Interim Report

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

Contents

Foreword

In nearly 11 years as a Member of Parliament, I have always sought to assist any constituent who has a child with special educational needs, but 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.

Between April 2006 and July 2007, in speeches and Parliamentary Questions, I raised the issue of children and young people with speech, language and communication needs over 20 times with ministers responsible for the subject. As no government is above criticism on the matter, I have sought at every turn to resist party political point scoring and instead to focus exclusively on the need for reform.

Towards the end of August 2007, the Secretary of State for Health, Alan Johnson, and the newly appointed 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 speech, language and communication needs of children and young people aged 0 to 19 in an affordable way.

● How planning and performance management arrangements, together with better co-operation nationally and locally between health and education services, can spur beneficial early intervention.

● What examples of best practice can 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 to the Secretary of State for Health, Alan Johnson, in March 2008. This would be followed by a final report to both Secretaries of State in July 2008.

By the middle of September, the Review's Advisory Group was in place and a work programme was agreed. Officials from the Department for Children, Schools and Families and the Department of Health were put at the Review Group's disposal.

In studying the issues over the last six months, my colleagues and I have taken evidence in three ways:

- we issued a consultation questionnaire in October 2007 to which we received over 2,000 responses – including almost 1,000 from families – by the January 2008 deadline;

- we 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; and

- 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 many children, young people and their parents, teachers, special needs coordinators, classroom assistants, speech and language therapists, together with other Primary Care Trust and local authority staff, to discuss the issues.

This interim report is the product of the work I have described. It sets out what we have learned, what we see as the main challenges and what we believe to be the principal issues for further consideration. I will make recommendations to Government on these issues in my final report in July.

I am privileged to have been asked to lead this Review which is both stimulating and rewarding. 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 helping to make this possible, I thank all of my colleagues on the Review Team and, above all, everyone who has so far contributed to the Review.

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

Introduction

1. This interim report presents the evidence contributed to the Review through the many responses to our "call for evidence", the visits we have made to local areas across the country and the meetings we have held with key stakeholders, including children, young people, parents, frontline professionals, service managers, academics, charities, voluntary organisations and professional associations. The report considers the important themes emerging from the evidence and sets out the more specific issues we will investigate further.

   We have identified five key themes:

   - **Communication is crucial** – communication is at the core of all social interaction. Communication is a key life skill. Communication is a fundamental human right. 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 order to avoid poor outcomes for children and young people** – in addressing delay and disorders, the most important facts we know are 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 – of lower educational attainment, of behavioural problems, of emotional and psychological difficulties, of poorer employment prospects and, in some cases, of a descent into criminality.

   - **A continuum of services, designed around the family, is needed** – 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. As demonstrated above, support for speech, language and communication needs (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.

2. Over the three main chapters of this report, we explore the five key themes: analysing the evidence, assessing the challenges and setting out our next steps.

Chapter One: Families' views of services for children and young people with SLCN

3. In this chapter, we hear of families' experiences of services. Whilst many children and young people have benefited from a range of services, such as those provided through Sure Start Children's Centres, to meet their SLCN, most parents tell us that information and advice are usually hard to find, needs are not always identified early and accessing services, particularly SLT, all too often involves a "fight". Parents see themselves as the unwitting victims of an incomprehensible relationship between health and education providers.

4. In order to address these important issues, the Review will consider:

- What further action is needed to raise the importance of speech, language and communication (SLC) on the national agenda, including the merits of a national campaign comparable in scope and investment to the National Year of Reading.

- How information and advice can be made more accessible to parents, including how services can be better signposted.

- What support should be available to families at particular times, for example, when SLCN are first identified and when a child enters primary or secondary school.

- How best to improve families' overall experience of "the system", including its accessibility, quality, continuity and transparency.

- How the Ofsted Review of SEN in 2009 might contribute to improving arrangements for the provision of services for children and young people with SLCN, including the range of services provided through funding delegated to schools.

Chapter Two: Joint commissioning of services for children and young people with SLCN

5. This chapter considers the important role of commissioners of services in meeting children and young people's SLCN. In particular, we identify that joint commissioning by health and children's services is critical. However, the evidence suggests strongly that, although Children's Trusts and joint commissioning arrangements are being encouraged by the Government, in reality, their establishment is not at all consistent. Moreover, provision for children and young people with SLCN is rarely identified as a priority for development, overall need in local areas is often not assessed and services are commissioned with little thought given to the desired outcomes for children and young people. In addition, we note the lack of services for young people, including vulnerable groups with high levels of need such as young offenders.

6. The Review's next steps are to consider:

- How to give full effect to the purpose of the Children Act 2004 through a comprehensive network of effective Children's Trust arrangements equipped to commission across agencies to deliver for children and young people with SLCN.

- The value of an audit tool to help with local needs assessment for children and young people with SLCN.

- The need for guidance for commissioners of universal, targeted and specialist services for children and young people with SLCN aged 0-19, throughout early years, primary, secondary and post-16 provision and the transition into adulthood, using a child-centred pathway model. This should include preventative services for those at risk of offending; services for young offenders and for the transition back into the community. The guidance should also reflect the circumstances in which regional commissioning may be appropriate.

- What further research needs to be carried out to enhance an evidence based case for cost effective investment in services for children and young people with SLCN.

Chapter Three: The right workforce, leadership and accountability for services for children and young people with SLCN

7. In this chapter, we look at the make-up, functions and skills of the universal, targeted and specialist services for children and young people with SLCN. We analyse how the workforce is led at both national and local levels and we consider accountability, including the role of performance management arrangements. The evidence presented to the Review demonstrates that the universal services workforce clearly has an important role to play, but it does not yet have a complete set of skills to support the full range of children and young people's SLCN. The evidence also suggests that there might be a shortage of speech and language therapists (SLTs) in the workforce and that there are significantly different numbers of SLTs in areas with similar levels of deprivation. Both the total numbers of SLTs and their distribution should therefore be reviewed. That two Government Departments (Department of Health and Department for Children, Schools and Families) and two sets of services (PCTs and local authorities) have leadership and accountability roles is clearly causing some confusion in the system, not least for parents "caught in the crossfire" between services.

8. The Review will therefore consider:

- How to enhance the skills of specialists and to ensure that more of the children's workforce are trained to identify and meet SLCN.

- Resources:

  - The number of SLTs, their distribution across the country and their deployment through the age range; and

  - Whether there is scope for improvement in the use of staff and facilities by local authorities and PCTs.

- How leaders of children's services and health services work together at present and what steps might be taken, for example through Children's Trust arrangements, to improve collaboration to meet SLCN.

- Accountability at national and local levels, including the role of performance management.

- Whether local authorities' accountability for provision of SLT for statemented pupils should be reviewed.

Conclusion

9. The Review will continue to build on the analysis set out in this interim report, with a particular focus on the specific issues identified for further consideration above. A final report, including firm recommendations on these issues, will be made to the Government in July.

Introduction

What do we mean by speech, language and communication needs?

This report uses the term speech, language and communication needs (SLCN) to describe children and young people who have difficulty in some aspect of communication. Needs are seen as arising from the interaction between the child and his or her environment, so the response to those needs should take account of both the individual and the environment in which people play, learn, communicate and live.

How many children and young people have SLCN?

There is a wide range of communication needs. Needs may be minor and temporary, or complex and long-term. Data from the research vary depending on the type of study, where it is carried out and the criteria used to identify needs. However, we can make a number of statements with some certainty.

There is a broad group of children and young people whose needs may be primarily related to their social environment. The size of this group varies widely and depends on the criteria used to define the group. It also varies with location. In some areas, particularly areas of social disadvantage, this group may be as large as 40 to 50% of children at school entry. Their needs can be addressed through a strong universal offer and a language rich environment.

There is a group of children and young people whose needs are more complex and enduring and arise from a specific language impairment. Estimates suggest that about 5-7% of children and young people may have SLCN as their main difficulty. In addition, many children and young people have SLCN along with or arising from other impairments, for example, autism, learning disability or cerebral palsy. These two groups of children and young people, those with primary and secondary SLCN, will benefit both from a strong universal offer and from carefully targeted interventions geared to their particular needs.

Different ages and stages

The predominant needs change at different ages and stages: early language difficulties may be alleviated by the provision of a language rich environment. Children and young people with more complex and enduring needs may develop associated needs, particularly as they move to secondary school where a child's SLCN may be seen as or be overshadowed by literacy difficulties or behaviour difficulties. In addition, children and young people manifest their difficulties differently: some may seem quiet and withdrawn, others may display challenging behaviour.

While research and data can give a general indication of potential numbers of children and young people with SLCN, local variation is high and it is for schools and service managers to assess, on a local basis, the needs of the children and young people for whom they have responsibility.

> *"Every child's basic fundamental human right is to be able to communicate, regardless of how they communicate… all these issues need to be addressed immediately and something done because I think at the moment these children's rights aren't being taken notice of."*
>
> *Parent of an eight year old child*

Communication is crucial

1. Why does communication matter? Why is communication now enjoying a higher political profile? Why has the Government initiated this review of SLC services?

2. The subject matters because SLC are the foundation life skills for the 21st century, the indispensable prerequisites for children and young people to learn, to achieve and to make friends.

3. No-one should underestimate the significance of this statement. It is not the expression of a private view. It is not a personal statement of value. It is a formal, public and multilateral declaration by UNICEF, UNESCO and the World Health Organisation which lists communication as one of the ten core life skills. Some would say that the ability to communicate is a precious gift. Others would say that it is a human right. Every one of us would say that communication is at the core of all social interaction. With the power of communication, the individual has the chance to engage and thrive. Without the power of communication, the individual may face isolation and a struggle to survive.

4. The subject is now enjoying a higher political profile because of the incidence of SLC problems, the likelihood that that incidence will rise and the welcome recognition by senior Ministers that the subject warrants urgent consideration.

Early identification and intervention are essential in order to avoid poor outcomes for children and young people

5. Research has not told us everything we need to know about communication problems but, equally, it has not told us nothing. In addressing delay and disorders, the most important principle is the value of early intervention and the danger of its absence. In most cases, if a child's speech, language or communication difficulties have been identified and addressed early on, the chances are that that child will learn to read and write at a similar rate to his or her peers, communicate adequately and access the National Curriculum. If a child's difficulties are identified and addressed only at a later stage, the danger is that the problems will have become entrenched, that the interventions required will be greater and that the cost entailed will be higher.

6. A failure to intervene brings multiple risks – of emotional and psychological difficulties, of behavioural problems, of lower educational attainment, of persistent communication impairment, of poorer employment prospects, of significant challenges to mental health and of a descent into criminality. These consequences of non-intervention carry a triple cost – a cost to the individual in unfulfilled potential, a cost to families from increased dependency and a cost to the economy of untreated communication problems which the children's charity, I CAN, calculates to be £26 billion over the lifecycle.

> ### 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 peers
>
> 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.

7.   Whilst studies and consultations will not yield uniform or even fully consistent findings, and it is important to continue to research service effectiveness, there is no denying that failure brings costs. Moreover, it is gradually dawning upon both service providers and politicians alike that, unless effective action is taken, these high costs will not fall, not least because welcome technological advances have improved survival rates from premature births and the associated risk that such children and young people will have special or additional needs. For some time to come, far from falling, these costs may be expected to rise.

A continuum of services, designed around the family, is needed

8.   At the heart of any services are its users. In this report, that is where we seek to place children, young people and their families. At every step of the journey, they are in the forefront of our minds as it is their needs which should drive public policy. What information and advice should be available to families? What mix of services is required and how should they be commissioned? Do we have the right provision and workforce to deliver what children and young people need at different ages and stages? Where there are gaps in the range of skills, what training has to be put in place to fill the void? In what ways can we monitor, challenge and continuously improve the system by identifying the right outcomes, measuring progress and offering accountability to individual families and the general tax payer?

Joint working is critical

9.   In gathering evidence for this report, one of the clearest messages from all quarters is the need for schools, local authorities and health services to work in partnership both with each other and with families. A failure to do so can result only in poorer outcomes for children and young people. The Government's *Every Child Matters* programme promotes a world of joint working, integrated services and shared objectives, particularly through the formation of Children's Trusts in every local area. It is vital that senior health and children's services managers move quickly to make a reality of Children's Trusts. The evidence suggests that much more needs to be done before we see effective joint commissioning arrangements across the country, not least in working with children and young people with SLCN and their families in order to take proper account of their needs and views.

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

10. The Government has initiated this Review because it knows that there is widespread dissatisfaction over access to services for children and young people with SLCN that cannot be brushed aside as anecdotal, misplaced or unrepresentative. Many of the parents contributing to this Review reported their frustration with the current system – that, by and large, there is no "system" as such and that service provision is something of a "postcode lottery". Clearly, this unsatisfactory state of affairs cannot be allowed to stand.

Political context[1]

11. This report is not about a blame game or the pursuit of petty party political point scoring. For the avoidance of doubt, responsibility for weaknesses in services cannot be laid at the door of one government rather than another. The weaknesses are of longstanding and have festered under successive administrations.

12. For years, parents of children and young people with communication difficulties have suffered in silence. Without help, the children and young people were isolated, under achieving and vulnerable. They still are. Yet we are now witnessing the beginnings of a sea change. In growing numbers, parents travel on a roller-coaster of emotions – from puzzlement to frustration to anger to despair to determination to better the lot of their child and the prospects of others similarly at risk. Parents lobby their MPs, attend self-help groups and join campaigning organisations to battle for improved services.

13. Part of the problem has been that speech and language issues were largely invisible and, therefore, politically unthreatening. If ordinary voters had known of the battles these parents had to wage to secure help for their children, they would have been sympathetic, but they had not and so they were not.

14. Slowly but perceptibly, this is changing. More people are seeing that children and young people with SLCN are slipping through the net or being cast adrift, through want of consistent sound policy or lack of resources. Politicians are starting to recognise that there is a real challenge. Parents expect the Government to meet it.

