reduced risk of exclusions from school
- Reduced risk of truancy
- Track of numbers and reasons for entering into the criminal justice system for young people

Qualitative indicators

- Increased sense of citizenship

5. Achieve economic well-being

Outcomes

- CYP have a plan for their future into adulthood which takes into account their skills and attributes

Indicators

- Tracking of where CYP go after leaving school
- Numbers in paid employment (other indicator, for example type of employment)
- Future plans for safe care

Qualitative indicators

- Supporting children and young people with their careers, including options for vocational careers
- Links with Connexions
- Feedback from families/carers and CYP about their future career/care plans

At local authority level outcomes could be measured through:

Percentage of schools that have confidence in managing the speech, language and communication (SLC) needs of children with identified delay.

Percentage of schools that have confidence in working collaboratively with SLT service in addressing needs of Children with SLC disorders.

Confidence/skill measured by/takes into account:

- Level/degree of specific training re SLC Needs
- Designated LSA/TAs with specialist skills
- Resources in place to support SLC needs
- Language groups/strategies implemented/positive communication environment

Individual child:

- Children with SLCN are progressing at same rate as peers, albeit with delay
- Decreased incidence of identified difficulties in literacy/social communication/behaviour
- Degree of satisfaction in progress of child with SLCN:
- Parental
- School

At commissioning level outcomes could be measured through indicators such as:

Outcomes

Commissioners work together with each other, and users and professionals to plan, design, procure and monitor children's SLCN services.

SLCN Service specifications are jointly developed using care pathway models

Equitable services are provided across all agencies

Appropriate services are easily accessed and delivered

Joint regular meetings are held between boards of commissioning agencies to set budgets and monitor performance

Indicators

Number of commissioning bodies in locality who commission jointly through Children's Trust arrangements

Number and range of children's services that are jointly commissioned

Evidence to show joint governance accountability frameworks are in place for children's services including investment planning , priority setting and pooling resources arrangements

Evidence of joint procurement and contract management between commissioning bodies

Evidence to show professional and user involvement in the design and performance management of contracts

(ii): Case studies of commissioning for low incidence needs

Moor House School

Moor House School (MHS) in Surrey is a non-maintained residential special school for around 90 children with severe, specific speech and language impairments. Pioneering work in many areas of speech and language therapy and in teaching methods continues to place MHS at the forefront of research, development and practice in the education of children with severe, specific speech and language impairments. Since MHS opened in 1947, over a thousand children have made significant improvement both academically and in their communication skills as a result of this intensive intervention.

MHS has a well resourced speech and language therapy service (13 SLTs for 86 students) allowing 'direct' and 'intensive' intervention to be planned and delivered around the needs of individual children. MHS is a valuable national resource which continues to gather a strong body of evidence of the effectiveness of direct SLT input. MHS holds nearly ten years of data demonstrating that the students at the school make statistically significant progress in receptive and expressive language standard scores from years 6 to year 11.

However, despite the growing evidence base, it is increasingly difficult for MHS to secure local authority funding for a place at the school, with the majority of cases now being resolved at Special Educational Needs and Disability Tribunal. Appropriate referrals directly from local authorities now constitute less than 6% of the school's annual referrals. The majority of referrals are from parents and SLTs.

The ACE Centres

Established in 1984, the two ACE Centres in Oldham and Oxford enable children with complex communication disabilities to use appropriate Augmentative and Alternative Communication (AAC) and Assistive Technologies (AT). The Centres provide assessments, training, information and advice, consultancy and research. The Centres are staffed by teachers, speech and language therapists, occupational therapists, technical advisors and administrators who work closely with local authorities, Primary Care Trusts, schools and others to promote the use of AAC and AT to support learning.

In recent years, core funding from the Gatsby Charitable Foundation and the Government has reduced and the Centres have been encouraged to seek Service Level Agreements (SLAs) with local authorities and PCTs. Some local authorities and PCTs are prioritising the needs of AAC users and are investing in the Centres' services. However, there are many local authorities and PCTs without clearly identifiable budgets for AAC or lead officers able to contract into SLAs. As a result, the Centres have been unable to maintain their levels of service and staff have been made redundant. Given that these regional hubs of expertise exist, it would be very unfortunate to lose the expertise and capacity they offer to local authorities and PCTs.

The Michael Palin Centre for Stammering Children

Since 1993, the Michael Palin Centre in London has provided a national specialist tertiary consultation service for thousands of children and young people with a stammer. It has an international reputation for providing specialist services in the field of stammering. It offers a comprehensive range of specialist therapy approaches and delivers a programme of education and training for speech and language therapists.

However, the Centre's long-term future is uncertain as referrals from PCTs across the country have declined sharply in recent years. Whilst some of the decline is attributable to PCTs developing their own local services for children with a stammer, it might be that some PCTs do not consider the commissioning services for these children a sufficiently high priority because of the small numbers in their area. In these cases where children and young people have relatively rare conditions, but for whom the impact of that condition is severe, there is a strong argument for PCTs – and, where appropriate, local authorities – coming together to commission or purchase services at a regional level.

Nuffield Speech and Language Unit

The Nuffield Speech and Language Unit is part of the Royal National Throat, Nose and Ear Hospital. Until recently, it provided a specialist service for 4-7 year old children with very severe speech and language disorders who were unable to participate in mainstream education. The Unit catered for between 12 and 14 children with statements of special educational need and whose places were usually funded by Primary Care Trusts, by local authorities or by a combination of the two. On average, children attended the Unit for two years.

Apart from the teaching and therapy work undertaken by a highly qualified multi-disciplinary team, the Unit has established itself as a centre of excellence in research and good practice, offering a dyspraxia programme which is used in countries across the world. The Unit has achieved impressive results. Between 1998 and 2003, 41% of children who had attended it for two years were able to go on to mainstream education; 7% went on to local language units attached to mainstream schools; 38% went to Meath School, a specialist school that caters specifically for children with severe speech and language disorders; and 13% went to other specialist schools.

However, despite its success, the Unit saw a downturn in referrals due to local authorities issuing fewer statements and funding fewer 'out of area' placements. As there is no comparable provision elsewhere in London, the implication was that local authorities did not consider meeting the complex needs of these children a sufficiently high priority. The reduction in referrals led to the Unit's Hospital Trust consulting on the possible closure of the Unit. This act in itself caused uncertainty and a further drop in referrals. In the absence of sufficient numbers of pupils, the Unit has been closed since July 2007. In these cases where children and young people have relatively rare conditions, but for whom the impact of that condition is severe, there is a strong argument for PCTs – and, where appropriate, local authorities – coming together to commission or purchase services at a regional level.

TreeHouse

TreeHouse School is an independent school in London for around 60 children aged between 3 and 16 with autism. All the pupils have severe or profound learning disabilities.

Since 2005, TreeHouse has developed a speech and language therapy department. The 2.5 therapists employed by the school work directly with the children and offer training for all new staff, ongoing training, and advice to families.

Every new member of staff receives speech and language-specific training at induction and ongoing training is based around speech and language goals in each pupil's Individual Education Plan. To ensure parents and families are involved, at least one meeting per year to review the child's progress is held and the speech and language therapist attends. Within TreeHouse, post-school training sessions are held by various departments for internal sharing of information and expertise. A system of open inspections has also been introduced in which parents are invited in to their child's classroom so that they can see for themselves what is involved in a typical morning at school. In its most recent inspection report on the school (October 2007), Ofsted said:

"TreeHouse School provides a good quality of education and pupils thoroughly enjoy learning. They make good progress overall and outstanding progress in their communication skills and in the way they *'learn to learn'*."

Dawn House School

Dawn House School provides intensive and specialist support for children and young people aged 5 – 19 years who have a severe communication disability. The school aims to support pupils' development in speech and language, thinking and reasoning, self-confidence and independence. Education, therapy and care programmes are tailored to meet the needs of each pupil.

Dawn House School was awarded Specialist School status in January 2007 and is one of five schools that specialise in the 'communication and interaction' part of the SEN Code of Practice. A recent Ofsted inspection described the school as 'good with many outstanding features'.

The Further Education Department was launched in 2004. This provides a highly inclusive programme for students from 16 to 19 years with courses suitable for their abilities and aspirations. Most students are supported to achieve an academic or vocational qualification through a partnership with West Nottinghamshire College. Some students achieve a vocational qualification through an extended, supported work placement whilst others continue to access their vocational course at the Dawn House School Study Centre. Additionally, all students access adult literacy, adult numeracy and life skills programmes at the Dawn House School Study Centre.

(iii): The Provision and Support of Assistive Technology and Augmentative and Alternative Communication in Children's Trusts

Final report

A Children, Young People and Families Grant Funded Project.

Authors: Ian Butterworth⁵⁴, Anna Reeves⁵⁵

ACE Centre Advisory Trust, Oxford & ACE Centre North, Oldham

In 2006 the ACE Centre Advisory Trust and ACE Centre North successfully bid for a Children, Young People and Families (CYPF) grant from the Department for Education and Skills (DfES), now the Department for Children, Schools and Families (DCSF). The grant was to fund a 3 year project to develop new protocols for the provision and support of Assistive Technology (AT) and Augmentative and Alternative Communication (AAC) within the emerging context of Children's Trusts.

The ACE Centres

The ACE Centres have been supporting children and young people with complex physical and communication disabilities, their families, schools and colleges for more than 20 years. They evaluate the role of Assistive Technology and Augmentative and Alternative Communication in supporting access to education, leisure and social interaction through their assessment service, training programmes, information services and research and development programmes. The Centres run highly valued and respected assessment services using a range of models designed to fit the requirements of individuals, their families, carers and professionals. The Centres' comprehensive programme of training includes accredited courses in AAC and AT, day courses on a range of topics across the field and bespoke training to fit local requirements.

Aim of project

Historically the support and provision for children & young people who use AT and AAC has been patchy with some areas providing high standard and effective services while other localities have minimal or non-existent services.

This project enabled the ACE Centres to work in four Children's Trust Pathfinders around the country to help them establish and develop their own local service for young people with AT and AAC needs. Each Children's Trust has its own particular circumstances and priorities so consequently four different models have been established which can then be used as exemplars on which other Children's Trusts might base similar services in the future.

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The ACE Centres have supported the Trusts in developing protocols and procedures for:

- local multi-disciplinary integrated service delivery;
- influencing the local agenda (including children and parent involvement);
- integrated multi-agency structures including management and funding.

A key objective of the models was to address and accommodate differences in individual Trust needs, priorities and the range of resources available (e.g. from DCSF, Department of Health (DH), Department of Work and Pensions (DWP), Local Authorities (LAs) and the voluntary and independent sector).

The project has built on expertise established during the DfES Communication Aids Project (CAP) which started in 2002 and finished in April 2006.

Background

The project has developed within the framework of several national initiatives to improve services to children and young people. Each Trust is developing local services to meet the requirements as detailed within the Disability Discrimination Act, SENDA, Every Child Matters, Every Disabled Child Matters etc.

Project Partner Children's Trust Pathfinders

Four Children's Trust Pathfinders were identified to participate in the project based upon their interest in establishing or developing AT and AAC services, the desire to have a geographical spread across England and a range of local authority size and models of service.

The Four Project Partner Trusts

Bolton

Bolton Metropolitan Borough Council is a relatively small unitary authority with a population in the region of 260,000. Whilst there are a number of special schools available, there is a strong commitment to supporting the inclusion of pupils with SEN in mainstream schools, which is reflected in the structure of the support services.

Prior to their involvement as a Children's Trust Pathfinder, Bolton Metropolitan Borough Council had a long history of investment in the provision and support of AAC and Assistive Technology for children and young people with complex needs. A communication aid steering committee was in place comprising senior SEN officers, an educational psychologist, representatives from speech therapy and occupational therapy services, SEN support services and a paediatric consultant who had initially invested funding in the establishment of a local loan bank of equipment. This steering committee met on a termly basis in order to approve expenditure based on assessment recommendations made by a multi-agency team (speech and language therapist, occupational therapist and SEN support service teacher) and to agree new referrals for this service.

The Communication Aids Project had been used as an opportunity to add value to existing provision, and when the project ended in 2006 there was recognition from the steering committee that new protocols and procedures needed to be established in order to continue this good practice.

Awareness and expectations had been raised in mainstream schools in Bolton by CAP, which extended the remit of the original communication aids group. Previously, technology to support written communication had not been considered as part of this service. However, with the increase in availability of Assistive Technologies that enable written and verbal communication, the change in population as a consequence of medical developments resulting in children with complex health needs surviving longer than ever before and therefore an increase in numbers, plus the increase in the inclusion of those children in mainstream schools, there was a need to re-visit the criteria for this communication aid service.

Brighton & Hove

Brighton & Hove is a small unitary authority with a population of approximately 248,000, which serves a diverse community with a significant variation in affluence and social groupings. The Children and Young People's Trust includes several special schools including Downs View School which works with young people with Autistic Spectrum Condition. For many years the local authority and health service have had close links with Chailey Heritage Trust and school which are located nearby. Brighton & Hove have been following an inclusion agenda for some pupils with physical difficulties and have recently placed the first communication aid user in a mainstream school.

Brighton & Hove has pursued a policy of devolving funding to schools and as a consequence has little centrally held funding for equipment. The expectation is that, under most circumstances, the schools will provide the resources their pupils require. Currently there is no local authority and health pooled budget arrangement.

