

# Effective and Efficient Use of Resources in Services for Children and Young People with Speech, Language and Communication Needs

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## **EXECUTIVE SUMMARY**

### **Introduction**

The Secretaries of State for Children, Schools and Families and Health invited John Bercow MP to review services for children and young people with speech language and communication needs (SLCN)<sup>1</sup>. The review was to focus 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; and 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.

The present study was commissioned to support the Review and to explore two main issues

- i) whether there is evidence on which to base recommendations to improve the effective and efficient use of resources in services for children and young people with speech language and communication difficulties (SLCD); and
- ii) The feasibility of a cost benefit analysis for investment in services for this group of young people. This report presents the findings of both strands.

### **Key findings**

- There is substantial variation in service provision and practice across the six case studies.
- Terminology and categorisation of needs also vary, undermining consistency and rendering assessment of the efficiency and effectiveness of different arrangements problematic.

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<sup>1</sup>Bercow, J. (2008). *The Bercow Report: A review of services for children and young people (0-19) with speech, language and communication needs*. Nottingham: DCSF.  
[www.dcsf.gov.uk/bercowreview](http://www.dcsf.gov.uk/bercowreview)

- Although LAs are data rich and these data are also available in aggregated form to explore the national picture, this resource is under-exploited at present; Primary Care Trusts lack such an extensive resource.
- There is a lack of integration of data from LAs and PCTs.
- LAs and PCTs differ in terms of the coherence of the integration of education and health services: the development of integrated practice remains under developed; where there is such integration, the results appear positive.
- The lack of agreement about terminology, the lack of effective data collection and analysis systems and the lack of targeted research and evaluation studies of interventions seriously restricts any individual LA/PCT pair in assessing effectiveness and efficiency.
- It is not possible, at present, to assess the efficiency and effectiveness of different arrangements for organising and providing services for children and young people with SLCN.
- At present there is a lack of evidence on cost effectiveness from studies; in addition, there is a lack of suitable data available, or at least used in practice, within LAs and PCTs.

## **Aims and Objectives**

The overall aims of the research were:

- In selected areas, to explore the efficiency and effectiveness of use of resources in the provision of services for children and young people with speech, language and communication difficulties to improve their outcomes, and so inform national improvements in service provision. (Strand 1)
- To assess the feasibility of conducting a cost-benefit analysis of investment in services for this group (Strand 2)

Specific objectives were:

### *Strand 1*

- To assess the efficiency and effectiveness of the different arrangements for organising and providing services in selected areas;
- To determine in these areas the resources deployed across different services; phases (early years; primary, secondary, post-16); universal, targeted and specialist services; and preventative and remedial services.
- To form a view as to whether in these areas the deployment of resources is achieving

the outputs and outcomes expected effectively and efficiently; and

### *Strand 2*

- To consider the feasibility of conducting a cost-benefit analysis for investment in service for this group.

### **Methodology**

Six local authorities (LAs) and associated primary care trust (PCT) were selected to represent a range of locations reflecting geographic spread, urban/rural, and data on the percentage of pupils with SLCN in primary schools (those at School Action Plus or with a statement of special educational needs (SEN), as recorded in the most recent DCSF statistics).

Within each case study (CS) a range of educational provision for pupils with SLCN was identified taking into account age (nursery to secondary) and type of provision (mainstream, mainstream with designated integrated specialist provision for pupils with SLCN, and special schools for SLCN) and a sample of professionals: the LA's senior SEN manager; a senior manager in the PCT; head teacher or head of integrated resource in each educational provision. The selection of the appropriate officer was determined by the LA or trust, as was the provision to visit: where possible this included pre-school, primary and secondary provision and both segregated and integrated provision if it existed within the LA. The stated aim for identification of the specialist provision was to select that designed for pupils with *primary* speech, language and communication difficulties, not provision that catered for pupils where SLCN was secondary (e.g. to hearing impairment or significant cognitive difficulties).

Interviews were held with the LAs' and trusts' managers and with the head teachers and heads of integrated resources. In some cases the LA or trust manager or the head was accompanied by a colleague with specialist knowledge, e.g. where the trust's senior manager was not a speech and language therapist (SLT) or the head invited the SLT or the school's Special Educational Needs Coordinator (SENCo). All interviews were conducted between March and May 2008 using a standard semi-structured interview schedule appropriate to the professional(s) and setting concerned. Many participants also provided documents. The SEN and SLT managers were also asked to complete the Index of Collaboration.

## **Detailed findings**

### ***Approaches to identifying children and young people with SLCN***

- There are considerable differences between the six local authorities in the approach to criteria and definitions of the SEN category SLCN. Some give very clear and detailed guidelines, as well as degree of need required to access different levels of funding. Others leave it to the clinical judgements of involved professionals – teachers, SLTs and educational psychologists (EPs).
- There are also differences in the way ASD is categorised – as a subset of those with SLCN, or as a separate category.
- Some SEN managers expressed reservations about the reliability of the way SEN were categorised by schools, with factors such as availability of SLTs and EPs affecting the category under which they sought additional funding.

### ***Trends in provision for children and young people with SLCN***

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

### ***SLT service working practices***

- Although SLT services collect data on contacts and numbers receiving therapy, there are relatively few collecting data on efficacy of therapeutic interventions.
- An important issue concerns how SLT services can provide data about the range of activities they carry out, and the outcomes of these activities, in a way which fits both health and education data collection and analysis requirements.
- As SLTs move towards a more consultative way of working, through other adults with responsibilities for children with SLCN, there is a need to consider the skills needed to carry out this work, and how it might be evaluated.
- As some SLT services become integrated across health and education departments, and education funds more SLT posts based in schools, a number of management issues were raised by head teachers, e.g. who has line management responsibilities? How can this work be evaluated within an educational framework?
- SLTs themselves felt that teachers needed to be made more aware of these different methods of working, and widen their expectations of SLTs beyond clinical one to one work. Three of the six SLT services mentioned problems with assessment, intervention and communications with parents because of English as an Additional Language (EAL) needs of both children and parents.

### ***Cooperation between the local authority and primary care trust.***

- Structures and processes to facilitate cooperation across Health and LA services are at an early stage of development.
- Cooperation and joint working between SLT services and education range from complete integration of services to minimal contact. Cooperation in all LAs seemed to be at its best in early years provision with close working relationships between different professional groups.

### ***Monitoring of provision for children and young people with SLCN***

- All LAs had developed databases gathering a great deal of information about pupil progress within the framework of the National Curriculum. However, it appeared that in many LAs the database was kept and analysed by a section set up for this purpose.
- The effect seemed to be very large differences between authorities regarding how the information was used to inform SEN planning, evaluate quality of provision, and to improve pupil outcomes. In some authorities all these processes were well developed, in others minimal use appeared to be made of the data. One of the



commonest responses to questions about data was “we don’t know, but we can find out”.

- At a school level, as well as national curriculum data, a great variety of different instruments and methods were used to assess progress. Although this led to a rich source of data, it often caused difficulties in providing information on how well a particular provision was performing, and made comparisons between provisions problematic.
- At both LA and school level there was a concentration on academic attainments and outcomes when discussing evaluation. Some schools, especially at secondary level, placed an emphasis on social, independence and life skills, and commented that the focus on academic attainments and National Curriculum levels could lead to an under-valuing of these broader skills.
- There was a lack of integrated data systems combining information from LA and health services. This seriously limits the development of monitoring of the children with SLCN and evaluation of provision made to meet their needs.

#### ***Training and continuing professional development.***

- Most LAs provided some training for staff working with children with SLCN as a primary need. Some was on-the-job training through joint working with an SLT and experienced teacher, some was through short training courses provided by SLTs.
- Some LAs had financed training for specific packages or had negotiated tailor made packages delivered jointly by staff from a local university, SLTs and EPs. Once in post, however, there is little opportunity for secondments to study for longer courses. Any teachers registered for higher degrees were studying part-time, and paying fees themselves.

#### ***Research and evaluation of services and provision***

- Potentially there are obvious benefits in terms of improving monitoring and evaluation of both individual progress on a broader front than just academic attainments, and comparing the effectiveness of different types of provision made both within inclusive settings and in special schools
- Both LAs and PCTs have staff qualified to undertake research, in particular educational psychologists (LAs) and both clinical psychologists and speech and language therapists (PCTs).
- Despite this, research was rarely undertaken by LA or PCT staff or by these staff in collaboration with researchers from local institutions of higher education, other than by staff as a component of a higher degree. This represents a wasted opportunity.

### ***The feasibility of a cost-benefit analysis of investment in services for children and young people with SLCN***

- The existing research literature is insufficient to act as a base for a robust estimation of the costs and benefits of investment in services for children with SLCN. Far more research is required to understand for whom and under what circumstances treatment is more cost-effective.
- Strand 1 of this study (Section 3) addressed the question of whether there are sufficient locally available data from the local authorities and schools to assess either cost-effectiveness or cost savings. Although such data do exist in some of the six authorities sampled, such data sets are not comparable across LAs and would not be able to provide cross authority comparisons.
- There was no evidence for the integration of LA and SLT data which would have the potential for costing across services. Any comparison of costs within and between services could only be carried out once a predetermined set of criteria were agreed.
- Cost-effectiveness analyses should be undertaken rather than cost-benefit analyses: too often the term 'cost benefit' is used to describe studies in which the benefits are estimated as financial savings and have little to do with outcomes. Cost-effectiveness studies allow joint analysis of costs and outcomes to assess which option represents a better use of scarce resources.
- Cost and cost-effectiveness evaluations should be incorporated into outcome studies. This will allow a body of evidence to develop over time. Care should be taken to ensure that the sample size is adequate and that the cost measure is sufficiently broad to encompass all areas where the impacts of SLCN are likely to be felt.

### **Recommendations**

#### ***Monitoring and evaluation***

- Every children's service should provide clear guidance derived from nationally agreed criteria, accompanied by appropriate training to ensure that SEN categories are used in the same way within and between authorities.
- The DCSF should consider giving more detailed guidance on the use of categories of SEN, especially in the area of SLCN, ASD and general learning difficulties.
- Progress for children with SLCN should be monitored across all key stages using nationally collected data. These data should be available nationally and serve as a baseline for monitoring value added service provision.

- Each Children's Trust should develop a system of data collection and interrogation across health and education. These data should help evaluate educational provision and therapy outcomes as well as support development of methods of evaluating practice to meet the needs of children with SLCN.

### ***Provision***

- LAs and SLT services should be encouraged to develop integrated services with SLTs working more in schools, at a variety of levels, not just in terms of providing individual therapy.
- In each LA SLT and SEN managers should consider line management, working practices and record keeping for SLTs working in school settings.
- Guidelines should be developed of good practice where SLTs are working with clients with EAL needs and their families.
- All children's services should review and evaluate provision for SLCN made in the secondary phase and FE in their area.

### ***Collaboration***

- LAs and SLT services should consider as a priority how they can work together to develop training courses to meet the professional development needs of all staff working with children with SLCN in educational provision across all age phases. The impact of these training courses should be evaluated.
- LAs and SLT services should provide sufficient funding and time to meet CPD needs of staff with expertise in the area of SLCN: support and advisory teachers, SENCOs, EPs and SLTs
- LAs should consider how they ensure that staff in integrated resources and special schools for children with SLCN as their primary need have sufficient and appropriate training, including access to specialist qualifications.
- DCSF should endorse and disseminate models of practice in professional development that are systematic, coherent and give an appropriate balance to competencies that all staff should have (e.g. through the SLCN material in the Inclusion Development Programme), what some staff in every school should have and what specialists working across the authority (e.g. specialists teachers, outreach staff from special provision) should have.

### ***Cost effectiveness***

- Cost-effectiveness analysis (CEA) should be employed rather than cost-benefit analysis. CEA should be incorporated into outcome studies so that the costs and outcomes of interventions can be jointly analysed.

### ***Research programme***

- The DCSF should implement a research programme for SLCN in order to guide the development of policy and practice. The main focus should be a study of interventions including examination of the following key issues:
  - locational (e.g. special school. Integrated resource, mainstream)
  - pedagogic (e.g. specific programmes for specific needs)
  - organisational (e.g. nature and deployment of support services, use of data informed developments),
  - employer base interaction (e.g. use of consultancy model v direct teaching/therapy)
  - cost effectiveness and efficiency of different interventions and models of collaboration
- An examination of the range of working practices in integrated/inclusive resources for children with SCLD is necessary in order to develop advice about good practice and relevant training.
- Data are needed to distinguish the similarities and differences between the SEN of children with SLCN and those with ASD in terms of learning environments and behavioural management regimes.

## 1. INTRODUCTION

### 1.1 The nature of the study

The Secretaries of State for Children, Schools and Families and Health invited John Bercow MP to review services for children and young people with speech language and communication needs (SLCN)<sup>2</sup>. The review was to focus 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; and 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.

The present study was commissioned to explore two main issues

- i) whether there is evidence on which to base recommendations to improve the effective and efficient use of resources in services for children and young people with speech language and communication difficulties (SLCD); and
- ii) the feasibility of a cost benefit analysis for investment in services for this group of young people. This report presents the findings of both strands.

It is important to note that the term given for the study was speech language and communication *difficulties* (SLCD) rather than *needs*. In many respects this was unproblematic for the study. For example, interviewees easily referred to both SLCD and SLCN. However, it is raised here as this reflects a more important issue concerning the group of children and young people we are studying in this research and the focus of the Bercow Review which the study was designed to inform. As we shall show, there are important problems faced by policy makers and practitioners in conceptualising and determining action for these children and young people reflecting the heterogeneity of the category(ies). A second challenge arises from the use of SLCN as both a superordinate

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<sup>2</sup>Bercow, J. (2008). *The Bercow Report: A review of services for children and young people (0-19) with speech, language and communication needs*. Nottingham: DCSF.

category covering all children and young people with speech, language and communication needs and a more specific category in the School Census (formerly the Pupil Level Annual School Census – PLASC) referring specifically to those for whom speech, language and communication is the *primary* difficulty. This issue will be explored initially in Section 1.2.2 and again in the Discussion. Throughout the report the term most appropriate will be used, with a general preference for SLCN to fit in with the Bercow Review whose remit is this broad, inclusive category.

First we present background information about SLCN, identifying key issues. Next the study of six local authorities (LAs) and their associated primary care trusts (PCTs) is presented. Third we present the cost benefit feasibility study. Finally we consider the implications of the study as a whole and make recommendations.

## **1.2 Background**

### **1.2.1 Effectiveness and efficiency**

Effectiveness and efficiency were terms developed to describe health services (Cochrane, 1972), although they are equally applicable to education services and have been used in the evaluations of some early years programs. Effectiveness (whether treatments work) and efficiency (optimal use of resources) are fundamental to the delivery of any service. For example, research examining reading interventions has identified both what interventions work and the relative cost-benefit analyses in terms of measurable changes in reading ability. These concepts have rarely been examined in relation to language support services for children and young people with speech, language and communication needs (SLCN) – but see Boyle, McCartney, Forbes, & O’Hare, 2007 for an analysis of models of therapy. This is a serious omission given the extensive funding of the services for these children the ways in which these children’s needs challenge the education system (Dockrell, & Lindsay, in press) and the likely extended participation of these young children in educational contexts (Dockrell, Lindsay, Palikara, & Cullen, 2007).

### **1.2.2 Who has speech, language and communication difficulties and needs?**

As noted in Section 1.1, terminology in this area is not straightforward. In consultation with the Review Group we present a description of children and young people with speech, language and communication needs which is also used in the report of the Bercow Review (Bercow, 2008b) – see Figure 1. In addition, Figure 2 presents a pictorial representation of

the relationships. We then discuss this approach within a wider context of language development and usage.

**Figure 1. What are Speech, Language and Communication Needs?**

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

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

Approximately 7% of 5 year olds or nearly 40,000 children going into school in 2007 in England had significant difficulties with speech and/or language. These children are likely to need specialist and/or targeted intervention at key points in their development.

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

SLCN may be a child's primary educational need. Primary speech, language and communication needs include specific difficulties for which there is often no obvious cause.

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

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

***When are speech, language and communication needs apparent in children?***

The majority of SLCNs are identifiable from the second year of life and can persist through school and into adulthood. Some may only become apparent as the school curriculum become more demanding.

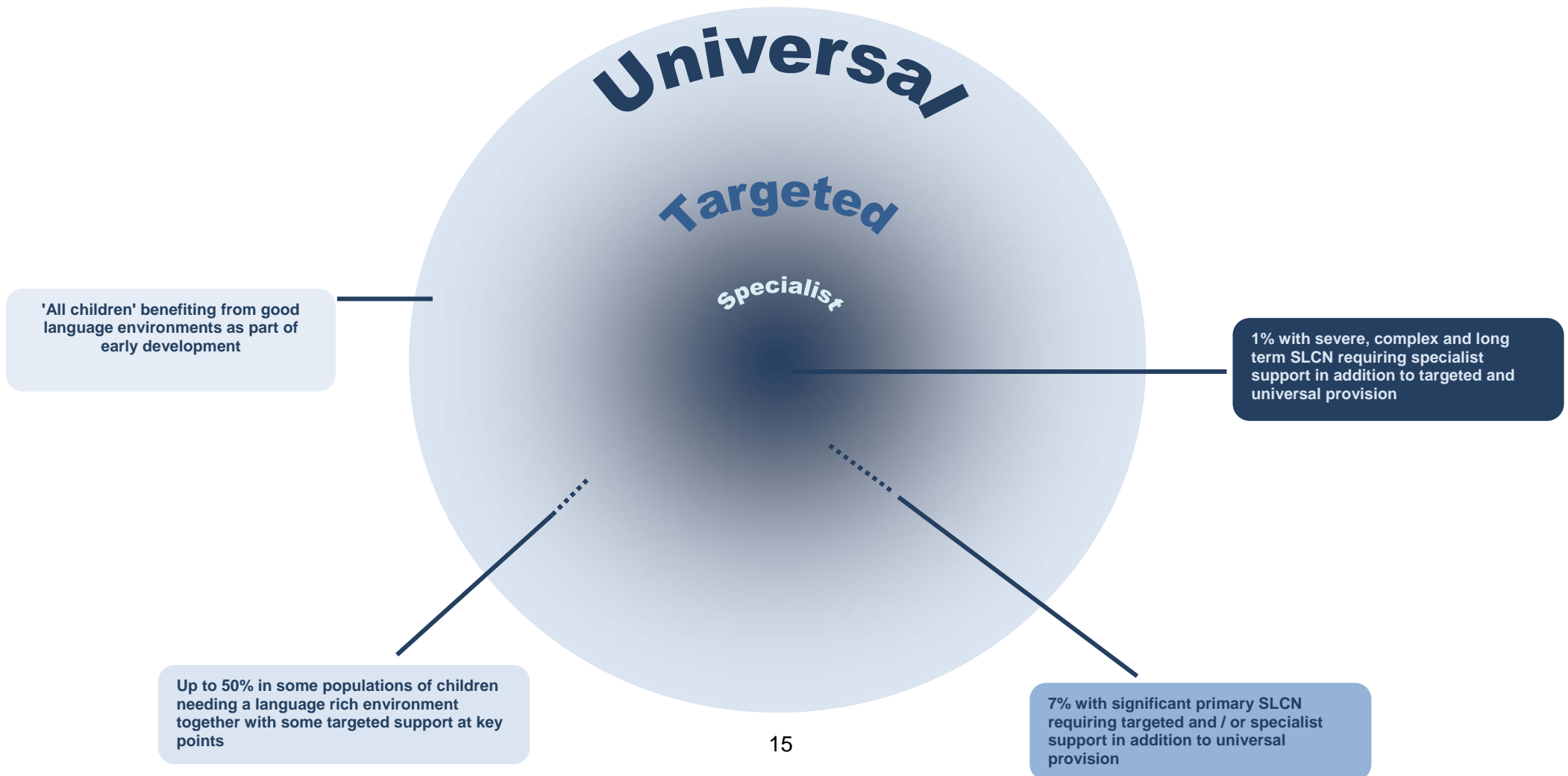
***Impact on children and young people***

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

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

Figure 2.

## Speech, language and communication support across the range of children with SLCN





A parallel approach to prioritising services is used by in some North American systems (Batsche et al., 2005; Dockrell & Lindsay, 2008). Here tiered intervention is determined by children's response to intervention (RtI). RtI can provide both data for effective interventions for children with language learning problems and a rationale for providing more specialist services or support. An intervention oriented service delivery is thereby constructed (Reschly & Ysseldyke, 2002). With the RtI approach there is general agreement that classroom instruction must be adequate in the first instance and that interventions should occur regardless of student category. The model also has potential implications for collaborations between professionals. Thus, greater 'value-added' may be provided by involvement of SLTs in early phases of education. In the later phases of compulsory education literacy experts and subject specialists may provided greater 'value –added' for pupils.

The description of SLCN set out in Box 1 makes clear that the use of this term is firmly linked to the child having developmental difficulties. In some cases there may be a clear 'condition'. Implicit here is the nature of causality. Broadly, there are four distinct but overlapping reasons for children and young people to have SLCN, as a result of:

- A developmental difficulty relatively specific to the speech and/or language systems, a *primary* speech and/or language difficulty.
- Another primary developmental factor, such as a significant hearing impairment which detrimentally affects speech, language and communication (SLC) development: in this case speech, language and communication difficulties are *secondary* to the primary difficulty (hearing impairment in the example).
- Reduced developmental opportunities limiting the child's learning of language, mainly linked to social disadvantage.
- English as an Additional Language (EAL). In this case the language system may be developing normally but the child has SLCN as a result of being in an environment where the home language is not spoken – the situation of many children immigrating into England.

Note that in all cases children have *needs* associated with speech, language and communication but the causal relationships vary. The typology suggests the importance of considering both *within-child* and *environmental* factors. Furthermore, the situation is made more complex by overlap and further associated difficulties. For example, children with primary language difficulties are at higher risk of behavioural, emotional and social difficulties than typically developing children (Lindsay, Dockrell & Strand, 2007). Finally, there is a third

dimension concerning time. As children develop, the nature of their difficulties may change, for example the relative impact of language and behavioural factors may vary over time.

The term speech, language and communication needs (SLCN), as used in the Bercow Review, and in the current report, is essentially concerned with the first three of the above: SLCN does not include children whose communication difficulties are the result of EAL. This is in keeping with a tradition that can be traced back to the Education Act 1981. Of course, children with EAL may have SLCN for one or more of the other three reasons.

### **1.2.3 The identification of speech, language and communication needs**

Language and communication needs are identified in different ways throughout the preschool and school years. In the early years identification may occur through parents (Lindsay & Dockrell, 2004), through the health system (Law, Boyle, Harris & Harkness 1998) or identification in early years settings. The identification of language and communication difficulties once children enter school differs. Both class and school level impact on these processes. At this point children may be referred because of concerns which are related to the language difficulty, such as literacy or behaviour, rather than with language itself. The identification of the possibility of SLCN may result in a referral to a speech and language therapist if the child is considered to have a developmental speech and/or language difficulty and is likely to need specialist or targeted support (Figure 1). For the majority, identification through the universal service provision is likely to be the norm. This will include the Foundation Stage Profile which is completed on all children in their reception year in school. In either case, intervention will involve educational professionals at the school and class level. An important key to intervention is the effective collaboration between agencies to coordinate individual support and the provision of universal and specialist services across the total population..

When considering children with developmental difficulties it is commonly argued that we should identify their needs early. The rationale is that early identification will allow early intervention and that this in turn will result in the child's difficulties being prevented, overcome or at least ameliorated. This model, however, is highly problematic in SLCN, as it is for other psychoeducational developmental difficulties.

- First, *prevention* can only occur if the condition can be identified before it has an effect; this is not possible for children other than those with secondary SLCN arising from a condition that can be identified pre-birth.

- Second, children's early development shows wide variation of trajectories and so identification of SLCN is typically not possible until the second year except in extreme cases.
- Third, children's subsequent developmental trajectories also vary greatly and 'normal' development is characterised by this wide range.
- Fourth, early identification requires a programme of *screening* followed by more detailed *assessment*. Each of these requires measures that are accurate with minimum numbers of false positives (children identified as having SLCN when they are developing normally) and false negatives (children with SLCN who are not identified). Some very well defined conditions can be identified easily and cheaply but this is far more difficult if there is not a clear condition but rather a cluster of characteristics which vary between children – the case with SLCN.
- Fifth, it is necessary to distinguish the identification of *existing* conditions (e.g. profound hearing loss) from developmental difficulties which are *likely* to occur (where the child is at risk). The latter requires the use of measures which strongly predict the later condition.
- Sixth, there are further complications if the nature of the condition changes over time. This is the case with SLCN. For example, a lack of stability in the classification of children with specific language impairment over time has been reported (Conti-Ramsden & Botting 1999) and it is well established that many (but not all) children with SLCN at an early age overcome their language difficulties.
- Seventh, the identification of SLCN is not limited directly to a clear process of intervention. The heterogeneity of SLCN requires a range of interventions. Furthermore, there is generally a lack of evidence for successful interventions.

As a consequence of these factors it is not possible to set up an early identification system for children with SLCN in the same way that it is for those with some specific conditions. What is required instead is a *system* that takes the limitations discussed above into account. The characteristics of such a system for the broad and varying groups of children is likely to include at least:

- Universal methods to identify children at risk
- Differential focussing on different subgroups within the population related to probable risk.
- An integrated system involving health and education services.

