

Joint Review of Therapy for Disabled Children

Evidence Sessions – Question Bank

Thursday, 4 March 2010, 10:00 – 12:30
Mitchell Room, Elizabeth II Court West

1. Hampshire County Council: Children's Services

Background issues

History of 'cost shunting' where:

- therapy has been specified in statements or by Tribunals
- NHS is believed to be responsible for providing the therapy, but is unable or fails to provide it in all areas when it is needed
- Where the NHS does not provide the therapy, it leaves the LA with the ultimate responsibility to provide it, and/or pick up the cost of it
- In the case of parents going to tribunal to attempt to get the therapy they believe is necessary, the Tribunal often supports parents who want the County to fund their child to go to an independent (out of County) school

SEN statements

- Part 3 of statements which specify special educational provision, do not always state specific outcomes for indicated therapy, thus making it difficult to know when the therapy has achieved its goal. It also makes it difficult to monitor progress if clear outcomes are not specified.

Tribunals

- Tribunals can be a problem for the County, because this is a mechanism that can result in high cost 'out of county' placements. Reasons for parents choosing to, have included:
 - Despite the trauma of going to a tribunal, the parents may nevertheless regard it as a better defined and understood route than continuing to 'battle with' the education system
 - Failure of schools and the wider system to provide clear information and support
 - A set of expectations, sometimes unrealistic, of the extent to which a school and/or therapy can improve the outcomes for their child
 - A belief that 'independent' schools must offer better opportunities for their child to progress than a 'County' school.
 - A sense that they and the County school have to fight for therapy support, combined with a sense of uncertainty about the security of provision.

Innovations

Innovations have come about in response to both the inequitable provision of therapy across the county, such that in some areas there is greater, and other areas less access to NHS therapy. In addition, there is doubt whether the full extent of need for therapy is clearly known, and whether the financial or human resources are (or will be) sufficient in the NHS to deliver a full service to all parts of the county.

The following is an example of innovation:

- ***Communication and Language (CAL) team.*** This is part of the Specialist Teacher Advisory Service for children with speech, language and communication needs. It is available to statemented children who attend mainstream secondary schools in Hampshire. The team includes input from educational psychology, speech therapy, teaching and special educational needs (eg. SENCOs), thus supplementing and complementing NHS provision. NHS speech therapy provides some training input to support this team. It illustrates, however, a recognition of the need to provide resource additional to that which is available from Health, but also a willingness on the part of Health to support such initiatives where possible.

Possible questions

1. To what extent do you expect the NHS to fund, or provide the capacity to deliver therapy services to meet the needs of statemented children in special and mainstream schools?
2. Is there any statistical data to suggest the profile of needs is changing or growing, and what are the implications for the NHS and County, say for the next 5 years?
3. If the NHS were to increase its capacity to deliver therapy to disabled children, how much would they need to increase it to meet current needs? In the current economic climate, is it realistic to believe any increase would be sufficient to meet the real extent of demand?
4. Several head teachers of special schools said they really wished they were in a position to manage therapy resources currently provided by the NHS (not from a clinical perspective). What advantages would they hope to gain from this?
5. How would making statements more specific and outcomes based, help control costs?
6. What actions could or should be taken to limit the budget risk inflicted by Tribunals on CS budgets?
7. What thoughts do you have as to any realistic, pragmatic proposals that might have the potential to move us on from the current impasse?

2. Special Schools / SEN Units in Mainstream Schools

Background issues

Not enough therapy input

- Not all, but many special schools do not receive enough NHS therapy support; there is also an issue around the difficulty of getting nursing

School funded therapy

- Most special schools use some of their own funds to employ therapy input.
- The SEN unit in a mainstream school had no NHS input at all. Speech and Language therapy was provided by the HCC Communication and Language team, and Occupational Therapy was bought in by the school.

Management of therapy resources by the school

- Some head teachers commented that they would prefer to manage the therapy resource (not the clinical aspects) so that closer integration with classroom work could be achieved
- It was pointed out that the common approach to providing therapy input for children was on the basis of setting up appointments with the school, but preference was often expressed for better integration of therapy with classroom work – a different style of delivery.

Innovations

Without exception the schools visited have been forced to ‘innovate’, or buy in therapy resources either to complement/add to any Health provision, or to compensate for no NHS provision at all. A minority of schools reported therapy or specialist support being delivered by one of their LSAs (Learning Support Assistants) who had received some special training.