Currently Brighton & Hove has no advisory or learning support services for AAC. The sensory and learning support services are able to assess and support a wide range of pupils with sensory and specific learning difficulties who need Assistive Technology [AT] to record and access the curriculum. In general, recommendations from the service for computer systems etc are funded by the school. The service made referrals to CAP and pupils received computer systems to support their access to education. In addition, Downs View School worked closely with the ACE Centre Advisory Trust to assess and support pupils requiring AAC. The Trust has continued to fund extended warranties for the communication aids funded by CAP. Downs View School has continued to develop its expertise as it supports its pupils using communication aids. The school has been developing its outreach service and is looking to gain specialist school status for communication and interaction.

Croydon

Croydon is the largest London Borough with a population of approximately 330,000. Between 2002 and 2006 Croydon used CAP to enhance their service to pupils and schools by funding both communication aids and technology to support recording and curriculum access. However, before this current CYPF project started there was no coordinated service to assess or support individual pupils who use AAC or Assistive Technology. Occupational Therapists and Speech & Language Therapists were assessing and supporting pupils as part of their caseload and making recommendations regarding equipment but these were often not acted upon by schools. The Borough has one special school for pupils with physical disabilities. St. Giles School was involved in some CAP assessments and is developing an outreach service to support mainstream schools in all aspects of working with pupils with physical disabilities.

Therapy services are closely aligned with the special schools and both the Speech & Language Therapist (SLT) and the Occupational Therapist (OT) from St. Giles school are involved with the outreach service.

Historically, Croydon has not provided AAC and AT equipment directly. The borough has a high level of devolved funding to schools with only a small centrally retained budget. Since CAP there has been no mechanism for funding expensive pieces of equipment except through the schools devolved funds.

North and North East Lincolnshire

North Lincolnshire has a much smaller population than the other three Trusts, in the region of 157,000 people, and its special schools are relied upon to support many pupils with SEN across the authority.

North Lincolnshire Primary Care Trust (PCT) had an increasing demand for communication aids from local residents – of all ages – and had no local expertise to assess or support people in the use of AAC. This coincided with North Lincolnshire getting Children’s Trust Pathfinder status and prioritising services for children with disabilities. At the same time, a North Lincolnshire secondary special school had established a basic level Assistive Technology resource bank and was in the process of applying for specialist status in SEN: Communication and Interaction, which has since been successful. Consequently, the ACE Centre North was approached to assist them in the establishment and development of a local AAC service and policy for children, young people and adults across North and North East Lincolnshire, which is being led by North Lincolnshire in the first instance.

Models and Developments through Project

Bolton

Once CAP had ended, the expectation in Bolton was that the steering committee that had been in place before and during the project would continue. The AT & AAC assessment team consists of a Speech & Language Therapist [S<], Occupational Therapist [OT] and teacher and responsibility for delivering this service is absorbed into their existing commitments. The assessment team had benefited considerably during CAP from the training made available and access to a specialist loan bank to assist with assessments and trial of devices. As a consequence, the pooled budget, which had been agreed between Bolton Children’s Services and Bolton PCT was for the provision of equipment only.

During this project, ACE Centre North has provided assistance and support in order to identify criteria for acceptance of referrals to access an assessment and funding for specialist ICT equipment, including the provision of communication aids. Criteria were agreed by the steering committee to clarify expectations from schools prior to referral and the service was advertised to all mainstream schools. Referrals were administered by a coordinator and distributed to steering committee members at each meeting. Additional support was offered by ACE Centre North to assist with the review of referrals submitted once this service had been promoted and publicity and guidance materials were modified accordingly. However, progress with the development of this service has been severely hampered on several occasions by changes in personnel.

Brighton and Hove

During CAP local support services and some schools referred young people who went on to receive communication aids and other equipment. The education authority funded extended warranties and schools agreed to provide on-going support. Since the end of CAP Brighton & Hove have continued to fund extended warranties and have provided some equipment. Downs View Special School, working with many of the authorities ASC children & young people, has been continuing to work with the communication aids provided through CAP and has sought to develop its expertise in this area. The school is currently seeking specialist school status for communication and interaction.

The school has been working with the authority to develop an outreach service supporting AAC across the Children and Young People's Trust [CYPT] as part of its bid to acquire specialist school status. The ACE Centre Advisory Trust, school, LA education officer, OT and SLT managers, representative from social services and Chailey Heritage met to identify a model which best suits the needs of the Trust. An outreach service based at the special school and supported by the Trust is a model which builds on the expertise developed during and since CAP. A small amount of funding has been identified by the CYPT which will be matched by the school to establish a pilot project which will work across Brighton & Hove. Unfortunately, changes in the management structures within the CYPT and the loss of a key officer led to a short period of time without education involvement in the steering group. A new representative has been identified and the steering group is being revitalised.

In addition to support with initiating the service and developing a draft AAC policy the ACE Centre Advisory Trust has delivered two day training courses to the AAC team at the school and have conducted a joint assessment of a mainstream pupil who will be supported as part of the pilot project. The ACE Centre Advisory Trust is continuing to support the AAC service in writing procedures and practice documents, establishing an equipment resource bank and developing the team assessment skills.

Croydon

Following discussions and meetings with local authority officers, OT & SLT managers, social services and representatives from schools a model of service delivery was identified that built on local skills and expertise. St. Giles Special School for pupils with physical disabilities has developed expertise in AAC and AT built upon work with the ACE Centre Advisory Trust during CAP. The school has experienced therapy and teaching staff who have previously supported mainstream schools working with pupils with physical disabilities. In addition, OTs are supporting pupils in mainstream schools with physical disabilities.

The ACE Centre has been involved in initial set up meetings, policy development and training including courses and joint assessments. Training has included two one day courses which covered AAC devices and systems and assessment processes and practices. A joint assessment including ACE Centre Advisory Trust staff working alongside Croydon staff has enabled the local team to develop its assessment skills.

The special school is developing its outreach service across the Trust and has identified a member of staff to manage the AAC work and project involvement. The Trust has identified funding for an assessment equipment resource bank which has now been established and is

housed at St. Giles School. Funding expensive equipment for individuals is still to be resolved as is long term funding for the service but there is a fledgling service which will be able to support schools across the Trust working with children and young people requiring AT and/or AAC.

The ACE Centre Advisory Trust is continuing to support the AAC service in writing procedures and practice documents, increasing its equipment resource bank and developing the team assessment skills.

North Lincolnshire

In the first instance a steering committee was formed which comprised:

- Assistant Director – North Lincolnshire PCT
- Speech therapy Managers for North Lincolnshire and North East Lincolnshire PCT
- Special school head teachers from North and North East Lincolnshire

This committee was invited to identify potential assessment team members from their own services/schools.

The special school with specialist status in SEN: Communication and Interaction has taken on an administrative role in chairing and hosting these meetings, which have been held every six weeks. Members of this committee have drafted an AAC multi-agency Agreement which details the protocols, procedures and financial arrangements for AAC assessment, provision and support.

In addition, a stakeholders' meeting was arranged in order to raise awareness of the establishment of this service. Stakeholders included:

- Community Equipment Services
- SEN Officers
- SEN Support Services
- Educational Psychology Services
- Adult Learning Disability Services
- Social Care representatives from Children's Services

Two multi-disciplinary teams have been established from recommendations made by the steering committee. An audit was undertaken of their training needs and a programme of training was delivered to these teams, including attendance at the accredited Assistive Technology Unit, one day courses and distance learning accredited Modules. The teams then continued to develop a referral form for approval by the steering committee. A Google group e-mail has been used by members of the assessment teams and the steering committee in order to share information, plan meetings and activities, and to discuss relevant documents.

A closed referral system has been used in the first instance in order to manage priorities, develop assessment skills in partnership with the ACE Centre North and monitor capacity for the assessment service. A small number of children and adults were prioritised for assessment, with the approval of the steering committee. The ACE Centre North worked alongside the emerging

assessment and training team in order to identify key issues in the assessment process and to identify appropriate AAC resources and strategies.

Specialist advice, training and assessment support has been agreed in order to address ongoing training needs, and continue to support local assessments as appropriate. It is anticipated that these teams will always need access to specialist advice, training and a loan bank of a wide range of AAC resources from a national or regional specialist centre which could not be emulated at a local level. This could be through a Service Level Agreement [SLA] with one of the ACE Centres as in the case of North Lincolnshire.

Outcomes

It is clear that the move from separate Education services, Social services and Health services to unified Children's Trusts arrangements has led to many transitional issues. In many areas, the development of management structures, interagency working procedures and other priorities have meant that Trusts have been reluctant to focus on any particular low incidence group.

The four Trusts working with the project have very different backgrounds with different levels of involvement with AAC services prior to, during and post- CAP. They have different funding systems and structures including levels of devolved funding to schools and consequent levels of centrally retained funds. In addition, they have different levels of commitment to supporting this group of children, young people and their families.

Where services exist or are developing the Trusts are benefiting from the high levels of interagency working required to ensure children and young people who need AT or AAC are assessed and supported adequately. All four Trusts either have or are developing multi-agency models of working, bringing together a range of professionals, including speech & language therapists, occupational therapists, physiotherapists, teachers, engineers and technicians. This model is enabling the different professionals to develop and share new skills and experiences and ensures children & young people receive a wide ranging and thorough assessment combined with the high levels of support and training required to ensure they derive the maximum benefit from devices and systems provided. This model also ensures parents, carers and families can meet the range of professionals together to discuss needs and solutions.

Some of the Trusts, who were initially invited to join the project, declined to do so as they felt the timing inappropriate or they had higher priorities at that time. All of the Trusts taking part in the project are reliant on the high level of commitment from one or more individuals. This confirms the ACE Centres' experience that where AAC services exist it is often due to a 'champion' who has pushed, cajoled and persuaded fund holders and commissioning managers to invest in this area and that this will reap benefits. The experience in two of the four Trusts involved with the project also reinforces our experience that changes in key staff and loss of champions can have a substantial impact on a Trust's desire and/or ability to support AAC services. There is very little, if any, consideration of succession planning within AAC services nationally even though the experiences in Bolton and Brighton & Hove clearly demonstrates the huge detrimental effect of key staff leaving a service.

The four Trusts illustrate that a long term commitment to ring fenced funding of both services and equipment is required. Where this type of funding is not available services have a hand to mouth, uncertain future which prevents the development and implementation of policies and

procedures. In addition, staff are less likely to develop and maintain up-to-date skills, knowledge and expertise, commitment and motivation if the service is always under threat. Parents are unlikely to be satisfied with a service and funding stream that may not exist in the next financial year. This will inevitably lead to pressure to provide resources immediately which may then not be supported and hence quickly become redundant. Ultimately this will be doing a great disservice to children and young people for whom AAC *could* make a significant difference to their learning and quality of life.

Experience suggests that funding direct from either the Local Authority or Health service is less secure than pooled funding from both the LA and Health. Where the LA has high levels of devolved funding to schools it is possible to get agreement from Head teachers to 'top slice' funding for AT & AAC equipment. This is in the best interests of schools as a small amount of funding from each school annually is generally perceived as preferable to the potentially huge investment in a high cost communication aid or device such as an eye-gaze system.

Important Factors for Successful AT & AAC Service Provision

1. The involvement of senior managers and fundholders at a steering group or committee level.
2. An AAC policy document or statement which includes a defined management structure, details of funding mechanisms, criteria for accessing the service and establishes procedures and practices. This policy should be widely available to parents, carers and professionals.
3. An experienced and well trained multi-agency team of professionals who have the opportunity to develop their knowledge and skills through a programme of continuing professional development.
4. An identified coordinator who will receive referrals and coordinate assessments and support.
5. Assessment team members have time allocated to planning, preparing and providing the service rather than as an addition to their role without appropriate time allocated.
6. Funding for staffing and resources is in place. Our experience suggests that ring-fenced funding is the only way to ensure children, young people and families have access to the services and resources they require. In many Trusts with established AT & AAC services some form of joint funding arrangement is in place. Joint or pooled funding for equipment recognises the wider importance of communication beyond the educational setting. Communication is an essential element of all social interaction and as such is required all day, every day.
7. Consideration of succession issues is essential. When a key member of the clinical staff or a manager leaves, the service can take a considerable time to identify and train new staff. This was exemplified in two of the four Trusts which participated in the project. With succession planning this hiatus can be minimised and the Trust can benefit from the additional expertise which is available.

8. The one Trust which has established a pooled budget is the only Trust which does not have to argue for equipment funding on a case-by-case basis and offers a far more efficient service as a consequence.

Acknowledgments

The authors and the ACE Centres would like gratefully to acknowledge both the funding for this work provided through the DCSF CYPF programme, and also the participation of the four Children's Trust Pathfinders.

Annex B: Letter from the Secretary of State for Children, Schools and Families



Rt Hon Ed Balls MP
Secretary of State

Sanctuary Buildings Great Smith Street Westminster London SW1P 3BT
tel: 0870 0012345 dcsf.ministers@dcsf.gsi.gov.uk

John Bercow MP
House of Commons
London
SW1A 0AA

September 2007

Dear 

REVIEW OF SERVICES FOR CHILDREN AND YOUNG PEOPLE WITH SPEECH, LANGUAGE AND COMMUNICATION NEEDS

We have discussed this Review and I am pleased that you have agreed to lead on this work.