- A flexible system of provision that matches needs at any particular time and changing needs over time.
- The active engagement of parents.

In brief, a simple screening procedure for SLCN is not practical so there is a need to set up systems of surveillance and monitoring in the early years which integrate with school-based systems, including the use of the Foundation Stage Profile. The stress is on a *system* rather than a *measure* to reflect the complexity of identifying and intervening with children with SLCN. For example, intervention cannot just be specific programmes, important though effective programmes would be. To address SLCN requires a pervasive approach to that addressing children's needs.

#### ***1.2.4 How many children and young people have speech, language and communication needs?***

The prevalence of SLCN depends on the criterion used to identify a need (Dockrell, 2001; Law, Boyle, Harris, Harkness, & Nye, 2000). In contrast children whose test performance scores are significantly below the average range represent about 7.4% of children at school entry (Tomblin, Records, Buckwalter, Zhang, Smith, & O'Brien, 1997) - representing something between 1 and 3 children in any classroom. Children with severe difficulties are likely to represent less than 2% of the population but are likely to have enduring difficulties. The extent to which language and communication continues to be the primary barrier experienced by the majority of children with a history of SLCN is a matter of debate. At this point language difficulties are often associated with other aspects of performance in school such as literacy and behaviour (Dockrell, et al., 2007; Joffe, 2006; Lindsay, & Dockrell, in press; Lindsay, Dockrell, & Strand, 2007).

#### ***1.2.5 What is known about services for children with speech, language and communication needs?***

Services for this group of children across England and Wales were described in detail in a DFES-funded study conducted by members of the project team (Law, Lindsay, Peacey, Gascoigne, Soloff, Radford, & Band, 2000; Law, Lindsay, Peacey, Gascoigne, Soloff, Radford, & Band, 2001; Lindsay, Soloff, Law, Band, Peacey, Gascoigne, & Radford, 2002) and extended by two further studies directed by Lindsay and Dockrell, funded by the Nuffield Foundation. These studies identified a number of key supports and constraints affecting the provision and services for children with SLCN. These included the considerable variation in

specialist provision across local education authorities and phases of education (Lindsay, Dockrell, Mackie, & Letchford, 2002), moves to indirect consultative models of services delivery by speech and language therapist (Law, et al., 2002), the role played by both parents and managers in developing services (Band, et al, 2002; Radford, et al, 2003). One of the features of the early project was the development of the Index of Collaboration (used in the present study -see Appendix 1) which makes it possible to establish which health and educational authorities perceived themselves to be collaborating effectively with one another. This Index has since been subject to further evaluation (Soloff, 2003) and collaboration has been used as a marker of good practice in separate studies of provision for children with SLCN in England and Wales (Lindsay, et al., 2002; Palikara, Lindsay, Cullen & Dockrell, 2007).

Good practice can be characterised by high levels of collaborations between speech and language therapy services and education but even in best practice settings the main responsibility for supporting the children's needs rested at the school and class level. Since then there has been a review of Best Practice in Speech and Language Therapy services but although a number of recommendations were made especially regarding practice, the results of this study were inconclusive in terms of the most effective and efficient use of resources (Tod, Godfrey, Soan, & Powell, 2007).

#### ***1.2.6 What is known about the effectiveness and efficiency of services for children and young people with speech, language and communication needs?***

Research examining the efficacy for interventions to support children with SLCN can be characterised by a) clinical interventions that target specific communication disabilities including stuttering and dyspraxia and b) educational interventions which aim to support the development of a range of oral language skills including vocabulary, grammar and narrative within educational settings. There are now a number of Cochrane/Campbell Collaboration reviews summarising the best quality data for the former sets of difficulty (Herder, Howard, Nye, & Vanryckeghem, 2006; Law, Garrett & Nye, 2003; Morgan, Vogel, 2007; Morgan, Vogel, 2007).

A difficulty with such studies which is of direct relevance to this proposal is that they tend to be carried out over a relatively short time frame (up to a year) and do not address long term educational outcomes. In contrast a number of more generic early years interventions have been evaluated over extended periods of time and point to key features of effective

interventions for children at this point in development (see Dockrell, Sylva & Husband 2008 and What Works Clearinghouse<sup>3</sup>). There are also studies in the primary years which attest to the efficacy of a range of interventions to support vocabulary development.

There has been a long history of examining the relative costs of different early intervention programmes (Barnett, 2000), but there have been relatively few studies that have addressed these issues with relation to primary language difficulties. Those in the public domain have tended to focus on the evaluation of “clinical” interventions (Barnett, Escobar, & Ravsten, 1988; Eiserman, McConn, & Escobar, 1990). For example, one study which examined the costs of provision within education was an examination of the introduction of the INREAL program for 3-5 year old disadvantaged children. The INREAL programme is a language stimulation programme that minimises the stigmatisation of children needing therapy by offering intervention within the classroom (Weiss, 1981). The results emphasised the cost effectiveness in terms of fewer repeated grades and fewer and less restricted special educational placements relative to controls (Weiss, & Heublein, 1981). A recent analysis of the costs of services to children in I CAN Early Years centres demonstrated that, when a comparison was made to existing nursery provision, the relative costs per student were comparatively low (Law, Dockrell, Castelnovo, Williams, Seeff, & Normand, 2005). Further evidence is provided by a study of an intervention programme in Scotland which also included an economic analysis (Boyle, McCartney, Forbes, & O’Hare, 2007)

### **1.2.7 The policy context**

The development of services for children with SLCN has been flagged up as an issue of concern for many years. A report funded by the Department of Health and the Department for Education and Skills and the National Assembly for Wales (Law, Lindsay, Peacey et al. 2000) reviewed practice in both health and education services and made a number of recommendations related to the funding of services, the need for common data sets, and collaboration more broadly between health and education services, the size and nature of caseloads and how children are prioritised together with a number of issues related to the training and employment of staff and the expectations of and the role played by parents.

These recommendations were responded to in a variety of ways by a number of different agencies but since then a series of major policy documents have been introduced at a national level which have had a bearing on services to children with SLCN, and their commissioning, as they have for all other areas of policy and practice related to children.

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<sup>3</sup> [www.ies.ed.gov/ncee/wwc](http://www.ies.ed.gov/ncee/wwc)

There are a variety of policy drivers affecting commissioning of services for children. Key drivers related to SLCN are outlined briefly below. In addition the future development of services for children with SLCN has been the subject of a recent policy document from the Royal College of Speech and Language Therapists, (Gascoigne, 2006).

The current SEN Code of Practice (DfES, 2001) stresses 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 in 1996 ruled that where a child's statement specifies speech and language therapy, and the health service is unable to deliver it at all, or at the level specified, the local authority is responsible for ensuring that the child receives the therapy that he or she needs. Collaborative working between education and health is also advocated as best practice for children with a communication disability. More recently the Children Act 2004 underlay the Every Child Matters – Change for Children programme, as well as writing into law the duty to cooperate between joint planning and commissioning. Provision for children with SLCN must achieve the standards detailed in the new 'Every Child Matters' Inspection Framework 2005.

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 well-being). Speech and Language Therapy is identified as a priority area. In particular, Every Child Matters in the Health Service, Department of Health (2006), (November 2006 circular to Local Authorities and Primary Care Trusts) recognised speech and language therapy as a "key challenge" for joint working. The National Service Framework for Children and Maternity Services (Department of Health, Department for Education and Skills, 2004) emphasised the importance of communication skills for children and recognised the value of speech and language therapy and specifically early intervention in this area. The new Early Years Foundation Stage Curriculum (Department for Education and Skills, 2007) 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. SLTs are seen to have a specific contribution to make to the training and development of the children's workforce.

Recent commissioning guidance underlines the expectation of joint working, from planning to funding and monitoring. The Joint Commissioning Framework (Department of Health, Department for Education and Skills, March 2006) sees effective joint planning and commissioning 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 (Department of Health, 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. There have been further recent developments to strengthen a needs based approach along with commissioning on outcomes / benefits to children with the launch by the Department of Health on 'world class commissioning' and the launch by the DSCF of the Children's Plan (December 2007).

Inclusive education is another major policy driver of relevance to this study. Past practice has included a focus on provision for children with significant SLCN through language units. Our previous work has identified that these have mainly been developed at reception and Key Stages 1 and 2, with substantially less specialist provision at KS 3 and 4 (Lindsay et al., 2005). However, the emphasis on increasing inclusion has led LAs to move away from such specialist provision, despite its popularity among speech and language therapists (Dockrell, et al., 2006). Furthermore, the evidence for the efficacy of inclusive education is contentious (Lindsay, 2007), and the Integrated Resource (IR) model (which has replaced more separate Units) has some evidence in its favour, albeit not for the current target group (Mills, Cole, Jenkins, & Dale, 1998).

Within the UK there are differences between England, Scotland, Wales and Northern Ireland. For example in Scotland there is no commissioning procedure as such. Instead authorities are required to collaborate under the Getting in Right for Every Child legislation (GIRFEC) (Scottish Executive, 2001; Scottish Executive, 2006). The GIRFEC plan will result in important and fundamental changes to the way that both universal and specialist services will be delivered. Specifically they are being re-designed so that the services are able to meet needs where and when they are needed. Services are intended to be timely and appropriate with greater collaboration and less bureaucracy. It is anticipated that GIRFEC will have a significant impact on joint working and will lead to a single assessment record



and significant legislative change. The plans will require agencies to agree an action plan for individual children and to ensure that local co-ordination and monitoring mechanisms are in place to monitor these plans. These mechanisms will have significant impact for the universal service providers who will be required to demonstrate that “all that could be done was done within universal services” prior to referral to specialist services. Although much of this legislation is targeted at child protection it has implications for another body of legislation for the child with additional support needs which will include children and young people with speech, language and communication needs (Children (Scotland) Act 1995.

Retrieved 12/02/07 [http://www.opsi.gov.uk/acts/acts1995/Ukpga\\_19950036\\_en\\_2.htm](http://www.opsi.gov.uk/acts/acts1995/Ukpga_19950036_en_2.htm)  
[Scottish Executive \(2004\)](#).

In the context of these political drivers and current service provision the current study aims to identify the ways in which services currently evaluate the effectiveness and efficiency of their provision for children with SLCN.

## **2. METHODOLOGY**

### **2.1 Aims and objectives**

The overall aims of the research were:

- In selected areas, to explore the efficiency and effectiveness of use of resources in the provision of services for children and young people with speech, language and communication difficulties to improve their outcomes, and so inform national improvements in service provision. (Strand 1)
- To assess the feasibility of conducting a cost-benefit analysis of investment in services for this group (Strand 2)

Specific objectives were:

#### *Strand 1*

- To assess the efficiency and effectiveness of the different arrangements for organising and providing services in selected areas;
- To determine in these areas the resources deployed across different services; phases (early years; primary, secondary, post-16); universal, targeted and specialist services; and preventative and remedial services.
- To form a view as to whether in these areas the deployment of resources is achieving the outputs and outcomes expected effectively and efficiently; and

#### *Strand 2*

- To consider the feasibility of conducting a cost-benefit analysis for investment in service for this group.

### **2.2 Sample**

Six local authorities (LAs) and associated primary care trust (PCT) were selected to represent a range of locations reflecting geographic spread, urban/rural, and data on the percentage of pupils with SLCN in primary schools (those at School Action Plus or with a statement of special educational needs (SEN), as recorded in the most recent DCSF statistics. This method ensured variation on several dimensions, allowing examination of policy and practice across a range of settings. This variation was important as the study was not seeking to identify 'good practice' but, rather, the *range* of practice that exists in the country and which would form the basis for any development that might occur nationally following government action following the study and the Bercow Review.

The sample comprised the following six case study LAs and associated trust:

- CS1 Inner London borough
- CS2 Small shire county
- CS3 Large shire county
- CS4 Large city
- CS5 Large city
- CS6 Small unitary authority

Within each CS a range of educational provision for pupils with SLCN was identified taking into account age (nursery to secondary) and type of provision (mainstream, mainstream with designated integrated specialist provision for pupils with SLCN, and special schools for SLCN- see Table 1.

Within each of the case studies a sample of professionals was identified: the LA's senior SEN manager; a senior manager in the PCT; head teacher or head of integrated resource in each educational provision. The selection of the appropriate officer was determined by the LA or trust. In some cases this was the head of the speech and language therapy service, in others it was a manager to which the head of the SLT service reported. In the latter case, the head of the SLT service (or a senior SLT) was also present. The selection of the educational provision in each LA was determined by the LA's SEN officer guided by the research team. Where possible this included pre-school, primary and secondary provision and both segregated and integrated provision if it existed within the LA. A summary of provision in each LA is given in Table 1 below. The stated aim for identification of the specialist provision was to select that designed for pupils with *primary* speech, language and communication difficulties, not provision that catered for pupils where SLCN was secondary (e.g. to hearing impairment or significant cognitive difficulties).

### **2.3 Procedure**

The LA and trust senior officers were identified by the DCSF and DH in conjunction with the research team, who knew several of the officers. The DCSF invited these officers to take part in the study, to be interviewed themselves, and to approve access to the appropriate educational provision. Ethical approval was secured through the University of Warwick Humanities and Social Sciences Research Ethics Committee and NHS approval for data collection was secured through the ROCR-Lite process.

Interviews were held with the LAs' and trusts' managers and with the head teachers and heads of integrated resources. In some cases the LA and trust manager was accompanied by a colleague with specialist knowledge. This was the case, for example, where the trust's senior manager was not a speech and language therapist (SLT); in such cases a senior SLT who had specialist knowledge about services to children and young people joined the interview. In schools, the appropriate head teacher or head of the specialist language integrated resource sometimes invited the SLT or the school's Special Educational Needs Coordinator (SENCo). The presence of these additional specialist professionals contributed to the range and quality of the information provided – see Table 1.

**Table 1 Interviews held in the six case studies**

	CS1	CS2	CS3	CS4	CS5	CS6
<b>SEN manager</b>	Integrated	yes	yes	yes	Yes	yes
<b>SLT Manager</b>	service, joint interview	yes	yes	yes	Yes	yes
<b>Pre-school provision</b>	yes	No*	yes	No**	Yes	yes
<b>Primary Mainstream</b>	yes	yes	No#	No#	No#	No#
<b>Primary with language resource</b>	yes	yes	yes	yes	Yes	yes
<b>Secondary Mainstream</b>	yes	yes	No#	No#	No#	No#
<b>Secondary with language resource</b>	None in LA	None in LA	yes	yes	Yes	no
<b>Special school</b>	NO#	yes	yes	yes	Two interviewed	Yes***

\* SEN manager asked not to use due to staffing issues

\*\* Provision could not arrange a time before June 2008

\*\*\* not used as it was not a provision for pupils with SLCN as primary need

# no provision suggested by SEN manager

All interviews were conducted between March and May 2008 using a standard semi-structured interview schedule appropriate to the professional(s) and setting concerned. The majority of interviewees agreed to their interview being recorded to provide a back up to the field notes taken contemporaneously. In the small number of cases where the interviewee declined, only field notes were taken. All interviews were conducted by the field researcher

(MD). A further member of the research team (JD, GL or NP) was also present for a selection of the interviews with the senior managers.

As well as oral responses, many participants provided policy documents, information leaflets and documents with a variety of data around speech language and communication provision and services. In some cases this was supplemented by information sent by email or hard copies of documents posted after the interview. At the end of the interviews the SEN manager and SLT manager were asked to complete the Index of Collaboration (Appendix 1). Some completed it immediately, others asked to complete it later and return it by post. Not all were returned, but the results of those returned are reported. In two cases, interviews were cancelled at short notice as the individual(s) to be interviewed were not available due to unforeseen circumstances. Interviews in these cases were conducted by a combination of written response to the questionnaire, a telephone interview, and follow-up supplementary questions by email.

## **2.4 Analysis**

A thematic analysis was carried out of all the interviews. Initially, headline themes were identified by two of the team (GL, MD). These were then confirmed by the whole research team. Two types of theme were identified: those which arose directly from the format of the semi-structured interview and emergent themes.

## **2.5 Report of findings**

The findings from the six case studies are presented in Section 3. In addition to the primary data provided by the interviews, references are also made to documents provided by interviewees. Analysis was also conducted on data provided by DCSF from the national School Census; these data are presented in Section 5, Discussion.

### 3. FINDINGS FROM THE SIX CASE STUDIES

#### 3.1 Approaches to identifying children and young people with SLCN

In this section we report the approaches used in the six case studies for the identification of children and young people with SLCN.

**CS1** uses agreed regional criteria for categories of SEN, with well produced documents setting out these criteria. The guidance separates out speech and language delay, impairment or disorder from disorders on the autistic continuum, or speech and language difficulties arising from hearing impairment. Under this scheme communication and interaction difficulties are split into two sections: i) Speech and language delay, impairments or disorders, and ii) disorders on the autistic spectrum. Descriptors are given for developmental language delay, developmental language disorder, phonological/severe pronunciation problems, expressive language, receptive language/language comprehension, social communication/ semantics and pragmatics. Disorders on the autistic continuum are classified separately, but still under the heading of communication and interaction. As well as the descriptors the LA provides an *identification of need* tool, a checklist where different factors are scored on a scale of 0-10, which helps identify degree of need.

Despite this detailed documentation, the interviews of teachers in-charge of the provision all referred to the clinical judgement of the SLT and SENCO involved as being the key factor in determining the classification. For example a teacher from a resource school stated:

*“we don’t have a written policy with guidelines or definitions of SLCD. It depends on the SLT and SENCO”*

In **CS2** the SEN manager identified very clearly the problems with trying to ensure that the term SLCD was used in a consistent manner

*“There are several different ways of using SLCD. Some use it as a term for general language and literacy difficulties, and this group would have some language and communication difficulties. Others see it as a developmental language problem, and it would include all aspects of language development. Some would include the autistic group. There are some that have language difficulties that can be catered for in primary, but in the socially and linguistically complex environment of a secondary*

*school can't cope and show behaviour problems. These are categorised as EBD rather than SLCD."*

The LA uses a banded funding model, and its guidance document sets out funding criteria at each of 4 levels for a variety of SEN. Two categories cover SLCN and ASD, linked to the Pupil Level Annual School Census PLASC). The example of Level 1 illustrates the scheme:

#### **Level 1 Language and communication (PLASC - SLCN)**

- Lowest 2% in language or verbal skills on a standardised test (standardised scores of 70 or below) or on a selection of other tests related to language
- Delay of 14 months at 4 yrs, 22months at 6 yrs, 29months at 8yrs, 36 months at 10yrs and 43 months at 12yrs

#### **Level 1 Pervasive Development Disorder (PLASC - ASD)**

- Evidence of diagnosis from paediatrician/psychiatrist or psychologist, preferably relating to clear international diagnostic criteria
- Involvement of a health professional, funding or support
- Evidence of Ed. Psych. involvement with an indication that any advice has been acted on

Criteria for each category of SEN are set out in a similar way for each of the 4 banded funding levels, with an indication of evidence required and actions that schools should have taken before submitting the application for funding support.

The SEN manager described another type of problem when using the SEN categories to access banded funding. SLCN assessment requires, amongst other information, some test results on language levels together with a report from a SLT. However, SLTs are in very short supply and there is usually a waiting time to obtain an assessment. This can cause some delays in accessing the funding.

The SEN category of general learning difficulties requires some indication of literacy skill assessment. Teachers can test for reading/spelling and can easily provide information for the funding panel. As children with SLCN also have literacy difficulties it is often quicker to get banded funding by going down the general learning difficulties route rather than that for SLCN. This illustrates how interacting with the system can lead to changes in the way in which categories are used. The SEN manager thought that all these factors meant that

PLASC data could not be taken as reliable in terms of categories as they were used in different ways by different users.

The interviewees from schools in this LA with special provision for SLCN said they accept the categories of special need set out in the papers sent to them by the LA, and therefore do not have their own criteria. The primary school visited that did not have any specialist language resource used the views of the staff, and SLT if involved, to identify pupils as having SLCN. At secondary level the criteria included that pupils came into school with an SEN record of SLCN: it was very rare that pupils would be assessed for the first time at secondary level and be categorised as SLCN. The special school making provision for children with behavioural, emotional and social difficulties (BESD) indicated that many of the problems of their pupils arose out of speech, language and communication difficulties, and they considered that the whole area of distinguishing between primary or secondary special educational needs was problematic.

**CS3** is in the process of updating its SEN policy documents; the draft document on SEN speech and language policy out for consultation has its own written criteria for SCLD.

*“Types of speech and language difficulties are delay, disorder, comprehension or receptive language difficulties, expressive language difficulties, phonological difficulties, pragmatic difficulties, stammering, selective mutism, verbal dyspraxia, voice disorders”*

Each of these categories is given an expanded descriptor. The document also notes that as well as children presenting with a primary educational need of speech, language and communication, others may present with speech, language and communication needs that are secondary to another condition affecting speech and language.

*“Some children have another condition or disability that affects speech and language, e.g. hearing impairment or Down’s syndrome. This type of speech and language difficulty is often called a secondary language difficulty. Some of the conditions causing these secondary language difficulties can be identified at birth or the first few months of life, for example Down’s syndrome or cerebral palsy. In others the delay in developing speech and language is the first indication of other conditions, for example Autistic Spectrum Disorders”*



The authority also has a document specifying criteria for access to provision by cluster lead schools for pupils with SLCN. This document states:

*“A specific language impairment (specific speech and/or language disorder) as opposed to language delay. Additionally the pupil may have a diagnosis of ASD, Asperger’s syndrome, social communication difficulties or pragmatic language impairment. The pupil will have long term speech and language difficulties that cause barriers to learning.....”*

The SEN manager reported that SLCN and ASD are kept as separate categories, but hearing impaired children with language needs are included in the SLCN category.

In the LA’s Children’s Centres the emphasis is on early assessment and intervention for all aspects of language development, and any concerns are initially assessed by the SENCO and referred on to the SLT as necessary. The issue of criteria is not regarded as important; rather, assessment and appropriate intervention are the prime concerns. The head of the language resource attached to a mainstream primary school said that there was no up-to-date written policy on criteria, but the original remit of the resource did not include autistic spectrum disorders.

The secondary school with a language resource has entry criteria set out, including a section setting out groups excluded from being considered by the selection criteria (language delay, phonological problems, children with moderate or severe learning difficulties, children with behavioural and /or emotional problems, children with hearing loss, and children with severe reading or spelling difficulty). The criteria for admission to the special school for children with SLCN include a statement of SEN with a formal diagnosis of either autistic spectrum disorder or specific language disorder, and for the pupil to be of average or above average general cognitive ability.

**CS4** uses an operational definition of any child referred to the SLT service who is assessed as needing some level of support from speech and language therapy. There is open access to the SLT service after assessment the extent of need is identified; and the support needed is agreed. The SLT manager said:

*“There is an open referral to the service and no hard criteria laid down. We prefer any adult associated with the child can refer to the SLT service rather than have criteria that may block referrals”*

At the special school visited, the head reported that around 60 per cent of pupils were designated as having ASD with at least moderate to severe learning difficulties, and that a further 40-50 per cent had SLCN associated with severe learning difficulties.

In **CS5** the SEN manager commented:

*“It depends who you talk to. Is it communication or interaction, expressive or receptive? And therefore autism? We are not rigid about a difference. There used to be a referral guideline document but it is no longer in use”*

She felt it useful to separate SLCN and ASD, but she did not think it would happen in the near future. No reference was made to any criteria to help schools reach decisions on classification of SEN.

The SLT service has no written criteria or policy documents. There used to be referral guidelines but these are no longer in use. The criteria for SLCN seem to be pragmatic and defined by the views of SLT assessing referred children and making a decision about whether intervention is needed, and whether the service has the capacity to deliver.

The language resources in mainstream schools visited in CS5 take a similar line – that the schools will take pupils with SLCD as identified by SLTs and have a record of SEN. At both the primary and secondary resources this included pupils with ASD and this was a feature of an increasing trend. The head of the secondary resource said:

*“The last SLCD pupil with just SLCD left three years ago and now all are ASD. I’m not clear why this has happened”*

In practice the SEN placement panel considers the papers sent in, and then having taken into account parental preferences, the papers are sent for the school or resource to consider.

**CS6** has written criteria for special educational needs, produced as a booklet. This booklet has separate categories for speech language and communication needs and for autistic spectrum disorder. SLCN are categorised in 4 areas of speech production, expressive language, receptive/ understanding of language and social use of language. Reference is made to the severity and complexity of the SLCN and how much progress is being made by

the child. Autistic spectrum disorder is treated as a separate category, and described as a triad of impairments in social relationships, social communication and imaginative thought.

### **3.1.1 Conclusions**

- There are considerable differences between the six local authorities in the approach to criteria and definitions of the SEN category SLCN. Some give very clear and detailed guidelines, as well as degree of need required to access different levels of funding. Others leave it to the clinical judgements of involved professionals – teachers, SLTs and educational psychologists (EPs).
- There are also differences in the way ASD is categorised – as a subset of those with SLCN, or as a separate category.
- Some SEN managers expressed reservations about the reliability of the way SEN were categorised by schools, with factors such as availability of SLTs and EPs affecting the category under which they sought additional funding.