Possible questions

1. Why would a school provide therapy out of their own budget when the NHS might reasonably be expected to provide that service? [eg. [SEN Code of Practice, Chapter 8, paragraph 8.50](#) “Prime responsibility for the provision of speech and language therapy services to children rests with the NHS...” see Appendix A]
2. Why would head teachers state that in an ideal world they would prefer to be able to manage therapy in their schools?
3. It has been commented that the way therapy is allocated to schools currently, does not track the needs of the child. Do you have any better suggestions for how therapy might be provided in schools?

3. Therapy Services

Background issues

Supply of therapy not sufficient to meet demand

- Supply of therapists with the right specialist skills is not sufficient to meet demand in special schools (or statemented children) in all areas (4 therapy provider organisations in Hampshire, some better resourced than others) – typically resources are stretched.

Meeting expectations of parents/teachers

- Parent, and sometimes teacher expectations, can exceed the ability of therapy to meet expected outcomes
- Honesty and clarity is needed around information provided and given to parents who simply want the best for their children – it is not clear that parents are fully aware of available sources of help, how their children might benefit, or what outcomes they can expect – issue around how well statements are written and the extent to which they are free of distortion.

Ability profiles of children

- Sometimes (or often?) a statement, especially if vaguely expressed, may indicate a child needs therapy, but care needs to be taken, especially in a context of limited resources, that therapy will result in desired outcomes – a child’s overall profile of ability may suggest where therapy would have limited success. Therapists can struggle to convince parents and teachers that therapy may not always be warranted.

Innovation

Implied in the 2008 independent review of therapy services, was that ensuring consistent, equitable provision of therapy provision, is challenging because of the historical multiplicity of provider organisations in the county. No known innovation addresses this to date.

It is thought that some therapy providers manage demand better than others, but it is not clear whether this is due to differences in local policy, approaches, or available resources. ([See Appendix B for example of the range of paediatric speech and language services provided in the Winchester area](#))

Possible questions

1. Given the observation in the 2008 review that the multiplicity and complexity of provision is “...a particular problem...”, do you have any suggestions as to how better equity of provision might be achieved across all areas of Hampshire?
2. To what extent is it reasonable to suppose that (particularly speech and language) therapy is primarily indicated if it is clear that a child’s ability profile identifies language and communication as significantly weaker than other areas?
3. What needs to be done to help parents (and teachers) to set realistic expectations for their children?
4. Do you have any examples of innovative practice or approaches that could or should be considered to ensure each child in need of therapy, can get it – within the system’s available resources – other than in exceptional circumstances.

4. The Communication and Language (CAL) Team

Background issues

- The team offers speech and language assessment and advice for children and young people in mainstream secondary schools. Members of the Panel visited the Romsey School SEN unit which benefited from speech and language therapy provided through the CAL initiative, complemented by occupational therapy bought in by the school. The arrangement works well, with each therapist integrating their input with the other and with classroom provision.
- The CAL team initiative is an example of multi-agency working between Children's Services' educational psychologists and Health speech and language therapists (and one CS therapist?).
- The CAL team also has an interest in training school staff.

Innovation

Whilst CAL initiatives have been used in other authorities, it is a practical service that is endorsed by the beneficial outcomes experienced, such as at the Romsey School.

Possible questions

1. Why does the CAL team operate only in mainstream secondary schools?
(Note: 45% statemented children are in mainstream schools)
2. As a multi-agency team with experience of working with Health, what lessons or ideas could you share with the Panel that might be helpful for us to consider?
3. If you engage in training, who do you train, what do you train them to do, what is the content, is it accredited, and how do you measure/demonstrate the effectiveness of it?

Appendix A: SEN Code of Practice, Sections 8:49 – 8:52

8:49 Case law has established that speech and language therapy can be regarded as either educational or non-educational provision, or both, depending upon the health or developmental history of each child. It could therefore appear in either Part 3 or Part 6 of the statement or in both. However, 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.⁵⁹

8:50 Prime responsibility for the provision of speech and language therapy services to children rests with the NHS. This applies generally and also to any specification of such services in a statement of special educational needs, whether in Part 3 as educational provision or in Part 6 as non-educational provision, or in both parts. Health authorities are responsible for purchasing therapy services through the contracts they make with providers of health care (NHS Trusts). The NHS provides a professionally managed speech and language therapy service covering pre-school, school-age and adult age groups, which has close links with the other child health services.