The Government believes that enabling all children and young people to communicate effectively is the foundation for their development, learning and participation in society. With the publication of the DfEE/Department of Health (DH) working group's report into speech and language therapy services to children in 2000, my Department and DH have been working closely to carry forward practical action to improve provision for children and young people with speech, language and communications (SLC) difficulties, including supporting the establishment of a Communications Trust, which was launched in June.

In the early years, communication, language and literacy is a core part of the new Early Years Foundation Stage and Sure Start Children's Centres are playing a key role in the promotion of children's speech and language development. We are working in partnership with ICAN to roll-out the *Early Talk* programme in 200 centres. In schools, the Inclusion Development Programme, to be launched later this year,

department for
children, schools and families



will focus on improving the workforce's confidence and skills in working with children with SLC needs.

However, I recognise that there are issues about the provision of services, particularly speech and language therapy, locally. As Chair of the All Party Parliamentary Group on speech and language difficulties, you have played a leading role in highlighting issues that I know affect the lives of many children with communication difficulties and their families. I am grateful that you have agreed to lead a review into the provision of services for children and young people with speech, language and communication difficulties, advising on:

- the range and composition of universal and specialist services to best identify and meet the diversity of needs and secure value-for-money within the context of the Comprehensive Spending Review and available resources;
- how planning and performance management arrangements and effective cooperation between Government Departments and responsible local agents can be used to promote early intervention and to improve services;
- examples of good practice in commissioning and delivering services which are responsive to the needs of children, young people and families and which can be viewed as benchmarks for the delivery of local services across the country.

In conducting the review you will want to involve key stakeholders, including the Royal College of Speech and Language Therapists, local authorities and Primary Care Trusts, voluntary organisations and children, young people and their families. The Rt Hon Alan Johnson MP, Secretary of State for Health, and I would welcome a report by Summer 2008. I have agreed with Alan Johnson that his officials will work closely with mine in supporting the review.

I am copying this letter to Alan Johnson.

Yours sincerely,



ED BALLS MP

Annex C: Terms of reference

The review will advise on:

- the range and composition of universal and specialist services to best identify and meet the diversity of needs and secure value for money within the context of the Comprehensive Spending Review and available resources;
- how planning and performance management arrangements and effective co-operation between government departments and responsible local agents can be used to promote early intervention and to improve services;
- examples of good practice in commissioning and delivering services which are responsive to the needs of children, young people and families and which can be viewed as benchmarks for the delivery of local services across the country.

Specific issues to be considered by the review will include:

- how the health service commissioning framework ensures sufficient and responsive SLT services to meet local needs;
- clarity of accountability and responsibility for planning and service delivery from national to local level across health, social services and education, including joint and consistent priorities;
- strategic, professional and operational leadership of services;
- recruitment and deployment of NHS speech and language therapists, particularly those specialising in working with children;
- analysing good practice in joint working by education and health services, particularly joint commissioning, including needs assessment and design of service delivery;
- the balance between intervention in the early years and provision to children and young people throughout the age range; including those in vulnerable situations such as those at risk of offending or re-offending;
- how to further improve workforce skills in early years settings AND schools;
- effective provision of AAC technology;
- improving support and information for parents; and young people
- transition to adult services

Annex D (i): Call for Evidence: Questionnaire

Article I. Bercow Review of Speech, Language and Communication Needs-Call for Evidence

Section 1.01 Consultation Response Form

- a. The closing date for this consultation is: 18 January 2008
Your comments must reach us by that date.

THIS FORM IS NOT INTERACTIVE. If you wish to respond electronically please use the online or offline response facility available on the Department for Children, Schools and Families e-consultation website (<http://www.dcsf.gov.uk/consultations>).

The information you provide in your response will be subject to the Freedom of Information Act 2000 and Environmental Information Regulations, which allow public access to information held by the Department. This does not necessarily mean that your response can be made available to the public as there are exemptions relating to information provided in confidence and information to which the Data Protection Act 1998 applies. You may request confidentiality by ticking the box provided, but you should note that neither this, nor an automatically-generated e-mail confidentiality statement, will necessarily exclude the public right of access.

Please tick if you want us to keep your response confidential.

Name

Organisation (if applicable)

Address:

If your enquiry is related to the policy content of the consultation you can contact Antony Thompson on:

Telephone: 020 72735161

e-mail: antony.thompson@dcsf.gsi.gov.uk

If you have a query relating to the consultation process you can contact the Consultation Unit on:

Telephone: 01928 794888

Fax: 01928 794 113

e-mail: consultation.unit@dcsf.gsi.gov.uk

Please could you tick the **ONE** box which best identifies you:

<input type="checkbox"/>	Parent/carer	<input type="checkbox"/>	Young person (19 and under)	<input type="checkbox"/>	School staff (Please state your role)
<input type="checkbox"/>	LA staff (Please state your role)	<input type="checkbox"/>	Academic/researcher	<input type="checkbox"/>	Professional body
<input type="checkbox"/>	Voluntary organisation	<input type="checkbox"/>	PCT staff	<input type="checkbox"/>	Other (please specify)

Please Specify:

Please note questions 1-4 are specifically for parents to answer. Questions 5-20 are mainly for local authority, PCT or school staff to answer. However, please feel free to respond to any question on which you have a view. If you are responding on behalf of an organisation, you might prefer to enter information in the comments section only of each question.

If you want to let us have your views without completing the questionnaire or if you want to comment on any issue not covered in the questionnaire, you can either complete the box at Q21 or e-mail your comments to Bercow.Review@dcsf.gsi.gov.uk

1. Overall, my family's experience of speech, language and communication services is that they are:

<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Satisfactory	<input type="checkbox"/>	Poor
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Comments:

2 a) The information I needed to find out about support for my child was:

<input type="checkbox"/>	Easy to find	<input type="checkbox"/>	Not easily available	<input type="checkbox"/>	Not available at all
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Comments:

2 b) And the quality of the information was:

<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Satisfactory	<input type="checkbox"/>	Poor
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Comments:

3 a) My child has a Statement of Special Educational Needs:

Yes No

3 b) If “yes”, is speech and language therapy is written into section 3 of the statement. If no, where in the statement is it listed?

Yes No

Comments:

4 a) Describe your family’s overall experience of speech, language and communication services. (E.g. What was most important for your child? Where did you go for information and who helped you? How long did it take to get help? In your experience, what works well and what needs to be improved? If applicable – are you satisfied with the speech and language aspects of your child’s Statement and the overall service being provided to meet your child’s needs?)

Comments:

4 b) Tell us how speech, language and communication services could be improved. (E.g. Does your child need more assistance than at present and, if, so what kind of assistance? What could be improved and how might it be improved? What would your ideal speech and language service look like?)

Comments:

Please note questions 1-4 are specifically for parents to answer. Questions 5-20 are mainly for local authority, PCT or school staff to answer. However, please feel free to respond to any question on which you have a view. If you are responding on behalf of an organisation, you might prefer to enter information in the comments section only of each question.

If you want to let us have your views without completing the questionnaire or if you want to comment on any issue not covered in the questionnaire, you can either complete the box at Q21 or e-mail your comments to Bercow.Review@dcsf.gsi.gov.uk

- 5 In my local area, the expertise of school staff and others in the children's workforce (e.g. health visitors, early years workers, children's social workers) to identify and deal with children's language, speech and communication needs is:

<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Satisfactory
<input type="checkbox"/>	In need of significant improvement				

Comments:

- 6 In my local area, access to speech and language training for school staff and others in the children's workforce is:

<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Satisfactory
<input type="checkbox"/>	In need of significant improvement				

Comments:

7 In my local area, access to training and development opportunities for speech and language therapists is:

<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Satisfactory
<input type="checkbox"/>	In need of significant improvement				

Comments:

8 a) Set out your views on the workforce in your local area, including people who work in the health and education sectors, as well as others in the children’s workforce. (E.g. the role of school staff and the role of speech and language therapists. What training and development opportunities are available? Is recruitment and retention an issue? Can some children’s speech, language and communications needs met by professionals other than speech and language therapists?)

Comments:

8 b) What are the important workforce issues to address? (E.g. Where improvements could be made and by whom. Do the different professionals all have the expertise and ability to identify and address children’s speech, language and communications needs? Are their sufficient numbers of the different types of professionals needed to work with children with speech, language and communications needs? What steps should Government take to make improvements and what should be done at a local level?)

Comments:

9 For health and education services in my local area, meeting children’s speech, language and communications needs is:

<input type="checkbox"/>	A high priority	<input type="checkbox"/>	One of many competing priorities	<input type="checkbox"/>	Not a priority
<input type="checkbox"/>	A priority for health only	<input type="checkbox"/>	Education only	<input type="checkbox"/>	

Comments:

10 Health and education services work well together to provide these services:

<input type="checkbox"/>	All or most of the time	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
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Comments:

11 a) Set out your views of the strategy to deliver to speech, language and communications services in your local area. (E.g. Is there strategic leadership from service heads? Are steps being taken to bring services closer together or to integrate them? Are formal arrangements in place to ensure effective commissioning and delivery of services? Are there agreed local plans and/or targets?)

Comments:

11 b) How could strategic leaders strengthen delivery of speech, language and communications services? (E.g. What would need to be done in respect of service structures and operations? Would priorities have to change? What levers might bring about change?)

Comments:

12 In my experience, resources are used mainly to provide [tick all that apply]:

<input type="checkbox"/> Support for children in their early years	<input type="checkbox"/> Support for 5-11 year olds	<input type="checkbox"/> Support for 11-16 year olds
<input type="checkbox"/> Support for 16-19 year olds	<input type="checkbox"/> Support for children with the severest speech, language and communication needs	<input type="checkbox"/> Support for children with low level needs
<input type="checkbox"/> Speech and language units	<input type="checkbox"/> Outreach work	<input type="checkbox"/> Information for parents
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/>	

Comments:

13 a) Tell us how funding for speech, language & communication needs is used in your local area. (E.g. Is funding invested where it will have an impact on a wide group of children or is it targeted at those with the severest needs? What is the balance of funding for the provision of speech & language therapists (including their training & development), capital investment (e.g. language units) and the provision of information & training for school staff and others in the children’s workforce? Are services investing in practices they know will produce the best outcomes?)

Comments:

13 b) Describe how you think resources at both national and local level should be used. (E.g. should more resources be directed towards early intervention? What kind of investment offers best value for money in terms of improving children's outcomes?)

Comments:

14 In my local area, lines of accountability in all services are:

Clear Clear on some issues Not clear

Comments:

15 In terms of improving children's outcomes, service standards are:

Excellent Good Satisfactory
 In need of significant improvement

Comments:

16 Evidence to show standards and children's outcomes are improving is:

Collected and shared regularly Available for some aspects, but not others Not available

Comments:

17 At national level, lines of accountability are:

<input type="checkbox"/>	Clear	<input type="checkbox"/>	Clear on some issues	<input type="checkbox"/>	Not clear
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Comments:

18 Central Government's contribution to raising standards is:

<input type="checkbox"/>	Clear and helpful	<input type="checkbox"/>	In need of strengthening	<input type="checkbox"/>	Not clear
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Comments:

19 Set out your views on service standards and lines of accountability within and across services. (E.g. Are standards clear and agreed? Is it clear who is responsible for what at all levels in each service? Is the evidence, including performance data, collected and acted on to ensure continuous improvement and higher standards? How are children's outcomes measured?)

Comments:

20 What are the important steps needed to improve standards? (E.g. What level of standards should be achieved (give examples)? What should be the role of Government departments and national regulators or inspectorates?)

Comments:

21 Do you have any further comments?

Comments:

Thank you for taking the time to let us have your views. We do not intend to acknowledge individual responses unless you place an 'X' in the box below.

Please acknowledge this reply

Here at the Department for Children, Schools and Families we carry out our research on many different topics and consultations. As your views are valuable to us, would it be alright if we were to contact you again from time to time either for research or to send through consultation documents?

Yes

No

All UK national public consultations are required to conform to the following standards:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
2. Be clear about what your proposals are, who may be affected, what questions are being asked and the timescale for responses.
3. Ensure that your consultation is clear, concise and widely accessible.
4. Give feedback regarding the responses received and how the consultation process influenced the policy.
5. Monitor your department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.
6. Ensure your consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

Further information on the Code of Practice can be accessed through the Cabinet Office Website: <http://www.cabinetoffice.gov.uk/regulation/consultation-guidance/content/introduction/index.asp>

Thank you for taking time to respond to this consultation.

Completed questionnaires and other responses should be sent to the address shown below by 18 January 2008

Send by post to: Consultation Unit, Area 1A, Castle View House, East Lane, Runcorn, WA7 2GJ

Send by e-mail to: Bercow.Review@dcsf.gsi.gov.uk

Annex D(ii): Call for Evidence: Summary of Responses

Bercow Review of Speech, Language and Communication Needs – Call for Evidence

Analysis of responses to the consultation document

Consultation Unit
Department for Children, Schools and Families
Castle View House
Runcorn
Cheshire WA7 2GJ
Tel: 01928 794888
Fax: 01928 794113
7 February 2008

Introduction

This report has been based on 2045 responses to the consultation document.

As some respondents may have offered a number of options for questions, total percentages listed under any one question may exceed 100%. Throughout the report, percentages are expressed as a measure of those answering each question, not as a measure of all respondents.