### **3.2 Trends in provision for children and young people with SLCN**

All local authorities in the six case studies appeared to be moving towards increased inclusion across the whole range of special needs and this is the case for children and young people with SLCN. A summary of the provision in each of the 6 LAs in this study for children and young people with speech, language and communication needs is presented in Table 2. The extent and range of provision in these six case studies appears to be similar to that found in recent national surveys (Lindsay et al, 2005).

**CS1** has identified 21% of its school population as having special educational needs and 7% of these are in special schools. The vast majority of children and young people with SEN (93%) have their needs met within a mainstream setting. The vision of the authority is expressed as:

*“(LA) believes that inclusion is an active and ongoing process by which groups’ schools, statutory agencies and society seek to develop cultures, policies and practices to include all children and young people. We actively seek to remove barriers to learning and participation. We believe that with the right training, strategies and support nearly all children with special educational needs can be*

*successfully included in mainstream schools. We aim to be an inclusive education service that offers excellence and choice and incorporate the views of parents.*

*We believe all children should have access to an appropriate education that affords them the opportunity to achieve their personal potential and that mainstream education will not always be right for every child all the time. Equally, just because mainstream education may not be right at a particular stage it must not prevent the child from being integrated and included successfully into mainstream at a later stage”*

*(speech and language policy document.).*

**Table 2 Range of provision for SLCN by case study**

	<b>Pre-school/Early years</b>	<b>Primary Resource</b>	<b>Secondary Resource</b>	<b>Special</b>	<b>Other</b>
<b>CS1</b>	All included in Early years centre support, or placed in nursery of primary resources	2 schools 3-11yrs each with 22 places, 2 places per year group	None for SCLD. Support in mainstream with SLT provision within school setting	Currently 4 special schools, reducing to 2 or 3. no SLCN as primary need in special	No out of authority places
<b>CS2</b>	Mainly in nurseries and Children's centres with support. Max of 5 half days in LA nurseries so some choose to use private sector. CDC in Health runs some groups for SLCN	1 school with resource – 1Key stage 1 class, 1 key stage 2 class, 6 places for ASD	None for SCLD, supported in mainstream. Some provision for ASD in 1 secondary school	1 special school has nursery provision for SLCN. 1EBD 7-16yrs many with SLCN. 3 schools for SLD/PMLD	2-3 out of authority places
<b>CS3</b>	All in early years settings. A number of special programmes run - SPARKLE, ABC, Early years curriculum - Hanen	9 resources in mainstream schools	3 resources in secondary schools	1 special school for SLCN	15 out of authority places
<b>CS4</b>	All in Early years and pre-school settings	*4 primary schools with SLCN resources	*2 secondary schools with resources	6 special inclusive learning centres, 5 are 5-16 for SLD/PMLD and have some SLCN as primary SEN need	Very little use of out of authority places. None for SLCN at present
<b>CS5</b>	Some special resources in nurseries, 1 CAN nursery, some provision in child assessment centre, some provision in nursery of special school	3 primary integrated resources have provision	3 integrated resources	12 special schools, and of these 2 primary and 1 secondary have some provision for SLCN	Little use of out of authority places
<b>CS6</b>	All early years and pre-school provision in integrated settings	1 resource for ASD (10places), 1 for SLCN (28 places)**	None for SCLD	2 special schools 1 primary, 1 secondary for SLD/PMLD	27 out of authority places none for SLCN

\*SLCN "25 pupils across 4 primary and 2 secondary schools"

\*\* currently 23 on roll and 5 have a primary need of ASD

Currently there are four special schools, and the aim is to reduce the number to two schools both providing for children with complex and severe SEN.

The commonest category of SEN in the LA is BESD. It should be noted that there is much debate as to the extent such difficulties are linked with SLCN as research has indicated that there is an important degree of overlap (comorbidity), whereby children with SLCN also have behavioural, emotional and social difficulties (e.g. Lindsay et al, 2007). The LA keeps figures on SEN and exclusions but does not break SEN down into different categories; consequently there are no figures on the number of pupils with SLCN or BESD among those with SEN that are excluded from school.

Early years provision is through children's centres with SLT provision on-site and referral to specialist services can be made by the centre. The main provision for children with primary SLCN comprises two integrated resources attached to mainstream primary schools with nurseries. In each school there are 22 places in the resource for children with SLCN and in both there are empty places. The SEN manager takes this as evidence that the policy of inclusion, supporting pupils in their local mainstream school, is working successfully. The SEN manager further reported that there are no children with SLCN as their primary need in special schools and none in out-of authority placements. Provision for children with SLCN is largely within a mainstream setting.

The primary school with the language resource base operates an inclusion approach where the children with SLCN are fully included in mainstream classes with support, and may be withdrawn for specialist teaching and speech and language therapy as required. The mainstream primary school and the mainstream secondary school visited, both with no specialist resource, operate in a similar way, with pupils included in mainstream classes, supported by teachers with some SLT input.

The LA policy document on inclusion of children with SEN, learning difficulties and disabilities sets out the implications for service development if this policy of inclusion is to be sustainable:

*"We will develop an inclusive practice which genuinely addresses the individual needs of pupils. We believe that we need to ensure a varied pattern of provision. This may include*

- *Inclusion within a mainstream class*
- *Separate provision for a limited time*

- *Part-time or short-term placements*
- *Specific in-class programmes of support*
- *Dual placement, where a pupil is on the register of more than one school*
- *Attendance at a resources school*
- *Attendance at a special school*

*We will work with partner agencies to support the inclusion of children with SEN and disabilities in a variety of education settings. We will:*

- *Ensure multi-agency support and approaches are adopted*
- *Ensure the use of resources is cost effective and flexible*
- *Provide a structure of support and training*
- *Provide a structure for recognizing and extending expertise and good practice*
- *Improve links between mainstream schools, resource bases, resourced schools and special schools*
- *Reduce the number of admissions to out-borough schools by developing the quality of local provision*
- *Improve the progress and standards achieved by pupils with SEN*
- *Monitor and audit the quality of all provision*
- *Increase the ability of all schools and settings to provide for a range of pupils with SEN and disabilities*

In the primary resource visited, it was reported that, once placed, pupils usually remained there until the usual age of transition.

The priority for this LA, therefore, is clearly set out: to extend further the number of pupils with SEN that can be catered for in mainstream settings, and to extend the range of SEN that can be met within mainstream settings.

In **CS2** the SEN manager reported that:

*“The move is towards a reduction in places in special schools, maintaining some integrated resource provision, but many pupils with SEN will be included, with support, in their local mainstream school.”*

The SEN manager also stated that important factors within education in the authority were:

*“coping with a relatively low population density spread over a wide geographical area; falling rolls and coping with buildings in need of repair and with surplus places.”*

The authority has to balance the cost of transporting pupils long distances, and the problems associated with children being educated outside their local community, against the difficulties of making special provision for each child with SEN in their local school.

Since 2003 the authority has been reviewing special provision, and this is still continuing. This is a very slow process. For example, the proposed format for a review of provision at a primary integrated resource for SLCN/ASD was supplied. This review was due to take place in spring 2007. Although much work has been done and a draft review document produced, this is not yet ready for decision making as there are still outstanding issues to be resolved, meaning that the review process will have taken more than a year.

The LA has 4 special schools, none designated specifically for SLCN. One is designated as BESD 7-16 yrs in the county town, and said to have many pupils with SLCN. There are also three schools for SLD/PMLD, one primary age 3-11, one secondary 11-19 and one 5-19 in the north of the county; these were not mentioned as catering for pupils with SLCN. A number of MLD special education centres have been closed down since 2003. These special education centres were for children with a range of moderate and general learning difficulties. The SEN manager said that before closure many were half empty because parents were wanting their children included in the local mainstream school. At primary level there is now an integrated resource with three classes, two for SLCN and one for ASD. At secondary level there is no resource provision for SLCN, but one resource attached to a mainstream secondary school for ASD.

This move towards inclusion has been financed using a model of banded funding that the SEN manager said had been developed by the educational psychology service. (see Section 2.1 for more information on this model). Since 2003 total numbers of statements of SEN have fallen from 1100 to 600. In 2003, 120-130 statements a year were issued, and by 2006-07 this had fallen to 25. However so far in the 2007-08 year 42 have been issued with 4 months still left.

In May 2007 402 pupils with SEN were receiving banded funding without having a statement, representing around 2% of the total school population. Of these, 15% were in the



category language and communication, and 0.7% in the category pervasive developmental disorder (designated ASD by the authority). There are 5 children in out of authority places for SLCN (1) and ASD (4).

The SEN manager noted a further trend, in that from 2004-2006 the percentage of pupils in the SLCN category on the PLASC data was around 2% (varying between 1.86 and 2.23%). In 2007 it was 1.24% and it appeared that it will be low this year. It was suggested that this may be due to difficulties schools have in accessing the assessments and reports from SLTs and EPs, needed to obtain banded funding for SLCN. Banded funding for the category general learning difficulties, by contrast, can be obtained with standardised scores on literacy/numeracy tests that can be administered by teachers, and it may be that schools are choosing this route for children that may have learning difficulties caused by SLCN. As the SEN manager remarked, this problem raises issues about categories into which pupils with SEN are placed, and the reliability of any data analysis which uses these categories (see also Section 2.1).

**CS2** is continuing to move towards support for inclusion of children with SEN in their mainstream school, and has funding allocation to support this. The SEN manager is concerned that as the trend of delegating more SEN funding to schools proceeds the LA will have less money to fund centrally retained support services such as support teachers, or to fund SLTs to work in schools. Without centrally retained services it may be more difficult for schools to access the support staff needed to support the inclusion of children with a greater range of SEN and with greater needs than mainstream schools have experienced.

In all provision visited staff reported that once placed in a school with a specialist resource, pupils usually remained there until the usual age of transition to the next phase of education. This has some similarity to the longitudinal study of Dockrell et al (2007) where the main time for movement to special provision was the end of Key Stage 2. However, in that study there was also such movement during KS3. It is also worth noting that the Dockrell et al study showed different patterns of movement from mainstream to special provision between the two LAs studied, reflecting the availability of specialist provision.

**CS3** has a plan to increase number of integrated resources for children with SLCN, but to maintain a range of provision. The Speech and Language policy has a section on provision which states:

*“All learners have a variety of educational and social needs which should, where possible, be met within the locality of their home. The LA recognises this in the provision of a range of educational settings where pupils with SLCN are provided with opportunities to develop speech language, communication and cognitive skills across the curriculum that will encourage and support the transition into adult life.*

*The provision may take place in mainstream or specialist pre-school settings, in mainstream schools or resourced mainstream where there are opportunities for inclusion during appropriate curriculum or social activities. Provision might also be in a day special or residential school with intensive support. It is essential that a range of options is available across a wide range of local provision supported by multi-agency involvement to meet the differing needs of children.”*

The LA has planned provision around clusters of schools, and within each cluster there would be a named lead school. Table 3 sets out the planned expansion of resource provision for SLCN.

**Table 3 Provision for pupils with SLCN as their primary need in CS3**

<b>Type of provision</b>	<b>Current resources for SLCN</b>	<b>Planned lead schools with resource for SLCN</b>
Infant mainstream	1	1
Junior mainstream	1	1
Primary mainstream	7	9
Secondary mainstream	3	7
Special school	1	1

The PLASC data from 2007 for School Action Plus (SAP) and statemented pupils indicates the authority has 2563 children at primary age and 742 at secondary age with a primary need of SLCN. Of these, 16 at primary level and 171 at secondary level are in special school places. A further 15 are in out of authority places, all of secondary age.

In all provision visited staff reported that once placed in a school with a specialist integrated resource, the pupils usually remained there until the usual age of transition to the next phase of education

In **CS4** the SEN manager stated:

*“We are committed to providing as much integration as possible.”*

The authority has around 900 pupils with statements of SEN, and most of these are in mainstream schools. The strong inclusion framework developed for SEN aims to improve the staff of mainstream schools to work with a greater range of pupils with SLCN. Funding for inclusion is allocated by different levels of need – school action, SAP and statements. Funding is determined by level and by extent and complexity of need within each level, allowing for individual variation within a set range. All early years provision is integrated into mainstream settings, with a commitment by the SLT service to provide a response to referral in this age group within 7 days.

In 2004 the authority closed all 10 special schools and re-opened 6 Special Inclusive Learning Centres (SILCS). Five of these provide for a full range of SEN within the categories of severe learning difficulties or profound and complex learning difficulties in a particular area of the authority, and to provide outreach support to schools in their area, thus enabling them to include a greater range of pupils with SEN into their local mainstream school. The sixth is an authority wide provision for BESD. Currently three secondary schools are in re-build programmes and each of the new schools will have high care facilities for up to 30 pupils with severe and complex SEN. This will further reduce the number and population of SILCs. The aim is to have SILCs spending much more time supporting pupils in mainstream and so reducing numbers of pupils placed in SILCs even further.

There are 4 primary resources and two secondary resources for pupils with SLCN as their primary need. In the primary language resource visited, both SLCN and ASD were included, 4 ASD and 4 SLCN. In the SILC visited the Head reported 135 pupils on roll and of these 50 pupils were categorised as ASD together with moderate-severe learning difficulties, and a further 50 with SLCN together with severe and/or complex learning difficulties. In discussion it was not clear whether these pupils had ASD and SLCN as the primary need on their statement, or whether they had severe and/or complex learning difficulties as the primary need and ASD or SLCN as secondary needs.

There is 1fte SLT post as part of a multi-professional team focussing on assessment and intervention with the BESD group who may also have SLCN. This group are at risk of exclusion and suspension from school, and may get into the youth offending system.

Exclusions were reported to have been reduced from 220 a year in 2004 to 22 in the first 6 months of the 2007-08 academic year.

The major trends in **CS4** were to reduce both numbers of secondary schools and numbers in each secondary school, and integrate an increasing proportion of children with SEN, including those with SLCN and ASD, into either their local secondary school or an area resource for children with SEN. The LA had changed the funding system for SEN to support this policy of inclusion.

**CS5** had very high levels of specialist provision – around 20 integrated resources and 12 special schools. Funding of SEN was said to be above the national average. The SEN manager commented:

*“The authority wants to increase integration, but mainstream not as inclusive as it should be. Parents experience it as not welcoming their child with SEN, and therefore they want special provision.*

*I sit in meetings with Head teachers saying this child shouldn't be in our school. I think that is 1990s. I don't expect it in 2008... We need to say, these are your children in your schools in your community and you must feel they belong to your community and it is up to you to think what you need to do to meet the child's needs, not what do you want the LA to do to take the child away from you. This is a cultural shift for the schools, and for the centrally retained staff. If we are honest, a lot of our staff still believe that these children shouldn't be in universal services, they should be in special provision.”*

The SEN manager sees a three stage process to move forward to a more inclusive system:

1. The development of a delegation model of SEN funding linked to statements of SEN
2. The development of an authority wide outreach programme linking central support services, integrated resources and special schools to provide a coordinated support network to mainstream schools. There will be service level agreements to show what each will provide to each school or group of schools. The focus will be to enable more pupils to remain in their local school.
3. Review of integrated resource and special school provision

The development paper raising these issues and proposing the move towards a more inclusive system of meeting SEN indicates that the authority has an increasing number of statements compared with other authorities and that this does not seem to be linked to improving attainment levels. It also claims that national research shows that good or improving attainment levels are linked to high levels of statements and low levels of statements. The paper included a specific proposal that

*“IRs [integrated resources] with a low occupancy rate will be closed or re-designated in order to refocus resources where required.”*

The section on special schools concentrated on the new outreach and support role of these schools, and did not contain any closure proposals. There was a stated intention to reduce the number of pupils in out-of-authority placements by expanding the capacity of special schools to deal with more complex SEN.

The authority currently has specialist provision for all phases. At pre-school there is an I-CAN facility, which for some time moved to different parts of the authority each term, but is now placed in a school in the south of the authority. There are three integrated resources at primary level which have SLT input and although they take children with SLCN they are not limited to this category. At secondary level there are three integrated resources which, like the primary resources, include pupils with SLCN, but also admit pupils in other categories of SEN. Two special schools at primary level and one at secondary level have some provision for SLCN. There are also a small number of pupils in out-of-authority placements.

According to the SEN manager, no figures are kept on children with SLCN as the primary need and it would need going through statements to get numbers. Most children with SLCN were thought to be in mainstream or integrated resources. ASD were the group that were in special schools catering for pupils with SLCN. The primary integrated resource visited catered for SLCN and ASD categories, and the head of the resource felt that some pupils with BESD were not appropriately placed in the resource. The head of the secondary resource said that they only had ASD pupils and it was 3 years since they had any pupils with SLCN.

The SEN manager wanted to see integrated specialist provision as more of a temporary placement with children moving back to mainstream after a period in the specialist resource. At present most pupils placed in these resources remain there until transition to the next phase.

This authority then is trying to move towards reducing number of statements and increase the proportion of pupils with SLCN included in mainstream. It wants to change the role of special schools to more support and outreach but no plans to close special schools were mentioned in the interview.

**CS6** has a policy to work towards increasing inclusion of pupils with SEN, and developing multi-professional working to support children and schools to meet this goal. The LA closed its four special schools in 1996 and built two new special schools, one primary and one secondary. At that time the intention was to provide integrated provision for as many pupils as possible, but to provide high level care facilities for those with complex needs that would be difficult to meet in mainstream settings.

The inclusion policy is promoted through the Inclusion Strategy group, and is a priority for all services. The authority has an Inclusion award, which recognises the development of better inclusive practice, and has encouraged a more systematic approach by schools. The authority is recognised as “A Hub of Excellence” for effective provision for SEN/LDD by the DCSF.

The authority has two special schools and also has 27 out-of-authority placements. No pupils with SLCN as their primary need are in special schools or out-of-authority placements. Early years SLCN are catered for through the Portage and Pre-school service and provision is in integrated settings. There are four primary resource centres (PRCs), one for SLD with 10 places, one for EBD with 22 places, one for ASD with 10 places, and one for SLCN with 28 places (currently 22 places are filled). Pupils in all these resources all retain some contact with their local school for at least one day a week, but it can be much more depending on the package of support they get. Pupils can access these PRCs without statements if they are at School Action Plus.

Again, this LA is has reduced both numbers of special schools and number of places in special schools, with all children with SLCN supported in integrated resources or mainstream schools.

### **3.2.1 Conclusions**

- In all case study LAs the trend is towards reduction in number of pupils in special schools, and in most authorities a reduction of number of special schools. However,

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

### **3.3 SLT service working practices**

Since 2005 **CS1** has had a completely integrated SLT service across health and education for the 0-19 age group. This integrated service is funded by health, education and from schools buying in additional SLT time from their own budgets. The service is divided into area teams and has some specialist posts but no specialist teams. The time allocated to universal, targeted and specialist work is transparent. Time is allocated to mainstream and special school based on age phase (children's centres, nurseries, primary and secondary), size of school, size of caseload, and complexity of need. As well as individual casework (assessment and intervention), a variety of intervention packages are available to support SLCN and ASD in mainstream education. The SLT service supplied a document prepared for a PowerPoint presentation explaining the workings of the service and the range of activities offered.

This new way of organising, funding and delivering SLT services to schools has led to the SLT service more than doubling in size between 2005 and 2008, from 20fte SLTs in 2005 to 47 fte in 2008. As schools have experienced the benefits of the service, with falling waiting

lists, more individual and small group casework in school settings, and an increase in time available for consultation and training, they have used more of their own budgets to purchase more SLT time. This additional income has allowed the SLT service to employ more SLTs and SLT assistants.

Monitoring and evaluation of this new way of organising and delivering SLT services is at an early stage. At an individual casework level progress is measured against individual targets set by teachers and SLTs. The types of assessments used are left to the individual SLTs and the schools, and the SLT service does not collate this information to provide an overview of the extent to which intervention is successful.

In the schools visited, one SLT reported that clinical work used peer monitoring. The same SLT said that they provided statistics to the service manager in terms of contacts made and estimates of progress. Several SLTs reported that individual casework was monitored by clinical judgements of progress against IEPs, use of a variety of standardised instruments chosen by the therapist to suit the case, and one SLT said there was no agreed outcome measure used by the service. A number of SLTs referred to the use of an "Identification of Needs" tool to help decision making about whether an individual needed therapy, and the extent of need. One therapist said she used the Identification of Needs tool on a termly basis with her clients and this allowed some more objective measure of whether progress was being made. One SLT noted that monitoring also used teacher and teaching assistant input to consider whether the SLT programme had been useful and others referred to informal monitoring by getting feedback from EPs.

Monitoring and evaluation of consultation and training work is conducted at an informal level of feedback from those being trained and self-evaluation by the SLT providing the service. There are no evaluation tools accompanying the packages of training offered to schools. However, the service has as one of its aims the improvement of user involvement in monitoring and evaluation, developing more systematic ways of eliciting and recording feedback. SLTs working with parents said they used questionnaires to evaluate their work. The evaluation of group work was seen as an issue by one SLT but she did not propose a solution:

*"Evaluation of group work is more difficult and we are trying to tighten up on this"*

Although this new approach to SLT service funding and delivery has achieved considerable success, the managers are aware of the challenges and risks associated with it. The



document provided by the service makes clear that active management is required, which takes up considerable time. It requires good communication to establish shared understandings of the model between all SLTs, and between SLTs and the service client groups. It requires different skills to work within school settings with a greater emphasis on consultation, joint working and training than working in a more traditional clinic setting.

*“A whole system approach destabilises the existing systems, and therefore has to work as a big bang. The infrastructure to support the model is still evolving, and now needs the formalisation of inter-agency protocols, especially in relation to resources and finance”*

Reference was also made to the ethnic and linguistic diversity in the borough, and the issues that raised for SLTs assessing clients who used English as an additional language.

**CS2** is a small county serving a widely scattered population. The SLT service is small and faces recruitment problems. Currently two SLTs are on long term sick or maternity leave. There is no locum cover, and this is a significant proportion of the service (20%). The service has specialist provision for severe and complex needs, ASD and SLCN. Much work is clinic based and this makes collaborative working with education staff more difficult.

Pre-school work is largely based in community clinics, with some education/training into children’s centres. This is provided mainly by SLT assistants working under the Sure Start umbrella. The LA funds part of the provision into children’s centres, but this is on a year by year basis, and causes problems of uncertainty of funding, with associated recruitment difficulties. Individual referral 0-5 years is open referral and largely clinic based, with some joint work with teachers in pre-school settings to support individual children and their parents.

At primary level SLT input is mainly clinic based. There is no primary school based service, but there is some input funded by the LA into the primary resource provision for SLCN/ASD (3 days a week), and into each of the 3 special schools (1 day a week in each). The service tries to give time to annual reviews of statemented children in mainstream primary with SLCN/ASD.

Children with SLCN or ASD can be referred to specialist post-holders if felt necessary. However, the pressure under which the service is working is illustrated by the service for ASD. In June 2007 the 1.0 fte specialist post (joint funded by health and education) had a

caseload of 125, and a growing waiting list. The service wanted to provide an equitable service, and did this by restricting the service for each individual to a maximum of 4 sessions to be used for assessment, report and recommendations, demonstration of recommended strategies to relevant adults, and to providing information about resources or providing resources.

There is no SLT service into mainstream secondary schools. Monitoring is at the level of examining the amount of therapist time against different activities. Data on individual casework is collected by the SLT in the casework file and there are no service-wide tools used for assessment. Individual targets set by the therapist and the extent to which these are met are recorded in the individual files. Discussions in the schools visited gave similar information – individual SLTs made judgements about progress based on their own choice of assessment materials and methods, with clinical judgement playing an important part in this process. There is no attempt to collate this information across the service to look at service effectiveness. A questionnaire is used to assess client satisfaction (usually completed by parents), but this is not linked to outcomes.

The LA did take part in a British Stammering Association survey which used a number of essential and desirable criteria to assess SLT services offered for pre-school dysfluency. The first assessment rated the service as poor, but by March 2008 the service had improved to good (Report supplied).

The SLT service offers the Elklan<sup>4</sup> training in speech and language support for under 5's, and this activity was evaluated in 2007 (Report supplied). Over a three year period 371 early years practitioners had attended courses from 46 of the 110 early years settings in the LA. One effect was that the number of allocations for banded funding to 5 yr olds going into reception rose from 9 in 2004 to 28 in 2007, whilst referrals to the SLT service during this period remained static around 300. This increase in successful applications for banded funding was attributed to Elklan trained staff successfully identifying those who needed additional support at an early stage. The SLT service have noted a rise in quality of information given for referrals to the service, with fewer inappropriate referrals. There is an assumption in the LA, backed up by reference to an Audit Commission report, that the costs of supporting a child with early diagnosis of SLCN is around £110,000 less than the costs of supporting a child with SLCN who did not benefit from early diagnosis.

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<sup>4</sup> See [www.elklan.co.uk](http://www.elklan.co.uk)

One school visited mentioned that recently they had experienced the arrival of pupils with English as an additional language (EAL) needs, and felt that the SEN support services, as well as the SLT service, could not make provision for children who might have both EAL needs and SEN. This is a very recent change and school felt that additional resources and specialist skills were needed to help them offer a service to these pupils and their families

**CS3** is moving towards cluster arrangements for the organisation of education provision in geographical areas, and from September 2008 the clusters will become local children's service arrangements. Relationships between health services and education are described as excellent because of long-term joint working and commissioning, with collaboration between health and education described as strong at all levels.