15. In a political market place in which a plethora of issues competes for ministerial attention and resources for improvements, part of the purpose of this Review is to obtain the focus which is the prerequisite of necessary change. On the strength of the questionnaire responses, consultation group findings and visits to North, South, East and West of England, this interim report aims to make progress on the key issues. In the chapters which follow, we will establish what we have learned, what we see as the main challenges and what our next steps will be.

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1   See annex A for the "Policy Context".

Chapter 1: Families' views of services for Children and Young People with SLCN

WHAT IS THE ISSUE?

## Speech, language and communication: key to life

> *"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 SLC are essential life skills for all children and young people. Language development feeds cognitive development as children grow up, and communication skills are the essential bedrock from which all social relationships develop.

1.2 Communication underpins the achievement of all five of the Every Child Matters[2] outcomes. Good communication skills are essential if children and young people are to achieve these outcomes: be healthy; stay safe; enjoy and achieve; make a positive contribution and achieve economic well-being.

1.3 All children and young people need support from their families, from the communities in which they live and from the full range of settings and services they use to develop the communication skills they need to thrive and fulfil their potential.

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2   E*very Child Matters* (ECM) – the Government's programme to improve the services supporting children and young people from all backgrounds. The five ECM Outcomes for all children and young people are to be healthy, to stay safe; to enjoy and achieve; to make a positive contribution; to achieve economic well-being.

Figure 1: Parents' experiences of services – response to online question: Overall, my family's experience of speech, language and communication services is that they are:

Excellent
13%

Good
16%

Poor
55%

Satisfactory
16%
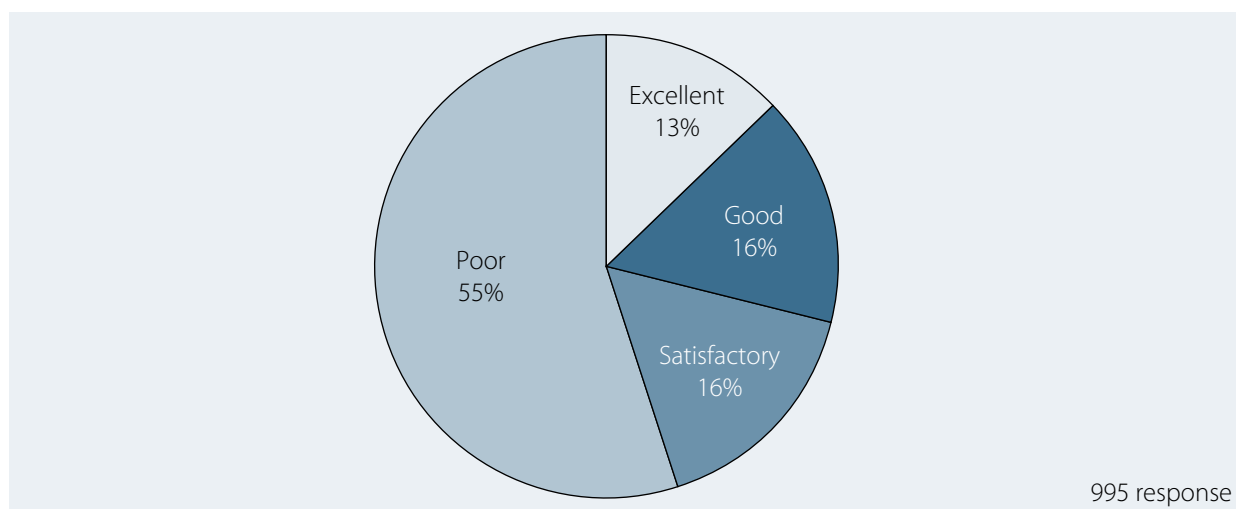
995 response

WHAT HAVE WE LEARNED?

1.4 The response to this Review has demonstrated powerfully that there are many families who hold strong views about the current provision of services for children and young people with SLCN and how they could be improved. Almost half of the 2,000 responses to the on-line "call for evidence" questionnaire[3] came from families and contributions were also submitted by the many organisations representing children, young people and their families. In addition, the Review team conducted an extensive programme of visits around the country and met many children, young people and parents who were all keen to give us their views[4]. We also arranged for ten in-depth consultation groups in different parts of the country: five with children and young people with SLCN and five with parents of children and young people with SLCN.

Communication is crucial

1.5 In the consultation groups, parents expressed concern that their children's ability to communicate, to speak and to understand is taken for granted. They wanted to see an increased understanding of their children's needs and, equally importantly, they pressed for greater inclusion of their children in society. They wanted to see information and guidance about SLC development given to all parents and the issue raised to the top of the agenda across children's services, including health and education services.

1.6 The children and young people who participated in the consultation groups took part in activities which explored their experiences of talking situations and their views of people who helped them.

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3   See annexes E(i) and E(ii).
4   See annex F.

> A 15 year old girl showed how her family, friends and teachers were helpful to her; her "speach teraphasted" was also quite helpful; but a particular boy in her class was placed right outside the "circles of friendship". This boy was unkind and teased her because of her speech.
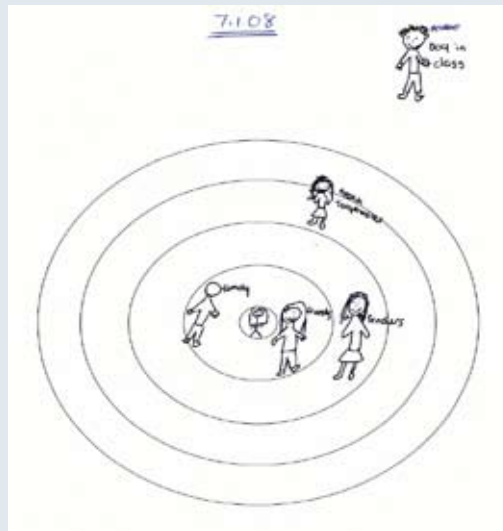
Early identification and intervention are essential to avoid poor outcomes for children and young people

1.7   Parents reported varying experiences regarding the identification or diagnosis of their child's SLCN. In some cases, the process goes very smoothly but, for many parents, the process 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 talked about their experiences of "fighting" to secure an appropriate assessment for their child and adequate support to help to address his or her needs.

> ### Parents' experience of identifying SLCN and early intervention varies:
>
> *"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."*
>
> *"He was taken for his two year assessment and straightaway the health visitor got on to Sure Start. Straightaway they sent in a speech therapist and I was lucky – it was caught just like that."*
>
> *"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."*

1.8 Concern was expressed that Speech and Language Impairments (SLI) were 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.

1.9 According to DCSF statistics, there is a drop of some 60 per cent in the numbers of statemented pupils having SLI named as their primary difficulty between primary and secondary levels. At the same time, there is a sharp rise in the numbers of young people categorised as having emotional and behavioural problems at secondary school level. Afasic[5] expressed concern that the implication is that many secondary schools are categorising young people with underlying SLI and other SLCN as having emotional and behavioural disorders. It might also be the case that some young people identified initially as having SLCN as their primary need are subsequently assessed as having another primary need, such as an autistic spectrum disorder.

Accessible information and well-signposted services

1.10 Once their child's SLCN had been identified, parents said they needed services that were well-signposted and were easily accessible. Parents wanted a clearly defined route providing access to information and easier access to services, including SLT.

1.11 Many parents commented that the whole subject of SLCN was new to them and 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. Many commented that they did not know enough about typical speech and language development.

1.12 Parents reported different experiences in finding and understanding information. For example, in response to the on-line question about the availability of information:

- 77 per cent of parents who responded said information about support for their child was not easily available or not available at all; whereas

- 23 per cent reported that such information had been easy to find.

1.13 Respondents mentioned a number of particular problems that they had experienced in obtaining information: for example, that there was no formal or coordinated system to provide parents with information and that they had difficulty locating the right person or department to contact. Some parents gained the impression 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.

1.14 Both responses to the on-line questionnaire and discussion in the consultation groups highlighted parents' differing experiences in finding and understanding information. A number of parents said they had received full and helpful information, particularly at the early stages. However, most reported real difficulty in obtaining sufficiently helpful information and felt that, unless parents knew the system, they struggled to know where to start. Several parents reported that other parents, support groups and independent organisations had been most helpful in giving them the information that they needed.

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5   Afasic is a UK charity which supports children and young people with speech, language and communication impairments and their parents and carers.

> ### Parents' experience of accessing information and help varies:
>
> *"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."*
>
> *"I had to do a lot of phoning and have got a lot of dead ends before I can find out the information I need. This is a new experience and I do find it frustrating at times that the specialists expect me to know all about the processes needed to get my son the help he needs. More information from the start would be helpful, as would the automatic right to be put in touch with people who know the processes and can guide you through the system."*
>
> *"Once you have come to terms (a bit) with the diagnosis, you have a lot of questions, there should be someone on hand to answer any difficulties you may have."*
>
> *"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."*
>
> *"Some professionals dispense with the farce and talk to you straight but remind you that you did not hear the information from them..."*

1.15 Many 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.

1.16 Some parents reported that they had been given information by service providers which had been vague or not easy to understand, with others being critical of what they saw as "misinformation". Afasic commented that:

"In spite of government guidelines requiring services to work with parents and give them accurate information, many parents' experiences do not reflect this at all. What they are told is often inaccurate, misleading or incomplete. In some cases, services appear to be more concerned with "managing parents' expectations", and tailoring what they say accordingly, than with establishing good relationships with parents."

1.17 Parents also pointed out that there was little point in having information if there were no services for children and young people with SLCN.

A continuum of services, designed around the family, is needed

Accessing services

1.18 Some parents said 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. There were many instances of parents having to pay for services themselves: for example, purchasing equipment such as Picture Exchange Communication Systems (PECS) or funding SLT privately.

1.19 Where parents had accessed good support for their children, they often tended to attribute this to "luck" or their willingness to "fight" rather than to the system working well.

Parents' experience of accessing services varies:

"I think because our son was diagnosed from the day after he was born, then we had the Portage from an early age, and the Portage service felt like it was a referral to all these other agencies and so we were able to access things really quickly."

"It was fine getting as far as the assessment, and then I really grew to hate the word "monitoring" because they kept saying especially with my child "monitor, monitor, monitor, monitor" and they monitored him until it was too late and then we couldn't get anything. He was monitored till he was 5 and then it was handed over to the school. And I can just remember this speech therapist actually said to me, "Well I'm afraid he's one of these children who slipped through the net" and I said, "Well, how can he, I've been on the caseload for 3 years, how can he have fallen through the net?"

"I am really angry and upset that I had to pay to learn my son's first language – British Sign Language."

"Prior to our son attending a speech and language unit, my husband and I had to pay for an independent speech and language therapist to visit our son as he was receiving nowhere near the amount of speech and language therapy he needed."

"I would like to get a communication aid for my son but there doesn't seem to be anyone that can offer advice to me and let me try out the products etc. The CAP project doesn't exist anymore and I feel at the age of 13 years my son has missed out."

Continuity of support

1.20 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.

1.21 In the consultation groups for parents, continuity was raised constantly as an issue: 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."

"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."

Personalised services

1.22 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.

Specialist support

1.23 Parents asked for more specialist expertise in order to support children and young people with more complex SLCN. For example, children and young people who stammer or those who need a communication aid would often fall in to this category. Parents 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 SLC skills and more SLTs developing specialisms.

Statements of Special Educational Need

1.24 Most parents who contributed to the on-line questionnaire had children with statements of Special Educational Need. 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 that fact that most parents do not find the statementing process easy or pleasant.

1.25 Many parents felt 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."

"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."

"I was advised by the Deaf Children's Society to ask for SLT 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."

Joint working is critical

1.26 Parents wanted to see effective joint working both between services and between professionals and families.

1.27 Parents expressed concern about the lack of clarity over the respective responsibilities of health and education services. The relationship between health and education with regard to speech and language services was seen as incomprehensible or even ridiculous by parents in the consultation groups. Parents often felt that they and their child were "caught in the crossfire" between health and education services. As a result, they believed that they were its unwitting victims and, in some cases, that they were even treated as the culprits.

1.28 Parents wanted to contribute and to help to support their children, and they valued working together with professionals in a partnership. They were critical when this did not happen, as they needed to be able to communicate effectively with their child in their home environment. There was a sense that a shortage of time from professionals added to a lack of opportunity for parents to engage profitably and to work in partnership.

> ## Parents' views of joint working:
>
> *"The Local Authorities have the responsibility to provide a service that is delivered by* [the PCT] *that seems to act separately and independently from them and which is not effectively accountable to them. Each side can blame the other for inadequacies – carrying out major changes to services without consulting adequately with stakeholders – both parents and schools."*
>
> *"Different departments provided isolated information. There is no flow chart to describe how all the agencies work together."*

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

1.29 Whilst some families had had positive experiences, parents generally were concerned about the difficulty of access to services, shortages across services and inadequate services. Many parents and professionals who contributed to the call for evidence spoke of a "postcode lottery" when it came to the services families received (or not). It is probably true to say that no two areas of the country commission and deliver the same level of services to children and young people with SLCN and their families and this inconsistency rankled families. Parents often found it difficult to understand why there was little or no 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."*
>
> *"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."*

Services provided by schools – delegated funding for SEN

1.30   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 what they like. The Government is committed to increasing the amount of funding delegated to schools to provide services to meet the special educational needs 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 special educational needs. The risk that funds might be diverted is compounded as delegation is not accompanied by oversight or monitoring by the local authority.

1.31   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 needs[6], and be subject to proper accountability, will be a continuing challenge.

WHAT ARE THE MAIN CHALLENGES?

Communication is crucial

1.32   From the evidence presented to the Review, it is clear that children and young people's ability to communicate effectively is essential to the quality of their lives and the achievement of positive outcomes. However, the need for good SLC development is not always recognised as a priority by children's services, including health and education services.