The organisational breakdown of respondents was as follows:

Parent/carer	931
PCT staff	408
School staff	243
LA staff	120
SLT (non-categorised)	61
Other*	53
Young person (19 and under)	53
Voluntary organisation	47
Professional body	45
Academic/researcher	31
Individual	25
Independent therapist	18
NHS Trust	7
Union	3

**Those which fell into the 'other' category included:*

Social Services; Paediatric Clinicians/Specialists; Music Therapists; FE Colleges; The Youth Justice Trust; Training coordinators/providers; The SENAD Group; The Local Government Association (LGA); Political Parties; The Museum and Libraries Archive; The Independent Schools Council; ISAAC UK; The Children's Legal Centre; and The Pre-School Learning Alliance.

The report starts with an overview, followed by a summary analysis of each question within the consultation.

Annex A provides a statistical analysis of responses by respondent 'type'. Comments expressed by less than 5% of respondents appear in Annex A only.

Annex B lists suggestions and comments made by respondents in answer to each question. This annex is intended to provide context to the summary and statistics and is not intended as a formal part of the report for publication.

Annex C lists all respondents to the consultation document.

Annex D lists respondents who would like to be included in future research or receive further consultation documents.

Overview

Many parents/carers were of the opinion that there was an insufficient number of speech and language therapists (SLTs), and lack of resource available to provide adequate speech and language therapy for their child. Although some were satisfied with the services, in the main respondents were generally not satisfied. They commented on lengthy waiting times and problems experienced when trying to access speech and language therapy through Local Authorities (LAs) and NHS/Health Authorities. A lot of respondents said they had resorted to paying for private services. They were also concerned that services were not available for all children, for example there was limited SLT provision in secondary schools.

Parents/carers said that their child needed more speech and language therapy than had been provided (in many cases stating that one to one therapy was required), and supported the need for the employment of more SLTs. They also felt strongly that additional information and courses for parents/carers/families would be beneficial in helping them to support their child.

Parents/carers mentioned a range of different circumstances affecting their children, mainly: autism related difficulties, Down's Syndrome (DS), stammering, feeding and swallowing problems, cleft palate, blindness, deafness and hearing impairments (HI), dyspraxia, dyslexia, cerebral palsy, learning difficulties, and children who were users of Voice Output Communication Aids (VOCA) and Augmentative and Alternative Communication (AAC) equipment. They thought that therapists should have more training related to these issues, and that there could be more therapists specialising in these areas.

Other respondents greatly supported the view of parents/carers regarding the fact that there were insufficient numbers of SLTs in post to support the services. There was also significant mention of the need for training in speech, language and communication needs (SLCN) for all staff in the children's workforce. SLTs commented that there was limited funding available for their own training, and that they did not have time to train others due to the fact that they had large caseloads exacerbated by shortages of staff.

Respondents thought cuts in funding and budget restrictions limited the SLT resource available, and that service delivery was greatly affected as a result. There was mention of the fact that there were a number of SLT graduates who were unable to get jobs due to posts being 'frozen'. They thought that services were also hampered by the fact that education and health had different and competing priorities which governed use of funding and resource. Each organisation

had separate funding streams, and respondents considered there to be no shared agenda or consistency of approach. There seemed to be no clarity on, or agreement for, responsibility and accountability.

In order to improve standards for SLCN respondents considered that more funding was required, training was needed across the board, and that it was essential to employ more SLTs. They were also of the opinion that there needed to be greater collaboration between health and education, with clear roles, responsibilities and accountability. They agreed that there ought to be a focus on early intervention and preventative work but felt that there should also be more ongoing support, particularly at secondary school level, and through to further education and adulthood where necessary.

There were a number of responses received from young people who were users of VOCA and AAC equipment. They stated that they were reliant on their communication aids, and said how vital they were in providing them with a means of expressing themselves and making themselves understood.

Summary

Q1 Overall, my family's experience of speech, language and communication services is that they are:

There were 995 responses to this question

Excellent 126 (13%) Good 159 (16%) Satisfactory 164 (16%) Poor 546 (55%)

Over half of the respondents described their experience as poor, citing circumstances where the service had fallen short of meeting their expectations or requirements in the following areas:

254 (26%) respondents said the amount of therapy received was not enough. They described instances where the child had not been given the sufficient amount of therapy required. Some mentioned that even in cases where the child was statemented the amount of therapy provided was less than the amount documented or recommended in the statement. A few said that statements were written in a manner depicting only what the service provider knew it was able to provide, not what was actually required. Respondents felt that availability to the service was greatly affected by a shortage of speech and language therapists (SLTs).

212 (21%) commented that it took too long to see a therapist. They described situations where they had waited considerable amounts of time for therapy. In some instances this was for an initial assessment, and in others it was the period spent waiting between each individual session. Some mentioned that they encountered significant delay while waiting to hear about appointments.

208 (21%) mentioned that services were not available for all children due to location, age, or type of disability. Examples of where they felt that service provision was deficient included the following:

- concern regarding an un-availability or inefficiency of services dealing in Downs Syndrome (DS), autism, cerebral palsy, dyspraxia, dyslexia, deaf or hearing impaired (HI), and for users of communication aids;

- significant lack of secondary school services, and services for older children/young people with a need for continuity, or transition arrangements between services;
- some concern regarding service availability to younger children; and
- differences in service provision between different Boroughs/Local Authority (LA) areas and Primary Care Trust (PCT) coverage. Parents/carers reported instances where their child travelled a considerable distance to attend a facility in another area.

(The above is not a comprehensive list, for more comments relating to this issue see Annex B of this report).

84 (8%) were concerned that their child's progress might have been hindered by either a delayed start to therapy, or the lack of/amount of therapy received. Some parents/carers were of the opinion that their child might have benefited from an earlier start to therapy, or additional therapy which might have resulted in their child making more progress. They mentioned that the opportunity for making optimum progress was narrow as children develop speech and language patterns at a young age. As such they felt they were at possible risk of their problems becoming entrenched if not given the right support at the earliest opportunity.

84 (8%) specified that their child currently attended a Language Unit (LU), or had at some point attended a LU. Some mentioned that their child had to leave at a certain age as the LU only catered for a pre-determined age range. Although not all the comments made regarding LUs were positive, (for example some stated there was still insufficient therapy provided even in the LU) in the main parents/carers were of the opinion that it was important for their child to have a place in such a unit as they believed that their child would receive a more appropriate level of support. There was mention of the difficulties encountered in securing a place in a unit, and some parents/carers were very concerned that a number of LUs were threatened with closure.

77 (8%) respondents thought that the therapist did not have the necessary experience to deal with the type of condition affecting their child. Parents/carers identified areas where in their opinion the therapist was not sufficiently trained to deal with their child's condition. These included:

- therapists being unable to sign
- therapist not trained to deal with DS
- therapist inexperienced in dealing with autism
- therapist inexperienced in working with children, or service was not child focused
- no experience of Augmentative and Alternative Communication (AAC)
- and the inability to deal with more severe or complex speech and language conditions.

(The above is not a comprehensive list, for more comments relating to this issue see Annex B of this report).

Respondents who commented on the more positive aspects of the service (although in answer to Q1 they might not have given an overall good or better rating) mentioned the following:

54 (5%) parents/carers were of the opinion that the service provided at nursery/playgroup or before entering school was good. Some mentioned that the service they received prior to their child starting school was better than the service they went on to receive once the child entered formal education. They said that support was more easily accessible through the early years. Parents/carers did not always indicate what type of pre-school support they had received.

49 (5%) indicated that the services received through school were good. Parents/carers did not always state whether the school was a mainstream or special school.

Q2a) The information I needed to find out about support for my child was:

There were 881 responses to this question

Easy to find 201 (23%) Not easily available 533 (60%) Not available at all 147 (17%)

Respondents were largely of the opinion that information was not easily available and commented on the following issues:

205 (23%) respondents mentioned difficulties they had experienced in obtaining information. Their answers covered a variety of issues among which the following areas of concern were included:

- there was no formal or coordinated system to provide parents with information
- difficulty in locating the right person/department to speak to
- a lack of information relating to more specialised requirements
- the impression that services were apprehensive in providing information, due to the view that it would add to the demand on their time and resource

(The above is not a comprehensive list, for more comments relating to this issue see Annex B of this report).

109 (12%) remarked that they 'needed to know where to look', or 'be in the know'. Some commented that experiences within their family, or their employment had helped them find the information they required. They also said that a lot of the information they received was by word of mouth, for example chance conversations with other parents had pointed them in the right direction.

68 (8%) respondents mentioned the fact that they had used the internet to find relevant sources of information.

Q2b) And the quality of the information was:

There were 813 responses to this question.

Excellent 103 (13%) Good 194 (24%) Satisfactory 211 (26%) Poor 305 (37%)

Respondents' opinions were split over the quality of the information they had received.

87 (11%) said that they been provided with, or had got the information they needed from a range of organisations such as SMIRA, Afasic, National Autistic Society, Mencap, Unique, Find A Voice, IPSEA, DS Associations, local charities and other regional support groups. They mentioned that they found these groups invaluable in providing them with information they had found

difficult to obtain from official departments, and respondents who had selected 'poor' in these cases were not in general referring to these channels.

77 (9%) specified that no information at all was available from speech and language departments. Almost all these respondents marked the quality of the information as 'poor'.

Q3a) My child has a Statement of Special Educational Needs:

There were 861 responses to this question.

Yes 643 (75%) No 218 (25%)

The majority of respondents who replied to this question did have statements of special educational needs.

Q3b) If "yes", is speech and language therapy written into section 3 of the statement? If no, where in the statement is it listed?

There were 611 responses to this question.

Yes 509 (83%) No 102 (17%)

In general where the child did have a statement, the speech and language therapy tended to be included in section 3. However, there were some instances where the therapy was listed in a different section. For comments on this please refer to Annex B of this report.

117 (19%) respondents stated that they had fought for their child's statement. These included instances where they went to ruling via the Special Education Needs and Disability Tribunal (SENDIST) to get the LA to specify or quantify speech and language in the statement. In some cases respondents said that they had to take this action more than once, while others mentioned that they were currently in the process of going to tribunal or seeking legal advice to attempt to get the statement changed.

Q4a) Describe your family's overall experience of speech, language and communication services. (e.g. What was most important for your child? Where did you go for information and who helped you? How long did it take to get help? In your experience, what works well and what needs to be improved? If applicable, are you satisfied with the speech and language aspects of your child's Statement and the overall service being provided to meet your child's needs?)

There were 906 responses to this question.

300 (33%) parents/carers held the view that a core factor was the general lack of sufficient therapy services caused by shortages in manpower and local resource. They referred to the infrequency and cancellation of appointments. They commented on the high staff turnover rate within speech, language and communication services, and claimed that therapists left at short notice without replacement. Respondents thought that therapists' caseloads were too large, and that some staff lacked sufficient experience. They also claimed that cuts in services and funding regimes were factors contributing to the lack of available therapist time. They said that there was a shortage of local suitable educational facilities for their child to attend, and also mentioned the lack of rooms within schools where therapists could work with children.

251 (28%) parents/carers described problems they had encountered in order to get the appropriate support for their child, with some depicting their experience as a 'fight' or a 'struggle'. A lot of these respondents pointed out that they had been through tribunal procedures in answer to this question or question 3b.

248 (27%) respondents agreed that waiting lists were too long. They thought that the service needed a swifter response to the first appointment after diagnosis and that assessment needed to be carried out more quickly. They also said that there should be more regular access to therapy. Some parents reported that they waited in excess of a year. Others mentioned the fact that the lengthy waiting times might have had an impact on their child's ability to make progress. The lack of manpower was recognised as a contributory factor to the time taken to get access to provision.

216 (24%) commented that they were satisfied with the overall service received. Although some of these might have reported certain negative issues, such as lengthy waiting times for example, once therapy had started they were content with the provision.

203 (22%) stated that they paid for the use of private therapy services or in some cases, private schools. While some paid for an independent report or assessment, others paid for a number of private therapy sessions.

147 (16%) respondents remarked that service provision in school had not been satisfactory. Their comments included the following views:

- that school staff did not understand the full nature of their child's condition, and that training was an issue;
- that there was an acute shortage of therapy provision in secondary schools, and limited therapy available in mainstream schools in general;
- that school staff did not have the time to dedicate to speech, language and communication needs as they had to focus more on the demands of the curriculum;
- the demands on the limited number of speech, language and communication therapists were too great to enable them to dedicate their time effectively to all schools on their caseload;
- there were no speech, language and communication services available during school holidays; and
- that even children in some special schools were not getting the amount of therapy they required.

(The above is not an exhaustive list. For a further range of respondents' comments refer to Annex B of this report.)

141 (16%) mentioned that their child was either Autistic or had DS. Many raised issues they thought were specific to these conditions. Where Autism was specified, respondents thought that services had little understanding of the full nature of their child's difficulties, and that there should be more therapists who specialized in this area, and more awareness among school staff. There was mention that DS children experience problems with tongue control, low muscle tone and hearing difficulties, and inevitable speech and communication difficulties ensue as a result.

They felt parents/carers needed more advice from an early age on how to help their child, for example with feeding. They said that the advice and support they had received from DS groups had been valuable, and some believed that there ought to be therapists who specialize in treating speech and communication problems associated with DS.