The authority has communication and interaction teams with support teachers and SLTs working together. Health funds 44 fte SLTs working with the school age population and the LA funds 25.5 fte SLTs. This is an indication of the value attached to SLTs working within education to support children with SLCN.

The SLT service plans to run pilots within the developing systems geared to the cluster lead school model for supporting SEN/disabilities. The children's trust has accepted bids for an education-based service with integrated multi-professional teams of educational psychology, specialist teacher and speech and language therapist. It is not yet clear when funding for these pilot projects will start.

Current practice of the service focuses on early identification through referrals from early years programmes, including Sure Start and children's centres. They get very occasional referrals at secondary age for ASD, and put very little time into this sector. Much pre-school therapy is delivered in local clinics, making work in partnership with education difficult. At primary level, screening is carried out at an early stage, and the key support is an integrated multi-professional team involving specialist teacher, EP and SLT. There are some issues with a shortage of specialist teachers: several schools mentioned only minimal allocation for EPs to work in the school, and concerns about having to go through the cluster board to access an EP.

An attempt is made to embed speech therapy targets within the classroom, and these are jointly planned with class teachers and usually teaching assistants, embedding the work in literacy, numeracy and science. As a result of this work, it was reported, there is a reduced need for SLT input by the end of Y6.

SLT input into mainstream secondary comprises one-off assessments including ASD assessments. although the SLTs feel they should start providing a service. As yet, there is no input to Youth Offending Services or to cases of exclusion and suspension from secondary schools.

The SLT managers felt that the special school SLT service was inundated with referrals and suffering high levels of demoralisation of staff. They decided to withdraw the service to pupils with generalised learning difficulties, review referrals three times a year to prioritise caseloads, and to support classes or whole school rather than undertake individual casework.

A number of different initiatives at early years have been successful. SPARKLE has a multi-disciplinary team of educational psychologist, a specialist teaching assistant, SLT and Occupational Therapist. The team works alongside nursery staff for around two terms using hands-on demonstration, professional development, observation and joint working to give them skills to develop language and communication skills across a wide range of needs. The initiative has been evaluated by a university team and the report is awaited.

ABC is a programme implemented by education and social services and provides four places for children to attend a nursery with special provision for SLCN three times a week for one term, and then return to their own nursery. During the term in the special provision the children have high quality assessment and intensive help, with additional support for one term when they return to their home nursery. Around 75% of these children go on to specialist language resource provision but the intervention eases the process of finding appropriate provision at school age and helps parents accept the need for specialist help.

A further strand is the Hanen work on an integrated approach to language for children with SLCN at pre-school level. The programme offers a play-based approach to speech language and communication. However, early years training is a problem area with many providers as it is difficult to find time to free up staff for professional development.

There is little evaluation of service activities although early intervention is seen as successful in that Year 6 referrals are much reduced. Discussions during school visits indicated that SLTs use their own individual ways of assessing progress, and these are not collated across the service. Schools were unclear about any monitoring and evaluation of SLT activities. There are also problems with data sharing between school and SLT. For example, an SLT

commented that SATs data on speaking and listening were not used and that it was difficult to look at curriculum outcomes for particular categories of special needs. This lack of data sharing was also picked up by schools. One head teacher commented that he was not aware that the SLT service did anything with their data other than contribute to individual assessments, making it difficult to gather data focussing on the benefits of SLT interventions.

In **CS4** The SLT manager summed up their main approach as:

*"We want to work with others to get them to have a realistic view of what SLTs can do. We want them to understand that the SLT can work through others, backed up by training".*

The manager demonstrated a firm grasp of quantitative information about the service and has a well developed set of documents to guide service delivery, monitoring and evaluation. The SLT service has around 65fte SLTs serving the 0-18 population. However, there are more than 300 schools, plus pre-school-provision to cover,

*"so it is impossible to meet all the demands".*

The PCT funds 42 SLT posts, Sure Start funds 5, the LA funds 8, the special schools fund 2.5, and the acute hospital trust funds 9. The main effort goes into early years, especially staff training funded by the LA. There is an open referral system and the service aims to make an initial assessment within 8 weeks of referral. This target is seen as more important than time taken from initial referral to intervention. There are service standards documents setting out in detail the level of service that will be provided, in terms of assessment, intervention, resources, records and discharge. These standards documents exist for mainstream schools, language resources, special schools, pre-school, and the deaf and hearing impaired service. There were documents with service specifications for the commissioning of SLT services and a range of other health and local authority services including early years and school age services offered in clinic settings, early years settings and school settings. The document also includes the funding provided by each of the commissioning agents.

The SLT service also provides an interim report for the first 9 months of the financial year for the commissioning agencies, providing summaries of service activities in terms of total referrals, number of contacts, total on caseload of the service, and outcomes in terms of care packages recorded.

In terms of evaluation and monitoring the head of service attempted an outcomes monitoring report for the year 2006-07. Care aims of SLT interventions were categorised into 4 types, using aims derived from pilot projects in other areas:

- aims defined as restoring or establishing communication or swallowing to within the normal range
- aims defined as promoting the fullest potential of the child
- enable the best environmental support
- mixed aims covering more than one of the above categories

Each therapist rated the extent to which the care aims were met and the extent to which the carer agreed with the SLT's rating (either when carers took a more optimistic view of the effect of the intervention, or where they were less positive than the SLT. In summary the results indicated around 65% of care aims focussed on assessment, with a further 25% focussing on establishing skills within the normal range. In 60% of the cases the SLT rated the aims as achieved, and in a further 30% of cases the aims were significantly achieved. The level of agreement between SLT and carer was very high, with only 6 out of 4576 cases registering disagreement, and 172 where the carer felt unable to give a view. However, the difficulties of this type of evaluation are summarised by the SLT manager at the end of the report:

*“There are some serious difficulties about the information, including the means of collecting it, the definitions used and the level of common understanding of what is meant, as well as individual variations in how SLTs interpret their relationships with carers and how they define success. But in spite of this, the evidence provides some additional confirmation that the service is providing some benefit to many of the children receiving it.”*

This was the only example provided of this kind of analysis of a range of activities across the six SLT services that had been attempted. The service had also attempted a best value model using national curriculum key stage data to examine improvement after therapy, but could not do it. Numbers involved were too small to get meaningful results and it proved difficult to trace all children and identify where they were in the education system.

**CS5**'s SLT manager considered that the important feature of the SLT service was that it is funded at a level such that it can provide only 25% of identified SLT needs. Tier 1 (universal services) and tier 2 (vulnerable population) services are not offered at all from NHS Trust funding. Tier 3 (referred for assessment and decision re intervention) and tier 4 (highly specialised services) are the focus of service delivery from the NHS Trust budget. LA funding is provided for tier 2 services in children's centres (language support groups, parent groups run by SLTs) provided through Sure Start (2.5fte SLTs for 2007-08), and early years providers (3fte SLTs for 2008-09).

The SLT manager noted that the authority had an established history of multi-disciplinary assessment of children with significant SLCN, with health and education staff jointly involved. The emphasis on multi-disciplinary assessments means early detection and intervention is the general rule, with most children with significant SLCN identified by nursery age. The ICAN nursery provision and footsteps nursery/early language provision at a children's centre on Health premises are two examples of provision developed in response to early identification. This was thought to be a good aspect of the service, and reflected the good working relationships between SLT service and early years service.

The service has an open referral system, with initial assessment and decisions made about the need for intervention. As noted above, however, only 25% of the identified SLT needs can be met, and this means intervention is rationed, and not provided to meet the full needs. Work is carried out in clinic settings, as well as work with parents and in schools with teachers and teaching assistants to help them deliver programmes.

In the school system relationships were described as good in some schools, usually those schools buying in time from the SLT service on an annual basis. In these cases the schools are often clear what they want to buy in and do not necessarily follow the suggestions of the SLT about what might best meet their needs. There is no service provision to mainstream secondary schools. The service has a policy of not working with pupils in schools unless a teacher or teaching assistant is present to observe and to take over delivery of the programme under SLT guidance. This continues to cause some tensions but is becoming more widely accepted as a good model of working practice.

Reference was made to difficulties of carrying out SLT assessments when the client, and often parents, used English as an additional language. The service did have therapists who spoke Punjabi, Arabic, French and Spanish but achieving a diagnosis in these circumstances was difficult, and took a great deal of time.

In the last financial year the SLT service had been asked to provide courses by 11 schools, to provide a session for a head teacher conference, and to provide a day course for secondary school teachers on supporting SLCN in mainstream classrooms.

The service has a number of ways of monitoring service delivery. Therapy outcome measures are used to monitor phonology caseload in terms of degree of need and amount of progress made during therapy.

*“This provides lots of data, and we record it by individual cases in each school, but we don’t analyse it to see the effects of service interventions... We are so busy that unless someone asks for it we don’t do it except for business reasons”*

The service also uses a checklist (developed by a separate LA) to monitor individual progress but its perceived usefulness was under exploited:

*“Health service has reference costs – price per intervention - for a hernia repair or appendectomy. We know the cost per contact for individual therapy. We can calculate cost per child as we know the number of sessions of what type and can calculate cost of a particular intervention as we know length and number of sessions. We have the potential to do this but we do not routinely do it. We have the capacity, by combining this cost per intervention with TOMS data and the Surrey checklist to work out cost per amount of progress. But we don’t do it as we have so much data we must provide for other purposes.”*

The service had carried out an evaluation of therapy outcomes from two treatment regimes for children with phonological disorders. The study concluded that the programme of intervention for severely phonologically disordered pre-school children led to significant improvements when compared with a control group not undergoing therapy, and that there was no significant difference in terms of progress made between the group having 4 weeks of therapy and the group having 10 weeks of therapy. The study was used to justify a policy of using the shorter intervention programme for this client group.

**CS6** is a small unitary authority and the PCT covers a much wider area. The SLT manager is therefore responsible for a much wider area than just this authority. The PCT community services have recently been restructured and the revised management structure is seen as



complicated, with the SLT's line manager not an SLT, even though there is a head of SLT service. The response to this was described as:

*“use matrix management to solve the problem”*

The service does not have policy documents or criteria for SLCN and only accepts referrals from health or education professionals. Criteria for provision derive from the clinical judgement of the SLT. Waiting lists exist and if intervention is needed the child is placed on the list. If they have been on the waiting list for a long time, re-assessment may follow before intervention takes place in order to judge whether they still need intervention.

The service has 8-9 fte SLTs working in the authority: 3.6 fte SLTs work in universal services in community clinics; the child development centre has 1.5 fte SLT and 0.2 SLT assistant; the children's centre has 1fte SLT funded jointly by the LA and a charity - this 3 year project ends in March 2009, and it is not clear whether it will be renewed. The LA will open more children's centres to a total of 8, so a major expansion of SLT time will be needed to maintain level of service. There is a total of 1.3fte SLTs providing a service to two special schools, one primary and one secondary and a further 0.6fte servicing an integrated resource for pupils with SLCN and ASD. Provision for pupils with SLCN in mainstream primary is allocated a further 0.6 fte SLT. There is no SLT provision in secondary apart from the special school mentioned above.

### **3.3.1 Conclusions**

- Although SLT services collect data on contacts and numbers receiving therapy, there are relatively few collecting data on efficacy of therapeutic interventions.
- An important issue concerns how SLT services can provide data about the range of activities they carry out, and the outcomes of these activities, in a way which fits both health and education data collection and analysis requirements.
- As SLTs move towards a more consultative way of working, through other adults with responsibilities for children with SLCN, there is a need to consider the skills needed to carry out this work, and how it might be evaluated.
- As some SLT services become integrated across health and education departments, and education funds more SLT posts based in schools, a number of management issues were raised by head teachers, e.g. who has line management responsibilities? How can this work be evaluated within an educational framework?

- SLTs themselves felt that teachers needed to be made more aware of these different methods of working, and widen their expectations of SLTs beyond clinical one to one work. Three of the six SLT services mentioned problems with assessment, intervention and communications with parents because of EAL needs of both children and parents.

### 3.4 Cooperation between the local authority and primary care trust.

Substantial differences were identified between LAs in the degree of cooperation over planning of services for children and young people with SLCN, the stage at which joint working had reached, the structures in place to support joint work, and the nature of the services offered. One measure of collaboration used was the Index of Collaboration developed by Law et al (2000) – see Appendix 1. The results are summarised in Table 4 which presents the scores provided by the LA SEN officer and the SLT manager of the associated trust. The possible scores range for 0-10. In some cases scoring was modified as responses appeared not to match the scoring criteria. For example, Q4 asked about developing a joint strategy with regard to inclusion of children with SLCN into mainstream settings. In the case of one pair, one interviewee answered that this was at an informal level and the other that it occurred in a limited way through specific training. In such cases half a mark was given. Of interest are both the score itself, with higher scores representing greater collaboration, and the level of agreement between the two managers. As above, the results will be presented by case study initially.

**Table 4 Scores on Index of Collaboration between SLT service and LA  
(Maximum score =10)**

LA	SEN manager	SLT manager
CS1	10*	10*
CS2	5	2
CS3	9	No return
CS4	8	8.5
CS5	8	4
CS6	6	No return

\*completed jointly as the SLT service is integrated across health and Education

**CS1:** The Index of Collaboration was completed jointly by the SEN manager and SLT manager – scores =10, 10)

The highest level in terms of absolute scores and agreement was in **CS1**. SEN manager of **CS1** judged that there were very good relationships with the PCT. **CS1** has implemented the most radical approach to joint working with respect of the SLT service. A major review in 2002-03 resulted in an integrated SLT service across Health and Education in 2005, with the LA SEN manager and Head of SLT service working together on policy development. This restructuring created an opportunity to take a new approach to service structure and delivery, which was implemented over a three year period. Decisions were made about the time allocation for each of universal services – support from SLTs available to all families as part of the children’s centre early years (30%), targeted services - support available on request via easy access to advice and direction to appropriate intervention (50%) and specialist services support available following clinical decision making by SLT and assessment of need (20%), together with the operational principles guiding decision making. Interventions would be available in the places most relevant to the child and their family, and there would be close links with schools together with joint working with teachers. The range of services offered was made explicit: as well as individual or small group therapy, group work and training packages would be available for parents, schools and other groups, as well as time for consultation work.

The new way of working was made explicit and transparent to user groups. The SLT service has expanded from 20 fte posts in 2005 to 47 fte posts in early 2008. The fact that schools are increasingly buying more SLT time is an indication of the way the service is valued. Across all age phases, early years, primary and secondary, visits as part of the fieldwork consistently revealed evidence of collaborative working between SLTs and teachers, both within classrooms and in small group work. However, SLTs, EPs and support teachers were not yet working in integrated teams but did jointly offer training. In some schools visited the EPs, support teachers and SLTs were involved in some joint planning sessions on how to work effectively together to support pupils with SLCN. EPs were represented on the SEN placement panel, and the principal educational psychologist chaired the panel looking at applications for statutory assessments. However, a limitation was that EP time available for each school was minimal (e.g. 12 hrs a year for a secondary school, plus a further 12 hrs bought in by the school).

There were still tensions between health and education over multi-agency funding of provision for complex health and social care needs in educational settings, but these were being worked on.

**CS2** The Index of Collaboration was completed separately by the SEN manager (score = 5) and the SLT manager (score = 2)

In **CS2** the SEN manager reported that:

*“a strong relationship” existed between Health and the LA. A new joint board will be set up from September 2008 between children’s services of the LA and the health authority. The chief executive of the new board has been appointed, but not yet in post.”*

Currently there is no representative of health serving on the panel which makes decisions about banded funding allocation for SEN, nor is there health representation on the schools’ SEN placement panel. The SLT service collaborates with the LA on a number of different levels, for example, with the early years manager on SLT provision for this group, with the extended services manager and with the inspector for school improvement.

The head of SLT services in this authority felt that because of a small budget, serious difficulties with staff recruitment, and offering services to a widely spread rural population they had to run a mainly clinic based service with long waiting lists and very little direct contact with schools. This led to expectations from schools that 1:1 work by SLTs with children with SLCN would lead to a marked improvement in the child’s speech language and communication skills, who would then function at a much higher level in school. The ideas of shared responsibility through collaborative work, or the SLT working through other adults to support the child, were not well received and it would need a great deal of work to move forward to a new and different way of working.

The authority had a banded funding system to allocate funding to schools for pupils with SEN, which had been developed by the EP service with some input from the SLT service. The EP service was represented on the SEN funding and placement panel. Currently the EP service had several vacant posts and was seen as under-funded. The SEN manager commented:

*“This causes some problems with early identification and intervention, and this aspect of our work is weak”*

Two of the four schools visited in the LA had a specified number of visits by the EP service, but two said they had no allocated psychologist and had to request a visit for a specific referral.

**CS3** Collaboration score: SEN manager = 9, no return from SLT service

**CS3** had health workers, funded by the NHS, working within an LA setting with LA managers to develop joint multi-agency working and provision. This is seen as working well, especially in the early years phase, and the managers are now looking to develop the same approach into other age phases. The SEN manager said:

*“Traditionally there have been excellent working relationships between services because of long-term joint working and commissioning. Collaboration between health and education is strong at all levels.”*

The LA policy on speech and language notes the importance of multi-agency working to deliver an integrated approach to the development of children’s speech, language and communication needs, and the county communication and interaction steering group includes members from health as well as education and other children and families practitioners and specialists.

*“We will maintain strong partnership with other agencies at a strategic and operational level through the communication and interaction steering group to ensure there is effective liaison between agencies promoting partnership between LA and all other agencies.”*

Interviews with SLT managers reinforced this view, noting that collaboration between health and education is strong at all levels.

For some years the authority has been developing area support teams for SLCN with integrated teams of SLTs, EPs and support teachers working collaboratively. The action plan for one such team had set out clear objectives, some of which are listed below

- *To continue developing working practices within the framework of school cluster priorities*
- *To focus on the area of autistic spectrum disorders at primary and secondary levels with regard to training and staff support mechanisms that aim to promote inclusive practices*
- *To enable staff to develop a systemic process for working effectively in schools and to evaluate outcomes of this for school and individual pupils*

- *To identify and agree school's priorities for training to be delivered by the SLT/Ed Psych/ support teacher team.*
- *To jointly work with staff associated with clusters to share expertise and develop resources for training*  
(Draft action plan of steering group)

In all provision visited, early years, primary, secondary, and special, there was evidence of joint working between SLTs and class teachers. In some schools SLTs were involved in policy development and decision making. The EP service was represented on the steering group of the children's centre, and both EPs and SLTs worked together on some of the language training projects (e.g. SPARKLE). The special school visited did have a time allocation with a named psychologist, but other schools could only access the EP service by applying to the school cluster board; in these schools there was no evidence of joint SLT/EP work.

**CS4** The Index of Collaboration was completed by the SEN manager (score=8) and the SLT manager (Score=8.5)

**CS4** In **CS4** the SEN manager said that the LA was committed to joint working with health to promote integrated services. There is an SEN group which meets regularly and has input from health (school nurses and SLTs). At a formal level there is partnership involving strategic planning as well as many informal networks to support joint working. There is a detailed service specification between the PCT SLT services, the PCT children and maternity commissioning and the LA education an early years services. Currently the early years deaf and hearing impaired team, the Specialist Inclusive Learning Centres and work considered by the Education Area Management boards are excluded from this agreement but it is hoped to include them in future years. This joint commissioning work has led to strong shared understandings between the LA and health personnel. The LA inclusion policy is regularly reviewed jointly with health, and any complaints with respect to SEN and SLCN are dealt with jointly by health and education.

The SLT service manager has worked in the service for over 20 years and feels that relationships with the LA have been very positive over that time. There is a long history of discussions about contracts, provision for language resource schools and deployment of SLTs in education. The SLT service standards document includes criteria for admission to language resourced schools in the authority. Another example of partnership was a focus on the BESD population and those who may also have SLCN who may get involved in

offending and the criminal justice system. There was thought to be some possible link between this group and those excluded from education provision. Funding was given to 1 fte SLT to work with the youth offending system and education. As noted in the interview with the SEN manager, as a result of this post there has been a reduction in suspensions and exclusion from secondary schools. (see section 2.2)

**CS5** Index of Collaboration was completed by the SEN manager (score=8) and the SLT manager (score=4)

**CS5** has a panel making decisions about statementing and SEN placements, with representation from health, including SLT services. The SEN manager described links with the SLT service as strong in the early years through the joint health/education assessment facility, through the I CAN pre-school provision, and early support for disabled children. The SEN manager reported that the SLT service was involved in policy review and development and was kept informed and involved on how the LA wanted the SEN service to develop.

The SLT manager commented that SLT representation on the placement panel had started up again recently after a long gap with no SLT presence on the committee. The SLT service manager said there is a multi-agency strategy implementation group on services for children and young people; health has one representative, a medical practitioner. The SLT manager also said that there had been a recent meeting between the health authority and acting head of children's services to discuss the lack of health involvement in changes to services for children and young people. In 2006 two SLTs were members of a group set up to make proposals for improving support to children with significant communication needs in mainstream schools. There are no regular meetings with the LA to discuss policy, service delivery, and discussions tended to be with individual schools. Recently the LA was said to have started to dismantle the specialist support teacher service, which was becoming a generic SEN support teacher service. The SLT manager commented that the service had not been involved in any discussions about how this might impact on children with SLCN and support offered by the SLT service. The LA was described as difficult to get responses from on particular issues and not easy to access. This lack of communication between the SLT service and Children's services was seen as a problem by the SLT manager – it was said to be more than three years since there had been any official meeting on policy. The very disparate Index scores provided by the two managers represent a substantial difference of perceptions, confirmed by the interviews themselves.

At school level, there could be differences of view regarding practice. In the specialist resources visited, one teacher expressed the view that the SLT for the school did not have the skills to work in a school setting and could not relate to groups of pupils; one head of a special school said she was unhappy at the way the SLT allocated her time – for example writing reports during core school time when she could have been working with pupils.

**CS6** The SEN manager completed the Index of Collaboration (score=5); there was no return from SLT service

In **CS6** the SEN manager said that there is a strategic partnership board for disabled children and a high level multi-agency group providing cohesive development and joint working of all services contributing to effective delivery of services to children and young people. The LA is recognised as:

*“a hub of excellence of effective provision of SEN/LDD”*

by the DCSF. Joint commissioning of services was described as well-established, ranging from early years support to a joint panel for complex cases leading onto transition into adult life.

A strategic commissioning group has just started, consisting of an LA senior officer and PCT officer seeking a more coordinated approach to disability and SEN. There is a new LA post of head of integrated services across the LA, health and voluntary sector to coordinate provision, as recommended by a research study. It started work on the early years phase, but took a final decision to leave SLCN until after the Bercow review had reported. Currently there are no voluntary bodies involved in policy development.

The SLT manager felt that commissioning was “in its infancy” and currently the SLT service was carrying out a review to look at what commissioners wanted to buy. It was noted that there was no SLT representative on the SEN placement panel.

### **3.4.1 Conclusions**

- Structures and processes to facilitate cooperation across Health and LA services are at an early stage of development.
- Cooperation and joint working between SLT services and education range from complete integration of services in CS1 to minimal contact in CS2. Cooperation in all



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

### **3.5 Monitoring of provision for children and young people with SLCN**

This section looks at ways in which local authorities monitor provision for children with SLCN. As noted in section 2.3 on SLT working practices, monitoring and evaluation of these services is not well developed. One important issue is how this monitoring can be improved and integrated into the LA system of monitoring.

**CS1** was described by the SEN manager as:

*“This is a fast moving authority, monitoring is done informally with rigour.”*

At a later stage a further comment was made:

*“Monitoring is not one of our strong points; we don’t go through long review processes. If we know it has validity we suck it and see.”*

The LA carries out an audit of provision by getting random files of pupils at school action, SAP and statemented levels and uses a SENCO from another school to check that the provision is being delivered. Annual reviews are not used for monitoring by the LA in that no attempt is made to obtain an overview of progress of SEN pupils. They do not routinely use bench-marking in terms of progress made by LA pupils compared with similar pupils locally and nationally.

The SEN manager said they do have data on key stage National Curriculum levels for pupils with SLCN at school action, SAP and statemented levels. It was not clear whether, or how, the data were used for monitoring, evaluation or planning of provision. It was clear that a great deal of data was collected within the LA but it was less clear to what extent the data were analysed in a way that informed monitoring and planning of provision. There was no link made between pupil progress and amount of funding for provision, so cost effectiveness was not yet addressed.

Data collected by the children’s centre focussed on user satisfaction of the services and facilities provided, with no data on effectiveness. All schools said they used progress on national curriculum assessments to measure progress, as well as IEPs and annual reviews.

In the primary resource the SLT used the identification of needs tool on a termly basis, both to plot progress of pupils and to consider the amount of therapy needed. The secondary school used the results of the Clinical Evaluation of Language Fundamentals – CELF administered by the SLT to monitor progress of pupils with SLCN. The SEN manager also referred to the use of Ofsted reports as a way of assessing the effectiveness of provision.