Early identification and intervention are essential in order to avoid poor outcomes for children and young people

1.33   Parents have articulated very clearly the difficulties they face in securing early identification of their child's needs and in accessing information to help them support their child. The challenge is for universal, targeted and specialist services to support families in identifying needs, both by the timely provision of information and by clearly sign posted services.

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6   See annex B(ii) for case studies of provision for children and young people with "low incidence, high needs".

A continuum of services, designed around the family, is needed

1.34 The evidence submitted to the Review indicates that there are examples of excellent services for children and young people with SLCN and the Review has met many highly skilled and committed individuals from a range of services who are delivering first class support. However, these examples are relatively isolated and the overall position is far from satisfactory. There are widespread difficulties of access to services, including specialist services, as well as of service quality and continuity across settings and over time.

Joint working is critical

1.35 Parents wanted service providers to work closely with each other and we agree that this is very important. We have, therefore, devoted the next chapter to look in greater depth at how services can come together to improve support for families and outcomes for children and young people with SLCN.

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

1.36 The weaknesses and gaps in the current system cause frustration to families and result in poor outcomes for children and young people. Moreover, they come as a result of the issues identified above: that addressing children and young people's SLCN is not treated as a priority; that needs are not always identified and addressed early; that services do not cover all "ages and stages"; and that service providers do not always work together effectively.

NEXT STEPS

Despite the hard work and commitment of many professionals, too many families find the experience of securing and maintaining support for their children difficult, protracted and stressful. Over the next few months, the Review will consider:

1. **What further action is needed to raise the importance of speech, language and communication on the national agenda, including the merits of a national campaign comparable in scope and investment to the National Year of Reading.**

2. **How information and advice can be made more accessible to parents, including how services can be better signposted.**

3. **What support should be available to families at particular times, for example, when SLCN are first identified and when a child enters primary or secondary school.**

4. **How best to improve families' overall experience of "the system", including its accessibility, quality, continuity and transparency.**

5. **How the Ofsted Review of SEN in 2009 might contribute to improving arrangements for the provision of services for children and young people with SLCN, including the range of services provided through funding delegated to schools.**

Chapter 2: Joint Commissioning of Services for Children and Young People with SLCN

WHAT IS THE ISSUE?

2.1 Amongst all who provided evidence and advice to the Review, ranging from Government Departments through to individual parents, there was a consensus that SLC services should be designed and delivered around the needs of children, young people and their families. For this purpose, joint planning and commissioning between agencies are vital. After all, no single agency can deliver any one of the five outcomes for children and young people in Every Child Matters (ECM) or the 25 aims in the ECM Outcomes Framework[7] by working in isolation. Separate silos produce misunderstandings, cause divisions and are bewildering or infuriating to parents for whose children services are delayed or denied as a result.

2.2 The key agencies responsible for services are local authorities and PCTs and the Government encourages them to work together in commissioning the complete range of universal, targeted and specialist services for children and young people. A framework for commissioning is set out in the box below:

Figure 2: Joint planning and commissioning for children's services
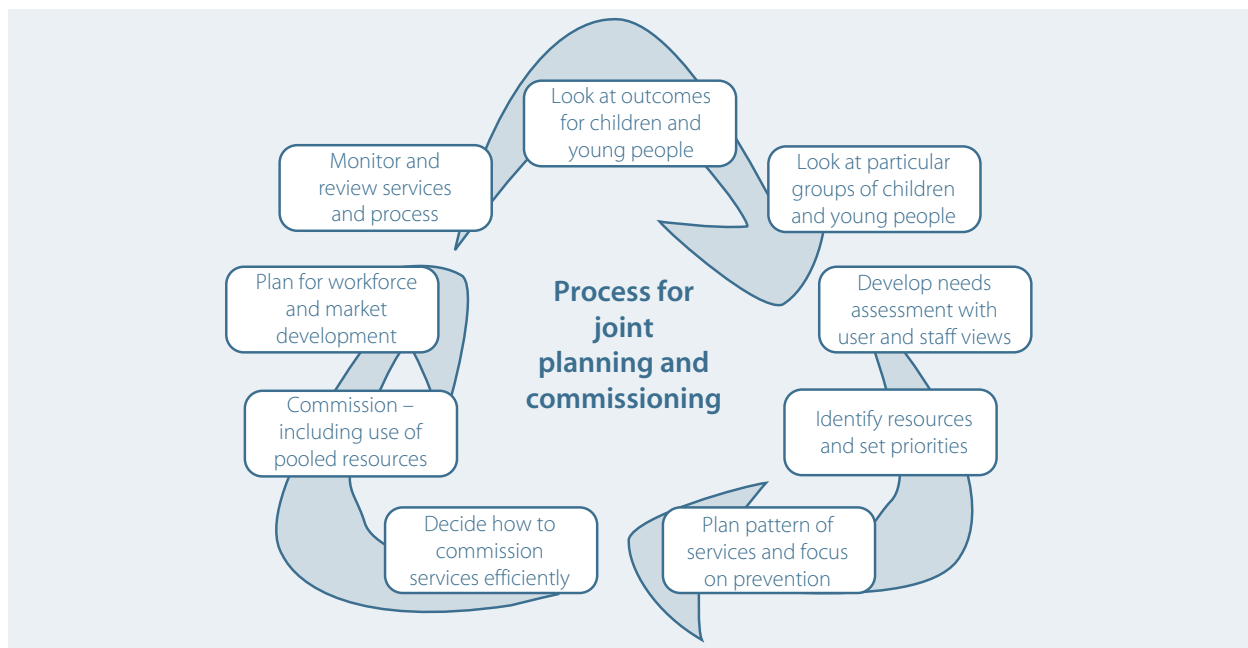
Joint planning and commissioning framework for children, young people and maternity services, March 2006, HM Government

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7   The ECM Outcomes Framework identifies the targets and indicators that measure progress towards the five ECM outcomes.

Commissioning can be summarised as the process of deciding what services or products are needed, acquiring them and ensuring that they meet requirements

2.3   However, 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;

- to agree outcomes, priorities and resources;

- to design and commission services around these needs;

- to ensure that the right skills and capacity are developed to deliver the services and agreed outcomes; and

- to monitor and review processes and services.

2.4   Given how fundamental commissioning is to ensuring that children and young people with SLCN receive the services they require and achieve their full potential, we found evidence that effective local commissioning practice is at best embryonic in most areas.

2.5   In this chapter we look at evidence of how the joint planning and commissioning process is operating, starting with joint working across local authority children's services and the health service; outcomes that services are trying to achieve; involving parents and professionals in defining local needs; determining resources and priorities; the pattern of services focused on prevention and early intervention; and effective commissioning of services, using pooled resources. The development of the workforce is dealt with in the next chapter.

WHAT HAVE WE LEARNED?

Joint working across children's and health services

2.6   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 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, 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.

2.7   Despite the many policy initiatives referred to above, the strong impression gained from visits is that coherent commissioning strategies for children and young people using a joint commissioning framework and consistent plans are not at all common. Although Children's Trusts and joint commissioning arrangements are being encouraged by the Government, in

reality their establishment is not at all consistent across England. As a result, they do not appear to be having an impact on provision for children and young people with SLCN which is rarely identified as a priority for development and which continues to be unhelpfully fragmented across the NHS and children's services in many places.

2.8 A national evaluation[8] 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 SLC services can be delivered when children's and health services commission separately, motivated by different understandings, choosing different priorities and using different processes.

2.9 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 (YOTs). Many front line 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.

2.10 The need for, and discernible lack of, strategic planning at a local level for children's SLC services has been a recurring feature of evidence presented to the Review over the past six months. 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.

2.11 By contrast, in Hackney, considerable progress had been made and a range of innovations introduced to make SLC services more responsive and accessible to local families. Specifically, a strong partnership across local education services and the NHS had served to integrate provision into early years settings and primary schools. One feature of particular interest was a drop-in service to parents of an initial consultation with a SLT about their children's difficulties.

Outcomes for children and young people with SLCN

2.12 Universal, targeted and specialist services should be commissioned to deliver positive outcomes for children and young people with SLCN and their families. Local authorities, PCTs and other partners should be agreeing key outcomes for different groups of children and young people with SLCN, over the short, medium and long term. The Every Child Matters five outcomes – being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being – provide a framework.

2.13 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

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8   *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

little evidence that services were outcomes-focused or commissioned with outcomes in mind. In some areas, 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*

Assessing local needs with parents and professionals

2.14   A joint systematic assessment of the needs of the local population, conducted with service users and professionals, underpins the commissioning of effective services. As well as seeking advice from key professionals, such as SLTs, there is a range of providers with whom commissioners should work jointly in developing plans and commissioning arrangements for SLCN. These might include occupational therapy services, physiotherapy, health visiting, school nursing, early years provisions including Sure Start Children's Centres, community paediatricians, GPs, Homestart, social services, housing officers, benefits agencies, educational psychologists, child and adolescent mental health workers, psychiatrists, Youth Offending Teams and many local voluntary providers. As with other parts of the planning and commissioning process, we found little evidence that practice in this area was well developed and much evidence that it was not.

2.15   A submission to the Review on commissioning incentives by Scope, the RCSLT, Communication Matters and Afasic, supported by a wide range of other voluntary organisations, made a number of points about how joint commissioning for services for children and young people with SLCN could be better incentivised across agencies, including the importance of good data on which to base assessments. In relation to needs assessment, changing needs of local populations, such as the increasing number of children and young people for whom English is an additional language (EAL), should be taken into account in the joint planning and design of SLC services. In what is not intended to be an exhaustive list, some illustrative examples of the evolving requirements of local populations include: the increase in identification of autistic spectrum disorders; the rise in the number of children and young people who require post surgical therapy following cochlear implants; and the growing incidence of babies and young children living longer with very complex communication and/or swallowing needs.

Determining resources and priorities

2.16   As an essential life skill, SLC should be a key priority in commissioning of services for all children and young people, at every age and stage of development. The low priority accorded to services for children and young people with SLCN as a whole, and for some types of provision in particular, is a common theme reflected in the Review's findings. This lack of priority is due in part to a poor awareness of its importance and to the absence of clear policy drivers across children's services and schools which mean that services can be uncoordinated and haphazard. This presents considerable commissioning and delivery challenges.

> *"One third of the children's SLT workforce in one area is externally funded and vulnerable, with two teams' contracts coming to an end in April next year. No one in either health or the LA wants to pick up the specialist Communication Support Service which is integral to the successful operation of the county-wide service."*
>
> *(Respondent to the consultation.)*

2.17 In terms of resources, there has been considerable additional investment in children's services, with 2,500 children's centres, affordable childcare, an entitlement to free part-time education for 3 and 4 year olds and funding per pupil rising from £3,370 in 1997/98 to £4,710 in 2006/07 in real terms. DCSF estimates of the additional school and local authorities resources for children and young people with SLCN are in the order of £450m, which comprises a proportion of the national SEN planned expenditure and additional costs with placements in special schools. Investment in health services is also at record levels. However, there are no data held centrally on the amount invested in SLC services for children and young people. Decisions about the resources to allocate for particular services are taken locally and the Review found wide variations. For instance, investment in SLT services varied significantly, even taking account of local deprivation, and this is considered in Chapter 3.

Patterns of Service Provision

Services across the age range, focused on early intervention

2.18 When designing services for children and young people with SLCN, commissioners need to understand the importance of early intervention both in chronological years and in the onset of conditions. Evidence shows that by prioritising services in this way there are better social, economic and health outcomes for children and young people and long term cost benefits for commissioners through more efficient investment planning.

> ### *Early Talk* at I CAN's Early Years Centre at Southway Primary School, Plymouth
>
> *Early Talk, I CAN's early intervention programme, used amongst other places at Southway Primary School, aims to work as a "glue" between local authorities, children's services and the NHS, seeking to provide the best possible support for all children, with a special focus on those with a speech, language and communication disability. It is designed to increase the knowledge and skills of staff working with pre-school children. Teachers and SLT work together, sharing their skills and knowledge. As a result, nursery staff are better able to identify children with communication difficulties and use a range of techniques to support them.*

2.19 Research[9] shows that SLT provision is concentrated in the early years with a decline as children get older. Respondents to the Review consultation confirmed this picture. Schools themselves, however, have a more positive picture of their links with SLTs and 71% of secondary schools say that they work with SLTs to support pupils[10], although there is no indication of the amount of provision that pupils receive. Our evidence suggests that this is minimal.