111 (12%) reported that they had reason to be dissatisfied with the services provided through the LA. Among these respondents were a number of parents/carers who mentioned the fact that they had taken the LA to tribunal to secure an appropriate statement or provision for their child. There was a view that some LAs did not fully comply with the requirements as laid out in the statement, resulting in failure to provide the recommended service. Other parents mentioned that the LA had to pay for the child to attend a private facility.

79 (9%) were not satisfied with the services they had received via the NHS. Again, they reported long waiting times, and mentioned experiences where they were displeased with individual GPs, health visitors and speech and language therapists. They also referred to the need in some cases to top up the amount of therapy provided by paying for private additional sessions.

75 (8%) were respondents whose child was deaf or had a hearing impairment (HI). Parents/carers claimed that there was a shortage of SLTs with specific training in this matter, or that the amount of therapy provided had been inadequate. There was mention of money spent by LAs on surgery for insertion of cochlear implants, but then failure to provide the amount of therapy needed after the operation. Not all the comments by parents of deaf/HI children were negative, a few said that they had received good services and commented on the effectiveness of their teacher for the deaf.

63 (7%) thought that parental/carer concerns were ignored. They described situations where they had not been taken seriously by professionals, or where professionals had not acknowledged their initial worries over their child.

55 (6%) parents/carers said that information or resources were out of date or bad quality, or that equipment needed to be replaced but there was no funding. There was also the mention of therapists using outdated methods when testing children.

Q4b) Tell us how speech, language and communication services could be improved. (e.g. Does your child need more assistance than at present and, if, so what kind of assistance? What could be improved and how might it be improved? What would your ideal speech and language service look like?)

There were 780 responses to this question.

354 (45%) agreed that more therapy was needed than had been provided, and many thought their child would benefit more through regular therapy delivered via one to one sessions.

288 (37%) supported the need for additional qualified SLTs to be in post. They felt quite strongly that the service was short staffed, and that therapists had too many clients on their workload. They said that more staff were needed in order to support their call for the extra therapy they felt their children required, and to limit the long waiting times experienced.

230 (29%) parents/carers said they required more access to relevant information, and more availability of courses for themselves and their families. The following suggestions were made:

- training sessions for groups of parents/carers and families
- more information available on the internet with relevant website addresses given to parents/carers upon initial contact with health visitors or therapists
- provision of lists of relevant reading material
- exercises for parents/carers to do at home with their child
- support for AAC and ICT skills
- and information to be more easily accessible and improved in general.

(The above list is not exhaustive, for more comments refer to Annex B of this report.)

140 (18%) agreed that more funding was an essential element required in order to improve all aspects of the services, including the employment of more staff and provision of staff training, and to provide communication aids.

133 (17%) respondents believed that improvement might be made if all schools had access to a therapist or if services were to become more 'school based'. Some felt that there should be more speech and language units attached to mainstream schools. As well as the need for more support within mainstream services, there was reference to a need for more provision for the independent sector too. Support within secondary schools was felt to be minimal.

130 (17%) mentioned that training needed to be improved. As well as additional training for SLTs who they felt required more specialist knowledge, they felt that training should be more extensive for school staff and teachers, and should cover conditions previously mentioned in this report such as autism. It was thought that training should also include early years staff and health visitors, and others who come into contact with children with speech language and communication difficulties.

90 (12%) parents/carers said services should be tailored to the individual. They specified that services needed to be able to respond more effectively to the needs of individuals rather than taking a 'one size fits all' or 'general' approach. There was also the idea that the SLT could deliver the therapy in the child's home.

81 (10%) respondents made further reference to the need for SLT services to have specialists in the likes of autism, deafness and HI, and other areas of speech, language and communication difficulty.

Q5 In my local area, the expertise of school staff and others in the children’s workforce (e.g. health visitors, early years workers, children’s social workers) to identify and deal with children’s language, speech and communication needs is:

There were 1319 responses to this question.

Excellent 73 (6%) Good 308 (23%) Satisfactory 348 (26%)
 In need of significant improvement 590 (45%)

Almost half the respondents thought that this was an area where significant improvement was needed.

261 (20%) were of the view that the expertise of staff in the children’s workforce varied considerably, both across and within services. They said that there were variations between different regional areas, with mixed approaches to the delivery of speech and language therapy. In practice the expertise ranged from ‘needed to improve’ to ‘excellent’, and opinions differed on which services were generally good and which needed developing.

258 (20%) said there was not enough knowledge of speech, language and communication difficulties across the children’s workforce. They felt that training was needed not only for teachers and school staff, but for other staff in the sector also.

75 (6%) commented on the difficulties for mainstream schools in supporting children with speech, language and communication difficulties. They felt that mainstream staff lacked sufficient knowledge and training in this area, and that there was limited access to specialist support. There was mention of lack of protocol or policy in training staff in developing their skills to manage SLC. There was reference to the number of children entering school with these difficulties and the theory that there was only so much that mainstream services could do to support them.

Q6 In my local area, access to speech and language training for school staff and others in the children’s workforce is:

There were 1081 responses to this question.

Excellent 90 (8%) Good 261 (24%) Satisfactory 204 (19%)
 In need of significant improvement 526 (49%)

Almost half the respondents were of the view that access to training was an area that needed significant improvement.

169 (16%) said that although training was available the worst problem was releasing staff to attend, due to lack of resources and time constraints. Their opinions included the following:

- access to training for learning support assistants (LSAs) was difficult, as schools utilised LSAs for other duties and could not spare time for them to attend training;
- there was no funding for supply staff to cover staff absences across various services, for training purposes;
- difficulties for social workers to attend training due to workload;

- teachers were unable to attend training, as it was difficult for them to be released from the classroom, and they were at pressure to deliver the national curriculum;
- INSET days were already fully booked up with other aspects of training, and the theory that speech and language was not considered a priority;
- there was no coordinated programme for training;
- uptake was limited on courses due to poor publicity;
- and no extra time was given to attend training.

127 (12%) stated that more funding was needed in order to improve access to training across the children's workforce.

114 (11%) respondents commented that SLTs did not have enough time to train schools, staff and other members of the children's workforce. They said that there were insufficient numbers of SLTs, and that therapists had large caseloads and needed to spend time seeing their clients which impacted on their availability to provide training.

Q7 In my local area, access to training and development opportunities for speech and language therapists is:

There were 790 responses to this question.

Excellent 39 (5%) Good 162 (20%) Satisfactory 158 (20%)
In need of significant improvement 431 (55%)

Over half said that access to training and development opportunities for SLTs was in need of significant improvement.

312 (39%) respondents stated that access to training and career development for SLTs was severely affected by the lack of available funding. They said that training budgets had been cut significantly. Many PCT staff and SLTs reported having to fund their own training and associated travel or accommodation expenses.

109 (14%) had various other comments to make on training and development opportunities within this sector. The following is a selection of their views:

- there was limited access to external training;
- therapists did not have time to attend courses;
- places on training courses were limited;
- there was limited training for SLT assistants;
- Masters level training was not easily available;
- training was not always viable for smaller services;
- the lack of training and support would inevitably impact on the quality of services; and
- specialist skills needed training which was not readily available locally.

(The above is not an all inclusive list. For more comments relating to this see Annex B of this report)

90 (11%) gave examples of instances where access to training and development opportunities were good.

71 (9%) highlighted the shortage of qualified SLTs, which impacted on the availability to attend training due to large workloads. Large workloads had the resulting effect of lowering priority for training. There was mention that downgrading of jobs had meant that a number of staff had left, and the suggestion made that pay needed to rise to attract more people into the profession.

Q8a) Set out your views on the workforce in your local area, including people who work in the health and education sectors, as well as others in the children's workforce. (E.g. the role of school staff and the role of speech and language therapists. What training and development opportunities are available? Is recruitment and retention an issue? Can some children's speech, language and communications needs be met by professionals other than speech and language therapists?)

There were 1022 responses to this question.

472 (46%) agreed that other professionals could, and in many cases did, meet some children's speech, language and communication needs. It was felt quite strongly that this could only be achieved with provision of adequate training and supervision from SLTs.

346 (34%) mentioned recruitment and retention issues. Where it was agreed that these issues were a problem respondents commented on the following contributory factors:

- when SLTs left the service they were not replaced so jobs were effectively 'frozen';
- the number of staff on maternity leave presented a problem;
- short term initiatives, or staff employed on short term contracts for which funding was subsequently cut;
- unsatisfactory working conditions and large caseloads;
- morale was generally low, as staff felt undervalued and changes to commissioning and funding had led to unrest among staff within PCTs;
- low rates of salary, and lack of career structure with limited progression opportunities; and
- the high cost of housing in some areas.

The above is not an all inclusive list. For more comments on this issue refer to Annex B of this report.

317 (31%) respondents felt that there was a shortage of SLTs, which meant that there was limited access to these staff, and there was a shortage of trained staff in other areas in the children's workforce. There was the mention from school staff regarding the lack of SLT cover in relation to the number of pupils. There was discussion surrounding the need to have a designated member of staff in school to support these students and to work with the other staff. There was also the recognition that TAs were not always sufficiently trained in dealing with speech, language and communication issues, yet they were expected to help support therapy. Others said that TAs were overstretched and their resource was used for other activities within the classroom.

295 (29%) commented on training issues. There were many comments regarding training. Some of the issues raised were as follows:

- there was the need for school staff to have more concentrated training on these issues rather than the periodic INSET day;
- there was a lack of funding for training for SLTs, therefore there was limited training available unless it was in-house;
- there needed to be a multi agency approach to training;
- training was available to school staff but schools had difficulty releasing staff to attend, training needed to be given more priority;
- more formal training was needed for health visitors, GPs and nurses;
- therapists needed a greater awareness of the national curriculum and new education strategies;
- SLTs did not have time to carry out training with other professionals, due to large caseloads and limited staff resource; and
- more training was needed for staff working in the Early Years sector and Children's Centres.

Other respondents mentioned various training methods that were available. For more comments relating to training refer to Annex B of this report.

274 (27%) said that a multidisciplinary approach was used, and thought collaborative working was the best method of service delivery. They agreed that staff from many organisations should be involved, to identify children's needs and to help deliver aspects of speech, language and communication therapy.

Among those mentioned were music therapists, occupational therapists, teachers, TAs, other school staff, parents, SLTs, health visitors, staff in the early years sector, teachers of the deaf, communication assistants, specialist teaching advisors, behaviour intervention teams, and autism outreach teams.

For more comments relating to multidisciplinary approaches refer to Annex B of this report.

196 (19%) agreed that more funding was needed in several areas, including the following:

- in schools to provide supply staff cover for releasing staff for training;
- in PCTs and NHS Trusts to recruit and retain more SLTs;
- to enable joint working and integrated approaches between services, without the need to 'guard' or protect their separate budgets;
- funding to support services in mainstream schools;
- to provide external training courses; and
- funding for communication aids and associated training.

For more comments relating to funding refer to Annex B of this report.

188 (18%) thought that experts or specialist professional therapists were needed to deliver speech and language therapy. Some thought that SLTs, (or teachers for the deaf for example), were the only ones who were trained sufficiently to deliver the services, and as such other professionals within the children's workforce (such as TAs for example), should not be involved. From another angle, others said that some difficulties such as autism or DS, or some children's more specific needs, warranted specific training, and that there should be more training for SLTs in such matters, or SLTs who specialised in these areas.

140 (14%) respondents commented on the fact that therapists had big caseloads and thought that SLTs were overworked.

62 (6%) made reference to the size of waiting lists, saying that they were too long as a result of a shortage of therapists and resulting large caseloads.

57 (6%) said that children with speech, language and communication needs (SLCN) needed to be identified early and their problems dealt with before there was an effect on their education, or other long term issues. They thought that there should be more training for pre-school staff in early identification.

8b) What are the important workforce issues to address? (e.g. Where improvements could be made and by whom. Do the different professionals all have the expertise and ability to identify and address children's speech, language and communications needs? Are their sufficient numbers of the different types of professionals needed to work with children with speech, language and communications needs? What steps should Government take to make improvements and what should be done at a local level?)

There were 888 responses to this question.

533 (60%) agreed that more therapists, communication assistants/SLT assistants, more resource in schools, and more local services were needed to help address workforce issues and deliver SLCN services.

402 (45%) referred to training and development. A selection of their views included the following:

- that initial teacher training needed to have a broader coverage of SEN issues, with a module incorporated into teacher training programmes to cover SLCN;
- that TAs needed more specific training;
- the view that more training was needed for staff in the Early Years sector;
- that trainee doctors, occupational therapists, physiotherapists etc. should be given more training on communication development during their degree courses;
- that awareness should be raised among employers, youth workers, the judiciary, police, prison staff, probation workers, college staff and staff in Pupil Referral Units (PRUs) etc. about SLCN;
- the opinion that there were limited career pathways for therapists;
- that collaborative training methods were needed;

- the view that training should be accredited and should be mandatory for all organisations working with children;
- that increased training was needed in AAC; and
- that time was needed to carry out training, for SLTs in providing the training, and for other members of the children’s workforce to attend training.

The above is not an exhaustive list of comments relating to training and development. For further comments refer to Annex B of this report.

279 (31%) respondents discussed funding. It was thought that sustainable long term funding was needed to support workforce and service delivery issues. There was mention of the need for a more cohesive budget arrangement between education, health and social services with cooperation between these services. There was also the idea that more funding should be given to schools to enable them to buy in more services, and that funding was needed to provide support in secondary schools.