8:51 Where the NHS does not provide speech and language therapy for a child whose statement specifies such therapy as educational provision, ultimate responsibility for ensuring that the provision is made rests with the LEA, unless the child's parents have made appropriate alternative arrangements. Schools, LEAs and the NHS should cooperate closely in meeting the needs of children with communication difficulties.

8:52 It is important that the nature and extent of provision required for individual children should be examined very carefully and that full consideration is given as to how such provision can best be delivered. In some cases, for example, children may need regular and continuing help from a speech therapist, either individually or in a group. In other cases, it may be appropriate for staff at the child's school to deliver a regular and discrete programme of intervention under the guidance and supervision of a speech and language therapist.

Winchester and Eastleigh

Healthcare NHS Trust

THE DELIVERY OF A SPEECH AND LANGUAGE THERAPY SERVICE TO CHILDREN

Philosophy

Research has shown that children brought up in an environment conducive to the development of communication are less likely to present with communication difficulties later on. Identification and early intervention may result in fewer referrals to SLT and prevent the many consequent social and educational difficulties that children encounter as a result of poor communication skills.

Research has shown that early intervention will result in early remediation.

Aims

- To facilitate the development of optimum speech, language, communication and feeding skills in children presenting with delayed, disordered or impaired ability.
- To educate parents and school staff
 - to deliver therapeutic programmes
 - to incorporate targets into the child's IEP and daily activities
 - to monitor and report on progress
- To establish alternative and augmentative forms of communication where conventional forms of communication are irremediable.

Service principles

- All children should have access to the service
- The service will be provided according to the child's needs within the limitations of available resources
- The service will be delivered in an appropriate setting **conducive to the development of communication and by staff who interact with the child on a daily basis**
- The delivery of the service will be guided by appropriately trained Speech and Language Therapists
- **Effective intervention is reliant on the support of those who work with the child every day.** As a result therapists have a responsibility to ensure that staff have the necessary knowledge, skills and attitudes to undertake this role to the best of their ability.

Training currently offered

Parents

The role of the parent is crucial for the speech and language development of children who are on the Speech & Language therapy caseload. As a result, the parents of all pre-school children who are deemed appropriate for group therapy are invited to attend a one hour information/training session about the specific problems faced by their child prior to/or at the time of the first group therapy session. Parents are informed each week about the progress their child is making and are also encouraged to form support groups.

Where possible and if appropriate, Makaton and early parent/child interaction groups are offered which are jointly run by Speech and Language Therapists and pre-school education assistants.

Pre – schools

Appropriate and excellent communication skills are crucial for all staff who interact with children on a daily basis. The Speech and Language therapy service therefore works closely with the Early Years Advisory service, CLLD consultants and INCOS to deliver training packages such as the Skillful Communicator Training, and the newly developed 'Helping to Develop Speech, Language and Communication Skills (Pre-school)' training which consists of 3 2+1/2 hour sessions and is open to all early years practitioners. This is delivered across the County by teams of INCOs and SLTs working together. In addition, Narrative Approach training, Makaton and ad hoc training is available to pre-schools on request.

Mainstream Schools

The Speech and Language Therapy Service offers a number of training packages on request to mainstream schools. These may include: training on the use of Cued Articulation, The Narrative Approach and Makaton. In addition, the service is involved in delivering an 8 session course for Special Needs Assistants in schools entitled 'Working with children with Speech, Language and Communication Needs in the mainstream setting'. This course is delivered jointly with the Educational Psychology Service. A course which is designed to run alongside the SNA course but is specifically targeted at school SENCOs is also available in Hampshire.

Special Schools

It has already been mentioned that '**effective intervention is reliant on the support of those who work with the child every day**'. An appropriate **communication environment** is also required for effective language acquisition. Language does not occur in isolation, therefore 1:1 with a Speech and Language Therapist on a daily basis may not provide the desired outcomes. What may make the difference are adaptations to the school environment such as visual cuing and signing. This is particularly true for children with language delay/disorder (although may also be relevant for children with speech sound delay/disorder). As a result, training to special schools may involve any of the above packages offered to mainstream schools but in most cases in the Winchester, Eastleigh and Andover area takes the form of weekly group therapy sessions in the main stream class which allows staff to learn specific techniques and observe appropriate modelling of good practice. Staff who learn these techniques effectively go on to embed them within the classroom setting and therefore provide an environment which allow the children to generalise goals and reach their potential.