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9   Dockrell and Lindsay, *Inclusion versus specialist provision: ideology versus evidence based practice for children with language and communication difficulties,* in *Understanding developmental language disorders in children: from theory to practice*, (2008) Editors Norbury, Tomblin and Bishop, Psychology Press

10 Clemens, Kinnaird, Mackey, Deakin and Ullman, *Extended Services in Schools: Baseline Survey of Maintained Schools in 2005*, RR681, Department for Education and Skills

Figure 3: Proportion of SLTs providing services by phase
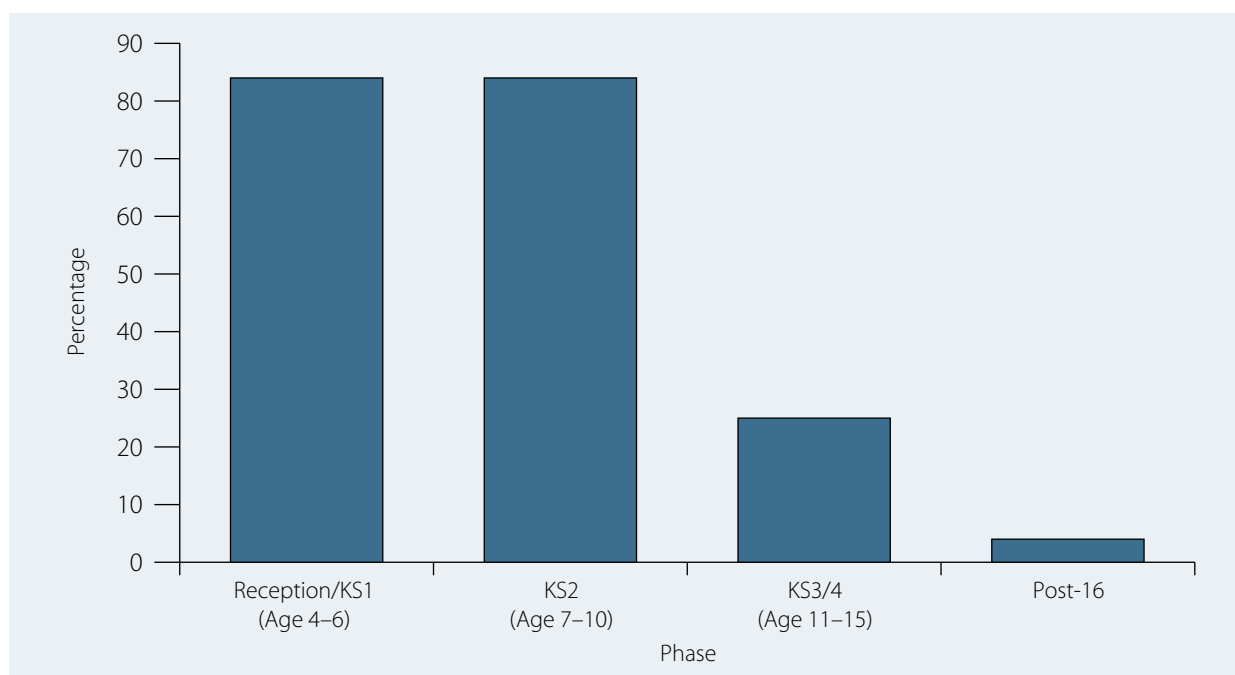
2.20 65% of respondents to the Review's consultation agreed that resources should be directed towards early intervention and preventative work to ensure better outcomes for children and young people.

> *"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*

2.21 In Brighton, local Children's Trust arrangements had resulted in a strong emphasis on services for children with SLCN and early intervention, including the introduction of innovative early intervention approaches in partnership with the voluntary sector.

2.22 The Review looked at practice outside England, with a visit to Denmark. In Copenhagen, outcomes for children have improved as resources have been focused on early years provision. However, the Danish Government now plans to pay more attention to children of primary school age and beyond. Although the Danes face similar challenges to deploy sufficient SLTs, and to establish clear responsibility for communication aids, two findings were of particular interest. First, SLTs are employed by education authorities. Secondly, the Danish Government is planning to offer all parents screening of their children at age three, though there is some uncertainty as to why that age has been chosen and it was suggested to us that screening should be undertaken significantly earlier.

2.23 For many children and young people, their SLCN are long-term conditions, with the added complexity of developmental changes as they get older and the influence of home and school. Commissioners need to take account of the fact that the support that is offered to children and young people and their families will or should differ in both type and intensity depending on their needs at any given stage of childhood. For their needs to be met adequately, individually

tailored or "personalised" pathways of care must be jointly commissioned across the system and over the whole age range.

2.24 Although early intervention is effective, there will inevitably remain some children and young people in the system who have continuing SLC needs. This will be either because their difficulties were not identified at an early age, or because their needs are severe, or both. The SLI Forum commented that:

"There is a need across the age range for provision. Early intervention gives good value for money as problems may be prevented from developing later. But some individuals will have SLC difficulties throughout life and need to be enabled to develop to their full potential."

2.25 An acute example of on-going SLCN is represented by the 11,000 people passing through young offender institutions (YOI) each year, of whom at least 60% are estimated[11] to have difficulties with SLC 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-offending[12]. 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."[13]

2.26 Research[14] has been cited that 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 provided[15]. 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[16]. In practice, therefore, the service is not available.

2.27 The Prison Reform Trust organised a helpful focus group on young offenders for the Review. In addition, we asked Professor Karen Bryan to propose models of service that would serve not merely to assist existing young offenders, essential though that is, but to reduce the incidence of communication problems in the future, bringing the obvious benefits to society that such a reduction would offer.

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11 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
12 Ward and Stewart (2003), Psychology, Crime and Law
13 Hansard HL Deb 27 October 2006 vol. 685, column 1447
14 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
15 Hansard HL Deb 27 October 2006 vol. 685, column 1457
16 This also appeared to be the consensus at the Review's meeting with the Prison Reform Trust and others.

Where services are provided

2.28 In the early years, evidence shows that less than 10% of local authorities make provision through designated nursery schools for pre-school children but specialist units in mainstream settings are more common, provided by a third of local authorities[17]. For school age children with SLCN, provision can include mainstream schools, a resourced unit in a mainstream school or a special school, which may be dedicated to children with SLCN or be one for a range of children, such as those with moderate learning difficulties. The research evidence[18] available does provide an overall picture of the types of provision available.

Figure 4: Educational provision for children and young people with SLCN
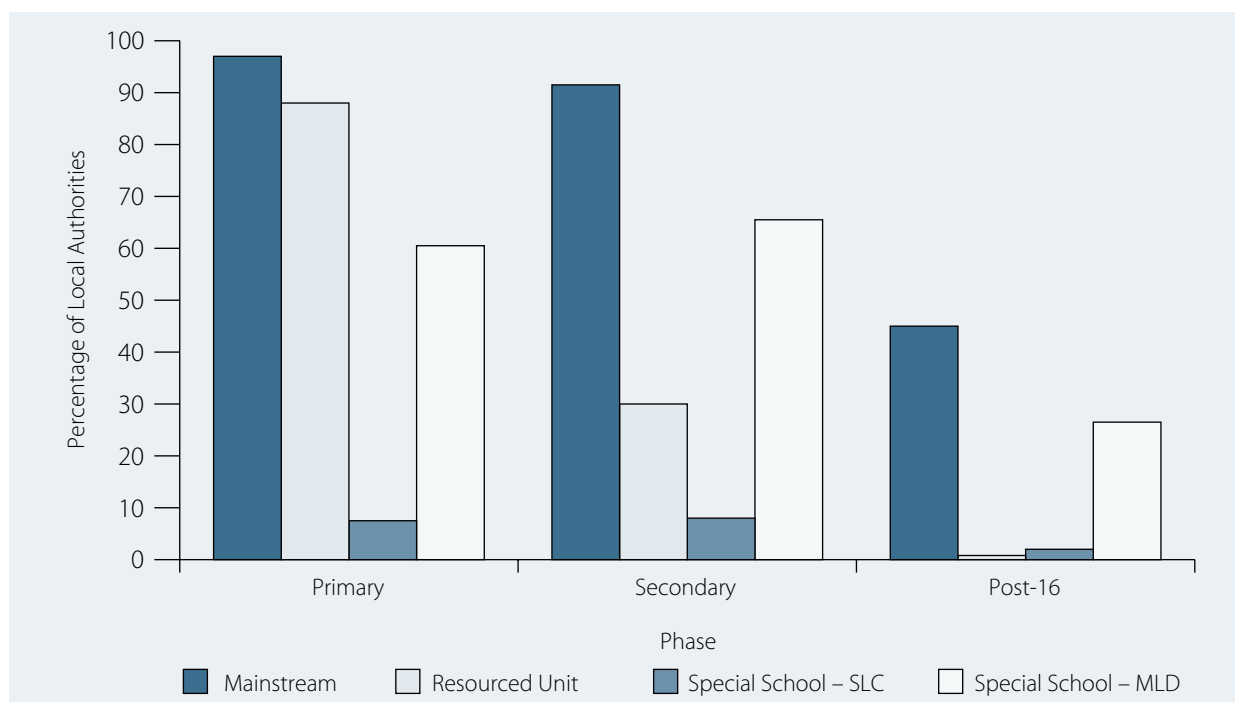
2.29 The graph above does not reflect the small number and size of many of the units and special school provision in authorities. With the most common size of a unit being for 10 pupils, there will be few children and young people in an area with access to resourced unit provision and demand will invariably outstrip supply. At secondary level, the most striking fact is that less than a third of authorities have resourced units in mainstream schools and post-16 few authorities have any specialist provision.

2.30 We did not find extensive evidence on the best mix of universal, targeted and specialist provision to meet the needs of the variety of children and young people with SLCN. Analysis of academic attainment at age 16 in one study[19] revealed no statistically significant differences between

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17 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

18 ibid

19 Dockrell, Lindsay, Palikara and Cullen *Raising the achievement of children and young people with specific speech and language difficulties and other SEN through school to work and college,* (2007), RR837, Department for Education and Skills

the outcomes achieved across these settings. Ofsted evidence[20] does show that for special educational needs in general:

"There was little difference in the quality of provision and outcomes for pupils across primary and secondary mainstream schools and special schools. However, mainstream schools with additionally resourced provision were particularly successful in achieving high outcomes for pupils academically, socially and personally. Pupils with even the most severe and complex needs were able to make outstanding progress in all types of settings. High quality, specialist teachers and a commitment by leaders to create opportunities to include all pupils were the keys to success."

Commissioning services effectively, including using pooled budgets

2.31 Commissioning services effectively depends crucially on a clear understanding of the most cost effective services to meet the identified needs of the local population and deliver outcomes for children and young people, across the age range. The patchy picture across the country of how well the early stages of the planning and commissioning process operate suggests that there is limited effective commissioning. It was also striking that there appeared to be little use of pooled budgets or sign of any plans for them.

WHAT ARE THE MAIN CHALLENGES?

2.32 The main challenge is to make a reality of the Government's aspiration for effective local planning and commissioning of services for children and young people. For children and young people with SLCN, the particular challenges are set out below:

Joint working across children's and health services

2.33 The difficulties of joint working in commissioning services for children and young people with SLCN apply across all children's and health services. Current commissioning cycles are typically of three years, and those of health and children's services do not always run concurrently, which can be problematic. The growing autonomy of schools from local authorities yields many advantages but it does pose a challenge for effective joint commissioning. There are particular issues with the commissioning of SLT services where, in many areas, both children's services and the NHS commission and this is dealt with in the next chapter. We believe it is important to consider other commissioning models. For instance, regional commissioning for children and young people who have low incidence SLCN may well be necessary to enable them to access the intensive, specialist help which might not be available at local level. Commissioning should also fully consider the needs of children and young people who require alternative and augmentative communication which can often involve specific equipment. This is often a source of friction between different local agencies who agree that a need exists, but not about which of them should meet it.

Outcomes for children and young people with SLCN and assessing local needs with parents and professionals

2.34 We considered the relevant outcomes for commissioners to use for SLC services across the age range. In Annex B(i), we have set out initial thinking on what an outcomes framework in this area

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20 *Inclusion: Does it matter where pupils are taught* (2006), OfSTED

could include. This is early work but it demonstrates that it is possible to design and commission services around outcomes. These outcomes can be shared and used across agencies, encouraging joint-working. Similarly, commissioners struggle with assessing local needs for SLC and the Review will consider further how to address this problem.

Determining resources and priorities

2.35 We believe the case for a higher priority for SLCN services is clear. However, convincing local commissioners will require hard evidence. Cost-benefit analyses are the classic mechanism for demonstrating the case for additional investment in particular services. Although the costs of services are often clear, quantifying the benefits of social outcomes, such as improved communication skills and relationships, is by no means straightforward. To address this, the Review commissioned a study of the feasibility of undertaking a full-scale cost-benefit analysis of services for children and young people with SLCN. It concluded that existing research findings are found to be insufficient for estimation of the costs and benefits of investment in services for children and young people with SLC difficulties. More research is required to understand for whom and under what circumstances interventions are cost effective[21].

2.36 Just as important as the overall level of resources is its equitable distribution. This is true both across the age range and according to need. Decisions as to who receives what should not reflect the vociferousness of lobbying but be based on evidence of need.

Patterns of service provision over the age range

2.37 The current focus on early assessment and intervention is welcome, though much still remains to be done. However, there is concern that the needs of older children, young people, those in transition to adulthood and particular groups, such as young offenders, are not being met. For instance, the evidence shows that specialist services drop off significantly as children get older. This was apparent in some cases for children as they progressed through primary school, but it was far more pronounced at secondary level where many people told us that services were extremely limited.

2.38 When young people are recognised as vulnerable or at risk of offending, preventative action should be taken to divert them from anti-social and criminal behaviour. It is vital to develop a service of specialist SLTs in order to provide support for these vulnerable children and young people in primary and secondary schools, units for children and young people excluded from school, YOTs, probation services and other community-based organisations. Similarly, YOTs should be able to draw upon SLT services in the community, e.g. visits for children and young people excluded from school and for those referred to probation, mental health and drug misuse services. YOTs currently identify the needs of each young offender by using a national tool called ASSET. This lacks a specific section on communication. Developing a communication skills page would be an invaluable tool in identifying needs, providing for referrals as necessary to SLTs for full assessments and thereby developing a more systematic basis for responding to SLCN.

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21 Jennifer Beecham and James Law with Geoff Lindsay, Julie Dockrell, Nick Peacy, Martin Desforges, Martin Knapp, *Feasibility of a cost-benefit analysis of investment in services for children and young people with speech, language and communication difficulties,* March 2008 (unpublished)

2.39 The Government will consult shortly on proposals for local authorities to take responsibility for the education of young offenders in secure accommodation (secure children's homes; secure training centres; and YOIs). This provides an opportunity to encourage effective joint commissioning of SLC services for those in local facilities. The model suggested by Professor Bryan is for a SLT for each secure training centre and YOI, allowing an understanding of how the young person functions on a day-to-day basis to enable effective interventions to be created and for good liaison with YOTs. Further work to assess how much provision is required for those in secure children's homes should also be undertaken.

2.40 If provision is to achieve maximum effect, it needs to comprise three elements: prevention of offending, provision of services within the criminal justice system and promotion of integration back into the community. For interventions to be effective, they should not be limited to the time in custody but, if required, continue through the transition back into the community.