124 (14%) were of the view that there needed to be further support for early intervention, with more services and funding available to the Early Years sector to identify SLCN in babies, toddlers and pre-school children. It was thought that a preventative and early intervention approach might help to alleviate pressure on services when children started school, and would be more cost effective long term. There was mention of the need for health visitors to have regular contact with families, and for early screening and developmental checks to be undertaken.

98 (11%) respondents thought that the service needed more experts in conditions such as Autism, AAC or deafness (HI) for example, and more specialist teachers and TAs.

84 (9%) commented on the fact that there was a number of unemployed SLT graduates who were unable to get work within the sector as no posts were available due to cuts in services.

66 (7%) agreed that implementation of core minimum standards was needed. It was thought that there could be guidelines regarding the size of caseloads, or national recommendation of the numbers of SLT staff per head of the population. There was also mention of the need for minimum training standards to be applied and national requirements for provision. There was additional reference to the need for a better career and pay structure.

Q9 For health and education services in my local area, meeting children’s speech, language and communications needs is:

There were 997 responses to this question.

A high priority 153 (15%)	One of many competing priorities 602 (60%)
Not a priority 171 (17%)	A priority for health only 24 (3%)
Education only 47 (5%)	

The majority of respondents thought that meeting children’s SLCN was one of many competing priorities for local health and education services.

141 (14%) respondents agreed that issues surrounding funding caused the main problems for health and education services in meeting children’s SLCN. Each organisation had different funding streams, and different organisational priorities. There was no shared agenda, and no

agreement of responsibility/accountability or consistency of approach. It was thought that funding in health was directed more towards targets in other areas. The following is a list of some of the points respondents made in relation to funding:

- that some funding for meeting SLCN needs had been provided by education due to legal obligations following tribunals;
- the view that funding to individual schools was insufficient to provide the resources needed;
- that the Communication Aids Project (CAP) had provided some funding but the project had now ceased;
- that money previously injected into SureStart projects had now ceased;
- that some funding which had been supplied via the Standards Fund was due to finish;
- the opinion that there were many other groups competing for funds in health services;
- the view that some PCTs and LAs were working more collaboratively but there was still uncertainty around funding;
- the idea that the increasing complexity of some communication needs had not been supported by extra funds; and
- that more funding was needed to support the model used in mainstream schools.

The above is not a complete list. For a further range of comments relating to funding see Annex B of this report.

112 (11%) respondents were of the view that limited availability of resource restricted the ability to provide adequate SLCN services. Even though some staff at delivery level said they viewed it as a high priority, they did not necessarily rate education or health as seeing it as such, as jobs were frozen and services were understaffed.

Q10 Health and education services work well together to provide these services:

There were 1070 responses to this question.

All or most of the time 196 (18%) Sometimes 591 (55%) Rarely 283 (27%)

Over half thought that health and education worked well together some of the time, in providing SLCN services.

173 (16%) were of the opinion that some worked well together, particularly at ground level, but thought that working relationships were not so good at higher management and strategic levels. Some respondents thought that services worked well together when good working relationships between staff had developed.

129 (12%) referred to conflicts between different health and education priorities. Diverse agendas and targets, dissimilar working practices, and different levels of accountability were factors taken into account.

103 (10%) commented on the funding mechanisms in place. There was the mention of education being the department who issued SEN statements, but health was the organisation

expected to provide the support, with very limited funding available. Some respondents were concerned that there appeared to be conflict between departments regarding ultimate responsibility for funding. Further comment was made regarding the cessation of funding streams such as SureStart and the Standards Fund. There was also the observation that SEN budgets had been devolved to schools with schools now making the decision on where the money was spent.

100 (9%) explained that communication was sometimes a problem between health and education. Their comments included the following concerns:

- that the two services did not communicate well at strategic level;
- that specialist teachers did not work closely enough with SLTs;
- that language barriers existed between the two departments;
- that confidentiality issues might be a factor;
- that there was no cross referral, leading to duplication of services in some cases or no service in others; and
- that SLT services were meant to respond to changes imposed by the education department but were not often consulted on proposed changes.

The above is not an exhaustive list. For further comments refer to Annex B of this report.

99 (9%) pointed out that service provision was unequal, with regional as well as local variation. It was thought that much depended on individuals, and on the different types of service delivery and provision.

62 (6%) mentioned instances when some did not work well together. Among the comments made there was mention of failure to work well together at higher managerial and strategic level.

Q11a) Set out your views of the strategy to deliver speech, language and communication services in your local area. (e.g. Is there strategic leadership from service heads? Are steps being taken to bring services closer together or to integrate them? Are formal arrangements in place to ensure effective commissioning and delivery of services? Are there agreed local plans and/or targets?)

There were 706 responses to this question.

213 (30%) said that yes, steps were being taken to integrate services and promote joint working between health and education, although it was acknowledged that in most instances this was in the early stages and much work still needed to be done.

116 (16%) discussed funding and budgetary arrangements with some respondents commenting that lack of funding was acting as a hindrance to effective integration and joint working. Others mentioned the restrictions put on the current service in dealing with demands, due to budget constraints and the administration of funding.

107 (15%) were concerned that there was no strategic leadership at present. Over half of these respondents were PCT/NHS staff and SLTs, some of whom were anxious about the

recent restructures made within their managerial levels, which they felt had left them without professional leads.

101 (14%) respondents considered issues surrounding resource, mainly concerning the need for more staff. A selection of comments made by respondents included the following:

- the view that although changes were in place to develop commissioning of services, provision was determined by staff skill and availability;
- that lack of professional resource was hampering the integration of strategic services;
- that plans and targets were in place but could not be implemented without increasing staffing levels;
- that schools needed more resource to address SLCN and investment was needed in this area;
- the opinion that if specialist SLT posts were reduced it would not be possible to deliver service levels expected by commissioners;
- that some services did not have the capacity to attend joint meetings with colleagues due to their clinical commitments; and
- that SLT services were being reduced to 'advisory services' and SLTs were spending less time delivering actual therapy.

The above is not an exhaustive list. For more comments on this refer to Annex B of this report.

97 (14%) said that there were no plans, targets or strategies in place, or they were not aware of any as none had been circulated.

85 (12%) were aware of some local plans or targets that were in place, for example one respondent mentioned that the LA and the PCT steering group met on a regular basis to plan and monitor services. Another respondent said that their steering group was involved in plans to make provision available to a wider group. For more comments on local plans and targets see Annex B of this report.

83 (12%) were apprehensive about commissioning arrangements. These respondents were mainly PCT/NHS staff and SLTs. A range of comments offered on commissioning included the following concerns:

- that commissioning did not seem to be linked to the clinical outcomes of the child, rather it seemed to serve market forces and economic outcomes;
- that no formal arrangements were in place for effective commissioning;
- the view that SLT services needed to be able to inform the commissioners what they should be aiming for based on evidence/research and good practice;
- that there was no long term strategy in place for joint commissioning of SLT;
- that education commissioned some SLT services through Service Level Agreements (SLAs), but this had resulted in several SLAs for different aspects of service delivery, making it fragmented, and planning was difficult;

- the opinion that there was lack of strategic leadership in terms of health and education working together; and
- that formal arrangements to commission services were ineffective, exacerbated by the lack of knowledge of SLT in LAs.

The above list is not an all inclusive list of comments. For further comments refer to Annex B of this report.

74 (10%) said they did not know or could not comment on the question.

69 (10%) commented on collaborative ways of working with mention of the need for closer working arrangements, joint funding and management of resources through health and education.

67 (9%) thought that good leadership was in place at present. They acknowledged that they had good professional leads who worked to ensure strategic planning around SLCN services, or good management in general.

41 (6%) were of the opinion that more support was needed for SLCN in secondary schools or for older children/young people.

Q11b) How could strategic leaders strengthen delivery of speech, language and communications services? (E.g. What would need to be done in respect of service structures and operations? Would priorities have to change? What levers might bring about change?)

There were 627 responses to this question.

181 (29%) agreed that better links were needed between health and education services to overcome the problems caused by differences in administration, and to facilitate a move towards more coordinated strategies. There was some mention of the move towards Children's Services, which was seen as a way to promote more harmonized working. Sharing of resources, joint planning and shared commitment were seen as ways in which departments could work together.

147 (23%) commented on funding issues. A range of comments made by respondents included the following:

- the view that more money was needed for equipment, accommodation and training;
- that more funds were needed to employ more SLTs;
- the opinion that money was needed to ensure that commitments made in statements could be provided for;
- that funding was needed to meet the needs of secondary school age pupils with SLCN
- that commissioners in the NHS needed to be aware of the importance of SLCN and not make cuts in services when financial savings had to be made;
- the view that more money was needed for prevention procedures;
- that more money was needed to support services in schools; and

- that more funds were needed for improvement to pay for staff in the sector.

The above list is not exhaustive, for more comments relating to funding see Annex B of this report.

135 (22%) remarked that clear strategies, and formalised roles and responsibilities needed to be identified. It was thought that government should develop policies or models of good practice which could be used to build enforceable standards. It needed to be made evident what would be provided by health and what would be provided by education. Responsibility needed to be made clear, both at service delivery level and management level, and also at government department level with the formulation of national policies. There was mention that SLCN needed to be given more priority and that speech and language development needed to be highlighted.

124 (20%) remarked that in order to improve service delivery employment of more staff was required. It was thought that an increased number of therapists was needed to alleviate staff shortages and pressure on services.

105 (17%) raised issues surrounding training. Respondents offered various comments relating to training, the following is a range of their views:

- that training needed to be recognised as a vital part of SLT service delivery, through which other members of the children's workforce would be enabled to deliver some SLT interventions;
- that SLTs needed further training on the education system and the curriculum;
- the view that training for SLCN needed to be embedded into teacher training;
- that training was needed for all Early Years workers, TAs, teachers and other school staff;
- that staff needed time allocated to enable them to attend training with supply cover made available where necessary; and
- that training was needed for parents and carers.

The above list is not an all inclusive list of comments. For more comments relating to training see Annex B of this report.

72 (11%) mentioned that time was needed by therapists and SENCOs to enable them to work with staff and pupils. It was indicated that there should be more focus on meeting children's needs, with more regular visits to schools by therapists and more direct therapy provided by the SLT. There was also the idea that SLTs could be integrated into school settings, or that all schools should have access to a therapist.

53 (8%) respondents believed that the views of 'those in the field' or 'those in the know' should be taken into consideration when reviewing service methods. Some of those mentioned included: local service heads; the local community; practitioners; schools; front line staff; independent bodies and trusts such as DS groups; parents; and teachers of deaf children.

52 (8%) were of the opinion that joint funding should be provided by health and education, as it was thought that common funding streams or pooled budgets might enable better delivery of services and integrated provision.

46 (7%) were concerned over the loss of professional leadership within their service. Again, these were mainly respondents from PCT/NHS and SLTs, who were anxious about the plans to restructure services, without having professional representation from speech and language therapy. There was the view that an SLT manager needed to be involved in the planning of service delivery, as he or she had a full understanding of the service. There was also the mention that services needed to retain their professional leads to maintain good clinical governance.

43 (7%) thought that funding for SLCN services and equipment ought to be ring fenced.

41 (6%) felt that some SLCN services might be better sited within education and be directly accountable to LAs. As SLTs worked with both children and adults, there was the mention that the service could be structured to deal with each separately with paediatric services belonging to education.

36 (6%) highlighted the need for an improved career structure for SLTs with opportunity for career development. They wanted appropriate pay and conditions, and incentives for recruiting more staff to the service.

Q12 In my experience, resources are used mainly to provide [tick all that apply]:

There were 1017 responses to this question.

Support for children in their early years	720 (71%)
Support for 5 -11 year olds	530 (52%)
Support for 11-16 year olds	102 (10%)
Support for 16-19 year olds	44 (4%)
Support for children with the severest SLCN	546 (54%)
Support for children with low level needs	125 (12%)
Speech and Language Units	322 (32%)
Outreach work	122 (12%)
Information for parents	127 (12%)
Other	112 (11%)

169 (17%) respondents mentioned the need for more secondary school provision, and support for children and young people over 11 years of age. They felt that the services were extremely limited in that area.

84 (8%) commented on the general lack of local provision with resources spread too thinly to be effective, and a shortage of suitable educational provision such as LUs in some areas.

Q13a) Tell us how funding for speech, language & communication needs is used in your local area. (e.g. Is funding invested where it will have an impact on a wide group of children or is it targeted at those with the severest needs? What is the balance of funding for the provision of speech & language therapists (including their training & development), capital investment (e.g. language units) and the provision of information & training for school staff and others in the children's workforce? Are services investing in practices they know will produce the best outcomes?)

There were 650 responses to this question.

166 (26%) commented on funding issues in general. Among the comments made respondents raised the following points:

- the view that some schools used the money in other ways, as the funds were not ring fenced;
- that there was an overall general lack of funding available;
- that cuts in funding had had a severe effect on LUs;
- the opinion that there was no funding for information;
- that more money was needed for supporting communication aids;
- that there was little capital investment due to integration into mainstream;
- that funding previously provided through SureStart, the Transformation Fund and the Standards Fund was due to cease;
- the theory that it was difficult to have a long term vision for planning services when funding streams were short term;
- that increasing demands were being made on the services but no funding had been allocated to back this up; and
- that some funding was being used to support bilingual children.

The above is not an extensive list of the comments made on funding, for more comments on this refer to Annex B of this report.