MODELS OF SERVICE DELIVERY

All children referred will be assessed by a qualified Speech and Language Therapist to determine which model of service delivery best meets their needs within current resources.

Pre-school child

Diagnosis:	Phonology/Articulation disorder/delay
Venue:	Clinic/Children's Centre for group therapy
Optimum age of referral:	3-4 years
Referral source:	HV, GP, Paediatrician

	<i>Mild/Moderate</i>	<i>Severe</i>
Model:	Parent Information Session with therapist 6 weeks group or individual therapy + Programmes / home work	As Mild/Moderate but more 1:1 sessions most likely 6 weeks on / 6 weeks off
Outcome:	Developmentally appropriate speech	Max. potential achieved in functional communication
Time scale:	Time limited / ongoing according to need	On going according to need

Pre-school child

Diagnosis:	Language delay / disorder
Venue:	Clinic for assessment/Children's Centres for group therapy
Optimum age of referral:	2 years
Referral Source:	HV, GP, Paediatrician

	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
Model:	Parent information and programme	Parent training + Group Therapy Regular review	Parent training Regular group therapy And / or parent groups
Outcome:	Developmentally approp language	Developmentally approp language	Developmentally approp language
Time scale:	Time limited	Time limited / Ongoing according to need	Ongoing

Pre-school child

Diagnosis:	Non-fluency
Venue:	Clinic
Optimum age of referral:	As soon as parents become concerned
Referral source:	HV, GP, Parents
Model:	Advice given to parents/carers to reduce anxiety and facilitate fluency
Outcome:	Fluent speech
Time scale:	Variable

Pre-school child with Special Needs

Diagnosis:	Severe/moderate delay / disorder of phonology/language with / without one or more special need, social need, need for delivery within a functional setting
Venue:	Early Years Centre
Optimum age of referral:	As early as appropriate
Referral Source:	HV, GP, EYC, Paediatrician
Model:	Multi-professional approach involving training and programmes for parents and staff with ongoing professional monitoring.
Outcome:	Maximum potential achieved in functional communication

Primary school aged child

Diagnosis:	Phonology / Articulation disorder / delay
Venue:	Usually school, may be clinic. Child with severe delay / disorder should ideally be placed in a Language Unit.
Optimum age of referral:	Ideally pre-school, otherwise on school entry upwards
Referral Source:	HV, School, School Health, GP, Paediatrician

	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
Model:	School programme integrated into IEP monitored ½ termly	School programme integrated into IEP monitored ½ termly	School programme with blocks of 1:1 therapy monitored regularly
Outcome:	Developmentally approp speech	Developmentally approp speech	Maximum potential achieved in functional communication
Time scale:	Time limited	Time limited / Ongoing according to need	Ongoing according to need

Primary school aged child

Diagnosis:	Language disorder / delay
Venue:	School. Child with severe language delay / disorder should ideally be placed in a Language Unit
Optimum age of referral:	Ideally pre-school, otherwise on school entry upwards
Referral source:	HV, School, School Health, GP, Paediatrician

	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
Model:	School programme integrated into IEP Monitored termly	School programme integrated into IEP Monitored termly	School programme integrated into IEP with blocks of 1:1 therapy Monitored regularly
Outcome:	Developmentally approp speech	Developmentally approp speech	Maximum potential achieved in functional communication
Time scale:	Time limited	Time limited / Ongoing according to need	Ongoing according to need

Primary school aged child

Diagnosis:	Severe speech and language disorder
Venue:	Language Unit.
Optimum age of referral:	Should already be known to service
Referral Source:	HV, GP, Paediatrician, CMO
Model:	Direct and indirect intervention (weekly therapy if appropriate), plus training and support of school staff and parents in conjunction with LUnit staff
Outcome:	To achieve speech and language skills which will allow the child to access the curriculum in a mainstream school
Time scale:	Ongoing