NEXT STEPS

Legislation, guidance and policies to drive the commissioning process to secure integrated approaches to SLCN across agencies are all in place, yet effective local commissioning practice is at best embryonic in most areas. This is the root of many of the access problems and service variability experienced by children and young people with SLCN and their families. In order to bring about a step change in performance such that effective joint commissioning for services for children and young people with SLCN becomes the norm, the Review will consider the following:

1. **How to give full effect to the purpose of the Children Act 2004 through a comprehensive network of effective Children's Trust arrangements equipped to commission across agencies to deliver for children and young people with SLCN;**

2. **The value of an audit tool to help with local needs assessment for children and young people with SLCN;**

3. **The need for guidance for commissioners of universal, targeted and specialist services for children and young people with SLCN aged 0-19, throughout early years, primary, secondary and post-16 provision and the transition into adulthood, using a child-centred pathway model. This should include preventative services for those at risk of offending; services for young offenders and for the transition back into the community. The guidance should also reflect the circumstances in which regional commissioning may be appropriate.**

4. **What further research needs to be carried out to enhance an evidence based case for cost effective investment in services for children and young people with SLCN.**

Chapter Three: The Right Workforce, Leadership and Accountability for Services for Children and Young People with SLCN

WHAT ARE THE ISSUES?

3.1 As we have seen in chapter two, it is essential to commission a combination of universal, targeted and specialist services in order to meet the full range of SLCN of children and young people. For services to be fully effective, they require a workforce with the appropriate skills, including the ability to work together with professionals in other services.

3.2 To fulfil its role, the workforce requires strong strategic and operational leadership at both national and local level: leadership that makes clear the priorities, leadership that manages the system and leadership that is accountable to stakeholders, not least children, young people and families. Parents look to national and local leaders to create the environment in which the needs of their child are addressed and in which he or she can thrive.

3.3 Robust and transparent performance management arrangements are required if leaders are to be held properly to account. Having appropriate mechanisms to track progress and to intervene early when progress is slow is necessary, but it is not sufficient to achieve the most effective performance management. Rather, the best arrangements will include on-going research and evaluation of service models and practice in order to identify what works and to support a cycle of continuous self-improvement.

Who makes up the workforce?

3.4 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 competences 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, SENCOS and classroom assistants; and

- others – such as health visitors, school health advisors and specialist staff who have regular contact with children and young people as part of 'universal' services.

3.5 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.

Who provides leadership?

3.6 The Department of Health (DH) and the Department for Children, Schools and Families (DCSF) are responsible for providing national leadership on SLC issues. They determine national level outcomes for children and young people. They set national priorities and standards for local authorities, schools and health services in order to achieve those outcomes. In addition, and crucially, they allocate the resources, sponsor the legislation and issue the guidance within which those outcomes are pursued.

3.7 In local areas, PCT chief executives and local authorities' Directors of Children's Services provide strategic leadership. Senior professionals, particularly head teachers, senior clinicians in SLT services and Children's Centre managers, provide operational leadership.

Who is accountable?

3.8 All those who provide leadership must be accountable for their areas of responsibility.

WHAT HAVE WE LEARNED?

1. WORKFORCE

Communication is crucial

3.9 In order to address the concerns raised by families and children and young people in Chapter 1, the whole of the children's workforce needs to have the skills and knowledge to understand the importance, and support the development, of SLC for all children.

3.10 This will also serve to address equity of access and inequalities for children and young people with SLCN in education and learning, family, social and community activities.

3.11 Parents and children in the consultation groups discussed how they meet with a lack of understanding of SLCN. Some children and young people with SLCN behave differently but, because they usually appear no different to other children and young people, they can be greeted with incomprehension and even hostility.

3.12 However, they also described positive experiences of support and inclusion and talked about special people and special places where they are supported and included.

Early identification and intervention are essential in order to avoid poor outcomes for children and young people

3.13 Early identification was raised many times in the range of evidence presented to the Review. Some contributors[22] considered that a screening programme would be helpful.

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22 For example, the Rt Hon David Blunkett MP

3.14 SLTs and early years professionals are concerned that recent changes in child health surveillance programmes (Hall 4)[23] may have an adverse impact on the early identification of children with SLCN. Their view was that, as health visitors will screen only those children thought to be vulnerable/at risk after the two-year check, many children who might otherwise have been identified early are missed.

3.15 Given the changes to child health surveillance, it was considered that all those providing early years services, including health, social services, education, community and voluntary providers must be skilled to identify SLCN and must know when to refer on to specialists, including SLTs, to support appropriate intervention.

3.16 For children with more severe SLCN, concerns were raised by national organisations that a lack of skilled experts as part of the team impacted on the effective screening, assessment, identification of needs and early intervention that are required.

3.17 The visits served to highlight the importance of a workforce equipped to meet the needs of children and young people for whom English is an additional language. In some places, there are bilingual support workers who are an integral part of the SLT team and who are trained to work under the supervision of a SLT in delivering services for children and young people with SLCN.

A continuum of services, designed around the family, is needed

3.18 The need for continuity of support both in terms of meeting the ongoing needs of children and young people with SLCN and of having contact with the same professionals was raised in submissions, visits and the Review consultation groups with children and young people with SLCN and with their parents. There were particular concerns that a lack of appropriately trained staff adversely affected the level of services for children and young people from across all ages and stages of development. Families believed that where service provision was good at a pre-school level, there was a decrease in support once children reached primary school, with little support at secondary school or none whatsoever.

Developing the skills of the wider workforce and working in partnership with parents

3.19 The Communication Trust submission highlights the fact that some individuals within the children's workforce, including teaching assistants, teachers, youth and play workers and volunteers, have developed a special interest in SLCN and acquired knowledge and skills in the area. However, many respondents to the on-line consultation found the required levels of training, knowledge and expertise amongst the wider children's workforce to be lacking.

3.20 The lack of training of the wider workforce to be able to provide a consistency of approach for all children and young people with SLCN (across universal, targeted and specialist services) was also raised as a significant barrier to securing a continuum of service provision.

- Teachers (including SENCOs), SLTs and other professionals considered that there was a need to have greater input on SLCN in initial teacher training, as well as continuing professional development.

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23 Health for ALL Children by D.M.B. Hall and David Elliman 7 Sep 2006

- 49% of respondents thought that, in their local area, access to speech and language training for school staff and others in the children's workforce was in need of significant improvement (32% thought it was good or excellent).

- 45% 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 language, SLCN was in need of significant improvement (29% thought it was good or excellent).

- From the NUT SENCO survey: 74% stated that they lacked professional development in the area of SLCN and they wanted to strengthen the education and training role of SLTs.

- Scope noted that there was an over reliance on parents to train teachers or workers in social contexts (e.g. Scouts) about alternative and augmentative communication (AAC).

3.21 A clear message was that the focus of development should not only be on early years and foundation stage staff. It should also be on developing the expertise of those working with older children and young people as this is extremely variable and sometimes non-existent. This expertise is required in a wide range of settings, including those covering social care, youth offending, and behaviour management.

The Inclusion Development Programme (IDP)

The IDP is a four-year DCSF programme of continuing professional development for teachers, support staff and early years practitioners. It is designed to increase the confidence and expertise of mainstream practitioners in meeting the high incidence of SEN in mainstream settings and schools.

The IDP's web-based materials include teaching and learning resources; training materials; guidance on effective classroom strategies; models of good practice for multi-disciplinary teams; and information about sources of more specialist advice.

During the first year of the IDP, the focus will be on speech, language and communication needs and dyslexia. Throughout the remaining three years of the programme, the focus will be on autistic spectrum disorders, behavioural, emotional and social difficulties and moderate learning difficulties.

3.22 Parent/carer empowerment and partnership working are seen to be central to addressing the SLCN of all children and young people. Parents should be seen to be an important part of the wider multidisciplinary team.

SLTs

3.23 A further consistent theme from parents was about the level of specialism that is sometimes needed for children and young people with SLCN. Parents wanted SLTs to have *'funding for ongoing training'*, in order to gain specialist knowledge and skills. The need for specialist SLTs was also raised by a number of national organisations.

3.24 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. These specialist SLTs are responsible for appropriate education and training to more junior SLTs, as well as to the

wider children's workforce, including that in schools. These clinical leaders also provide the "back up expertise" which, amongst other roles, enables them to be directly involved in complex cases.

Other specialist professionals: the "team around the child"

3.25 National organisations, including Afasic, The British Academy of Childhood Disability, Special Education Consortium and professional associations, were concerned that there should be access to high-quality assessment, identification of needs and the process of intervention. All of these arrangements should be overseen and delivered by a skilled multidisciplinary "team around the child".

3.26 Families also valued the need for a range of specialists to be part of the "team around the child". In addition, parents saw themselves as members of the team and welcomed the increasing recognition from professionals of their important role.

3.27 On visits undertaken, 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, educational psychologists, paediatricians, occupational therapists and, for some children and young people, clinical psychologists, child and adolescent psychiatrists or other CAMHS staff, portage teams, physiotherapists and arts therapists.

3.28 In order to support the continuum of service provision required by families and children and young people with SLCN, it was suggested by some national organisations that Government should strengthen "transdisciplinary working".

3.29 This suggestion is 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. This includes families and takes place via everyday activities in a range of settings including home and schools.

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

3.30 Ensuring the development of the skills of the wider workforce and access to appropriately trained specialists appeared to be key factors in tackling the variability and lack of equity of services.

3.31 Evidence collected by the Review team also indicated that other factors, which impact on equity, include the variability of the numbers of professionals available at a local level.

Speech and language therapists

3.32 Parents commented on the expertise of individual SLTs, describing them as *'brilliant', 'great', 'fantastic'* and *'gold-plated'*. Parents value the *'unique blend'* of skills and knowledge that brings specific expertise to their child. Continuity was raised as an issue, both in terms of having contact with the same therapist and of having that contact on a regular basis. At present, there appears to be too little continuity and too much turnover of personnel.

- 33% of respondents to the Review's online questionnaire believe resourcing issues have impacted on the family's overall experience of SLC services, with 27% stating that waiting lists are too long.

- 37% of respondents to the Review's online questionnaire believe that more therapists/ qualified SLTs are needed to improve SLC services.

3.33 This lack of continuity contrasts with the Danish system, which seeks to give children and young people continuity through the same therapist seeing them from age 6 to 16 years.

3.34 The national figures on SLTs mask significant local variations in numbers. The DH/Durham University Child Health Mapping Project (CHMP) provides the number of WTE SLTs and assistant SLTs per 100 thousand of population for Primary Care Trust (PCT). Excluding extreme cases[24], the numbers range from 0.22 to 0.77. A better comparison is to look at the range for similar authorities, because we would expect local authorities serving more disadvantaged communities to have a greater need for SLTs. The chart below shows the number of SLTs and assistant SLTs per 100 thousand of population by the index of deprivation for the 56 PCTs on which there are complete data. Areas with similar levels of deprivation have significantly different numbers of SLTs[25].

Figure 5: SLTs and Assistant SLTs per 100k of population and area deprivation
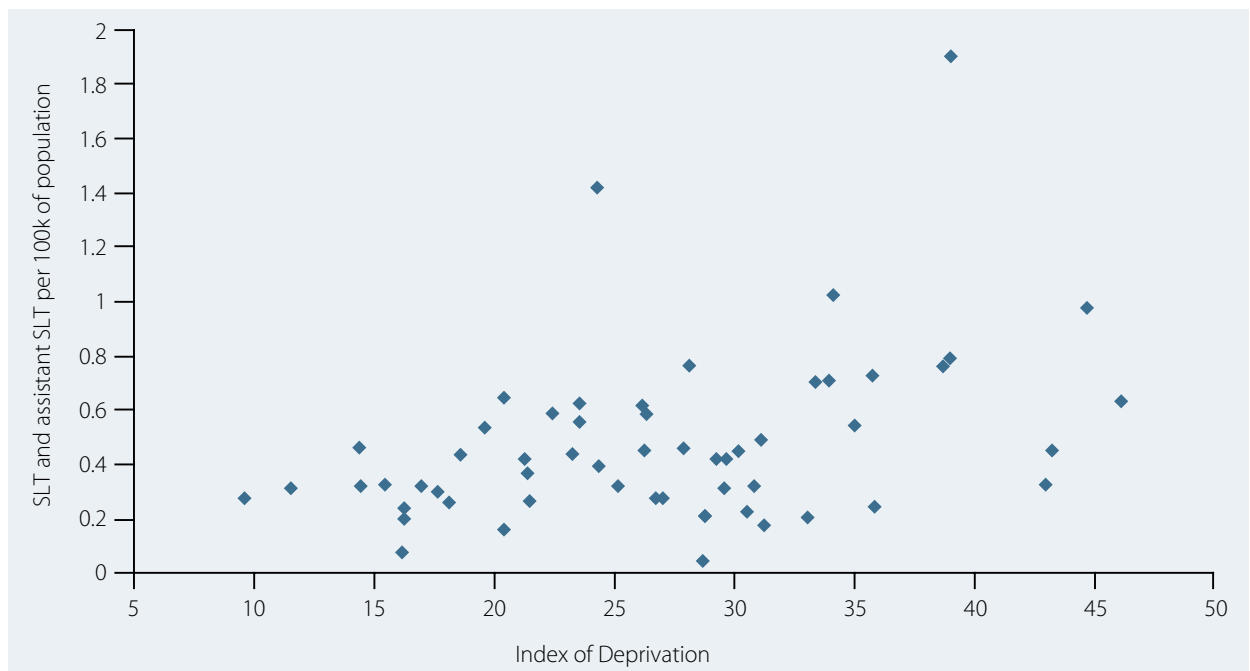
3.35 The visits undertaken also highlighted that there are significant differences in the numbers of SLTs per population and the caseloads for SLTs, even taking on board differences in demographics and models of service delivery. In one city, there are 10 SLTs for 2,500 population, whereas in another area there were 21.4 SLTs for 3,000 children and young people. In the area with 10 SLTs, concerns were raised that the needs of children and young people with SLCN were not being adequately met, with children and young people with high levels of need receiving a consultancy model rather than direct therapy because of resource constraints.