155 (24%) said that funding was used to support services and children through early intervention practices, in the Early Years sector (including SureStart and Children's Centres), or targeted towards younger children and those in the primary school years.

153 (24%) commented that they didn't know.

130 (20%) said that support was targeted to those with the highest or severest needs. There was also the opinion that support was sometimes allocated to those with the most demanding parents/carers, or parents/carers that 'shouted the loudest'.

114 (18%) commented on how funding was used to support or provide training.

76 (12%) mentioned that funding was used to provide SLTs and services for SLCN to children in mainstream schools.

70 (11%) referred again to the fact that they thought there were not enough therapists.

65 (10%) stated that LUs were used.

61 (9%) said that funding came from the LA.

59 (9%) were concerned that there was very little funding available for training. Most of these were respondents from the PCT/NHS sector.

44 (7%) respondents mentioned that they based their practice on evidence of best outcomes, and that this method should be used to ensure that services were most effective.

35 (5%) made further reference to instances where funding had not been identified to support SLCN services, and in some cases there was limited capital investment.

34 (5%) mentioned that some funding was used to support special schools.

Q13b) Describe how you think resources at both national and local level should be used. (e.g. should more resources be directed towards early intervention? What kind of investment offers best value for money in terms of improving children's outcomes?)

There were 930 responses to this question.

608 (65%) agreed that resources should be directed towards early intervention and preventative work to ensure better outcomes for children. Some of these respondents also mentioned that this support should not be provided at the expense of support needed for older children or those with ongoing needs, but in addition to it. It was thought that one should not take priority over the other.

294 (32%) felt that more ongoing support was required for long term SLCN. They mentioned that more support was needed throughout school, especially at secondary level, in the Further Education sector, and into adulthood.

165 (18%) commented on funding issues. Among the comments made by respondents the following points were raised:

- that funding was needed to support services for older children;
- that CAP funding should be reestablished;
- that funding was needed for AAC;
- the view that money was need to provide TAs to help deliver SLCN programmes;
- that funding needed to be long term;
- that schools needed more money to allow them to buy in additional help as required;
- the opinion that money was needed for screening children;
- that money was needed for carrying out research;
- the view that more funds were required for children with the severest needs;
- that funding was needed to support training;
- that more money was required to employ more SLTs; and
- that more funding was required to support work on early intervention.

The above list is not all inclusive. For further comments on funding refer to Annex B of this report.

155 (17%) thought that it was important to address training issues for those in the children's workforce. Respondents offered a variety of comments among which the following points were mentioned:

- that SLTs needed deaf awareness training;
- the view that I CAN nurseries offered a good model with structured training for Early Years staff, and parents and families;
- the idea that employers, prison staff, police, colleges etc should be provided with training packages;
- that training should be provided jointly by education and health;
- the opinion that families should be offered training so they could support the child at home;
- the mention of the need for specialist teachers to have on going training;
- the view that more training needed to be directed at early intervention; and
- that funding was needed to invest in staff skills.

The above is not a complete list of comments made relating to training. For a further range of comments on training refer to Annex B of this report.

137 (15%) were of the opinion that SLT support in schools needed to be increased, with SLTs offering more guidance and training to staff in schools. It was felt that more robust training packages were needed for school staff, with more information about SLCN delivered during routine teacher training. Some respondents mentioned that more SLT support staff such as SLT assistants, or school TAs was required.

118 (13%) held the view that more work with, and more support for parents/carers was necessary. It was thought that educating new parents/carers in how to communicate and play with their children might lead to an improvement in preventative measures. Respondents also said that parents/carers of children with SLCN needed guidance to enable them to support their child as early as possible. It was also mentioned that parents/carers of children with life long or on going problems would need guidance on how to help support their child through all stages of their education and to work towards independence.

86 (9%) said that more resource was required to support SLCN services in mainstream schools to help facilitate inclusive education policies. It was thought that there could be more specialist units or LUs in mainstream schools for children to attend, and mention of the need for more outreach services to support mainstream education.

76 (8%) thought that investment in collaborative working practices might be beneficial with health and education working more effectively together and sharing resource. Multi agency working and multi disciplinary teams were viewed as a means of delivering a more efficient service.

72 (8%) were of the opinion that more LUs were needed, with a view that LUs were the best environment for some children with SLCN, or that LUs were the most effective and therefore the best value. Some of the support for LUs came from parents/carers who had expressed their opinions earlier in questions 1-4.

66 (7%) respondents restated the need for more SLTs to support the service.

51 (5%) said that research was needed into the most effective methods of intervention for children with SLCN. Among suggestions offered were: that research could be undertaken on where resource was needed most at any given time; and the possibility of following the outcomes of SLT intervention at key stages 3 and 4, in raising attainment and in reducing exclusions/behavioural problems/youth offending.

45 (5%) thought that more support was needed for children in primary school.

42 (5%) were concerned that some children would still require special schools, saying that integration into mainstream was not suitable for all children. Almost half of these respondents were parents.

Q14 In my local area, lines of accountability in all services are:

There were 800 responses to this question.

Clear 155 (20%) Clear on some issues 323 (40%) Not clear 322 (40%)

There was split opinion on whether local lines of accountability were clear on some issues or not clear at all.

As the most common issues were all below 5%, comments relating to this question are included in Annex B of this report.

Q15 In terms of improving children's outcomes, service standards are:

There were 913 responses to this question.

Excellent 45 (5%) Good 261 (28%) Satisfactory 216 (24%)
In need of significant improvement 391 (43%)

There was a difference of opinion on the level of service standards, reflected in the fact that 46 respondents said that there were many variations between organisations (see below).

119 (13%) commented on a lack of resource and funding which they believed had a direct impact on the level of service standards in this area. They said that in some cases children were not receiving the degree of support they needed, and that SLT was no longer available to the extent that it had been in the past. It was mentioned again that more SLTs and more funding was required to help improve children's outcomes. Over half of the respondents who commented on lack of resource/funding were PCT/NHS staff and SLTs.

51 (6%) agreed that outcome and evidence based measures were needed, with some commenting on various methods already in use.

46 (5%) respondents said that the levels of service standards varied. Variations in methods used between services and between organisations led to different standards and mixed outcomes.

Q16 Evidence to show standards and children's outcomes are improving is:

There were 776 responses to this question.

Collected and shared regularly 126 (16%)

Available for some aspects, but not others 437 (56%) Not available 213 (28%)

Over half the respondents thought that evidence was available for some aspects, but not others.

53 (7%) said that information or evidence was collected by education in schools, mainly in the form of national curriculum key stage assessments, individual education plans (IEPs), and P levels.

41 (5%) thought that better data collection systems were needed with improved PC and IT systems, shared data bases, and standardised levels of data and outcome measures.

Q17 At national level, lines of accountability are:

There were 719 responses to this question.

Clear 31 (4%) Clear on some issues 199 (28%) Not clear 489 (68%)

Over two thirds of the respondents felt that lines of accountability were not clear at a national level.

39 (5%) felt that this was down to issues between health and education, with no clear lines of responsibility established. Some respondents mentioned the different priorities and funding arrangements that existed between the two organisations.

35 (5%) said that nobody took responsibility, or accepted accountability. There was also the mention of no organisation being identified as having responsibility for AAC.

Q18 Central Government’s contribution to raising standards is:

There were 838 responses to this question.

Clear and helpful 40 (5%) In need of strengthening 410 (49%) Not clear 388 (46%)

Views were split as to whether the government’s contribution to raising standards was in need of strengthening, or not clear.

73 (9%) were of the opinion that more, or long term funding was needed to back up government policies and recommendations.

58 (7%) said that government had imposed too many changes resulting in many reorganisations which had left feelings of uncertainty. They said that continual change and new directives were introduced before previous changes had been given a chance to set in and develop. Some felt that there needed to be a period of consistency. Over half of the respondents who commented on this issue were PCT/NHS staff and SLTs.

58 (7%) felt that SLCN had not been given a high enough priority or profile, with some respondents having the view that government had not previously appeared to have been interested. A range of their comments included the following:

- that speech and language was essential to children for development of social skills and was a prerequisite for literacy skills, yet funding had been cut;
- that the link between standards in education and communication skills had not been recognised;
- that speech, language, attention and listening skills should be targeted before literacy; and
- the opinion that SLT was viewed as a low priority for most in Health.

The above list is not an all inclusive list of suggestions made, for further comments refer to Annex B of this report.

52 (6%) proposed that guidelines could be strengthened to provide clearer direction, and shared goals and strategies.

Q19 Set out your views on service standards and lines of accountability within and across services. (e.g. Are standards clear and agreed? Is it clear who is responsible for what at all levels in each service? Is the evidence, including performance data, collected and acted on to ensure continuous improvement and higher standards? How are children's outcomes measured?)

There were 522 responses to this question.

134 (26%) respondents said 'Yes', that evidence, data and outcomes were measured. (79 of these respondents were PCT/NHS staff and SLTs.)

For a sample of comments made by respondents relating to this refer to Annex B of this report.

123 (24%) mentioned that lines of accountability or responsibility were unclear to them.

97 (19%) felt that there was much variation in service delivery, with different models of provision, different standards, priorities and lines of accountability. Outcomes were measured differently in various schools, for example, and in some areas data was collected but not measured. There was also the mention of the fact that services seemed to be going through constant change.

92 (18%) said 'Yes', that standards were clear or agreed.

86 (16%) said 'No', that standards were not clear or agreed.

69 (13%) commented that accountability and responsibility was clear.

61 (12%) stated that they did not know.

55 (11%) said that 'No', evidence, data and outcomes were not measured.

49 (9%) mentioned that P Levels, national curriculum tests (SATs) and IEP data was used. (31 of these respondents were school and LA staff.)

44 (8%) thought that service standards could be based on the needs of the child and delivery of service provision. Some respondents held the view that the outcome for the child could be considered in a more meaningful manner, rather than be based on academic achievement, or focused on statistics relating to numbers of children seen/waiting times.

37 (7%) felt that it was difficult to measure progress or outcomes. There was the opinion that measurement of standards in this area could be subjective or qualitative, and that there were many factors which needed to be taken into consideration when measuring success. Others said that it was difficult to get the right kind of information, or that it was difficult to set outcome measures for some children with profound difficulties. There were also references made to the quality of the data collection systems in use.

**Q20 What are the important steps needed to improve standards?
(E.g. What level of standards should be achieved (give examples)? What should be the role of Government departments and national regulators or inspectorates?)**

There were 638 responses to this question.

204 (32%) considered issues relating to funding and budgetary arrangements. A sample of comments made by respondents included the following:

- that more funding or dedicated funding was needed to support communication aids;
- the view that budgets were controlling delivery and were impacting on the aims of central government;
- that funding needed to be long term, and needed to support uniform provision to eliminate what some respondents saw as a 'postcode lottery';
- the opinion that more money was needed to support research;
- that funding was necessary to support an improvement in service standards;
- that money was required to develop effective liaison and information sharing;
- the idea that funding could be jointly provided by health and education;
- the belief that more funding was needed to employ additional SLTs; and
- that money was required to support training better.

The above list is not an exhaustive list of comments relating to funding and budgets, for further comments on these issues refer to Annex B of this report.

144 (23%) commented on a range of issues relating to training. Among the points raised, the following matters were mentioned:

- that staff in Children's Centres needed training and supervision from SLTs;
- the belief that training for teachers and TAs should be part of their basic training, and should also be ongoing in schools;
- that additional knowledge was needed by SLTs in areas such as the National Curriculum and the Literacy Strategy, deaf awareness and basic sign language training, and that training needed to be more accessible for therapists;
- the mention that there should be post graduate qualifications for specialist teachers;
- that health visitors needed training in order to carry out appropriate identification;
- the claim that there could be universal standards of training for all those connected with children with SLCN, including LA inspectors and Ofsted inspectors;
- that childminders could be given more training;
- the opinion that training in communication issues could be given to SENCOs;
- the view that more joint training opportunities should be available;
- that training had to be more affordable for all;

- the opinion that recognised training such as ELKLAN accredited courses could be used; and
- the mention that more specialised training was needed for SLTs.

The above is not an exhaustive list of comments relating to training. For further comments on this matter refer to Annex B of this report.

138 (22%) stated that government legislation such as policies on national/minimum standards, such as guidance on maximum caseloads for example, was necessary to improve standards. A number of respondents supported the idea of the application of the Royal College of Speech and Language Therapist (RCSLT) standards across the board. There was also the call for the national consistency of standards to address the discrepancies in service provision referred to by respondents as the 'post code lottery'.

137 (21%) highlighted the fact that more therapists, (and more trained staff in supportive roles such as TA's, communication assistants, health visitors, AAC coordinators and technicians etc) were required to deliver the required services and support the standards.

128 (20%) said that greater collaboration between health and education was necessary. There was support for a multi agency approach, with common working and training opportunities, and better liaison/communication between staff. There was the mention of the need for long term joint strategic plans, and joint funding from the two departments.

96 (15%) felt that the importance of communication and SLCN ought to be given higher priority. It was thought that communication was a foundation skill, pivotal for children to develop and thrive in education and life, and that the ability to communicate was essentially a 'basic human right'. There was the mention of the fact that speech, listening and motor skills should be targeted before literacy. It was also noted that there should be more public awareness about communication, and that the profession ought to be better respected more with an improved pay structure and career profile.