Primary school aged child

Diagnosis:	Speech and language delay/disorder due to hearing impairment
Venue:	School attended by child.
Optimum age of referral:	Already known to service
Referral Source:	HV, GP, Paediatrician, CMO
Model:	Training and programme given to staff to be incorporated into IEP and monitored termly. If child has severe communication disorder over and above what is expected, as a result of their hearing loss, then more direct and indirect intervention will be required.
Outcome:	Maximum potential achieved in functional communication
Time scale:	Ongoing

Primary & Secondary School aged child

Diagnosis:	Dysfluency
Venue:	School or clinic according to child's preference
Optimum age of referral:	As soon as concern is expressed.
Referral source:	Pre-school sources or School Health / School
Model:	Advice to teachers and parents. Review or weekly therapy as appropriate. Individual or group sessions with the child if aged over 6 years.
Outcome:	To reduce or if possible eliminate dysfluency or anxiety caused by speech behaviour and promote a positive attitude to self.
Time scale:	Ongoing

Primary and Secondary School aged Child with moderate special needs

Diagnosis:	Speech sound/language/communication delay /disorder not in line with other skills
Venue:	MLD School/Mainstream School
Optimum age of referral:	Should already be on caseload
Referral Source:	Pre-school / School / School Health
Model:	Training, modelling of good practice in groups/in the classroom and programme given to staff to be incorporated into IEP, and monitored termly. Individual therapy for children with severe communication problems over and above learning disability if appropriate
Outcome:	Maximum potential achieved in functional communication
Time scale:	Ongoing

Primary and Secondary School aged Child with severe special needs

Diagnosis:	Speech sound/language/communication delay /disorder not in line with other skills
Venue:	SLD School
Optimum age of referral:	Should already be on caseload
Referral Source:	Pre-school / School / School Health
Model:	Training, modelling of good practice in groups/in the classroom and programme given to staff to be incorporated into IEP, and monitored termly.
Outcome:	Maximum potential achieved in functional communication
Time scale:	Ongoing

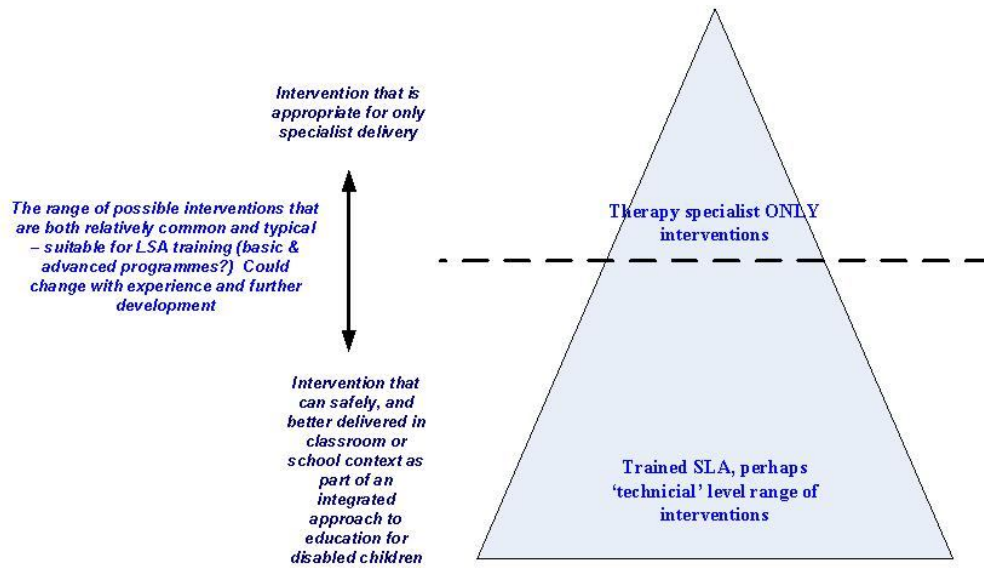
Secondary aged child in mainstream school

Diagnosis:	Speech, language, communication delay/disorder
Venue:	School
Optimum age of referral:	Pre-school
Referral Source:	Pre-school / School / School Health
Model:	Assessment and advice only, except for fluency or voice problems Referral to CAL team for statemented children
Outcome:	Developmentally appropriate speech. language, communication
Time Scale:	One off visit

Marion Jones
Head of Paediatric Speech and Language Therapy
Winchester & Eastleigh NHS Trust

Hands-on delivery of therapy intervention

Total demand / provision of hands-on therapy required



*Marion Jones
February 2010*