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24 Taking out the first and last decile
25 Correlation coefficient is 0.40

Numbers of SLTs and workforce planning

3.36 NHS data[26] show that there were 3,023 (2,544 SLTs plus 479 SLT assistants) full-time equivalent posts working with children and young people. In addition, a sizeable proportion of local authorities employ SLTs. A survey[27] of local authorities suggests that around a third employed SLTs directly in addition to those employed by the NHS.

3.37 RCSLT membership figures of the numbers of SLTs working with children and young people (though not all practising SLTs are members of the RCSLT). These show that there are 7,794 SLTs practising in England and 60% are considered to work with children and young people (this equates to 4,676 SLTs). The membership figures do not differentiate between full and part time workers or those employed by the NHS, local authorities, schools or the independent and charitable sector. SLTs also work in private practice and the majority (approximately 490) work with children and young people.

Impact on service delivery

3.38 National organisations report that a lack of cohesion between workforce planning and local commissioning can result in difficulties with respect to supply and demand. Evidence gathered from Review visits highlighted that financial constraints within the NHS have resulted in posts being 'frozen' or removed. This is despite heavy caseloads, long waiting lists and parental complaints about having to undergo expensive tribunal processes to secure access to SLT.

3.39 In visits to Nottingham, Manchester, Middlesbrough, Southwark and Kent, parents and professionals alike talked about the lack of SLTs and the consequent inability to meet demand for services. For example, in one school, although every child had a statement, and many of those statements specified SLT, no therapist had been in the school for over a year.

3.40 Teachers also commented on the pressures of time being an issue and resulting in SLTs not being able to build the links that were required within schools.

3.41 National charities and families were concerned that inadequate resources and other strains on the system mean that many families struggle to access a quality service. This was of particular concern for children and young people with severe needs for whom some organisations and families found that the only support apparently readily available at both the pre-school and primary school stages was generic 'low-dosage' support. While this would be suitable for children and young people with mild speech delays, it was grossly inadequate for children and young people with more severe SLCN.

3.42 From visits and submissions, it was clear that resource constraints also impacted on the ability of SLTs to provide support to young people in secondary schools, where there appeared to be little or no provision. SLTs raised concerns about the poor knowledge of SLCN in further education.

3.43 There was a significant difference in the approach in Copenhagen, where SLTs had quality time to spend with families. This included time with parents and carers to observe videos of children and young people and jointly to agree future needs and priorities.

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26 Barnes, Appleby and Parker. *A profile of children's health and maternity services in England* (2006). Table 4.2c: WTE of allied health professionals employed in targeted services, Department of Health and Durham University.

27 Dockrell, Lindsay, Palikara and Cullen. *Raising the achievement of children and young people with specific speech and language difficulties and other SEN through school to work and college* (2007) RR837, Department for Education and Skills.

2.   LEADERSHIP

National leadership

3.44 Feedback from Review visits, consultations and the online questionnaire is resoundingly clear. Respondents want Government to demonstrate, through its leadership of the national system, that it understands and acknowledges that communication is a fundamental life skill. This includes communication through a range of means such as signing and communication aids.

3.45 The strong message from the Review visits and submissions from national organisations was that meeting the SLCN of children and young people is not a priority. Commissioning services for children and young people with SLCN was also felt to be affected by conflicting priorities and targets, particularly within the Health Service where the focus is on other important areas such as stroke, coronary heart disease and other medical conditions, as well as waiting lists and reducing hospital admissions.

Local leadership

3.46 There is consensus amongst the submissions, and evidence gathered from Review visits and consultation groups, that strategic leadership at local level needs to be clearer and more unified than at present. What is needed is a joint vision of strategic leadership roles for children's services across health, social care and education in order to provide services that are equitable, efficient and effective.

3.47 The visits undertaken highlighted the importance of local leadership in ensuring effective partnership working across health, social services and education. For example, in Hackney, effective leadership from the SLT service manager, working in partnership with the Directors from the PCT and Learning Trust, has driven the successful integration of services for children and young people across universal, targeted and specialist provision.

3.48 In a number of Review visits, many professionals indicated that strengthening and formalising local leadership roles through Children's Trusts or Children's Centres would result in more effective integrated working across health, social care and education at the level of the individual child. Strengthened joint commissioning arrangements and a period of organisational stability were also needed, as the previous chapter explains.

- Only 18% of respondents to the online questionnaire believe health and education services work well together to provide these services.

- 30% of respondents considered that steps are being taken to integrate services with 15% stating there is no strategic leadership at present.

- 22% stated that clear strategies/responsibilities are needed.

- Only 20% of respondents believe that in their local area, lines of accountability in all services are clear.

3.49 The current situation is not satisfactory for parents. They sensed a lack of leadership from local authorities and the NHS.

3.50 Strategic leaders whom we met on visits to local areas confirmed that they considered SLC as important issues. However, it was not always the case that the workforce they led felt that sufficient priority was given to addressing the needs of children and young people with SLCN.

3.51 Whilst there is evidence of some effective joint working at a senior level, it was not always clear that strategic leaders in different services worked closely together in order to manage the local system. For example, it was rare to find services with shared objectives, with only a small number of local area Children and Young People's Plans including meaningful objectives relating to SLC.

3.52 Generally, leadership on SLC tended to come from operational leaders, such as senior clinicians in SLT services, Children's Centre managers, head teachers or heads of language units or similar resources.

3.53 However, evidence presented to the Review, particularly that from parents, suggested that many local leaders still did little to recognise and promote the importance of SLC or to address the needs of children and young people with SLCN.

3.54 The evidence from visits and submissions supports the need to achieve higher quality professional leadership within schools across the piece. Leadership by the heads of primary schools visited by the Review made it clear that their support and backing were instrumental in the development of whole school approaches to communication skills development.[28]

> **An example of impressive leadership:**
>
> 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%[28] of pupils are eligible for free school meals.
>
> 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. ACCOUNTABILITY

National accountability

3.55 68% of respondents to the relevant question in the on-line questionnaire said that, at national level, lines of accountability were not clear.

3.56 Some organisations called for stronger joint working across Government Departments. For example, I CAN raised the need for clear lines of shared accountability at Ministerial level and for strong political leadership in order to support cross-sector working and the RCSLT called for clear political accountability. The Association of Directors of Children's Services (ADCS) suggested that the DCSF should have sole responsibility for SLC services.

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28 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.

Local accountability

3.57 40% of respondents to the relevant question in the on-line questionnaire said that, at local level, lines of accountability were not clear. A further 40% said that lines of accountability were clear on some issues.

3.58 One of the issues most frequently raised with the Review has been the provision of SLT. Many parents of children and young people with statements have complained that the SLT component of those statements has not been delivered. Equally, many parents of non-statemented children and young people with SLCN are disgruntled that they have been unable to access SLT at all.

3.59 Although local authorities have a statutory duty to provide the services specified in statements, they rely on PCTs to provide SLT. However, PCTs are not always able to meet the demand for SLT and the onus falls back on local authorities to provide the service by another means. Local authorities told the Review that they considered it inequitable that they were held to account for provision over which they had no direct control.

3.60 In its meeting with the Review, the ADCS suggested that Children's Trusts or local authorities could determine and be accountable for the deployment of SLTs. However, the Review's visits found that others, including some SLTs and their managers, supported transferring SLTs to local authority employment.

3.61 For both SLT and other SLC 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 SLC in Children & Young People's Plans or Local Area Agreements.

WHAT ARE THE MAIN CHALLENGES?

1. WORKFORCE

3.62 The wider children's workforce needs to have the skills and knowledge to support the development of SLC for all children and young people. As a result of more limited screening since the publication of the Hall 4 report, there is a particular challenge to ensure that more members of the workforce are equipped with the skills to identify SLCN.

3.63 The wider children's workforce needs to have the skills and knowledge to support children and young people with SLCN in every part of their lives, and at all ages and stages, be it at home, in school or as they participate in social activities.

3.64 For children and young people with SLCN, developing the skills and knowledge of the wider workforce will bring a triple benefit. It will amplify the efforts of the specialists through delivery of a personalised programme of support around the child or young person (led by specialists and implemented by the wider workforce). It will ensure that children and young people with SLCN have the same opportunities as their peers to make friends, enjoy and achieve. It will improve the consistency of approach by professionals and support a continuum of service provision.

3.65 The Review has identified that it is also important to address the inequalities of service provision which result from a lack of training for specialists in the team, including specialist SLTs and specialist teachers. There is also a need to look at the variability of SLT numbers within local areas.

2. LEADERSHIP

3.66 The importance of national leadership in making SLC a priority throughout the system cannot be underestimated. At present, although the two Departments are working together on issues such as childhood obesity and mental health, it is not always clear that they are working sufficiently closely together to provide effective joint leadership on SLC. The challenge is to find a means by which to strengthen that role sufficiently.

3.67 In the same way that joint leadership at national level needs to be more effective, local leaders must work more closely in order to improve services and outcomes for children and young people with SLCN in their area. At a strategic level, the challenge is for local authority and health service senior managers to work in collaboration through Children's Trusts in order to create the best conditions in which universal, targeted and specialist services can provide support to children and young people and their families.

3. ACCOUNTABILITY

3.68 The challenge at both national and local level is to establish clearly who is accountable and for what. That there are a variety of leaders makes this challenge all the more difficult and it might well be that leaders are jointly accountable for overall provision.

3.69 At a local level, there is the additional issue of accountability for the provision of SLT. Under present arrangements, local authorities find themselves accountable for provision of a service for which they have no direct responsibility and over which they exert no control.

3.70 Having decided who is accountable and for what, the remaining challenge is to decide how leaders are to be held to account.

NEXT STEPS

The workforce contains many skilled, dedicated and enthusiastic staff who aim to deliver universal, targeted and specialist services. Nevertheless, it is remains an open question whether there are sufficient specialists and it is clear that there is much to be done to upskill the wider children's workforce in relation to SLC. Effective leadership demands shared objectives, shared understanding of how to deliver them and shared effort to do so. Yet such leadership still needs to be developed. Just as importantly, we need to know who is accountable, for what and how agencies or people will be held to account. The Review will therefore consider the following:

1. **How to enhance the skills of specialists and to ensure that more of the children's workforce are trained to identify and meet SLCN.**

2. **Resources:**

● **The number of SLTs, their distribution across the country and their deployment through the age range; and**

- **Whether there is scope for improvement in the use of staff and facilities by local authorities and PCTs.**

3. **How leaders of children's services and health services work together at present and what steps might be taken, for example through Children's Trust arrangements, to improve collaboration to meet SLCN.**

4. **Accountability at national and local levels, including the role of performance management.**

5. **Whether local authorities' accountability for provision of SLT for statemented pupils should be reviewed.**

Conclusion

1. Over the last six months, my colleagues and I on the Review team have been privileged to engage in the opening phase of the first review of SLC services for seven years. 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 to date 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 resources, 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 SLC 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.

2. We do not expect to achieve utopia. There are no panaceas. Moreover, devising and implementing sound policies 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 policies in a fashion which reflects local needs. In doing so, policy makers have a solemn duty not to settle for what is adequate but to strive for what is best, with access to it irrespective of where in the country parents, children and young people live.

3. Listening to 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.

4. 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.

5. Our purpose is to keep the best and improve the rest. There is a challenge to deliver change for the better. That challenge embraces the main principles which are enshrined in and should resonate throughout this interim report:

    ● Communication should be a priority. Making it just 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 care offer is made to all children and young people with SLCN.

6. The report describes a series of next steps. A national campaign to raise the importance of SLC. Bolstering Children's Trusts. Providing an audit tool for local needs assessment. Offering guidance for commissioners of SLC services and considering the benefit of a child centred pathway to inform the commissioning process. Considering Ministerial responsibility for meeting children and young people's SLCN. Working out how best to resolve the recurrent tension between local authorities and PCTs. Reflecting how to establish strategic leaders responsible for services at local level. Thinking about how OFSTED can improve monitoring of SLT services. Strengthening competences in the children's workforce. Studying the case for early assessment for language and communication of all children and young people. Aiming to identify what provision of SLT at all levels is required.

7. These are important questions. We wish to pose and answer them because they are all relevant to our biggest challenge which is to ensure that every child and young person can communicate. The power to do so is a vital piece of equipment for citizenship and no one should be denied it. We will consult on our proposals, study what we are told and produce our final report with recommendations to Ministers in July 2008.

Annex A: The Policy Context

1. There are a variety of policy initiatives which affect commissioning of services for children. As will become apparent, these initiatives come from both the one time Department for Education and Skills (DfES) and the Department of Health (DH)[29]. To the uninitiated observer, including a parent who first discovers that his or her child needs help, there can appear to be a bewildering array of different laws, agencies or services that are in some way relevant. Negotiating the learning curve, including working out what one's rights are and how best to make progress for the child, can be very burdensome. Part of the difficulty is that, as in so many aspects of public policy, no one started with a blank sheet of paper and produced a complete guide which catered for every eventuality and, realistically, it would have been almost impossible to do so.

2. Instead, in keeping with the tradition of British law making, policy formulation has been a process rather than a fact. Changes of government have inevitably spawned some changes of emphasis and a series of new initiatives. That said, the story in special educational needs policy has been characterised by considerable continuity from one administration to the next. Such changes as have taken place have been inspired by the prevailing consensus as to the types of approaches conducive to children's development and the organisational means for delivering them. The effect of several incremental changes has been to create a body of law and guidance which might seem labyrinthine and disconcerting. At the outset of this report, however, it is useful to consider the instruments that are shaping public policy and individual experiences. This is offered below in the form of a factual description of the big ticket items and a brief discussion of some current controversies.