92 (14%) respondents held the view that support/equipment should be given to all children with SLCN when they required it, without a long wait, including those with high and low level needs and those with and without statements. It thought that there should be equitable access to services, with an end to the 'post code lottery'.

78 (12%) discussed monitoring procedures. Their views were wide ranging, a selection of their comments included the following:

- that an inspectorate should monitor cohorts of children with SLCN to ensure they made consistent progress, and were working towards meeting their potential;
- the view that the inspectorate should be a fully independent body, not linked to health or education;
- that parental satisfaction could be monitored to assess individual therapists and services, and that parents could be more involved in monitoring procedures;
- that monitoring the use of funding was necessary;
- the opinion that services could be monitored via Ofsted;

- that national standards should be imposed across health and education and monitored by the Health Professionals Council and Ofsted;
- the opinion that targets based on assessment, intervention and outcomes should be set and monitored;
- that an inspectorate body was needed to issue statements for children and to check that adequate provision was provided; and
- that improved monitoring of standards of educational settings was required.

The above list is not an all inclusive list of comments made in relation to monitoring, for more comments refer to Annex B of this report.

72 (11%) agreed that clear roles, responsibility and accountability needed to be established. Respondents said that there needed to be more awareness of individuals' roles, and recognition of the role of each professional in meeting service objectives. They felt that government should provide clear direction on which organisation was responsible for provision of funding, and where accountability lay for the provision of SLCN services.

56 (9%) mentioned the need to identify and share good or best practice, in order to provide a quality service. They said that current good practice should be looked at as evidence, rather than the introduction and expense of more change. There was the view that more research was needed into effective interventions.

48 (8%) were supportive of the need for more investment in early intervention and prevention, and early screening of children.

44 (7%) said that strategic plans needed to incorporate the views of the staff and professionals/professional bodies who deliver the services, as well as 'users' of the services.

40 (6%) commented on Ofsted involvement. There was the view that Ofsted inspection teams should be more involved in the scrutiny of all SLT provision, and should be trained to be able to assess children's progress in communication skills. It was also thought that Ofsted reports made little mention of the quality of SEN education in mainstream schools.

Q21 Do you have any further comments?

There were 508 responses to this question.

146 (29%) respondents welcomed the review, saying a review of these services was long overdue. They were hopeful that the review would lead to improvements in the current service.

121 (24%) made further comment regarding funding. They covered many points that have already been highlighted within this report, generally reflecting on the view that the services were limited due to funding restrictions and that more investment was needed.

102 (20%) respondents said that they would be willing to give more information to the Review team, and offered their contact details.

99 (19%) professed that some children with SLCN develop behaviour problems which might be caused by frustration at not being able to communicate effectively. Others mentioned the fact that communication difficulties could become a barrier to educational attainment and

employment. There was reference made to the fact that there were considerable numbers of offenders with SLCN, and some respondents highlighted the long term cost to society associated with this.

97 (19%) made reference to the fact that they believed there was an insufficient number of SLTs in post, or lack of local services effectively to support SLCN in their area.

58 (11%) respondents mentioned training issues, reference to which has already been raised throughout earlier parts of this report.

57 (11%) pointed out that some parents/carers were more able than others to push/fight for SLCN services. They said that some parents/carers might not be aware of their options or might just accept what they were told. They also mentioned the ability/inability of parents/carers to pay for private services or meet costs associated with tribunals. 42 of the respondents were parents/carers themselves and might have referred to this while answering questions 1-4.

24 (5%) issued an invitation for Bercow to visit them or to attend various events they were involved in.

Annex E: Visits and meetings

In the course of this review, we conducted a wide range of visits and meetings with interested parties. The visits were to all corners of England and there was a short study visit to Denmark. The visits took place in a variety of settings and allowed evidence and opinions to be collected at a more detailed level. We consulted a wide range of stakeholders, including local authority and PCT managers and their representative bodies, professionals and their associations, the voluntary and charitable sectors and, of course, most importantly, families and children and young people themselves.

Below is a list of our visits and meetings between September 2007 and July 2008 (with apologies for any omissions). We are very grateful to all those who organised and hosted our many visits and meetings (with a special thanks to all the drivers!). We send very many thanks to everyone who participated and contributed their views.

- Carden Primary School, Brighton
- Brighton & Hove City Council
- Wallands Primary School, Lewes
- East Sussex County Council and East Sussex Downs & Weald PCT
- West Green Primary School, Haringey
- Haringey Council and Haringey PCT
- Smallwood Primary School, Wandsworth
- Wandsworth Council and Wandsworth PCT
- Thomas Bewick Special School and Stepping Stones Nursery, Newcastle
- Percy Hedley Special School, Newcastle
- Speech and Language Therapists from the North Eastern region
- Overfields Primary School, Middlesbrough
- Ormesby Secondary School, Middlesbrough
- Bright Stars Children's Centre, Middlesbrough
- Middlesbrough Council and Middlesbrough, Redcar & Cleveland PCT
- Stone Bay Special School, Broadstairs
- Kent County Council and Eastern & Coastal Kent PCT
- Manchester PCT and Manchester City Council
- Salford Youth Offending Team and Salford PCT

- Michael Palin Centre for Stammering Children, London
- Lyndhurst Primary School, Southwark
- Southwark PCT and Southwark Council
- Southway Primary School and Nursery, Plymouth
- Sir John Hunt Community College, Plymouth
- Longcause Special School, Plymouth
- Plymouth City Council and Plymouth PCT
- Churchill Gardens Community Primary School, Westminster
- Westminster Council and Westminster PCT
- Belgrave Children's Centre, Leicester
- New Parks Children's Centre, Leicester
- Barley Croft Primary School, Leicester
- Glebelands Primary School, Leicester
- Leicester City Council and Leicester City PCT
- Dawn House Special School, Mansfield
- Robert Mellors Primary School, Nottingham
- Sycamore Infants School, Nottingham
- Southwark Primary School, Nottingham
- Nottingham City Council, Nottinghamshire County Council and Nottinghamshire PCT
- Tyssen Primary School and Children's Centre, Hackney
- City and Hackney Teaching PCT
- The Learning Trust, Hackney
- Market Field Special School, Colchester
- The Children's Legal Centre, Colchester
- Thriftwood School, Chelmsford
- Thorpe Hamlet Children's Centre, Norwich
- Heartsease Primary School, Norwich
- Norfolk County Council and Norfolk PCT
- Highview Special School, Folkestone
- ACE Centre, Oxford
- ACE Centre, Oldham

- Possum Communication Aids, Aylesbury
- Merton Infants School, Sittingbourne
- Sutton Council and Sutton PCT
- Puzzle Pre-school and Specialist Nursery, Buckingham
- Småbørnscenter Amager, Copenhagen
- Ryparken School, Copenhagen
- Valby Kulturhus, Copenhagen
- Copenhagen Stuttering Centre, Copenhagen
- Centerbørnehaven, Copenhagen
- Pebble Brook School, Aylesbury
- Research Autism
- The PACE Centre, Aylesbury
- Buckinghamshire Council
- Afasic Youth Group, Ilford
- Xtraordinary People
- Elmtree School, Chesham
- Efficient Learning, Winslow
- The Communication Consortium
- Prof Karen Bryan, University of Surrey, Jackie Freer, North Staffs PCT and Cheryl Hanson, Stockport PCT
- 1Voice
- AAC focus group – hosted by Scope
- AAC commissioning event – hosted by Scope
- TreeHouse parents
- Researchers focus group – Nick Peacey, Julie Dockrell, Caroline Pickstone, Mary Hartshorne, Sue Roulstone, James Law, Geoff Lindsay
- Young Offenders focus group – hosted by the Prison Reform Trust
- Association of Directors of Children’s Services
- Mencap
- I CAN
- Special Educational Consortium
- The Literacy Trust

- Sir Jim Rose, Primary Curriculum Review
- Eileen Visser HMI, Ofsted
- British Healthcare Trades Association (electronic communication and assistive technology members)
- Communications Trust Advisory Panel
- Commissioners consultation meeting – London
- Commissioners consultation meeting – Wigan
- Moor House School, Oxted
- North Lincolnshire PCT
- Central Children’s Centre, Grimsby
- Littlecoats School, Grimsby
- North East Lincolnshire Care Trust Plus
- RCSLT
- “Home Access” consultation – hosted by BECTA
- Islington PCT
- North Tyneside PCT
- Northumberland PCT
- National Union of Teachers
- Children’s Workforce Development Council
- General Teaching Council
- Association of School & College Leaders
- National Association of Head Teachers
- Association of Teachers & Lecturers
- Training & Development Agency for Schools
- Qualifications and Curriculum Authority

Glossary

AAC	Augmentative and alternative communication/Augmentative and assistive communication
ACE	Charity giving a voice to children who struggle to communicate
ADCS	Association of Directors of Children’s Services
Afasic	UK charity representing children and young people with speech and language impairments and supporting their parents and carers.
ASD	Autistic spectrum disorder
AT	Assistive Technologies
Autism	A lifelong developmental disability. People with autism can often have accompanying learning disabilities but everyone with the condition shares a difficulty in making sense of the world.
CAF	Common Assessment Framework, a standardised approach to conducting an assessment of a child's additional needs and deciding how those needs should be met.
CAMHS	Child and adolescent mental health services. CAMHS promote the mental health and psychological wellbeing of children and young people and provide high quality mental health services to children.
CAP	Communication Aids Project
Cerebral Palsy	If a child has cerebral palsy, it means that part of his or her brain is not working properly or has not developed. The affected area is usually one of the parts that control the muscles and certain body movements
Children’s Plan	Launched by the Government on 11 December 2007 – a ten year strategy to make England the best place in the world for children and young people to grow up.
Cleft Lip and Palate	The result of improper facial development during pregnancy. A cleft lip is a condition that creates an opening in the upper lip between the mouth and nose. A cleft palate occurs when the roof of the mouth has not joined completely
CLL	Communication, Language and Literacy
(The) Communication Trust	The Trust aims to raise awareness of the importance of speech, language and communication across the children’s workforce and enable practitioners to access the best training and expertise to support children.
CYP	Children and young people
DCSF	Department for Children, Schools and Families
DfEE	Department for Education and Employment (succeeded by the DfES)

DfES	Department for Education and Skills (succeeded by the DCSF)
DH	Department of Health
Down Syndrome	Down Syndrome is a condition caused by excess genetic material, in the form of additional genes. Most people with Down Syndrome have some level of mental retardation and delayed development.
DSA	Down Syndrome Association – provides information, counselling and support for people with Down Syndrome, their families and carers.
Dysfluency	Stammering (or stuttering) is the most common form of dysfluency and is the word most familiar to people
EAL	English as an additional language
Early Years	0-5 years old
ECM	Every Child Matters
EYFS	Early Years Foundation Stage
FE	Further Education
Hearing Impairment	Hearing difficulty/impairment – a level of deafness
I CAN	Charity for children with speech and language needs – provides specific educational services
IDP	Inclusion Development Programme
IPSEA	Independent Panel for Special Education Advice – free advice to parents of children with special educational needs
ITT	Initial Teacher Training
LA	Local Authority
LSA	Learning Support Assistant
Makaton	An international unique language programme offering a structured, multi-modal approach for the teaching of communication, language and literacy skills. Devised for children and adults with a variety of communication and learning disabilities
NAS	The National Autistic Society – the UK's foremost charity for people with autistic spectrum disorders
NEET	Not in education, employment or training
OATS	Out of Area Treatment Services
Ofsted	Office for Standards in Education – the official body for inspecting childcare, early years, schools and local authorities
PACE	Parents Autism Campaign for Education
PCT	Primary Care Trust
PECS	Picture Exchange Communication Systems
Pre-school Learning Alliance	Leading educational charity specialising in the early years.
RCSLT	Royal College of Speech and Language Therapists

RNID	Royal National Institute for Deaf People. RNID is the largest charity representing the 9 million deaf and hard of hearing people in the UK
SLC	Speech, language and communication
SLCN	Speech, language and communication needs
SLT	Speech and Language Therapy
SLT(s)	Speech and Language Therapist(s)
SATs	Standard Assessment Tests
School Action Plus	A part of the graduated response to meeting a child's special educational needs, as set out in the Special Educational Needs (SEN) Code of Practice. School Action Plus involves seeking advice or support from external specialists
SCOPE	A UK disability organisation whose focus is people with Cerebral Palsy
SEC	Special Educational Consortium
SEN	Special Educational Needs
SENCO	Special educational needs coordinator with responsibility for managing the effective delivery of the education psychology service, learning support, behaviour support, SEN assessment and administration, and parent support
SENDA	The Special Educational Needs and Disability Act 2001
SENDIST	Special Educational Needs and Disability Tribunal which provides advice for parents of children with special educational needs and disabilities
SLAs	SLAs Service level agreements
SLI	Specific language impairment
SSLPs	Sure Start Local Programmes
Sure Start	Government programme for 0-4 year old children to develop physically, intellectually and socially
TA	Teaching assistant
The British Academy of Childhood Disability	BACD – formerly Child Development and Disability Group is an organisation for professionals working in the field of childhood disability.
VYP	Vulnerable young person
WCC	World class commissioning
WDC	Workforce development confederations
YOIs	Young Offender Institutions
YOTs	Youth Offending Teams

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ISBN: 978-1-84775-211-6

D16(7771)/0708/13

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