**CS2** had tried to link monitoring to the system of banded funding for SEN. The SEN manager explained:

*“Banded funding is allocated according to information provided by the school on the degree of need of the pupil. A programme to meet that need is drawn up, with clearly specified outcomes that should be achieved by the end of the period over which the allocation is made. The school is supposed to report back to the LA on the progress made by the pupil and if the period is more than a year there should be an annual return of progress made.*

*A monitoring officer was appointed to look at the returns, analyse them and produce reports. The monitoring service was going to make spot checks to see how the money was being used. This model was developed from 2006 and started in 2007. The system soon hit problems. First, many schools refused to complete monitoring forms, then the monitoring officer was made redundant, then we found the data base being used for SEN data could not be adapted to accept the monitoring data so a different system had to be set up.*

*We hope that the system will be slowly accepted and data will build up”*

If this system had been implemented it would have been possible to start analysing data to make a link between cost of banded funding and the progress made by the pupil. The SLT service had no data on cost effectiveness of interventions.

The LA asks schools to use the annual review form developed by the regional consortium of LAs, but not all schools use it, and the LA does not collate information from annual reviews to monitor progress across different categories of SEN. The SEN manager feels that PLASC data are unreliable and because of this any analysis of progress of different SEN categories based on these data would be flawed. No benchmarking for SEN data is carried out.

All the schools and resources visited used IEPs and annual reviews to monitor progress of individuals, and all made reference to national curriculum scores and progress against levels or P-levels. There were a variety of other approaches taken to look at progress – Middle Years Information System (CEM Centre, University of Durham) using literacy, numeracy and cognitive tests, and use of a variety of standardised tests. When asked about monitoring, all schools focussed on academic outcomes, citing National Curriculum levels and standardised tests together with progress on IEPs and progress as described at annual reviews. Some made reference to Every Child Matters outcomes, but there was less of a focus on social skills or independence skills. The special school said they used Success Maker, a checklist from Every Child Matters, and an emotional intelligence checklist.

In **CS3** the SEN manager started by saying:

*“I confess we are not good at monitoring.”*

Reference was made to the fact that for children with SLCN the input of SLT services was very important, but there is no agreement between the LA and health on the use of data for monitoring.

*“Pooling databases with health is a long way off”*

A number of structural problems were raised. Monitoring is seen as a function of the advisory service and not within the remit of SEN. It needed more discussion and collaboration with colleagues to share information. Further, there was a particular section of the LA dealing with data collection, management and analysis. The researchers made a brief visit to the statistics section of the education department of the LA, where it was clear that huge amounts of data were collected but analysis depended on specific requests being made. Several of our questions were answered by:

*“it would be possible to get that.”*

However, the important point is the extent to which different sections of the LA make use of this database by asking for particular analyses to be made and particular data sets to be abstracted from the base.

The SEN manager reported that the advisory service had set up a system of examining statistical predictions based on attainment levels and rate of progress, which allows

judgements of whether progress is as expected, better than expected, or worse than expected. This information is used by schools as part of the self assessment but is not collated across the LA. However, the authority had nothing on cost effectiveness in the sense of measuring progress made and the cost of the input for that progress. The SEN manager wanted to make a start on this by looking at out-of-authority places. The SLT service did not provide any information on effectiveness related to cost of input.

In the educational provision visited a variety of approaches to monitoring were used. The special school for children had an outstanding OFSTED report from its recent inspection. The school also used value added scores which for the most part placed it as performing within the top 5% of schools nationally. Careful pupil tracking was used each term, and targets set for pupils. Lesson planning was also carefully monitored. The school also said it considered life skills and independence important and used Every Child Matters targets.

All schools used IEPs and annual review to monitor individual progress, but data were not usually collected or analysed in a way that addressed the functioning of the school or resource as a whole. The exception was the special school visited which used a value added formula and bench-marked progress against national data. The primary resource used the Vernon spelling test, Salford reading test, Burt reading test and I-CAN school talk checklists to monitor progress of pupils. The secondary resource used an NFER reading test, the Neale Analysis of Reading Ability, the Young spelling test a measure of handwriting speed annually to measure progress.

Two of the provisions visited (early years and the special school) mentioned Ofsted reports as evaluations of their work. The special school remarked that it was crucial that independence, social and life skills were part of any evaluation as they were vital for life after school. They believed the academic success enjoyed by their pupils was to a large part due to the attention the school paid to these other aspects of development.

In **CS4** the SEN manager said of LA monitoring:

*“It is currently being worked on. We need to be more robust in monitoring”*

There were doubts about the reliability of PLASC data, especially in how schools use the different categories, but it was thought to be improving. The LA was moving towards service level agreements for pupils with SLCN, linking funding to expected outcomes in a specified

time period. Funding will be allocated by levels of need at school action, SAP and statementing:

*“We need to have more clearly specified expected outcomes and have answers to the question – How will we know we have value for money? We want joint shared outcomes measures and indicators of success e.g. they reach N.C. criteria levels in speaking and listening. What value has been added by interventions? What is the impact on the child and on the school? We want to move to setting expected outcomes for specified finances and educational inputs”*

An analysis of national curriculum outcomes at each key stage for pupils in receipt of banded funding, broken down by category of need, was supplied as an example of the types of data analysis carried out as part of the monitoring and evaluation process for SEN. KS1 gave percentages in each category achieving level 2 or better for reading, writing and maths (but not speaking and listening). KS2 gave similar data for pupils achieving level 4 or above, and KS3 gave percentages of pupils achieving level 5 or above. KS4 gave an analysis of GCSE results achieved by category of need.

An example of the use of benchmarking LA data against national data was given for KS2 pupils with SEN. The data were analysed according to pupils at school action, school action plus and statemented, as well as by category of need. On cost effectiveness the SEN manager said:

*“Cost effectiveness – we want joint shared outcome measures and indicators of success... They reach national curriculum criteria levels in speaking and listening - what value has been added by intervention? We want to move to setting expected outcomes for specified finances and educational inputs.”*

The LA is not yet in a position to do this.

The schools visited all mentioned use of national curriculum data to assess progress, together with the use of IEPs and information from annual reviews. The special school visited made a DVD of pupils each year to show a short film of the pupil using communication and social skills representative of their skill levels. A copy was kept for records, and a copy supplied to parents. This school also noted the importance of independence and social skills in evaluating progress. They referred to a recent OFSTED report as another form of evaluation.

Again it was clear that a great deal of data existed within the LA, and that managers were aware of this and wanted to make more use of it. Addressing the management pressures of a SEN system in a process of change was very demanding and perhaps monitoring and evaluation issues had a lower priority, and would have more work at a later stage.

A similar theme emerged in **CS5**, with validity and reliability of SEN categories questioned. The SEN manager noted that in this LA SLCN and ASD were not separated out. She said that all OFSTED inspections of special schools produced reports with ratings 'good' or better, and that reports of Integrated resources indicated they were working well.

All schools in the LA use the same annual review format, that produced by the regional consortium of LAs. The LA does not analyse the annual review returns to look at patterns of progress by primary category of need but the SEN manager said it was planned to start this analysis. Current data collection using national curriculum assessments was currently limited but a more sensitive data collection had started this academic year. P-levels will be used to look at progress of cohorts of different special needs and to compare progress between schools. No analysis had yet been conducted to examine progress rates for different categories of need across schools and integrated resources. However, the SEN manager considered that unless the issue of categories is addressed problems will remain. As well as the problem distinguishing ASD/SLCN (the LA conflated these two categories), the LA had a large number of pupils categorised as MLD with very few specific learning difficulties (SpLD) or SLCN, indicating a more pervasive problem with its use of SEN categories.

The SEN manager provided some costing information; no cost-effectiveness analysis had so far been undertaken, but this was said to be coming on-stream in September 2008. The LA is looking at a model of value for money calculation developed by another LA.

The primary resource visited used the Boxall social skills profile<sup>5</sup> to evaluate progress in this area of development, and in both resource and one of the special schools mention was made of standardised tests used to assess progress,. The secondary resource used the same value added formula as the mainstream school, and the pupils compared very favourably in terms of actual progress versus expected progress, with most doing better than expected. This led to the head of the resource expressing doubts about how such information might be interpreted:

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<sup>5</sup> Bennathan, M & Boxall, M (1998). *The Boxall Profile Handbook*. London: The Nurture Group Network.

*“I don’t want to publicise this in case they are moved out and then start failing”*

He was clear that he believed the pupils did well because of the level of support they had available to them in the resource. If this support was removed he was certain they would fail. He felt that administrators may take the view that the pupils had now acquired the skills to cope as independent learners and no longer needed the support of the resource. He also considered that too much emphasis was placed on academic attainments and not enough on social skills, life skills and independence. For him, whether or not the young people leaving the resource could go on to some form of further education, training or employment was just as important. Similar views on the importance of life skills were expressed by the heads of the two special schools visited. Finally, three of the five provisions visited referred to OFSTED reports as another source of data on evaluation

In **CS6** a briefing paper of December 2007 on children and young people with learning difficulties and disabilities in the LA noted:

*“Our outcomes against ‘enjoy and achieve’ for children and young people with SEN/LDD are considerably better than similar authorities and exceed national averages. The collaborative work between services that provide support and challenge schools has resulted in sustained improvement over time both against age related expectations and also in the progress pupils make from their own starting points... There has been a marked decrease in the number of pupils working at 0-3 points in the foundation stag... The use of data informs intervention and effectively monitors and tracks progress and outcomes.”*

Progress in terms of national curriculum targets indicates:

*“pupils also progress well from their own starting points. Analysis of progress of the pupils who achieve W and level 1 at KS1 shows an improvement of 6% achieving two levels in reading and 19% in writing by the end of KS2.” (SEN/LDD data 06-07)*

The SEN manager said

*“we have detailed data sets for SEN pupils – numbers below key stage thresholds, conversion rates across levels by the end of key stages.”*

The authority uses Fischer Family Trust methodology<sup>6</sup>, referred to as 'contextualised value added'. The results are discussed with schools during monitoring visits by the link adviser and EP And the EP and support teacher visit schools to work with the school staff in looking at these data and how outcomes might be improved. An LA document states that:

*“Schools are supported in rigorous self-evaluation through the self-review framework, which provides clear standards against which all schools can benchmark progress. This has been central to the monitoring and evaluation of SEN/LDD provision”*

The document goes on to say:

*“The comprehensive use of data also enables the LA to effectively track outcomes for low attaining pupils against delegated budgets and to fulfil the statutory duty to monitor the effectiveness of provision through an established cycle of monitoring visits”*

Hence, this LA has extensive use of data. However, there is no link between the LA and PCT in terms of data management that allows sharing of outcomes for children with SLCN. The LA does benchmark performance of SEN pupils against national data, but not down to the level of categories and settings that would separate out pupils with SLCN. Delegated budgets were said to be hard to break down by amount per pupil so data on costs per pupil are difficult to determine. There is no link made between spending and amount of progress or improvement, so cost effectiveness is not yet addressed.

Some of the difficulties of this kind of analysis were illustrated in the evaluation of enhanced resource centres (ERCs) in the LA undertaken in 2006. The LA wanted to examine the cost effectiveness of the ERCs compared with other types of provision. They found two factors making the job difficult:

*“variation in practice and lack of consistency regarding the overall remit of individual centres and their relationship to wider authority policy and support for other settings”*

and

*“lack of consistency in assessment arrangements making it difficult, in some centres, to track individual progress and comparative progress. PIVOTS, for example, is not used consistently across all centres”*

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<sup>6</sup> [www.Fischertrust.org](http://www.Fischertrust.org)



The report suggested that:

*“The authority should establish comprehensive data collection and management systems for its ERCs which clearly demonstrate impact and outcomes for all pupils, and devise and implement a uniform, detailed service level agreement with all ERCs”*

The problems encountered are not unique to this authority, and provide an insight into why efficiency, effectiveness and value for money are difficult to demonstrate. The LA also placed great emphasis on the broader context of the Every Child Matters framework to evaluate outcomes for children and young people with learning difficulties and disabilities. The present situation was summarised in a briefing paper which also highlighted key areas for further development.

### **3.5.1 Conclusions**

- All LAs had developed databases gathering a great deal of information about pupil progress within the framework of the National Curriculum. However, it appeared that in many LAs the database was kept and analysed by a section set up for this purpose.
- The effect seemed to be very large differences between authorities regarding how the information was used to inform SEN planning, evaluate quality of provision, and to improve pupil outcomes. In some authorities all these processes were well developed, in others minimal use appeared to be made of the data. One of the commonest responses to questions about data was *“we don’t know, but we can find out.”*
- At a school level, as well as national curriculum data, a great variety of different instruments and methods were used to assess progress. Although this led to a rich source of data, it often caused difficulties in providing information on how well a particular provision was performing, and made comparisons between provisions problematic.
- At both LA and school level there was a concentration on academic attainments and outcomes when discussing evaluation. Some schools, especially at secondary level, placed an emphasis on social, independence and life skills, and commented that the focus on academic attainments and National Curriculum levels could lead to an under-valuing of these broader skills.

- There was a lack of *integrated* data systems combining information from LA and health services. This seriously limits the development of monitoring and evaluation of SLCN.

### **3.6 Training and continuing professional development.**

The majority of SEN managers and heads of SLT services noted that policy and provision were in transition, with change already underway and expected to continue for some time. Continuing professional development (CPD) and having a strategic view of the training needs of staff is vital if change is to be managed efficiently and successfully. In nearly every provision visited some aspect of training was mentioned in terms of delivering a quality service for children with SLCN.

Training can be considered at different levels: LA or SLT service level, training of other specialist support staff to work in a more collaborative and consultative way to ensure skill sharing with colleagues working in educational settings, and the training needs of all staff working in inclusive settings with children with a greater range of SEN than they may have previously experienced. Interviewees reported on their priorities, who should deliver the training, and the methods of evaluation.

**CS1** had a policy development document which set out clear priorities, aims and objectives, including training and staff development. One priority was early intervention:

*“Raising the skills and awareness of staff in early-years settings by*

- *Early years specialist advisory team offers training to all early years settings*
- *All early years settings access core offer of SEN and disability training*
- *All staff in early years have individual learning plans ensuring SENCOs have skills that transfer*
- *100% early years settings access core training to meet OFSTED requirements”*

Priority 3, Raising expectations and Achievements, had 12 objectives, four of which involved training:

- *training and professional development opportunities improved for staff in education, social services and health*
- *core skills improved for all teachers in all schools and settings*

- *advanced skills developed for some teachers and teaching assistants in some schools*
- *specialist skills developed within each community of schools*

The section on developing the role of special schools notes:

*“We will support the development of staff expertise across primary and secondary schools by working with primary and secondary school staff to develop the curriculum and provision for children and young people with SEN and disabilities. This will involve facilitating and providing training for teachers and learning-support staff....”*

In terms of training to support children and young people with SLCN, the SEN manager and manager of SLT services noted that a variety of packages for delivery to meet language development needs were available (e.g. talks to and discussions with parents on a range of language topics and *Chatter matters*). Nearly all training offered is in-house with SLTs and educational psychologists working together to deliver training for health visitors, nursery nurses, teachers and teaching assistants. Examples of courses included Makaton, using symbols for communication, communicative environments, and developing the speaking and listening curriculum. As well as these formal training sessions, collaborative working was seen as leading to skill sharing and professional development of staff.

Three of the four children’s centres and schools visited referred to the need for training, with two commenting that a variety of training was offered by the LA, either as central courses or by individual schools using the support services (EPs, SLTs or support teacher service). However, one school with an integrated resource for SLCN commented:

*“staff turnover is high with serious implications for training SLCN issues and practice.”*

She was supporting her point that in schools with integrated resources, especially if they were working to an inclusion in mainstream class model, the need was to have not only specialist staff, but also a whole-school staff skilled and knowledgeable about the needs of children with SLCN, and how to meet those needs in mainstream classrooms.

The SEN manager in **CS2** acknowledged the importance of training and CPD, but did not refer to an LA training policy on SEN in general or SLCN in particular. The problems faced by the LA with respect to training were explained. Firstly, the support services were

overstretched dealing with individual referrals, and were getting smaller because of budget constraints. Secondly, the funding for support services was likely to be delegated to schools, creating an uncertain future. The support service had delivered a training package on language and literature and *Teaching Talking*. Together with the SLT service they had been involved in delivering *Teaching Talking* and the Elklan training package to support speech and language development in the under-5s. In the recent past there had been a major initiative on signing, with free training offered to all schools. This was still available to schools, funded by the voluntary sector, but not taken up by many schools. The SLT manager commented:

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

However, the service did provide some training packages in language support at pre-school level, particularly the Elklan package, and also courses on ASD and on severe and complex needs for 11-16 age group.

In **CS3** the SEN manager had a positive approach to training:

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

The LA works on a model of clusters of schools, and within each school there is a designated lead school for SEN. The lead school has the finance and specialist provision as well as an outreach function to work to improve the skills of staff in other schools in the cluster. The draft speech and language policy has a section on training needs:

*“The LA places great emphasis on the development of a co-operative group of practitioners and specialists in Children, Families and Education and Health through the county communication and interaction steering group. This group draws on the skills of staff to focus on the documentation and sharing of good practice, increased liaison between agencies, and the identification of training needs and the development of multi-agency training groups.”*

*It is the expectation of the LA that there will be a three stage training framework. The framework offers general awareness raising at a whole school level leading to accredited courses aimed at expanding knowledge and developing skills and competencies. Parents can access this training. As understanding increases about how children and young people with SLCN learn, the approaches used become modified and developed. The LA's training takes account of such modifications and developments"*

The SEN manager explained:

*"Training is seen as three phases 1) awareness raising of what the needs are, 2) knowledge and skills in General language development, 3) Dealing with difficulties."*

Phase 1 was seen as general awareness raising of the importance of spoken language, phase 2 would involve delivery of packages such as language for learning, communication matters, and early talk delivered by SLTs and specialist teachers. She noted that SLTs service offers training in a variety of early years packages, and have a vital training role through the consultative and collaborative working with classroom teachers and teaching assistants.

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

The SLT team offer training in a variety of packages for early years language development – *Sparkle, ABC, Learning Language and Loving It*. The joint working between SLTs and early years staff has a strong skill sharing function.

In the children's centre visited, the manager raised an important point about difficulties in getting time and funding for training:

*"Getting a basic right for all workers to have CPD and training time. It should be built into contracts. Also getting supply cover for those on training."*

The head of the integrated resource visited noted the need for specialist training for the resource staff to ensure they had skills updated regularly, but also noted:

*“Training is a whole school issue, not just for resource staff, and the needs are different”*

The SEN manager in **CS4** talked about the change in function of the support services from an emphasis on individual casework to a wider role of skill sharing and training. The hearing impaired support service had specific training for this new role, and they were then used to help other specialist support services in developing training and consultation skills. The educational psychology service was described as:

*“ahead of the game and done more of this type of work.”*

However, no mention was made of using the service to train others.

The LA had used the National College of School Leadership to provide staff training on the “Every Child Matters” strategy. There was a post within Central Services of the LA to coordinate training which is currently considering the training needs of the staff of the special inclusive learning centres to be able to carry out the outreach and training function that these centres now have. The next phase will be to have a similar exercise for the integrated resource staff that will have a similar outreach role. Transformation funds have been specifically earmarked for early years training to improve staff skills to work with children with SLCN, as this is seen as a vital part of improving service delivery to this group. The SEN manager also noted that the training budget for school staff is delegated to schools so they are free to buy what they feel best meets their needs. This does present the LA with some issues over pursuing whole service training objectives. The SLT manager summed up the approach to training as:

*“Working through others backed by training.”*

The service training function is carried out through joint working within the classroom to share skills with teacher and teaching assistants, and by formal training courses. The service has induction training for new SLTs to skill them up in the delivery of commonly used training packages – *Derbyshire Language scheme*, *Makaton* training courses, and in some early years language courses. The service is involved in training health visitors in language development. Schools are also offered a range of courses they can buy into.

In **CS5** the SEN manager commented:

*“Staff don’t understand roles/remit of a system of integrated support and have stereotyped views of particular professionals. We need to increase awareness of what people and services actually do.”*

This aspiration fits with the phase 1 training needs as outlined by the SEN manager in CS3. Interestingly, the solution was seen as improved communication rather than training:

*“better communication between different parts of the service together with encouraging different working patterns to make use of existing skills is more important than giving staff new skills through training.”*

In terms of the direction in which the manager wanted the service to go, this was to

*“improve the general level of all teachers so we can move towards universal SEN provision. We want a proactive policy towards inclusion so meet the needs locally to empower and enable others rather than do it for them.”*

Again training seems to be an important aspect of implementing this vision but rather than a LA policy setting out priorities the manager said that training priorities arose mainly out of individual appraisal.

One special school in the authority had tried to develop its own approach to CPD and had negotiated an agreement with a local university for a modular Masters degree in SEN. This had worked initially but had folded due to funding not being available for fees. Another special school had a staff induction programme which included a 3 day Makaton training course and 3-5 days ASD training. Perhaps the most structured approach to training was reported by a special school head:

*“The management team produces the school development plan, and from this the staff training implications are clarified. The in-school training programme is then constructed from these priorities”*

The SLT service offered a menu of courses for schools, and over a 12 month period had put on 13 course or training sessions ranging from whole authority courses (communication friendly environments for head teachers, supporting children with SLCN in secondary school)

to courses for individual schools ( e.g. word finding and vocabulary difficulties, cued articulation). The service also had its own programme of CPD for SLTs

**CS6** had a clear policy towards training as indicated in its plan for 2007-2010:

*“An inclusive philosophy is not just about location but providing a range of facilities and support that can be within the school or brought into school...by offering training to school staff and through support services offering consultation and collaborative working to improve skills of school staff to work with a greater range of SEN.”*

Training is offered by LA staff, but for SLCN there is an initiative with the EP service and a local university to provide a 6 day training course for teaching assistants and teachers on meeting language needs. So far 30 have been trained and another 30 about to follow the course. The LA holds an annual SEN conference/training day for head teachers and SENCOs and in 2007 this focused on meeting SLCN. The educational psychology service has a number of training packages it developed on language – *Talking partners* and *Select* (social and emotional aspects of language development). The support teacher service also runs courses on language development (e.g. *Talking partners* and *Talk across the curriculum*).

The SLT service also offers some courses: training for teaching assistants in integrated resources, and some language packages. The manager said they were not well equipped for this work and need to access lap-tops, projectors and screens to be able to use power-point. The service saw the importance of CPD and training for SLTs but:

*“Service budget for CPD is only £350 per head and a time allocation of four days. This means attending substantial training courses is not possible for SLTs”*

### **3.6.1 Qualifications of staff in special schools and integrated resources.**

As more children with SLCN are supported in mainstream schools or inclusive provision in mainstream schools, it is important to ensure the skills and knowledge of all teachers in mainstream schools, but especially those working in integrated resources, are developed to ensure they can meet the varied and complex needs of children with SLCN. Although many LAs and SLT services are providing short courses and on-the-job training, there is also a need for some teachers to be trained in greater depth, both to work directly with individual children with SLCN but also to be trained to develop these skills in colleagues. Examples of



longer courses are the M.A. offered jointly by the Institute of Education, London and City University; the University of Sheffield offers an M.A. in language disorders; the University of Birmingham offers a post-graduate certificate, diploma and M.Ed. in speech and language difficulties. Kingston University offers similar courses. Voluntary sector providers such as I-CAN offer courses for primary school teachers and are considering offering courses for secondary school teachers.

The number and types of qualifications held by staff in the provisions visited were not recorded consistently as the head of school or unit was not always sure of qualifications of staff. Of those settings where information was available, about half either had staff that had secured (5) or were currently studying for (2) a relevant qualification, compared with seven whose staff had no relevant qualification. Interestingly, of the former, there were three settings where staff had or were studying to secure dual qualifications in education and SLT, a positive development. The two teachers studying for Masters degrees were doing so part time and at their own expense.

### **3.6.2 Conclusions**

- Most LAs provided some training for staff working with children with SLCN as a primary need. Some was on-the-job training through joint working with an SLT and experienced teacher, some of it was through short training courses provided by SLTs.
- Some LAs had financed training for specific packages or had negotiated tailor made packages delivered jointly by staff from a local university, SLTs and EPs. Once in post, however, there is little opportunity for secondments to study for longer courses. Any teachers registered for higher degrees were studying part-time, and paying fees themselves.
- Although both SLTs and EPs are trained in research skills as part of the professional training courses, there were few examples of research projects helping to develop evidence based practice, or to evaluate interventions and provision for children with SLCN. This is a significant wasted opportunity.
- Potentially there are obvious benefits in terms of improving monitoring and evaluation of both individual progress on a broader front than just academic attainments, and comparing the effectiveness of different types of provision made both within inclusive settings and in special schools

### 3.7 Research and evaluation of services and provision

There were some examples of research and evaluation projects in five of the six LAs surveyed, but neither education SEN services nor the SLT services actively sought such work or encouraged staff to become involved in research. None of the SEN managers mentioned action research as a way of gathering information about the quality of special provision with a view to its improvement, and little use was made of research students or research workers from local institutions of higher education. However, three of the SLT managers mentioned the importance of research as one aspect of the work of SLTs. One noted that:

*“Lots of data exists for individual therapy interventions – we use the Surrey checklist and therapy outcome measures devised by Professor Enderby but we don’t use it to evaluate our work”.*

The head of the SLT service in **CS6** said that a recent revision of the job specification for SLTs in the primary trust had removed research work as an aspect of work that SLTs could legitimately carry out. The evaluation report for accreditation of the nursery facility in **CS5** noted the potential for action research and gave some encouragement to staff to carry out such work.