3. The Education Act 1981 established the modern framework within which local authorities must fulfil their duties towards children with special educational needs by assessing their needs, specifying the provision (including within a statement) to meet them and arranging for its delivery. It introduced a broader and more flexible concept of SEN and replaced the former system of categorising children on the basis of disability. The Education Act 1993 reenacted the main provisions of the 1981 Act but also made significant changes. It established the Special Educational Needs Tribunal. Its jurisdiction was later extended to disability discrimination (following the 2001 Act – see below) and is now known as SENDIST. Also the 1993 Act introduced the requirement for the Secretary of State to issue the Code of Practice on SEN and for all those concerned to have regard to it.

4. The Education Act 1996 upholds the existing SEN framework of assessments and statements and makes provision for a Code of Practice containing guidance on how schools and local authorities should support children with SEN. The principle that speech and language therapy should in most cases be educational provision and so included in part 3 of the statement was established

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29 The Department for Education and Skills was reorganised in June 2007 and replaced by the Department for Children, Schools and Families and the Department of Innovation, Universities and Skills. It is with the work of the Department for Children, Schools and Families that we are overwhelmingly concerned in this report.

by the Lancashire judgement in 1987. The judge at the time stated that 'To teach an adult who has lost his larynx because of cancer might be considered as treatment rather than education. But to teach a child who has never been able to communicate by language, whether because of some chromosomal disorder…or because of social cause…seems to us just as much educational provision as to teach a child to communicate in writing'.

5.   The Special Educational Needs and Disability Act 2001 (referred to as SENDA) made important amendments to the Education Act 1996 by strengthening the rights of children to inclusive education in mainstream schools, and extended the Disability Discrimination Act 1995 to education. The current statutory framework for SEN is contained in the Education Act 1996, as amended by the 2001 Act and most recently by the Education and Inspections Act 2006 (which makes changes on SENCOs and time limits relating to SEN statements). The Education Act 1996 is a huge consolidating piece of legislation.

6.   The current SEN Code of Practice, which was last amended in 2001, reflects the Lancashire judgement, stressing that 'since communication is so fundamental in learning and progression, addressing speech and language impairment should normally be recorded as educational provision unless there are *exceptional* reasons for not doing so.' The Harrow judgement of 1996 ruled that where a child's statement specifies speech and language therapy, and the health service is unable to deliver it either at all, or at the level specified, the local authority is responsible, for ensuring that the child receives the therapy he or she needs. Reflecting that ruling, as the Code of Practice states: 'Where the NHS does not provide speech and language therapy for a child whose statement specifies such therapy as educational provision, ultimate responsibility for ensuring that the provision is made rests with the LA, unless the child's parents have made alternative arrangements.'

7.   In 2004, the DfES published *Removing Barriers to Achievement*, the key document underpinning the Government's SEN policy. Seen by Ministers as a statement of its agenda on Special Educational Needs for the decade ahead, the strategy proposed

- To focus on early intervention – to identify the needs of children as soon as possible and to provide the right support to help them learn.

- To personalise learning for all children and make education more responsive to individual children's diverse needs.

- To remove barriers to children's achievement by developing the skills of teachers to meet the diverse range of needs and to sharpen the focus on children's progress.

- To educate more children with Special Educational Needs in mainstream schools, supported by special schools which will become centres of excellence.

- To provide a clear and continuing role for special schools – educating children with the most severe and complex needs, working closely with mainstream schools to share expertise and extend the range of learning opportunities for all children in both settings.

- To foster closer partnerships between education, health and social services and the voluntary sector to ensure that children with SEN and disabilities get the services they need to make the most of their education.

8. Most recently, the backbench Labour MP, Sharon Hodgson, has introduced a Private Member's Bill, the Special Educational Needs (Information) Bill, which the Government has undertaken to support[30]. The Bill contains two substantial provisions – to require the Secretary of State to secure information about children with SEN that will assist in improving the well being of such children and to publish that information. The Review will consider how it might tie in with, or be used as a lever for, improvement in data we will want to see.

9. Collaborative working between education and health is advocated as best practice for children with communication disability, and the Children Act 2004, which underpins the *Every Child Matters – Change for Children* programme, wrote into law the duty to cooperate between health and education on joint planning and commissioning. If, however, this fails to deliver for the child concerned, parents can have recourse to the legal framework as just outlined to ensure delivery of speech and language therapy for their child. *The Early Years Foundation Stage* (EYFS) will be the single quality framework covering children's development and learning experiences from birth to five years. The EYFS will maintain the current approach that aims to ensure that all providers meet the needs of all young children, including those with special needs, whilst ensuring that they promote equality of opportunity and antidiscriminatory practice.

10. Government policies are also communicated through guidance documents and initiatives. The *Every Child Matters* programme (from 2003 onwards) encouraged all those providing services to children (from hospitals and schools, to police and voluntary groups) to work together in order to achieve five outcomes (Be healthy, Stay safe, Enjoy and achieve, Make a positive contribution, Achieve economic wellbeing). Speech and Language Therapy is identified as a priority. In particular, *Every Child Matters in the Health Service*[31] recognised speech and language therapy as a "key challenge" for joint working. The *National Service Framework for Children and Maternity Services*[32] (2004) emphasises the importance of communication skills for children, recognises the value of speech and language therapy and specifically highlights the need for early intervention. The new *Early Years Foundation Stage Curriculum*[33], which becomes mandatory in September 2008, identifies Communication, Language and Literacy (CLL) as one of the key strands of the curriculum from 0-5 years. Joint working across health and education at a commissioning and provider level is identified as essential if children are to achieve the early learning goals outlined in the curriculum. Speech and language therapists are seen to have a specific contribution to make to the training and development of the children's workforce.

11. Sure Start Children's Centres are one stop central hubs for children under the age of five and for their families offering each access to family health care, advice and support for parents including drop in sessions, outreach services, integrated early education and childcare, together with links through to training and employment. The overriding objective of the centres is to improve outcomes for young children, reducing inequalities in those outcomes between the most disadvantaged and the rest, and helping to bring an end to child poverty.

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30 Kevin Brennan MP, Parliamentary Under-Secretary of State, Official Report, 1st February 2008, col. 609
31 Department of Health (November 2006) *Every Child Matters in the Health Service*, circular to Local Authorities and Primary Care Trusts, *London: DH.*
32 Department of Health, Department for Education and Skills (2004) *National Service Framework for Children and Maternity Services* London: Department of Health.
33 Department for Education and Skills(2007) Statutory Framework for the Early Years Foundation Stage: Setting the Standards for Learning, Development and Care for children from birth to five. London: Department for Education and Skills

12.   There are currently over 2,400 Sure Start Children's Centres providing access to services for over 1.7 million children and their families in the most disadvantaged areas of England. The Government has announced that there should be 3,500 centres by 2010, a Children's Centre for every community in England offering permanent universal provision designed to ensure that every child gets the best start in life. To deliver this capacity, revenue funding for Children's Centres is set to rise to £1.3 billion in 2010-11[34]. By any yardstick, the inputs involved are significant. Inevitably, outcomes can be more difficult and certainly take longer, to measure. The same National Audit Office report[35] that noted these significant inputs also noted, "many of the improvements they [Children's Centres] are seeking to make in children's lives will show their main results only after a number of years". However, an independent evaluations report in March 2008 did show that children behave better and are more independent if they live in areas with Sure Start Children's Centres[36]. Nevertheless, three relevant concerns remain in the context of our review.

13.   First, the National Audit Office report notes[37] that "only five of the 27 local authorities we examined had formally agreed with Primary Care Trusts what services to provide through Children's Centres." Given that the centres are empowered to provide their preferred selection of up to 17 different services, and that speech and language development is one of those that will require a strong link with Primary Care Trusts, evidence of clear agreements will be important. Secondly, the report notes that "very few areas have established a joint strategy with health bodies for working together to target disadvantaged groups"[38]. It is difficult to overstate the need for collaborative working to deliver early intervention in these areas, given the higher prevalence of speech, language and communication difficulties in the most disadvantaged parts of the country. Concerted efforts to encourage hard to reach households to access the services offered by the centres will obviously be a challenge and should be a priority. Thirdly, the House of Commons Public Accounts Committee, in addition to echoing the concerns of the National Audit Office that not enough is being done to reach the most disadvantaged families, has emphasised that centres need more clearly to signpost the services they can offer. In its own words "families with children with disabilities need better information on what services they can expect to be provided in Children's Centres and help with referral to services that the Centre cannot provide itself. For some disabled children, Children's Centres can play an important part, for example by providing early help for children with speech and language difficulties, which can potentially reduce the need for more expensive support as a child gets older. Centres should communicate clearly which of these services they can provide directly."

14.   In addition to these concerns, there is at the time of writing a particular unease amongst early years professionals about the funding of speech and language therapy in Children's Centres. Guidance issued by DCSF in November 2007 states "family and community health services … are not funded through children's centre revenue. We expect these services to be provided by the NHS"[39]. It appears that the expectation from the DCSF was that the Department of Health had known that this shift in funding was to occur. However, the Department of Health and therefore

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34 NAO report 18.12.2006 http://www.nao.org.uk/pn/06-07/0607104.htm , p.5
35 NAO report 18.12.2006 http://www.nao.org.uk/pn/06-07/0607104.htm
36 National Evaluation of Sure Start report, March 2008 http://www.surestart.gov.uk/events/newsevents/whatsnew/index. cfm?news=322
37 NAO report 18.12.2006 http://www.nao.org.uk/pn/06-07/0607104.htm P.32
38 (ibid)
39 DCSF, November 2007, Sure Start Children's Centres: Phase 3: Planning and Delivery, p.16

NHS commissioners were apparently unprepared for the announcement. This breakdown in communication between the two government departments is having an immediate effect on speech and language service provision in Children's Centres with reports from around the country that these services are being cut.

15. The DCSF has emphasised that the expectation that funding of speech and language therapy should come from the NHS is not new. Some Children's Centres have developed from Sure Start Local Programmes (SSLPs) that were able to fund health services within their area-based programme previously by using the grant they received from the then Department for Education and Skills. However, SSLPs were part of a pilot programme. Moving to a national model for the delivery of mainstream children's services through Sure Start Children's Centres, based upon the learning from the earlier programmes, DCSF stresses that services are to be funded through the normal routes. On that assumption, it would be appropriate for NHS to pay for health services provided through Children's Centres. Whatever the source of funding, a shared understanding about the issue is essential. In January 2008, the Children's Minister, Beverley Hughes, indicated that officials would be asked to 'clarify' the advice which is being provided to PCTs by the Department of Health. In addition, she signalled that "the results of your review will give both my Department and the Department of Health a further opportunity to consider how services which support speech and language needs are being delivered at a local level through Children's Centres"[40]. The nature, funding and operation of these arrangements are important to the policy context and the review team will look at them carefully in the run up to the final report.

16. *The SEN Review – SEN Select Committee Report* (2006) stated that "the Government needs to develop a child-centred approach with regard to each stage of the process by which children receive a statement of educational need: assessment of needs, allocation of resources; and placement. It should develop a system based on early identification and intervention, where schools are fully resourced and staff are fully equipped to meet those needs, and where there is a broad range of suitable high quality provision available to ensure all children are healthy, safe, enjoy and achieve, make a positive contribution and achieve economic well being."

17. The report noted that there is huge variation nationally in provision, (The audit commission identified this as 'unacceptable variation', being especially concerned about pupils with low incidence special needs[41]. Debate about placement should not be about making a simple distinction between mainstream and special school provision. It should be about quality and range of provision for children in **all** types of provision and the key factor is "effective and skilful leadership with the ability to apply skills and knowledge and enshrine principles into practice for all learners"[42]. It was noted that the Government is moving towards a "flexible continuum of provision".

18. Importantly, the Select Committee report also noted the potential for a conflict of interest where the same body is responsible for assessing need and making provision. The place of special schools in the range of provision for children with special needs was reinforced in the Audit Commission Report *Out of Authority placements for Special Educational Needs* (February 2007). This report specifically recommends that statutory and voluntary agencies work together to spread skills, knowledge and expertise in order to reach the maximum number of children.

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40 Beverley Hughes letter to John Bercow, 9 January 2008
41 *Audit Commission: Special Educational Needs – a mainstream issue (2002)*
42 ibid

19. The commissioning of services is informed by:

- national and local priorities

- the assessment of needs of the local population

- improving outcomes for children based on evidence of what works

- affordability and value for money which need to be balanced out by a cost – benefit analysis of short – term investment versus longer term outcomes

20. With reference to the potential for a conflict of interest referred to in paragraph 1.18, a report by the Children, Schools and Families Select Committee in October 2007 recommended three options as to how the link between assessment of need and funding of provision could be broken. These were

- assessments commissioned by local authorities of children's trusts

- delegated assessments of schools

- making educational psychology services more independent

21. In its January 2008 response, the Government indicated that commissioning by local authorities was consistent with both the Education Act 1996 and the Deregulation and Contracting Out Act 1994 under which local authority SEN assessment functions are already undertaken. That said, the Government believes that advice should come from education, health and social service professionals who have led contact with the family and a *requirement*, as distinct from an entitlement, to contract out assessments was undesirable. However, recognising that there is parental discontent with the status quo, the Government announced that it will set up a group of experts to investigate the most effective ways of increasing parental confidence. The group will look at whether this would be best achieved through:

- making the provision of educational psychology advice "arms length" from the local authorities

- sharing best practice in developing good relationships between the authority and parents, through effective Parent Partnership Services and other local mechanisms; and

- effective practice by schools and local authorities in meeting the needs of children at School Action Plus

22. Meanwhile, the Government proposes to carry out a pilot based on a "team around the child" approach to SEN Statutory Assessment. This is designed more closely to reflect and to build upon the principles that underpin the Common Assessment Framework.