In **CS1** the inclusion manager of the primary language resource visited was registered on an M.A course, and her research project was being carried out in the school. She was evaluating a language for thinking programme followed by all pupils in the school, including those in the language resource. She pointed out that this was not an initiative from the LA, but a project arising out of her M.A.

The **CS2** SLT service had two examples of evaluation. The manager reported that the British Stammering Association had carried out a survey of 67 Primary Care Trusts (PCTs) of services to young dysfluent children (copy of report supplied by the SLT service). As a result, the Association set criteria which were considered necessary to provide a good standard of service for this client group. The criteria consisted of seven essential features of the service offered, and five desirable features. On the basis of these criteria the 67 PCTs were categorised as outstanding, good, satisfactory, poor or inadequate. Following the initial analysis of findings from the 67 PCTs taking part, a questionnaire was developed which was sent to all PCTs, and a further 58 responded. Results were therefore obtained from 125 PCTs in England, and each was given feedback on how they had been rated. Ratings were

Outstanding (11%) Good (30%), Satisfactory (38%), Poor (10%), Inadequate (10%). **CS2** was rated as poor in Sept 2007, and used the criteria to change the service offered, such that by March 2008 it was rated as Good. This is a useful example of how evaluation can help improve service standards of delivery.

**CS2** has offered Elklan training for workers in pre-school and nursery settings in the authority since 2004, and in 2007 an independent evaluation of this intervention was undertaken. The consequent report examined numbers trained and their cost, and the monitoring of the long term impact of the training: 371 early years practitioners from around half the early years settings in the authority were trained during the time covered by the report. The major outcome seems to be an increase in the early identification of children going into reception classes. It is hoped that this will lead to a decrease in referrals of children of school age, and monitoring is continuing to see if this is the case (NB this criterion was used by **CS3**. to measure success of the early intervention by the inter-agency pre-school team).

In **CS3** one of the early years intervention programmes offered to workers in the authority is *Sparkle*, run by a joint team of SLTs, EPs and support teachers. The aim is to empower nursery and playgroup staff by giving them knowledge, skills and confidence to meet a broad range of needs. A local university was asked to evaluate the programme with a report expected by April 2008. The report had not yet been received by the team at the time of interview.

In **CS4** The SLT service had carried out a pilot study to look at SLT interventions. The head of service attempted an outcomes monitoring report for the year 2006-07 (see Section 3.3) Each therapist rated the extent to which the care aims were met, and the extent to which the carer agreed with the SLT's rating examining, for example, when carers took a more optimistic view of the effect of the intervention, or where they were less positive than the SLT. In summary the results indicated around 65% of care aims focussed on assessment, with a further 25% focussing on establishing skills within the normal range. In 60% of the cases the SLT rated the aims as achieved, and in a further 30% of cases the aims were significantly achieved. The level of agreement between SLT and carer was very high, with only six out of 4576 cases registering disagreement, and 172 where the carer felt unable to give a view. The difficulties of this type of evaluation are clear and it was the only example across the 6 services in this survey that had attempted such an exercise across a range of activities.

The **CS5** SLT service had carried out an evaluation of therapy outcomes from two treatment regimes for children with phonological disorders. The study concluded that the programme of intervention for severely phonologically disordered pre-school children led to significant improvements when compared with a control group not undergoing therapy, and that there was no significant difference in terms of progress made between the group having 4 weeks of therapy and the group having 10 weeks of therapy. The SLT and EP had started a longitudinal study of children that had been through the I Can nursery, with standardised baseline assessment of cognitive and language skills before they entered the nursery, when they left, and at agreed follow-up times.

### **3.7.1 Conclusions**

- Both LAs and PCTs have staff qualified to undertake research, in particular educational psychologists (LAs) and both clinical psychologists and speech and language therapists (PCTs).
- Despite this, research was rarely undertaken by LA or PCT staff or by these staff in collaboration with researchers from local institutions of higher education, other than by staff as a component of a higher degree.
- Studies that did take place had clear service delivery implications, including evaluations of interventions or services.
- The lack of policy and practice research by local research-trained practitioners especially when supported by and in collaboration with researchers from HEIs, represent a wasted opportunity.

## **4. THE FEASIBILITY OF A COST-BENEFIT ANALYSIS OF INVESTMENT IN SERVICES FOR CHILDREN AND YOUNG PEOPLE WITH SLCN<sup>7</sup>**

### **4.1 Introduction**

The overall aim of this section is to assess the feasibility of conducting a cost-benefit analysis of investment in services for children with speech, language and communication difficulties (SLCN). This comprises Strand 2 of this research study, Strand 1 being the study of six case studies (see Section 3) and was presented as an Interim Report to the DCSF in March 2007. Strand 2 assesses the capacity of existing information to address economic questions related to SLCN. Four tasks were identified:

- The first was to explore the extent to which existing research findings can help identify the parameters for a study of the costs and benefits of services for children and young people with speech, language and communication difficulties. This would include consideration of the most appropriate mode of economic evaluation and the complexities around estimating costs for the various interventions.
- Second, and linked to this review was to assess whether these existing research findings could provide the basis for cost and benefit estimations to be made
- The third task was to assess whether current publicly available datasets hold sufficient data to identify longer-term outcomes (for example, into adolescence and adulthood) that have economic implications.
- The final task was to explore the extent to which data held by local education authorities and schools could be used to assess the outcomes and costs of interventions for this group of children and young people. Information relevant to this task was collected in Strand 1 of this study, during the fieldwork in the six sites.

### **4.2 Identifying a model and key parameters for economic analysis of services for children with SLCN**

The short timescale of this project would not allow a full literature search and review but the researchers' in-depth knowledge of the field were considered such that they would be able to

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<sup>7</sup> Jennifer Beecham and James Law led Strand 2.

identify the most important literature in this area. In fact, there are few economic evaluations of speech and language therapies. A recent review for a Health Technology Assessment (HTA) study found just three, only one of which was UK-based. We have identified two more UK studies, giving a total of four studies with an economic component that have been carried out on UK populations in the last fifteen years. All four studies are briefly described in Figure 3.

### **Figure 3 Studies of SLCN services which have an economic component**

The economic component of the HTA study considered only the costs of treatment (Boyle et al, 2007). Children in the four trial arms attended between 13 and 45 treatment sessions around a mean of 37-38 session: direct individual therapy (n=34 children); direct group therapy (n=28); indirect individual therapy (n= 33); indirect group therapy (n=29). The control group received the usual level of community-based speech and language therapy (n=28). The study was powered to detect a treatment effect on the Clinical Evaluation of Language Fundamentals (CELF) scale at 50 children in direct and indirect treatment. Indirect therapy, particularly indirect group therapy, was found to be the less costly than direct therapy although there was no significant difference in outcome.

Gibbard et al (2004) explored the costs of treatment with a speech and language therapist and a parent-practitioner intervention for children under 3 years with expressive language delay. Their analysis contradicts that of Boyle and colleagues suggesting that the language skills gained by the parent-practitioner group cost more to the NHS Trust than did the gains made by the clinician-treated group, although the cost per outcome was similar. The sample size was again very small; 10 children receiving standard care and 12 receiving the parent-based intervention.

Thirty-seven children took part in a Manchester-based trial of direct and indirect (clinician to carer) treatment for children with a diagnosis of language impairment aged 2-3 years. Costs were taken as a measure of therapists' time per child and foregone leisure time based on the number of therapy hours. The indirect carer-based programme was found to be more costly in terms of therapist time and there was no difference between the two in terms of language skills gained (Baxendale and Heskith, 2003).

The final economic evaluation compared costs and cost-effectiveness for two Early Years Centres (EYC) for pre-school children with primary language difficulties (n=58 children) with the local speech and language therapy (SLT) services in a nearby area with no EYC service (n=33; Law et al, 2006; Law et al, 2005). Average treatment costs were higher for children using the EYC, in part because of the wider range of work undertaken with the children. The EYC service was also delivered in a more consistent fashion than that provided through the local SLT services. The outcome evaluation found that the EYC group made greater improvements in language and behaviour than the comparison group. The wider range of EYC services meant that the comparison group children used more nursery and school services. Further analyses showed that EYC costs were small relative to the potential difference between the groups in the costs of nursery and education services. However, the authors note that since the numbers in the study are small, and the standard deviations large, the differences in cost between the EYC and comparison groups are not significant at the 5% level (p76).

Three points are worth noting about these studies. First, the scope of the cost measurement tends to be narrow; in three of the studies it only included the costs of treatment. Yet, as noted above, we know that speech and language problems may also have an impact on, for example, progress at school or behaviour problems. It may be the case that children with SLCD also use additional supports at nursery or school, see social workers or child psychologists for their behaviour or see their GP more often. Each of these professionals may have an impact on the SLCDs – and indeed, following effective treatment, contacts with these professionals may be reduced. It is important, therefore, that a wider cost perspective is taken to assess the full public sector impact of both the problems and interventions.

Second, they are all very short-term studies, commonly employing a six-month evaluation period. We can tell little from these data about whether the impact of the intervention is maintained in the medium- or longer-term. Third, each study includes a very small number of participants. Some of the treatment cost differences are large (for example, between individual and group treatment in the study by Boyle and colleagues) so may not require a larger sample to show a valid difference. However, small sample sizes usually mean wide variation, and often skewed data with just a few participants using high levels of service. Both of these factors may mean that the costs differences found are not as statistically robust as, say the differences found in language improvements. Of course, given there are very few economic evaluations in this area it is difficult to assess the sample size required in advance of the study but none show whether the studies are sufficiently powered (statistically speaking) to provide a valid estimation of cost or cost-effectiveness differences and only one uses additional statistical techniques. It is likely that larger samples would be required for a full economic analysis measuring a range of relevant costs and educational and social outcomes.

Thus, from the evidence to date, it is very difficult to assess the parameters for a future cost and outcome evaluations of services for children with speech, language and communication difficulties.

#### **4.2.1 *Estimating the costs of speech and language interventions***

As the studies described in Figure 3 show, the methodologies and techniques to cost direct and indirect speech and language interventions already exist. Data on the use of other services is needed to assess the full impact of SLCD and the interventions. Some information on nationally applicable unit costs for health and social care professionals can be

found (see, for example, Curtis, 2007) and clear methodological guidelines are already available (see for example, Beecham 2000).

Cost estimation methods are not complex but are time-consuming. Importantly, greater accuracy comes with site- or person-specific salary and other data which may be difficult to obtain. Often service providers are unwilling to release this information as it is considered 'commercially sensitive'. So while the demand for cost (and cost-effectiveness) evidence is high from both providers and commissioners, they are rarely able, or willing, to contribute information.

To complete the cost estimations, detailed descriptive data are required alongside income/expenditure accounts. These include time use, numbers of staff and workload measures, numbers of patients, etc. As the study by Boyle and colleagues has shown, it is important to include costs that in routine practice may fall to families. Examples given in that study were the costs of travel and travel time, and the costs of escorting children to appointments. We could extend this list to include the opportunity costs of parents' lost employment as a result of the child's difficulties or as they attend treatment. Again, obtaining this information can be difficult, even where agreements have been reached early in the research process, and the data must often be collected from the family members.

#### **4.2.2 *Models of economic evaluation***

The original tender for this research asked for information concerning the feasibility of a cost-benefit analysis of investment in services for children with speech and language difficulties. Cost-benefit analysis is a particular form of economic evaluation in which outcomes and costs are measured in the same metric, commonly money. This requires that any change in, for example, language skills or behaviour as a result of the intervention, is valued in monetary terms. This is a complex research methodology but techniques, such as 'willingness to pay', are being developed. The term 'cost benefit' is often used incorrectly for studies that measure 'benefits' in terms of financial savings - either current or future savings. These 'benefits' are in fact lower costs and such studies are actually cost comparison studies.

Cost-effectiveness analyses are probably more appropriate for speech and language interventions. This type of analysis retains the outcome measure(s) in their natural form (scores on a standardised test, for example) and compares the costs of achieving an additional unit of outcome. The studies described in Figure 3 have either compared costs



alone or compared costs per unit of outcome. Where these studies have compared costs the results have usually been set in the context of the study's outcome findings and interpreted using a set of 'decision rules'. These decision rules help assess whether one option is likely to be more cost-effective than another: Does this service produce the same level of outcomes as the other service but at less cost? Does this service produce more (better) outcomes than the other service for the same money? A 'yes' to either of these questions means *this* service is more cost-effective than *the other*.

One of the studies used a single outcome measure to assess cost-effectiveness using the ratio between costs and effectiveness (Boyle et al, 2007). The incremental cost-effectiveness ratio (ICER) is calculated thus:

$$\frac{\text{Change in outcomes from start of the 'intervention' to end of study}}{\text{Change in support costs from the start of the 'intervention' to end of study}}$$

Comparing all five intervention modes, group direct therapy was found 'to provide more outcome for less resource' (p83). Figure 4 briefly describes other models of economic analysis each with the necessary linking between costs and outcome measures. They require comparative designs in the research, which carry all the rigour desirable for an outcome study.

#### **Figure 4 Other models of economic evaluation**

Another common form of cost-effectiveness analysis employs multiple outcomes measures and is often seen as preferable for interventions which are likely to have an impact on more than one area of a child's life; SLCD may affect not just communication but also behaviour, peer relationships, school progress etc. The draw-back with this evaluative mode is that the results may not be as clear cut as when using just one outcome measure; an advantage is that they may provide a better reflection of the multiple aims of the services.

A more recent development of cost-effectiveness analysis is to calculate the net-benefit ratio for each person in the study. From these data a graph can be plotted that illustrates the probability of either option being cost-effective at a range of costs. This cost-effectiveness acceptability curve is particularly useful where an 'experimental' intervention is both more costly and more effective than its comparator.

Cost-utility analysis can be thought of as a special category of cost-effectiveness. These studies are more commonly undertaken in health care and there are particular problems around using utility measures in children (see, for example, Petrou, 2003). Quality Adjusted Life Years (QALYs) or Disability Adjusted Life Years (DALYs) are common measures used in health economics.

There are two further types of cost analysis that should be mentioned. First, cost of illness studies in which the current costs of a disease or disorder are estimated. These estimate the costs of current provision for a particular group of individuals with similar health problems, and may also look at the costs falling to the individual, family, or national economy. These are not, however, 'evaluative'. They describe current patterns of expenditure and costs and can say little about how to make the best use of scarce resources, the central tenet of economic evaluation. The second type of cost analysis, and linking closely to the discussion in Section V of this report, are estimates of 'downstream' cost implications, such as the costs in adulthood of childhood speech, language and communication difficulties. These can provide the basis for long-term cost-effectiveness analyses, but again they are not in themselves evaluative. *The Costs to the Nation of Children's Poor Communication* summarises many of the potential costs falling to individuals and the families as well as to the national economy by drawing on range of evidence in linked areas of study (ICAN, 2006).

Just four UK studies of the costs and cost-effectiveness of services for children with SLCD have been found evaluating different interventions for different groups of children with SLCN. None included large enough sample sizes to provide unequivocal findings on cost or cost-effectiveness. Only one included sufficient data to assess sample sizes for future studies, but even so, the cost measure employed in this, and in the other studies was too narrow. In many cases the data recorded about the interventions was incomplete and assumptions were made about service use which in turn potentially reduces the accuracy of the cost measures. The agenda for economic evaluations in interventions for children with SLCN is massive.

One of the key tasks in economic evaluation is to discover for whom and under what circumstances a particular therapy is more cost-effective. The Cochrane review of speech and language therapy interventions and subsequent update (Law et al, 2003; Law et al, forthcoming) lay out a number of areas where further research is needed. However, these are not just questions of effectiveness but may also have differential cost and cost-effectiveness implications. Given that we found only four economic evaluations in this area, detailed cost-effectiveness evaluations are sorely needed. Proposals for future research are set out in Section 5.7, Research Agenda.

### **4.3 Capacity of existing research findings to assess costs and benefits of services for children with speech and language problems**

The studies reviewed above provide insufficient data to undertake an assessment of costs and benefits for interventions for children with speech and language difficulties. Moreover, these studies only provide short-term costs and outcome data, usually only for six months post-treatment.

### **4.4 Capacity of publicly available data to assess longer-term costs and benefits of service for children with speech and language needs**

#### **4.4.1 Background**

Felsenfeld and colleagues (1994) usefully summarise the previous literature on valid longer-term (adult) outcome measurement for children and young people who have had SLCN needs. Apart from the (clinical) measurement of changes in speech and language ability, the paper identifies two broad outcome domains:

- 'objective status' such as educational performance and attainment, and occupational status and work record
- 'subjective well-being' sometimes conceptualised as psychosocial adjustment or perceptions of life satisfaction

In this Section we concentrate on the former of these domains as they are inherently easier to value in monetary terms, but there is also evidence that associated co-morbidities in adulthood will require attention for other public services, for example, mental health services.

#### **4.4.2 Domains**

Law et al (2008) drew on the BCS70 Birth Cohort of children born during one week in 1970 to identify 211 children with specific language impairment (SLI), 195 children with non-specific language impairment (N-SLI) and 9613 children with normal speech and language abilities (NL). The longitudinal British Cohort Survey allows children to be followed from school onwards and the study examined both literacy and mental health implications at 34 years old. For example, once various parental and environmental factors had been taken into account, the likelihood of low literacy skills and mental health problems at 34 years were

found to be greater in those with a history of non-specific language impairment than those with specific language impairment.

#### **4.4.3 Continuing speech and language problems and co-morbidity**

This population-based study highlights important adult consequences of childhood speech and language difficulties: continuing communication problems and linked mental health problems. Other studies, usually involving smaller groups of children who attended clinics, support these longer-term findings (Figure 5). They each show that not only will the continuing SLCN have cost implications for services but so too will the associated disorders and difficulties – and may have far wider support (and cost) implications in unforeseen areas. For example, the costs of crime were particularly high in adulthood for children diagnosed with conduct disorder but also fell to adult mental health services and social care services (Scott et al, 2001).

The authors of one UK study conclude:

*“The withdrawal of specialist educational support and services from about 9 years onwards assumed that the language, literacy and educational needs present in childhood would simply resolve, presupposing that these children would reach a level of functioning that would equip them for adult life. Yet the psychosocial consequences of DLD [developmental language disorder] were perceived by families to be more pervasive in adult life when no services were available than in childhood when services were available”.* (Clegg et al, 2005, p146).

From the point of view of research, existing data on the support costs for adults who as children had SLCN are going to be hard to come by. Follow-up studies will be required, and they need to include data collected on service use. A range of technical skills will then be needed to convert these to costs and appropriately analyse the resulting data. This requires not only funding for longer-term studies, but additional funding for this economic component.

### **Figure 5 Studies identifying longer-term impacts of SLCN**

One small comparative US study showed that children with moderate language disorder continued to perform significantly more poorly on language tasks and were more likely to perform significantly more poorly in articulation and expressive language functioning by their early thirties (Felsenfeld et al, 1995). A longitudinal Swedish study that identified children at age 6 and re-assessed them at age 18. Although the study was incomplete at the time of publication, the findings suggest 'language problems are difficult to outgrow' (Naucler and Magnusson, 1998, p280). Howlin and Mawhood (2000) also cite a number of studies that suggest that developmental language disorders tend to run in families (p563).

A recent review of co-morbidity with language disorder found that reports are more variable than those for children with autism because of methodological problems, in particular with regard to diagnosis and heterogeneity of samples (Howlin et al, 2000, p561). The authors found that the literature reported a wide range of risk figures for continuing language problems; between 50% and 90%. They also found that the even where skills improve, the children are at risk of other difficulties such as behavioural and attentional problems, cognitive and academic delays, and social and psychiatric disorders, including difficulties with peer relationships. The authors cite some evidence to suggest these difficulties become more rather than less evident as the children get older.

Thirty-nine children were followed up by Howlin and Mawhood (2000). The young adults were now in their early twenties and included 20 young adults who had been diagnosed with a developmental receptive language disorder (and 19 diagnosed with autism) in the early 1970s. On a measure of overall functioning, just 25% of those with language disorder were considered to be near/normal functioning and just over half were rated as having 'intermediate' levels of problem behaviour, and a similar proportion had problems establishing relationships.

More positive findings come from the latest report of a longitudinal study of 69 children with specific speech and language difficulties (SSLD) now aged 16+ and first identified in 1983 (Dockrell et al, 2007). Literacy was a key problem as the children moved into Key Stages 3 and 4, leading to lower achievement levels than their typically developing peers. They also had less success at their GCSEs examinations. At 16, about half the group had peer problems and a third had significant levels of behavioural, emotional and social difficulties. In their first year of post-16 education, 50 young people with SSLD were interviewed; 45 had moved on to further education and four went into employment or training. This study also demonstrated the potential usefulness of other services, including Connexions.

#### **4.4.4 Variation**

The analysis of the BCS70 also highlights that there is variation of symptoms, predictors and outcomes among adults who as children have had SLCN (Law et al, 2008) and again we see this finding reflected in smaller studies. A prospective 14-year follow-up of 114 children with and 128 without speech and/or language impairments was undertaken in Canada (Johnson

et al, 1999; and see also Young et al, 2000). The children were initially identified at age 5, and followed up at ages 12 and 19. High rates of continued communication difficulties were found among the young people; however, the longer-term outcome was better for those with initial speech impairment than for those with language impairment. A US follow-up of children to 16 years old suggests that those with a speech disorder of unknown origin may start with slower than normal articulation (the pace at which speech segments are produced) but that eventually they catch up to their typically developing peers (Flipsen, 2002).

These are important findings that highlight the variation within this group of children both in terms of their service needs (support costs) and their outcomes. Some problems may well disappear in older childhood but others will continue to make their impact felt in many different domains of the person's life.

#### **4.4.5 Objective status outcomes**

The BCS70 analyses point to likely differences in 'objective status' outcomes in young adulthood through its measures of literacy and mental health status (Law et al, 2008). Smaller studies point to some of these although comparability in terms of outcomes in adolescence and adulthood can be limited (Lindsay & Dockrell, 2008). It is very difficult to find data that stretch past the early-twenties and the three studies we found all suffer from small sample sizes. One is from the US, and should be used to guide UK policy and practice with some caution. Different education and other service systems, and different employment market, mean that positive findings from one country may not translate into such good outcomes in another.

One UK study found that as adults, children with developmental language disorder (DLD; n=17 children) are less likely than non-DLD peers (n=16) to live independently (41% v 94%), and less likely to have passed exams at age 16 - only one child with DLD did so compared to 63% of peers who gained five passes at O-level now replaced by GCSE. They are also less likely to be continuously in paid employment (18% v. 94%), and more likely to have ever received social security benefits (64% v 6%; Clegg et al, 2005).

Findings from the linked study by Howlin and Mawhood (2000) are similar. None of the 20 children with language disorder had obtained formal education qualifications. At the time of the study, 13 had experienced a prolonged period of employment – mainly in manual or unskilled jobs – but many had unstable work records.

In a US study to which we made reference to above, outcomes for 24 adults with moderate phonological/language disorder were compared to those for 28 adults from the same birth cohort who had at least average articulation skills (Felsenfeld et al, 1994). By their early thirties, those with language problems had lower self-reported high school grade point average, higher use of special academic help in school, fewer years of formal education (although most had completed high school) and were less satisfied with their educational attainment. They were at risk of later academic difficulties and less likely to pursue post-secondary school education. Although most participants in both groups were employed, those with language disorders were more likely to be in jobs considered semi- or unskilled (Felsenfeld et al, 1994).

#### **4.4.6 Potential solutions**

A broad approach to estimating these down-stream costs would be to link educational outcomes to income prospects. Dearden et al (2004) calculated the 'economic returns' (the effect of the level of schooling on earnings) for different qualifications. Compared with stopping education at age 16 without qualifications, they found increasing economic returns to O-levels (18% wage gain by age 33 compared to having no O-levels: now replaced by GCSE), A-Levels (24%) and higher education (48%). There is an average return of 27% for those completing some form of higher education compared to anything less. These analyses used the BCS70 so provided population-level average incomes. Broad data on education attainment for children with SLCN (say proportions achieving these levels of qualifications) could be 'converted' into potential incomes and compared against the broader population data to assess adult costs to the national economy of childhood speech, language and communication difficulties.

To focus more specifically on SLCD would require an extension of the analysis of the BCS70 by Law and colleagues (2008). This would use the same populations (SLI, N-SLI, NL) and identify their educational achievement, employment history and (equivalised) incomes at age 34. These types of analyses have already been undertaken for other groups of children now approaching adulthood; children identified as having high needs for personal and communication support (Knapp et al, 2008) and for those who displayed delinquent behaviours (Healey et al, 2004). This approach would help to estimate the longer term costs of speech and language difficulties relative to peers without SLI or N-SLI. In turn, this could identify the cost savings to the national economy were these children (or proportions of them) to be treated successfully and attain the same outcomes as their peers.

Neither of these approaches will be able to take into account the additional costs of providing support to these adults. As we saw above, there is considerable evidence to suggest that early SLCD continue into adulthood, and are often associated with mental health and social functioning problems in adulthood.

There are, however, two issues concerning the use of long term studies of the types described here that require consideration.

First, these studies tend to focus on the subsample of children with significant speech, language and communication difficulties, i.e. those likely to require specialist (or targeted) services and for whom SLCD are their *primary* area of need. Extending studies to the much larger group of children with SLCN (up to 50 per cent in some areas) introduces new methodological challenges. For example, the Law et al (2008) study is based on a total of 406 children out of 9613 children.