23. *The PSA Delivery Agreement 12: Improve the health and wellbeing of children and young people* (October 2007)[43] has a section on the development of Children's Centres. This states that Children's Centres and other early years settings should give young children a healthy start in life and offer support and advice to parents. This means early identification of developmental problems that will benefit from early help, for example speech and language therapy.

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43 HM Government (2007) *PSA Delivery Agreement 12: Improve the health and wellbeing of children and young people* London: The Stationary Office

24. Commissioning guidance underlines the expectation of joint working, from planning to funding and monitoring. The *Joint Commissioning Framework*[44] (March 2006) sees effective joint planning and commissioning as at the heart of improving outcomes for children and young people through children's trusts, identifies the problems joint working needs to address and promotes the use of pooled budgets. Joint commissioning should also involve children and their families. The *Commissioning Framework for Health and Wellbeing*[45] (March 2007) states that commissioning for health and well-being means involving the local community to provide services that meet their needs, beyond just treating them when they are ill, but also keeping them healthy and independent. Assessing and understanding the needs of individuals as well as of the population as a whole is integral to helping them achieve good outcomes.

25. Further guidance on the commissioning of services has been provided in recent government documents and these are detailed below.

- World Class Commissioning (Department of Health)[46]. This work includes the development of competences, which aim to support "world class commissioning" (WCC). The section on process and knowledge stresses that the Commissioners should 'routinely seek and report on research and best practice evidence that will assist in commissioning and decision making.'

- *The Operating Framework for the NHS 2008/09*[47] also puts a new emphasis on 'identifying actions and setting local targets for children with disabilities and complex needs and their families. This includes…improving access to therapies'. There is also a 'focus on evidence-based prevention, early intervention and access designed around the needs of the individual', with an expectation that PCTs work with local authorities within the context of Every Child Matters and the Children's Plan.

- *The Children's Plan* (Department of Children, Schools and Families)[48]. The Children's Plan looks at whether Children's Trust arrangements need to be strengthened. The Children's Plan also has an ambition for Children's Trusts to "have in place by 2010 consistent, high quality arrangements to provide identification and early intervention for all children and young people who need additional help." The Trusts are local area partnership arrangements underpinned by the duty in the Children Act 2004 to cooperate in coordinating key agencies to deliver services to children and young people. The Trusts are the Government's preferred model for integrating services. 150 local authorities have developed Children's Trusts *arrangements*. It should be noted too that the Children Act 2004, which promotes the Trusts, provides a power, but does not impose an obligation, to pool budgets across different agencies. At present, it is not clear how many Trusts have been formed, to what extent schools are working with them, or whether pooling of funds is taking place on any significant scale.

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44 Department of Health, Department for Education and Skills (2006) *Joint planning and commissioning framework for children, young people and maternity services* London: HMSO.

45 Department of Health (2007) *Commissioning framework for health and well-being* London: Department of Health

46 Department of Health (2007), *www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Commissioning/ Worldclasscommissioning/index.htm*

47 DH / NHS Finance Performance & Operations (2007) *The NHS in England: The operating framework for 2008/9* London: Department of Health

48 Department for Children, Schools and Families (2007) The Children's Plan – Building Brighter Futures London: The Stationery Office

26.   Another important feature of current policy which should be mentioned, not least because it is the subject of debate in the special educational needs sector as a whole, is delegated funding. The Government is committed to increasing the amount of funding delegated to schools to provide services to meet the special educational needs of children. It argues that passing resources directly to schools bypasses bureaucracy and allows them more quickly to address 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 special educational needs. The risk that funds might be diverted is compounded if delegation is not accompanied by any oversight or monitoring by the local authority.

27.   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 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". Government policy is committed to the principle of delegated funding and it can yield benefits in practice. How such a policy can provide local flexibility, safeguard the interests of children with speech, language and communication needs, including those with low incidence needs, and be subject to proper accountability, will be a continuing challenge.

28.   Of course, in undertaking this review, it is as well to recall that we are not the first to do so. Over a period of two years, the then Department for Education and Employment and the Department of Health Speech and Language Therapy Working Group studied the issues, assisted by a team of external advisors, and published its report in November 2000. It is instructive, and salutary, to consider the main recommendations it made and the results which flowed.

29.   The report recommended that addressing speech and language impairment should normally be regarded as educational provision and that this principle should be reflected in the revised Code of Practice. This did indeed happen and the Code of Practice now uses the precise wording that the Group recommended. Nevertheless, debate continues to rage on behalf of thousands of children over who delivers the provision, what exactly it is and how much of it is on offer.

30.   The report recommended that the DfEE should make available grant support through the Standards Fund to enable local education authorities to create enhanced speech and language therapy services in partnership with the NHS and the voluntary sector. That support should be provided to all English local education authorities. Standards Fund pilot projects were backed by the Department in 2000/2001. Following a positive independent evaluation by the University of Manchester, Standards Fund support was extended to all English education authorities from 2001 to 2002. Worthwhile projects were supported and one important effect of them was to trigger a move away from clinic based provision towards provision in school. Since then, most Standards Fund grants have been merged into an expanded School Development Grant and it

is hard to know what share of the previous funding devoted to therapy services continues to be used for that purpose.

31. The report recommended that the Teacher Training Agency should reemphasise the importance of communication within the initial teacher training modules dealing with speaking and listening, and encourage joint training opportunities for student teachers and therapists. In order to be awarded Qualified Teacher Status all trainees must demonstrate that they can personalise teaching according to pupils' needs, have knowledge of SEN and disability legislation, understand the roles of colleagues with SEN responsibilities and are able to communicate effectively with students, colleagues and parents. Awareness is essential, but it is not synonymous with knowledge, understanding or capacity to perform tasks. As part of a £1 million series of DCSF funded measures to improve coverage of SEN and disability in teacher training, the Training and Development Agency have developed new SEN and disability units for primary, undergraduate, Initial Teacher Training courses which include a specific component on speech, language and communication needs. These units have been successfully piloted and will be rolled out to all primary ITT providers from the summer. Although the units are not mandatory, they do carry funding and course providers may therefore feel incentivised to embrace them.

32. The report recommended that voluntary organisations active in the field of communication difficulties should be encouraged to provide training to therapists, teachers and learning support assistants. On the back of work by I CAN, the Joint Professional Development Framework was published in 2001 and DCSF has offered approximately £1 million funding over two years to help to establish the Communication Trust with a brief to improve workforce skills. An early task of the Trust has been to establish a new speech, language and communication framework designed to assist in the auditing and planning of professional development in speech, language and communication needs. The external bodies which have advised on this work are to be congratulated, but it has taken Government over seven years to reach this point.

33. The report recommended that organisations produce case studies of good practice to share with teaching staff and speech and language therapists undertaking training courses. Afasic, I CAN and The Communication Trust have all done so but it is not clear how much follow through is taking place at local level.

34. The report recommended that the Department of Health should arrange for education interests to be represented on NHS Consortia. Higher education institutions are to be represented on Workforce Development Confederations (WDC) in order to inform the training commissions. The Department of Health has also highlighted the need for WDCs to consider local education authority representation in their workforce planning processes, but progress to date has been at best distinctly mixed.

35. The report recommended the promotion of greater opportunities for specialised training at post-graduate level. Following a successful bid, City University/Institute of Education received pump-priming funding to set up an MSc for teachers and speech and language therapists; the MSc in Joint Professional Practice – Language and Communication. DCSF support for the Communication Trust is designed to promote opportunities for further specialised study.

36. The report recommended the adoption of a National Speaking Strategy for schools, building on speaking and listening aspects of the curriculum, together with a focus on pupils aged 3 to 4 and provision for targets. The DCSF Early Language and Communicating Project, now known as Communicating Matters, provided training materials designed to raise awareness of how children develop language and of ways in which early years staff can best assist them to do so. DCSF has also supported roll out of I CAN's Early Talk Programme. Material on speaking and listening has been available to primary schools since 2003, though take up of it is uncertain. The Inclusion Development Programme has now been launched, but as yet it is at an early stage.

37. The report recommended that LEAs and health bodies should use the Health Act 1999 to extend joint working in the provision of speech and language therapy. Unfortunately, there is much less evidence of that joint working than authors of the report might have hoped.

38. The report recommended that the Department of Health, working with the then DfEE, should identify models of good practice in providing speech and language therapy services to children in schools. The failure to do so provided at least part of the rationale for our review.

39. The legislation, guidance and policies described in this annex highlight a series of key themes which should permeate speech, language and communication services. Recognition of the educational implications of speech and language needs is essential.

Annex B(i): Commissioning for outcomes

1. In chapter 2, the importance of outcome focused services for children with SLCN was highlighted.

2. 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.

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

4. In the first part of this annex, we set out developing work on an outcomes framework for services, and in the second part, case studies of low incidence services.

DRAFT OUTCOME MEASURES FOR CHILDREN WITH SLCN

5. The Review would like feedback from stakeholders on what an effective national guide in this area would look like how helpful it would be.

6. Set out below is some early thinking on some potential outcomes and indicators commissioners could use to guide their design and planning for services.

7. Please send feedback to Bercow.Review@dcsf.gsi.gov.uk.

Towards outcomes for commissioning SLCN services for children

When considering outcomes for children 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 individuals 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 individuals 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 individuals 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 (for example type of employment)
- Future plans for safe care

Qualitative indicators

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

At LA 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

Annex B(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 of 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. A final decision on its future has yet to be reached.

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.

Annex C: 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 D: Terms of Reference

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 E(i): Call for Evidence: Questionnaire

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

Consultation Response Form

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:

☐ Parent/carer	☐ Young person (19 and under)	☐ School staff (Please state your role)
☐ LA staff (Please state your role)	☐ Academic/researcher	☐ Professional body
☐ Voluntary organisation	☐ PCT staff	☐ 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:

☐ Excellent   ☐ Good   ☐ Satisfactory   ☐ Poor

Comments:

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

☐ Easy to find   ☐ Not easily available   ☐ Not available at all

Comments:

2 b) And the quality of the information was:

☐ Excellent   ☐ Good   ☐ Satisfactory   ☐ Poor

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 you 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:

☐ Excellent   ☐ Good   ☐ Satisfactory

☐ 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:

☐ Excellent   ☐ Good   ☐ Satisfactory

☐ In need of significant improvement

Comments:

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

☐	Excellent	☐	Good	☐	Satisfactory
☐	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:

☐	A high priority	☐	One of many competing priorities	☐	Not a priority
☐	A priority for health only	☐	Education only	☐	

Comments:

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

☐	All or most of the time	☐	Sometimes	☐	Rarely

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]:

☐ Support for children in their early years   ☐ Support for 5-11 year olds   ☐ Support for 11-16 year olds

☐ Support for 16-19 year olds   ☐ Support for children with the severest speech, language and communication needs   ☐ Support for children with low level needs

☐ Speech and language units   ☐ Outreach work   ☐ Information for parents

☐ Other (please specify)   ☐

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:

	Clear		Clear on some issues		Not clear

Comments:

18   Central Government's contribution to raising standards is:

	Clear and helpful		In need of strengthening		Not clear

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 E(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 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%)

Respondent's 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 is 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 were 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 of, 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 therapist's 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 occurred 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 quicker. 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 genera;

- that school staff did not have the time to dedicate to speech and 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 was too great to enable them to dedicate their time effectively to all schools on their caseload

- there was 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 respondent's 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 opinion 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 who's 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 the 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 you 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 and 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 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 and other members of the children's workforce. They said that there was 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 was 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

- 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 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?

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 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 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 they had a full understanding of the service. There was also the mention that they 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 (Eg 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 was 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 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 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 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 that 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 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 better support training.

The above list is not an extensive 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 for 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 individual's 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 of 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 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 to effectively 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 F – Call for Evidence: Visits and Consultation Meetings

As well as the online "call for evidence", John Bercow, members if the advisory group, and supporting DH and DCSF officials conducted a wide range of visits and meetings with interested parties.

The visits were to all corners of England and there was also a short study visit to Denmark. The visits took place in a variety of settings and allowed evidence and opinions to be collected to a more detailed level with the opportunity for follow up. A full range of stakeholders were consulted, including local authority and primary care trust officials, professionals working on the front line, specialists working in the sector and of course families and children and young people themselves.

Below is a full list of the provision visited by the Review and the meetings we held between September 2007 and March 2008. Many thanks to all who organised our visits and meetings and to all those who participated.

- 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 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

- 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

- 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

- Bucks County Council

- Afasic Youth Group, Ilford

- Xtraordinary People

- 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

- 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

Glossary

AAC	Augmentative and alternative communication/ Augmentative and assistive communication
ACE	Charity giving a voice to children who struggle to communicate
ADCS	The 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.
ASBOs	Anti Social Behaviour Orders
ASD	Autistic spectrum disorder
Asperger's syndrome	Asperger's syndrome is a form of autism, a condition that affects the way a person communicates and relates to others.
ASSET	A structured assessment tool to be used by YOTs in England and Wales on all young offenders who come into contact with the criminal justice system.
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
CDC	The Council for Disabled Children is the umbrella body for the disabled children's sector in England, with links to the other UK nations.
Cerebral Palsy	If a child has cerebral palsy, it means that part of their 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
Cochlear implant	Electronic device to aid hearing
(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
DfES	Department for Education and skills (succeeded by the DCFS)
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	Education for 0-5 year olds
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
Larynx	Colloquially known as the voicebox.
LEAs	Local educational authorities
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
NUT	National Union for Teachers
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
SEN Tribunal	The Special Educational Needs & Disability Tribunal – established by the Education Act 1993 considers parents' appeals against the decisions of LEA about children's special educational needs if parents cannot reach agreement with the LEA
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
SLC	Speech language and communication
SLCN	Speech language and communication needs
SLI	Specific language impairment
SLT	Speech and Language Therapist

SSLPs	Sure Start Local Programmes
Sure Start	Government programme for 0-4 month 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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