Second, the context in which young people are educated and receive other support (e.g. speech and language therapy) has changed greatly over time: compare the educational context for a child in BCS70 aged 5 in 1975 with the provision for a 5 year-old in 2005 (see Lindsay & Dockrell, 2008 for a fuller discussion).

#### **4.5 Conclusions**

- The existing research literature is insufficient to act as a base for a robust estimation of the costs and benefits of investment in services for children with SLCN. Far more research is required to understand for whom and under what circumstances treatment is more cost-effective.
- Strand 1 of this study (Section 3) addressed the question of whether there are sufficient locally available data from the local authorities and schools to assess either cost-effectiveness or cost savings. Although such data do exist in some of the six authorities sampled, such data sets are not comparable across LAs and would not be able to provide cross authority comparisons.
- There was no evidence for the integration of LA and SLT data which would have the potential for costing across services. Any comparison of costs within and between services could only be carried out once a predetermined set of criteria were agreed.
- Cost-effectiveness analyses should be undertaken rather than cost-benefit analyses: too often the term 'cost benefit' is used to describe studies in which the benefits are



estimated as financial savings and have little to do with outcomes. Cost-effectiveness studies allow joint analysis of costs and outcomes to assess which option represents a better use of scarce resources.

- Cost and cost-effectiveness evaluations should be incorporated into outcome studies. This will allow a body of evidence to develop over time. Care should be taken to ensure that the sample size is adequate and that the cost measure is sufficiently broad to encompass all areas where the impacts of SLCN are likely to be felt.
- The analyses will require specific skills and a similar level of rigour as required in an outcome evaluation. Extra funding will be required for the economic component, although the marginal cost to the research funding organisation will be relatively small.

## **5. DISCUSSION**

Before going on to discuss specific issues which arose from this study it is worth reflecting on the progress made since the 2000 report commissioned by the Department for Education and Schools and Department of Health on the provision of services for children with speech and language needs (Law et al, .2000). The first thing to observe is that there are many commonalities across these two research reports. It is clear from the very existence of the Bercow Review that there is a continued pressure to recognise the importance of speech, language and communication and this will be reflected in the recommendations of the review itself. With respect to speech and language therapists, in general there has been an incremental change to the way that they work with children with SLCN in schools, becoming more integrated into the practice of the schools, with a better understanding of the curriculum.

That said, there remain issues about the initial training of both teachers and therapists in this respect. Commissioning of services continues to be a major issue but much has changed since 2000. Equity of delivery remains a major concern but as we found in the present study this requires good data collection across health and education and, in most cases, this is simply not available. Similarly lack of good data, or limited analysis of existing data, make effective strategic planning across agencies difficult. In places where good collaboration between health and education services exists, new resources have been allocated to address the needs of children with SLCN.

Many of the recommendations in the earlier report have direct application to services at local level. As the present report indicates, these services have continued to develop across time but using very different models and with very different levels of collaboration. Work has been carried out by both the public and the third sector to improve the level of training available to those working with children with SLCN but, as we found in this study, the experience on the ground can also be fairly ad hoc. No research came out of the recommendations made in the earlier report. This continues to be a major issue and is picked up in the recommendations in the present report.

### **5.1 What are speech, language and communication needs?**

In Section 1.2.2 we discussed the nature of SLCN arising out of different patterns and causes of speech, language and communication difficulties. It is evident from that section that the group is highly heterogeneous and this presents a number of challenges to policy

makers and practitioners, as well as researchers. The latter often have the ‘luxury’ of being able to define their sample for the purpose of the research study. Policy makers, and practitioners, including teachers, however, must deal with children and young people with SLCN as they present. In Section 1.2.2 we referred to variation with respect to causality including the common distinction between primary and secondary speech, language and communication difficulties; associated difficulties (comorbidities); changes over time in the nature of the primary problem and the nature of any constellation of difficulties and hence of needs.

The case studies identified that these factors present very real challenges in terms of policy and practice. For example, the case studies have indicated a significant problem with consistency of use, and indeed of conceptualisation of the term SLCN used in education. This has implications for policy making and practice. One of the major reasons for this confusion is the nature of the term SLCN itself: as discussed here, it is highly heterogeneous. A second factor is the involvement by LAs and schools with the School Census (previously PLASC). This data collection system requires that in the case of a pupil with SEN, the primary need must be specified (a secondary need may also be specified). There is a superordinate category of Communication and Interaction Needs, below which are two subordinate categories: ASD and SLCN. In all other cases the superordinate category also refers to needs (e.g. Cognition and Learning Needs) but no other second order category uses the term ‘Needs’; rather, these categories are ‘Difficulties’ (e.g. Moderate Learning Difficulties) ‘Impairment’ (e.g. Visual Impairment) and Autistic Spectrum Disorder. Furthermore, as discussed above, SLCN can also be used to cover a much wider group of children – but those with other *primary* difficulties will be classified in the School Census, presumably, by that other primary need, e.g. hearing impairment.

Consequently, and as revealed in this study, there appears to be differences in practice resulting from different use of the concept SLCN. This is also seen when data from LAs are examined – see Section 5.3 below. Different practices have been revealed among these six LAs, Some are conceptual but others are pragmatic. In one LA, for example, difficulties in accessing an SLT was reported to lead to a focus on the child’s general learning difficulties, as evidenced by literacy difficulties, and to access banded funding for support by this route.

The relationship between SLCN and ASD has also been identified as an important factor, supporting the results of a national survey recently (Lindsay et al, 2002; Dockrell et al, 2006). In the School Census, SLCN and ASD are separated requiring that children’s primary needs are attributed to one or the other. Again, however, we found that this was complicated.

Distinguishing ASD from SLCN is problematic conceptually and in practice and the result appears to be varied practice. Also, LAs have developed different practices with respect to provision. Whereas perhaps 20 years ago LAs would have language units, now their comparable provision (integrated resources) are likely to have many if not a majority of pupils designated as having ASD.

Related to this confounding of categories is the overlap with the category Behavioural, Emotional and Social Difficulties. Distinguishing between children and young people whose difficulties are 'only' language, or to be classified as on the autistic spectrum, or language but with aspects of BESD is challenging: again, the indications are of varied practice.

It is important to stress that these LAs, schools and SLTs are seeking to make sense of a number of different systems concerning identification, assessment, the making of provision to meet needs, and the national data monitoring system through the School Census. Central to the problems revealed here are the heterogeneity of the term children who fall within the category of SLCN and its existence as both a superordinate construct, as used in the Bercow Review, and a subordinate construct, as used in the School Census.

## **5.2 The coherence of provision in primary and secondary schools**

Factors affecting the inclusion of pupils with SLCN into mainstream schools can be considered within a two-dimensional model. One dimension will be that of the severity/high or low incidence of the difficulty; the second will be that of the level of coherence in practice across the authority and within schools.

Characteristics of high coherence include:

- Health and education working well together
- Schools and external providers/agencies working effectively together
- Strong belief in within-school collaboration to remove barriers
- Strong belief that every institution should be able to modify their pedagogy and curriculum offer in a way that benefits a wide number of pupils with SEN, including SLCN, backed with appropriate professional development, such as the inclusion development programme (IDP) and the commitment of curriculum leaders to the task
- Belief that appropriate teaching and curriculum development for pupils with SEN will benefit all

- Monitoring and evaluation that checks for these characteristics across the local system

Characteristics of low coherence include

- Health and education not working well together
- Schools and external providers/agencies not working effectively together
- Strong belief in schools that external agencies are needed in all matters to do with SLCN
- Strong belief that most teachers should concentrate on the pupils that they can teach and leave those with SEN to work with someone special, like a teaching assistant, or in somewhere special, like a unit or special school
- Curriculum development separate from support for pupils with SLCN
- Monitoring and evaluation that does not draw together local data on outcomes on SLCN.

‘Coherence’ in this sense is not the same as ‘inclusion’: it is used to suggest shared ideals and structures that work together for collaborative practice across an authority and with and within its schools to achieve the best outcomes for pupils for all pupils with SLCN.

#### *Primary provision*

**CS1** There was some evidence of a high degree of coherence across its primary provision for pupils with SLCN as their primary need, with empty places in the resource bases, a strong commitment to supporting pupils in mainstream schools and a resource base that is exactly that, with pupils normally placed in mainstream classrooms. The health and education services are working successfully within a whole system framework. At least one resource manager was clearly committed to whole-staff training approaches.

**CS2** provides a less coherent model with some provision in special schools, concern about the future for inclusion without specialist support services and little evidence of substantial support from the schools taking on pupils with SLCN without funding. There was no evidence of a clear training policy. Much of the SLT service work was described as clinic-based. Ideas of shared responsibility through collaborative work ‘...were not always well received.’ However, there is increased within-school provision at the low incidence/severe end of the spectrum.

**CS3** is moving towards substantial coherence in the overall framework of provision with its cluster lead schools and collaboration between health and education at a high level. It has for some time provided strong support to coherence within schools through its primary support team of EP, specialist teacher and SLT working within a systemic school model (see Figure 6). The policy on training reinforces this approach.

**Figure 6**

**Case Study 3**

This case study has a tradition of excellent relationships between health services and education. The strong links have enabled them to put in place early years provision that directly targets the institutional development of nurseries, as opposed to an approach based on individual need. This programme, known as SPARKLE, is important both for the multi-disciplinary teamwork it has developed (EP, specialist teaching assistant, SLT, and OT) its commitment to careful monitoring of impact through partnership with a university team. It has wider significance:

- The approach is designed to benefit all children including those with SLCN.
- The model uses support provided systematically over time to optimise change.
- The commitment to rigour in monitoring and evaluation has enabled the work to develop coherently and successfully.

At primary level a similar approach is adopted. In this case an EP, a specialist teacher and an SLT provide additional support to primary schools working within a strong systemic model combined with support for individuals. Once again this team is valued across the local area and benefits from its multidisciplinary nature and systematic impact over time.

The model has wider significance because:

- It is not common to find system-based interventions that work effectively across a local area.
- As with SPARKLE, the team approach ensures that both high and low incidence SLCN are recognised and appropriate intervention taken forward
- The approach is designed to benefit all children, not just those with SLCN.

Note: the success of the approach depends on specialist teacher input as well as that of the other professionals. There would be concern if increased delegation of funds to schools caused any elements of the team to be withdrawn: the impact of the team working is seen as far greater than that possible by individual services.

**CS4** has a developing and coherent model of primary provision across the authority with mainstream schools co-operating to bring low incidence SLCN onto their sites, as well as using the strong LA support to improve provision across their systems. The aims set out in the SLT service evaluation system are strong evidence of a service seeking to monitor the coherence of its practice. The SLT service has shifted its training policy to an increased emphasis on joint working within the classroom.

Evidence from **CS5**, suggests limited coherence overall, (no mainstream heads were interviewed in **CS5**), with some disagreements between schools and LA in terms of SEN provision. The SEN manager indicated that some special provision was still maintained because many mainstream schools were not yet ready to accept a broader range of pupils with SEN. Training policy appeared to be driven more through individual needs than by a comprehensive LA training policy for SEN. Multi-disciplinary assessment is an encouraging feature, but the under-provision in the SLT service must make the prospects of collaboration on many forms of intervention less likely.

**CS6** shows substantial coherence on SLCN. No pupils with SLCN as their primary need are in special schools and the resource centres for SLCN and ASD are working effectively with pupils' local schools. EPs, specialist services and the SLT service all make contributions to training. The different boundaries of the PCT and LA have raised some issues but re-structuring to address these is underway.

#### *Secondary provision*

It is much less easy to characterise coherence in secondary provision for SLCN from our study because:

- there is little provision for the more severe end of the SLCN continuum, particularly from SLT services. This issue surfaced in the responses to the questionnaire distributed as part of the Bercow Review (see the Interim Report, DCSF, 2008a): respondents to a question (Q4a) on the family's overall experience of SLT services reported 'an acute shortage of therapy provision in secondary schools'. Provision tends to be in special units or schools.
- in a brief study like this one, an in-depth view of secondary school practice is not possible. So while there may, for example, be 'coherent' practice on high incidence SLCN within individual schools we were not able to hunt it down and comment on it.

Even if we cannot complete the model, some patterns can be discerned. As might be expected, they are similar to those found in primary provision.

**CS1** is unusual in that pupils with SLCN are able to benefit from SLT support in mainstream secondary as well as primary schools. There are no secondary resource bases.

**CS2** has some support for mainstream pupils at secondary level with an ASD resource at one school. This school had also made provision for pupils with SLCN, but finance came through banded funding for individual pupils, not because the school was designated by the LA as a resource for pupils with SLCN. The LA's SEN manager worried about the effect delegated funding would have on support services working to support the inclusion of children with SLCN. There is no SLT service to secondary schools.

The area of **CS3** studied has no SLT service for secondary mainstream schools, beyond assessment of pupils thought to be on the autistic spectrum. It may be that the increasing number of resourced secondary schools (Table 5) will be able to improve provision; the SLT service is also hoping for funding to increase its secondary operation. The service has recently 'rationalised' its provision to special schools and moved towards a more system-focused approach.

**CS4** has two substantial secondary resource bases and their plans include the intention to move more of their support into the mainstream.

**CS5**, as in the primary phase, offers a less coherent model of provision. The secondary specialist SLCN resource in this study now only includes pupils with ASD. There is no specific SLT provision for secondary schools, but they provide training for secondary staff.

**CS6** seems to have no secondary educational provision specifically for SLCN, though pupils with severe SLCN may well be in its special school for S/PMLD pupils which has SLT service support. However, the head of the special school in this study indicated clearly that the school did not have any pupils with SLCN as the primary need.

In the absence of detailed evidence about secondary provision across all LAs in this study, we need to consider the possibilities.

- It might be argued that in resource-limited situations it is right that there should be less support available at secondary level while early intervention is emphasised. Early intervention may have reduced the number of concerns by secondary schools.
- There is certainly a strong case for encouraging early intervention: the literature suggests it helps in many cases. None of the authorities in this study produced detailed evidence of the success of early intervention.



- Research elsewhere has consistently suggested there is a substantial ‘co-morbidity’ between SLCN and BESD and while concerns about levels of BESD in secondary schools remain high, we should be cautious about accepting that intervention in the primary phase has removed all barriers for pupils with SLCN. The difficulties may simply have been re-labelled.
- An approach based on an appropriately modified curriculum will remove many barriers to learning and participation for secondary pupils with high incidence/less severe SLCN. This is something that mainstream schools, particularly given delegated funding for SEN, should be able to implement on their own.
- However, research evidence from other studies (e.g. Dockrell et al, 2007) suggests that there is an association between a history of primary speech language and communication difficulties and continuing difficulties with literacy development and accessing the curriculum at KS 3 and 4. Therefore:
  - it would be optimistic to believe that removal of barriers by an appropriately modified curriculum is the case in every school, for example in each of the four authorities that do not report significant collaboration on SLCN at secondary level
  - it might be more appropriate to make more cautious assumptions about the coherence of practice in many secondary schools, in particular in relation to appropriate curriculum offer
- Certainly the data from LAs 2 and 5 on school attitudes suggest limited interest from many of their schools in collaboration on provision for pupils with SLCN. It is however encouraging to note the resourced school model being developed in **CS3**. These schools will have responsibility for supporting other schools in their locality on specified areas of SEN and offer one way ahead in a delegated system. It is hard, however, to see how they will be able to offer appropriate assessment and support for pupils with persistent SLCN, particularly where attitudes need challenging, for example in relation to the identification of BESD, without substantial input from SLTs.
- Overall, the data suggest that pupils with SLCN in the primary phase benefit from much more effective collaboration and coherence across authorities than do those in secondary schools. The single most striking finding for policy makers, however, must be the lack of evidence of a systemic monitoring and evaluation system that can be used to develop practice in most aspects of authority/school/health service provision in the SLCN

field and provide evidence of the effectiveness of interventions. This seems to be a particularly important issue for SLT services to address. There is a need for this to be reinforced within the professional agenda for both primary and secondary phases. This will require an approach that recognises that at every level from authority-wide statistical returns to the pupil tracking of the small primary school we are data-rich but that the data-analysis systems are not coherent. However, it is also important to recognise the problems with classifications identified in this study, an issue that must be addressed in order to improve the reliability and validity of any monitoring. Furthermore, the integration of monitoring systems between education and health services must also be addressed. It is noteworthy that one of the reasons for positive developments in the case studies was that the authorities in question have come together and funded local activity which has a knock on effect on joint thinking about the issue of SLCN. We address these issues in Section 5.4.

We can be optimistic about many of the primary phase inputs we were able to see in our study, some of which were so well thought through and coherent that it seems likely that outcomes will be positive. It is not possible to feel the same optimism about secondary provision, which from our knowledge of other studies does not always prioritise whole-school provision for SEN and SLCN. This position seems to offer an unacceptable level of risk to pupils and parents and carers. An explicit description by all secondary schools of provision for SLCN, available on their websites, would allow parents and carers to take a view of what is on offer.

### **5.3 Integrating specialist and universal services**

#### **5.3.1 *SLT s working in school***

There was considerable variation in the extent to which SLT services for children and young people with SLCN were integrated with education support services, but there was a trend towards an increasing number of SLT posts funded by education, with some SLTs spending the majority of their working time within school settings. This raised questions of management, skills needed to work within school environments, and daily working practices compared with working in hospital or community clinic settings.

Accompanying this change in setting is an increase in the time SLTs spend in consultation, support and training rather than individual or group clinical work. These changes in working practice demand a different range of skills compared with those needed for clinic based

work. Consultation and support work in schools may involve working with teachers and other support agencies to differentiate the curriculum, develop materials and innovative teaching and learning methods to widen access to the mainstream curriculum for children and young people with a range of SLCN. Another innovative area of work involving SLTs was the project with BESD pupils with SLCN, working to reduce exclusions from school and involvement with the youth offending system.

A number of issues need to be considered:

- What skills are required by SLTs to work in these ways? Are these skills developed in initial professional training courses, or is there a need to develop specialist CPD courses to ensure SLTs have the skills and professional support to work in these new ways? At least one SLT manager interviewed felt that induction of newly trained SLTs needed to cover these aspects of work, and some schools indicated that, in their experience, not all SLTs allocated to them had the necessary skills to work in educational settings.
- Much of the work carried out by SLTs in school was highly valued, as indicated by the increase in SLT posts funded either by education, or directly by the schools themselves. However, it is not always clear that SLTs are the most appropriate service to carry out this work. Educational psychologists are trained in child development, including language development, and most are also experienced and trained teachers. Specialist support teachers might also carry out some of this work. As SLTs are a scarce resource, careful thought needs to be given to their role in consultation and curriculum support to ensure an optimal use of their skills. Working in multi-professional teams (SLTs, teacher, EPs and support teachers), with agreed roles and tasks for the different professionals will help address some of these issues.
- As SLTs spend more time in schools, line management responsibilities and working practices, documentation and data management need to be compatible with those of the school and education system, not simply reflect clinic based practice within the N.H.S. These issues were raised by a number of head teachers in the survey, and will need to be addressed by managers in order to develop supportive management systems.

### *Specialist support teachers*

As noted in Section 2.2 above, an increasing proportion of children and young people with SLCN are educated in mainstream settings, either in schools with specialist resource provision for primary SLCN, or included in a mainstream school with some support. The teachers in these settings may benefit from specialist peripatetic support services to enable them to educate children and young people with a greater range of SLCN. At the same time, delegation of SEN budgets to schools can cause problems for LAs funding centrally retained support services. Several LAs indicated they were working to increase outreach work of teachers in special schools and specialist resource provision to allow the expertise of these specialist staff to be shared with mainstream colleagues. The reality in many of the specialist provisions visited in this survey was that staff in these specialist provisions were already working under considerable pressure within their home institution and outreach work was difficult to deliver within the constraints of their teaching and administrative load.

### *Educational psychologists*

Across the six LAs in this survey EPs carried out a wide range of tasks. In one LA the SEN manager was an experienced EP, and in another LA the banded funding scheme had been developed by an EP. In most authorities an EP served on the SEN placement panel or on the group responsible for allocation of banded funding. In one authority EPs were involved in supporting schools to draw up the school development plan. In many authorities EPs, often in cooperation with SLTs, were involved in some training of teachers and teaching assistants. Involvement of EPs in research and evaluation, however, was mentioned in only one LA.

At the level of routine school visiting for casework, involvement in termly or annual reviews, some schools in several LAs indicated that they did not have an allocated psychologist or an allocated time allowance of EP time. In those that did have a time allocation it was very small – 12 hrs a year was quoted by one large secondary school. It was not clear that specialist EP posts for SLCN existed in all LAs. One SEN manager raised the difficulties they had recruiting EPs, and said the service was both short staffed and under-funded. Other studies have noted the shortage of EP time for specialist work with SLCN (e.g. Kelly & Gray, 2000), and the role of EP services in the support of children and young people with SLCN should be investigated further.

## 5.4 Information management

Planning and performance management can be enhanced by the collection of reliable and valid data. Moreover, performance data forms the backdrop to the evaluation of services to examine efficacy and efficiency. The extent to which data are available, reliable and used was examined across the 6 case studies. In this section we consider these findings in the context of other data available. Of particular interest was the integration of information gathered, and used, by schools, SLTs and LAs. It is important to note the caveats regarding use of SLCN as revealed in this study, a point to which we return below.

First we consider the national context for SLCN using data provided by the DCSF on national pupil attainment data for KS2 and KS4 for pupils designated as having SLCN<sup>8</sup>. There were 5,460 pupils identified in KS2 and 2,030 pupils in KS4. National data indicated that 25% of pupils with SLCN obtained a level 4 in KS2 English, 29% maths and 45% science. However these averages masked significant variability between authorities (range 0 to 47% for English). Similar variation in achievement was evident in the KS4 data where overall 64% of pupils obtained level 1 passes including English and Maths but again there was a substantial range, from none to 100%. There were large variations in reported numbers of children with SLCN, with LAs with similar demographics reporting substantial differences in numbers of children with SLCN.

Tables 5 and 6 illustrate the relatively low numbers of pupils with SLCN as their primary need achieving the 'expected' level of academic attainments for the 6 case studies; there is less variation in the achievements of the case study LAs than in the national data. At Key Stage 2, 79% of pupils nationally achieved Level 4 and above in English in 2006, compared with only 25% nationally of pupils designated as having SLCN (at School Action Plus or with a statement of SEN) – the range for the case studies was 17-38%. The 2006 results for Key Stage 4 show a similar, indeed more concerning picture, with only 15% of pupils with SLCN gaining 5 or more Level 2 passes at GCSE (A\* - C) compared with the national 57% for all pupils; and only 6% of pupils with SLCN nationally achieving 5 or more Level 2 GCSE passes including English and Maths compared with 44% nationally – the numbers in the Case Study LAs were too low for analysis and are not reported by DCSF.

The DCSF now collect detailed attainment data on all pupils in LAs, as indicated in Tables 5 and 6 and these data have the potential to contribute to detailed monitoring systems. These

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<sup>8</sup> These data concern pupils with SLCN as a primary need. Consequently, they exclude other pupils designated as having other primary needs, e.g. hearing impairment.

data are based on the national systems of assessment (National Curriculum tests and GCSE and equivalent examinations at 16 years). Consequently, there is a need to supplement those with more detailed data at individual level using other measures although schools and LAs in our study were using these data to monitor progress for pupils with primary SLCD.

**Table 5 National Curriculum Levels 2006 for pupils with recorded SLCN in the case local areas Levels Key 2**

Local authority	ENGLISH		MATHS		SCIENCE	
	Eligible Pupils	Level 4+ (%)	Eligible Pupils	Level 4+ (%)	Eligible Pupils	Level 4+ (%)
CS1	220	21	220	26	220	42
CS2	35	21	35	21	35	39
CS3	80	38	80	46	80	52
CS4	80	17	80	22	80	33
CS5	20	38	20	29	20	57
CS6	-	-	-	-	10	-
<b>England SLCN</b>	<b>5,440</b>	<b>25</b>	<b>5,450</b>	<b>29</b>	<b>5,460</b>	<b>45</b>
<b>England all</b>		<b>79</b>		<b>76</b>		<b>87</b>

Note: No data are provided by DCSF where there is a cohort denominator or fewer than 11 pupils or fewer than 6 pupils in a percentage numerator

**Table 6 Percentage of pupils with SLCN in the Case Study authorities gaining Level 1 and 2 passes at 16 years in 2006.**

Local authority	Eligible pupils	Any Level 1 pass	Level 1 5 passes (%)	Level 2 5 passes (%)	Level 1 inc E&M 5 passes (%)	Level 2 inc E&M 5 passes (%)
CS1	95	85	61	9	53	-
CS2	15	93	50	-	50	-
CS3	25	88	71	-	67	-
CS4	40	77	56	-	51	-
CS5	35	100	91	24	88	-
CS6	-	-	-	0	-	0
<b>England SLCN</b>	<b>2,030</b>	<b>89</b>	<b>69</b>	<b>15</b>	<b>64</b>	<b>6</b>
<b>England all</b>		<b>97</b>	<b>91</b>	<b>57</b>	<b>88</b>	<b>44</b>

These analyses confirm the relationship between low attainment and pupils having SLCN as their primary designated special educational need.

Monitoring and evaluation of speech and language therapy by the PCTs in this study was limited. To a large extent this reflected the lack of relevant data although attempts to map activities were more common. Individual clinicians would set targets for children and record their relative improvement in case files, typically based on clinical judgment. In the one LA which attempted to analyze activities these were at a very general level or not linked to objective markers of outcomes. Training was evaluated by feedback and in some cases parent satisfaction was established through responses to questionnaires. However, these data were not linked to outcomes or changes in practice and no questions were raised about the reliability of these data. Where data did exist there was little evidence of using the data to link back to service evaluation, indeed data were not analyzed due to time constraints. Apart from one evaluation, *Sparkle*, it appeared that little use was made of external agencies to support evaluations and links to educational outcomes were not mentioned.

In contrast to the PCTs, LAs had access to a wide range of data, often held in the statistical division and primarily comprising those data passed on to DCSF as shown in Tables 5 and 6. Use of the data was limited and, typically, not used to coordinate activities. Checks were sometimes used to ensure that provision was delivered, but not to monitor progress. Ofsted reports were cited as providing valuable monitoring information; however the appropriateness of these reports to evaluate provision for children with SEN has been challenged (Flockton, 2005). As with the professionals in the PCTs individual monitoring activities were common place. Thus schools used National Curriculum levels, IEPs and some standardized assessments to monitor the progress of individual pupils. These data were reported to inform professional judgment, but it appeared that the data were not used to feed into and develop practice. Focus on individual data alone raises concerns about the reliability of the decisions made on the basis of these data. Not all respondents were confident in the validity and reliability of the data collected, specific concerns were raised about use of PLASC (now School Census) categories.

A number of interviewees reported that they were in the early stages of establishing monitoring systems but it was not clear how the systems would be developed and there was little attempt to build in the potential to examine cost effectiveness. Links with PCTs for this initiative were absent.

In sum, information from both PCTs and LAs indicated that individual practitioners were often attempting to monitor their activities and in some cases this monitoring could be conceptualized as evaluation of the efficacy of the intervention. However, the failure to collate and interrogate data across and between the relevant services meant that it was not possible to evaluate the efficacy of system changes, types of provision or intervention effects. Effective monitoring and comparative analyses were also compounded by apparently different interpretations of 'SLCN' in LAs' systems for completing the School Census. This dataset is a very important resource and has been used successfully, for example, to examine over- and under-representation of pupils from different minority ethnic groups with respect to SEN (Strand & Lindsay, in press). There is a major need to guide schools and LAs in order to improve the accuracy, and hence usefulness, of this resource.

From our evidence it appears that to make progress in developing effective, integrated monitoring systems four factors are important:

- Bringing together such data requires time. Dedicated part-time posts in front-line services, backed by explicitly collaborative systems at LA and PCT level and appropriate use of higher education institutions for support with specific reviews, will help.
- SLCN, ASD and BESD figures for an authority need to be explored and shared to encourage all professionals to challenge themselves on how the identifications are made and how they affect attitudes, practice and outcomes for the children and young people concerned.
- All the Every Child Matters outcomes need to be valued and their achievement monitored. Substantial progress towards this has been made in recent years, but the persistent belief that academic success is all that matters needs to be challenged by all senior managers including those leading local authorities and governing bodies and head teachers. The pursuit of data on literacy and numeracy and other academic areas can divert schools and others from developing the systems needed to monitor other outcomes, and can seem to devalue the broader aims of the Every Child Matters agenda.
- Furthermore, there is a need for LAs, schools and PCTs to develop *integrated* systems of data collection and analysis. This has been a frequently noted difficulty



across education, health and social services but studies have indicated that integration is possible (Rigby et al, 1999)

## 5.5 Training and professional development

In order to support the development of a coherent service for children and young people with SLCN, LAs and PCTs need to address the post-qualification training needs of their staff and the government needs to consider the pattern of initial training. Speech and language therapists and educational psychologists are an important resource for the development of practice in front line professionals such as teachers. A programme for training and professional development requires consideration of their needs and their input to meet the needs of front line staff.

Five of the case studies had a strong commitment to awareness training on SLCN. There were also examples of staff undertaking courses developed by other practitioners and made available, sometimes with course-specific accreditation, e.g. *Teaching Talking*<sup>9</sup> and *Elklan*<sup>10</sup>. There is limited availability of access to more sustained professional development programmes at university level. However, in one case study there was a commitment to a substantial programme of accredited training involving 60 professionals so far. Where university courses do occur, they are generally available to low numbers of professionals. CS6, however, has committed to a substantial programme of accredited training involving 60 professionals so far.

By the time pupils with SLCN reach Key Stage 2, training for teachers and TAs needs to encompass ideas on classroom practice (typically available on such courses) *and* curriculum/lesson development to remove barriers to the learning of such pupils. The latter appears to be far less common. Significantly, when this occurred services also favoured a multi-agency skill-sharing and modelling approach to professional development: this allows partnerships on school sites between the school and service teams to develop.

Curriculum/lesson development is even more vital in the secondary school in which the increasingly abstract and theoretical nature of curriculum can present many barriers to those whose communication is impaired in any way. This approach also appeared to be uncommon in the six case studies. There is, of course, much secondary schools could do on their own in this area that would not have been picked up by our brief study.

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<sup>9</sup> Locke, A. & Beech, M. (2005). *Teaching Talking (2<sup>nd</sup> edition)* Windsor: nferNelson

<sup>10</sup> [www.elklan.co.uk](http://www.elklan.co.uk)

More specialist training for practitioners with children with complex needs is also essential. Several SLT services reported courses targeting augmentative and alternative communication, including sign and symbol systems. Two told us of specific courses on severe and complex difficulties, though it was clear that others, as would be expected, offered forms of professional development through more informal approaches relating to groups and individual pupils. Specialist education and SLT services are involved in a range of training events on autistic spectrum disorders.

In developing policy and practice it is necessary to consider three major issues:

- The comprehensiveness or otherwise of the professional development on offer in terms of the knowledge, skills and understanding required for supporting pupils with SLCN.
- The comprehensiveness or otherwise of professional development in terms of the groups to whom it is offered and the take-up of the opportunities available.
- The appropriateness of the delivery styles adopted for the professional development. This relates to the role and responsibilities of the professionals involved.

As in other areas of this study, the data suggest an inconsistent picture. The range of continuing professional development on offer varies from the relatively comprehensive in the primary years to the offer only triggered by individual cases. At secondary level the offers found were slimmer still. Respondents who reported a relatively full offer sometimes noted how difficult it was to guarantee that the groups at whom the training was aimed attended the courses. Overwhelmingly, the most typical form of training available was the unaccredited short course. Some services, encouragingly, had appreciated the power of school/setting based training and had moved to models that involved skill-sharing and modelling followed up by support within the classroom for course participants.

Web-based media to disseminate training offer an opportunity to reach larger audiences and the DCSF's Inclusion Development Programme's roll out provide useful resources to be developed: for example, CS3 has a strong record of developing electronic packages to support (for example) teachers and teaching assistants in work on language.

Behind the detail of what was or was not on offer was a fundamental issue: the way in which services, settings and schools conceptualised what they should be doing to improve outcomes for pupils with SLCN. This relates to their construction of special educational

needs. If inclusion of children with SLCN is to be successful, professional development for school based staff needs to:

- empower all staff to reflect on and learn about communication: much of the relevant knowledge applies to all pupils including those with SLCN
- create an environment in which communication and comprehension are enhanced in every aspect of school life
- improve the learning and outcomes for many pupils across the curriculum, because speech, language and communication are important for so many aspects of education
- ensure that pupils with SLCN experience far fewer barriers to learning and participation because so many aspects of the environment (including pedagogy and curriculum) have improved

The evidence from the case studies suggests that a much more systematic approach to professional development is needed if barriers to learning and participation are to be removed for all children and young people with SLCN.

## **5.6 The cost effectiveness of services for children with SLCN**

As part of this project we were asked to ascertain the feasibility of carrying out a cost-benefit analysis of investment in services for children and young people with speech, language and communication needs. This involved a review of the existing literature and a matching of a set of external criteria to what is already known about outcomes for children with SCLN. There are few economic evaluations of services for children with SLCN. A total of four studies were identified but they tend to be narrow in focus, limited in terms of the follow-up period and they include relatively few participants. We also looked at existing birth cohorts and existing education data sets. The cohort data sets (e.g. NCDS and BCS70) have the potential to inform the process in terms of long term outcomes but they tend to be restricted in what they say about the levels of SLCN and understandably, given their long term outcomes, tend to include limited relevant educational data. The data held locally in educational and speech and language therapy services also have the potential to inform economic analysis. However, we found that, while such data sets do exist, they are rarely compatible across LAs because of differences in the terms used to define SLCN. Nevertheless, it is probably true that such datasets are under used and more that can be done to exploit them.

## **5.7 A research agenda**

The previous sections have discussed the implications for various aspects of practice as identified in this small scale project focussing on six case study LA and PCT pairs. This discussion has also indicated possible development of policy and practice. In this section we consider what might be an appropriate research agenda to support the development of policy and practice.

We propose a research programme with five main research areas which together provide a comprehensive approach which can also provide a coherent research strategy. We propose that cost effectiveness should also be built into the research agenda as this is an area where evidence is seriously lacking, particularly studies of interventions. For clarity we present proposals for this area separately. We also present two models for implementing the research strategy. In addition it is important to stress that the programme we propose focuses on *applied* rather than fundamental research into the nature of speech, language and communication difficulties. The programme emphasises the importance of research which is of relevance to practice and policy.

### **5.7.1 Interventions**

We propose that interventions are the core of the research programme. However, this concept needs unpacking. First, it is helpful to distinguish the following issues:

- locational (e.g. special school. Integrated resource, mainstream)
- pedagogic (e.g. specific programmes for specific needs)
- organisational (e.g. nature and deployment of support services,
- employer base interaction (e.g. use of consultancy model v direct teaching/therapy)

The DCSF does not have a history of funding research which examines the effectiveness of specific programmes, unlike in the US where for example there is a stronger tradition of focussed and rigorous studies into specific programmes. The research councils (e.g. ESRC) and charities (e.g. Nuffield) are more likely to fund such research. However, an alliance between DCSF and, say, Nuffield could be a productive way forward at this level, joint funding of some trials of well developed interventions. There are now two or three manualised interventions which are almost ready to go to effectiveness studies.

The What Works Clearinghouse<sup>11</sup>, Campbell Collaboration<sup>12</sup> and the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre)<sup>13</sup> have begun to include profiles of interventions, their target population and efficacy. There is a need to consider creating a similar database/review that addresses the varying needs of this population and the professionals who work with them. This would require an extension of the current reviews of SLT to include

- Educational interventions targeting the pupils' specific associated needs such as literacy, numeracy and social emotional dimensions
- Interventions which purport to support practitioners' skills in supporting children and young people with SLCN at different curricular phases.
- The importance of different provision in meeting pupils' needs

These reviews could, where possible, include cost-effectiveness data.

The challenge within SLCN is to develop interventions which are feasible in the normal world of mainstream classrooms settings where there are significant competing demands on staff and heterogeneous groups of children with SLCN, as opposed to the more controlled settings of the specialist intervention or therapy session. In terms of the majority of children and young people with SLCN it is the former that is more likely to apply. Hence, interventions must be conceptualised as more than specific programmes but rather as *systems* where location, pedagogy, organisation and their interaction are all fundamental. For example, which teams? working in what configurations? on what elements of SLCN? in the settings in which the children and young people are educated show effective practice?

A way forward here is to identify approaches that have evidence for effectiveness and then to roll out a small number across pathfinder LAs – the Parenting Early Intervention pathfinder funded by DCSF is a good example of this model, whereby three evidence-based parenting programmes were rolled out across 18 LAs and the roll out was evaluated. Evidence from this study is now influencing the further roll out over the next three years across more LAs. Hence, this approach combines aspects of rigorous study of specific programmes within an ecological framework, i.e. the reality of educational provision. The study would examine not only the evidence of the programme itself but also the factors which supported its effective implementation in the 'real life' setting of diverse LAs and schools

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<sup>11</sup> [www.ies.ed.gov/ncee/wwc](http://www.ies.ed.gov/ncee/wwc)

<sup>12</sup> [www.campbellcollaboration.org](http://www.campbellcollaboration.org)

<sup>13</sup> [www.eppi.ioe.asc.uk](http://www.eppi.ioe.asc.uk)

Note that this approach avoids the pitfall of rolling out 'good ideas' before the initial stage of evidence gathering has been undertaken. It also respects the reality of the situations in which children and young people are being educated and avoids an inappropriate and limited focus on 'clinical' interventions alone. It also allows a more refined examination of issues concerned with location (e.g. mainstream v specialist provision) and could inform LA policy in terms of overall provision

### **5.7.2 *Intensive longitudinal studies of children and young people with SLCN***

A separate longitudinal design takes a sample of children and young people with SLCN and follows them up over time. This complements the large scale studies (4.6.3) as more detailed information can be gathered through individual assessments, also interviews/observations etc with the children and young people, parents, teachers and other professionals. Such a study also reflects the current educational context. The Bercow Review Interim Report (Bercow, 2008a) refers to the evidence gathered to date from one such study which demonstrates the power of the method (Dockrell et al, 2007).

In terms of priorities (see also below) the secondary (KS 3-4) phase is important because of the relative lack both of provision and data. At this phase it is important to establish how curriculum differentiation is achieved, the specific educational challenges for the children and young people and the ways in which accommodations and differentiations result in improved performance. Of particular importance is the identification of how the pupils' competencies are supported in order to meet the demands of further education opportunities. This would also link to the development of the 14-19 curriculum and the government's proposals for the post-16 phase. This would therefore be an opportunity to examine needs for this group of children and young people with SLCN and to include investigation of their own perspectives.

It is important in such studies to be able to relate the SLCN findings with those of others with SEN and also typically developing children and young people. Appropriate comparison groups are therefore necessary

### **5.7.3 *Large scale and long term population data***

Large scale data sets are available from two sources: the DCSF national dataset on all pupils in the state system (about 6.5 million) and the longitudinal studies (e.g. Millennium, ALSPAC). These provide rich sources which are complementary and so address different issues.

The DCSF data set provides a rich source of current and recent data on SLCN (and other SEN). The first issue is to examine the underlying validity of the data and the use to which it is put, by DCSF and LAs. Our initial findings from the current study suggest that LAs are now rich in data but are not always using the information in the most effective way. A study of effective data usage would be beneficial to provide guidance to LAs to improve their practice of intelligent data usage.

In addition, however, it is necessary to examine the data per se. For example, how are children and young people identified as having SLCN or ASD? This includes issues of LA practice, consistency and validity of data and the implications arising there from for effective planning.

The birth cohorts allow studies relating SLCN with the population as a whole and to look at the relative impact of demographic and within child factors and the way that this informs adolescent and adult outcomes. The moderating effects of behaviour and SES are two key issues particularly given the association between SLCN and BESD, for example. The focus could usefully be on resilience factors leading to 'coping' with SLCN, and indeed in overcoming these difficulties (in some children and young people). This theme could usefully include a health economist element also to examine the costing of outcomes or at least working out what one would cost

#### ***5.7.4 The service user perspective***

There is a benefit in knowing more about what those with SLCN, their parents and teachers think about what is needed. There is a case for studies at different ages. However, we consider that this is more profitably seen as a theme within other studies rather than a substantive research area itself.

#### ***5.7.5 Research strategy***

In order to optimise the benefits of this concerted research programme it is also necessary to consider the strategy for implementing the research. We present two main options:

1. DCSF determines priorities and devises a series of studies for which it invites tenders for each individually
2. DCSF funds a 'Centre' to undertake the research programme for a set period (e.g. 5 years) renewable.

The latter has the benefit of focusing the research endeavour into a coherent programme allows explicit and continued national and international collaborations related to policy and practice. It requires confidence in the researchers selected to run the Centre but this model is well established by ESRC and indeed the DCSF funds such Centres already. Safeguards, therefore, are known (e.g. regular reporting, reviews including external experts). The Centre would need access to the range of researchers that could carry out the studies prioritised but the core staff could also be enhanced as necessary by additional staff for specific programmes. This would also provide the basis for a dissemination programme aimed at policy makers and practitioners.



## 6. CONCLUSIONS AND RECOMMENDATIONS

### 6.1 Conclusions

This research study was commissioned to explore two main issues:

- i) whether there is evidence on which to base recommendations to improve the effective and efficient use of resources in services for children and young people with speech language and communication difficulties (SLCD); and
- ii) the feasibility of a cost benefit analysis for investment in services for this group of young people.

This report presents the findings of both strands. In these conclusions we draw together the evidence from our six case studies (Section 3) and the economic analysis (Section 4).

A striking feature of the case study element (Strand 1) is the substantial degree of heterogeneity in services. This is a characteristic found in the earlier studies by Law et al (2000) and Lindsay et al (2002). It is evident that over the intervening period there has not been a clear movement towards more common approaches. This raises the question of the degree of (in)equity that is present in the system: it appears that this is still substantial. The question of whether heterogeneity is in itself a positive or negative attribute of a system is not straightforward: local variations in the demographic profile may legitimately require variations in provision. For example, more disadvantaged areas are very likely to have more children with SLCN. However, our study suggests that the variation cannot simply be accounted for by this benign interpretation.

A number of positive factors have been identified by our study although their description will typically be accompanied by significant caveats and cautions.

#### *Terminology*

The term 'speech, language and communication needs' is contentious. It may be used to cover a wide range of children with needs in these domains arising from different factors, both intrinsic to the child (developmental difficulties) and extrinsic (related primarily to factors in the child's environment, including family disadvantage). This range renders assessment of the efficiency and effectiveness of different arrangements problematic. Not only is it

necessary to consider different groups of children and young people, it is also evident that LAs vary in their approach to the SLCN group as a whole.

### *Data*

To develop effective and efficient use of resources it is necessary to have *evidence*. We have shown that LAs are data rich and these data are also available in aggregated form to explore the national picture. This is a highly impressive resource and possibly unique in scale internationally. However, this resource is under-exploited at present. In particular, LAs need to ensure close collaboration between policy and data analysis staff to optimise the use of available data for policy and practice purposes.

Primary Care Trusts lack such an extensive resource. There is also a lack of integration, in general, of data from LAs and PCTs. Furthermore, there is a lack of systematic data collection within LAs and PCTs which is fine grained enough to monitor those children and young people making relatively slow improvements. Hence, there is the basis of a useful information system to support effective planning, monitoring and evaluation but more needs to be done to optimise its usefulness.

### *Coherence of service delivery*

Our evidence suggests that LAs and PCTs differ not only with respect to provision (e.g. the use of integrated resources) but also in terms of the coherence of the integration of education and health services. The need for these two services to develop 'joined up' policy and practice was identified in the earlier study by Law et al (2000) so it is disappointing to find the relative lack of this occurring. Where there is such integration, the results appear positive, confirming the importance of addressing this issue.

One of the challenges in this respect is the commissioning of services. In 2000 this was in its infancy. Our study did not specifically examine commissioning but it is evident from the information we gathered that relates to this topic, and the input into the Bercow Review, that there is a major need to examine this issue.

At present there is a lack of evidence for a 'best practice' or even 'good practice' model. Our conclusion, therefore, is that models of commissioning should be examined relative to local circumstances. In other words, we consider that it is possible that more than one model might be effective and efficient depending on the specific factors for LA and PCT partnerships.

### *The effectiveness and efficiency of service delivery*

Our study suggests that it is not possible at present, to assess the efficiency and effectiveness of different arrangements for organising and providing services for children and young people with SLCN. The lack of agreement about terminology, the lack of effective data collection and analysis systems and the lack of targeted research and evaluation studies of interventions seriously restricts any individual LA/PCT pair to assess effectiveness and efficiency.

To offset this rather negative judgment, it is important to stress that there are examples of practice that might be effective and efficient and could be the basis for more specific research and development. Some of this, rightly, is the domain of funders including the research councils and other major bodies such as the Nuffield Foundation. However, given the important policy and practice implications, this will benefit from, and indeed require, a research and development programme funded by DCSF, e.g. with the setting up of pathfinders in LA/PCT pairs which can be evaluated and used as models to roll out effective and efficient practice across the country. There is also a benefit in DCSF exploring a joint research programme with a funder such as Nuffield.

### *Cost effectiveness*

Given the lack of systematic and consistent data noted above it is perhaps not surprising that we have identified a similar, if not less developed, situation with respect to an economic analysis. At present there is a lack of evidence on cost effectiveness from studies; in addition, there is a lack of suitable data available, or at least used in practice, within LAs and PCTs. We conclude that analysis of cost effectiveness is the preferred economic analysis rather than cost benefit analysis. Examination of cost effectiveness is an important process to ensure that resources are used efficiently as well as effectively. This is important for public accountability but also for the welfare of children and young people with SLCN.

To summarise, we conclude that, at present, LAs and PCTs are not in a position to provide sound evidence for the efficiency and effectiveness, including cost effectiveness, of their use of resources for children and young people with SLCN. However, we consider that there are a number of examples of practice from which such analyses can be developed. The challenge is for DCSF and DH to engage with and support LAs and PCTs in the development of these initiatives.

## **6.2 Recommendations**

### ***Monitoring and evaluation***

- Every children's service should provide clear guidance derived from nationally agreed criteria, accompanied by appropriate training to ensure that SEN categories are used in the same way within and between authorities.
- The DCSF should consider giving more detailed guidance on the use of categories of SEN, especially in the area of SLCN, ASD and general learning difficulties.
- Progress for children with SLCN should be monitored across all key stages using nationally collected data. These data should be available nationally and serve as a baseline for monitoring value added service provision.
- Each Children's Trust should develop a system of data collection and interrogation across health and education. These data should help evaluate educational provision and therapy outcomes as well as support development of methods of evaluating practice to meet the needs of children with SLCN.

### ***Provision***

- LAs and SLT services should be encouraged to develop integrated services with SLTs working more in schools, at a variety of levels, not just in terms of providing individual therapy.
- In each LA SLT and SEN managers should consider line management, working practices and record keeping for SLTs working in school settings.
- Guidelines should be developed of good practice where SLTs are working with clients with EAL needs and their families.
- All children's services should review and evaluate provision for SLCN made in the secondary phase and FE in their area.

### ***Collaboration***

- LAs and SLT services should consider as a priority how they can work together to develop training courses to meet the professional development needs of all staff working with children with SLCN in educational provision across all age phases. The impact of these training courses should be evaluated.
- LAs and SLT services should provide sufficient funding and time for CPD needs of staff with expertise in the area of SLCN: support and advisory teachers, SENCOs, EPs and SLTs

- LAs should consider how they ensure that staff in integrated resources and special schools for children with SLCN as their primary need have sufficient and appropriate training, including access to specialist qualifications.
- DCSF should endorse and disseminate models of practice in professional development that are systematic, coherent and give an appropriate balance to competencies that all staff should have (e.g. through the SLCN material in the Inclusion Development Programme), what some staff in every school should have and what specialists working across the authority (e.g. specialists teachers, outreach staff from special provision) should have.

### ***Cost effectiveness***

- Cost-effectiveness analysis (CEA) should be employed rather than cost-benefit analysis. CEA should be incorporated into outcome studies so that the costs and outcomes of interventions can be jointly analysed.

### ***Research programme***

- The DCSF should implement a research programme for SLCN in order to guide the development of policy and practice. The main focus should be a study of interventions including examination of the following key issues:
  - locational (e.g. special school. Integrated resource, mainstream)
  - pedagogic (e.g. specific programmes for specific needs)
  - organisational (e.g. nature and deployment of support services, use of data informed developments),
  - employer base interaction (e.g. use of consultancy model v direct teaching/therapy)
  - cost effectiveness and efficiency of different interventions and models of collaboration
- An examination of the range of working practices in integrated/inclusive resources for children with SCLD is necessary in order to develop advice about good practice and relevant training.
- Data are needed to distinguish the similarities and differences between the SEN of children with SLCN and those with ASD in terms of learning environments and behavioural management regimes.

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## APPENDIX 1

### Index of Collaboration

#### A. Joint strategic planning between SLT and education; inclusion

1. Do you meet with the LA manager with responsibility for SEN/speech and language therapy services manager to develop a joint approach for SLT provision to education?
2. Do the outcomes of these meetings contribute to any formal development plan within the LA?
3. Do the outcomes of these meetings contribute to the SLT service's development plan?
4. Are you developing a joint strategy with the SLT service/LA with regard to the inclusion of children with speech, language and/or communication needs into mainstream settings?

#### B. Service development at practitioner level

5. Do speech and language therapists and key education staff (e.g. Ed. Psychs, learning support services) take part in joint meetings/working groups, e.g. to discuss policy, develop criteria, etc?

#### C. Operational issues

6. Are quality assurance mechanisms in place for the review and monitoring of the impacts of SLT provision to children in educational settings (e.g. SLT outcome measures, progress with IEP targets, movement up/down the SEN register)?
7. Is the SLT service represented on the SEN placement panel (or equivalent)?

**D**     **Continuing Professional Development**

8.     Do SLTs and educational personnel receive joint training on issues of common interest e.g. IEPs, literacy how, etc?
  
9.     Do SLTs contribute to the planning and/or delivery of CPD provided to education staff (e.g. teachers, classroom assistants, learning support assistants)?
  
10.    Do education staff (e.g. Ed. Psychs., specialist teachers etc.) contribute to CPD provided to SLTs?

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