Department of
Health, Social Services and Public Safety
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Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

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Speech, Language and Communication Therapy Action Plan:

Improving Services for Children and Young People

2011/12 – 2012/13

March 2011

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MINISTERIAL FOREWORD

I am pleased to publish the DHSSPS Speech, Language and Communication Therapy Action Plan: *Improving Services for Children and Young People* (2011/12 – 2012/13). This follows a pre-consultation phase in the summer of 2009, and a formal public consultation on the draft Action Plan during the autumn of 2010. I wish to thank all those individuals and organisations who took the time to provide very informative and helpful responses during both consultation phases.

The publication of this document is an important step forward in improving the delivery of services to children and young people with speech, language and communication needs in Northern Ireland.

The ability to communicate effectively is a vital skill for every child or young person in their home, school and social lives. Indeed, it is such an important aspect of personal development that without good communication skills, children may never develop to their full potential or make the kinds of lasting friendships that characterise a full life.

The Report of the Northern Ireland Commissioner for Children and Young People (2005/06) was a welcome contribution to this work in that it helped identify key issues to be addressed. The Report of the Speech and Language Therapy Task Force (2008) was also helpful, as it involved many children, parents, teachers and therapists in making high-level recommendations about how services might be improved. These useful contributions have provided a challenge to those who design, fund, commission and deliver speech and language therapy services: to work together in a joined-up manner and to put in place real service improvements across community, health and education settings. This Action Plan is one part of the answer to that challenge.

In order to take the initiative in making some real, practical and lasting improvements to services, in July 2009 I established a multi-agency, multi-disciplinary Project Team involving staff from the health and education sectors, the Youth Justice Agency and the Royal College of Speech and Language Therapists. The Team was tasked with developing the specific actions which are now contained in this Action Plan. Whilst

many of these actions relate to health and social care settings, they recognise the importance of collaboration at local and regional levels.

This Action Plan is intended to provide the direction for the further development of speech and language therapy services over the next two years working in partnership with other organisations. It is focused on children who have clinical and social care needs arising from speech, language or communication difficulties. Joint working with other Departments will continue to be important as services will need to be developed in a multi-disciplinary model, designed around the child and their family.

The challenge for us all now is to use this Action Plan as a tool to further transform service provision in order to enhance the lives of children and young people with speech, language and communication needs and their families.

MICHAEL McGIMPSEY MLA
Minister for Health, Social Services and Public Safety

HOW TO READ THIS DOCUMENT

1. The Speech, Language and Communication Therapy Action Plan is divided into four sections:

2. **Section 1:**
   This section provides an introduction to Speech, Language and Communication Needs (SLCNs) and the effect these can have on children and young people throughout their lives, as well as introducing Speech and Language Therapists (SLTs) and the role they play. This section also details the scope of the Action Plan and the issues that must be addressed.

3. **Section 2:**
   Section 2 details current Speech and Language Therapy provision, and the service improvements that are already underway or complete.

4. **Section 3:**
   This section outlines the way forward for Speech and Language Therapy services, and provides a generic care pathway for progression through these services. Principles of best practice are also identified in this section.

5. **Section 4:**
   Section 4 contains the Action Plan itself, detailing a series of actions to be completed over the next two years to improve Speech and Language Therapy services. The actions are divided into four themes:
   (a) Commissioning and service redesign to maximise outcomes;
   (b) Supporting and empowering children, parents and carers;
   (c) Enabling HSC staff to promote early recognition, assessment, intervention, treatment, care and support;
   (d) Collaboration between speech and language therapists and teachers and education professionals to enable them to promote early recognition, assessment, intervention and support.

6. Each action also has: a timetable for completion; a person or body responsible for its implementation; the outcome required; and details the benefits for individuals and for society by the completion of the action.

7. Supplementary information is also provided in the Appendices to assist understanding and to complement the main contents of the Action Plan.

NB. If you require the document in an alternative format, please contact the Department to make your request:

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POTENTIAL IMPACT OF SPEECH, LANGUAGE AND COMMUNICATION NEEDS

SECTION 1: SETTING THE SCENE

INTRODUCTION

8. Speech, language and communication are crucial to every child's ability to succeed in life. The ability to communicate is an essential life skill for all children and young people and it underpins a child's social, emotional and educational development[1]. It is a key skill in future employment opportunities and defines who we are and how others perceive us.

9. This revised Action Plan builds on a number of pieces of work focused on improving outcomes for children with Speech, Language and Communication Needs (SLCNs), including the Speech and Language Therapy Task Force Report, published in July 2008. The Task Force report emphasised the need for better partnership and collaborative working between health and education professionals to support the early identification of children's needs and to secure better outcomes for them. It also highlighted gaps in speech and language therapy provision for children and young people in Northern Ireland.

10. Following the publication of the Task Force Report, the Department recognised the need for an Action Plan to drive improvements. In July 2009 the Department established a multi-agency Speech and Language Therapy Action Plan Project Team to develop and agree a Speech, Language and Communication Therapy Action Plan, taking account of the recommendations made in the Task Force Report. A full list of Project Team members is provided in Appendix 2.

11. A programme of pre-consultation was also initiated at this time, with an initial focus group event for health and education professionals being held on 12 June 2009. At this workshop, participants identified key areas for improvement.

12. The Royal College of Speech and Language Therapists (RCSLT) facilitated two further focus group events with parents/guardians and children with speech and

[1] The Bercow Report: A Review Of Services For Children With Speech Language And Communication Needs, 2008

language needs. These events were held on 23 and 25 September 2009 in Sperrinview School, Dungannon and Thornfield School, Jordanstown.

13. At these events, parents were given the opportunity to raise concerns about current service provision and highlight areas where improvement or service redesign was required. A children's facilitator enabled the children present to voice their views on speech and language therapy and identify what they wanted from the service.

14. The draft Speech, Language and Communication Therapy Action Plan was launched for full public consultation on 7 September 2010 and placed on the Department's website (www.dhsspsni.gov.uk/index/consultations.htm). An Easy Read version was also provided.

15. The consultation phase closed on 30 November 2010, and 33 responses were received from a broad range of professional, local government and voluntary bodies, as well as the Health and Education sectors and a number of individuals. Some of the issues highlighted during the consultation included:
    - Concerns about the training of HSC and education staff in the identification of speech difficulties;
    - Need for truly collaborative working and joint planning between Health and Education;
    - The importance of Speech and Language Therapy input at Transition; and
    - The difficulties parents have in accessing information about what services are available to them.

16. Each of the responses were carefully and individually considered during the revision of the Action Plan, and have helped the Department and HSC officials understand the needs, wants and expectations of the population in relation to speech and language therapy services. A full summary of responses is available on the Departmental website (http://www.dhsspsni.gov.uk/index/publications.htm).

WHAT ARE SPEECH, LANGUAGE AND COMMUNICATION NEEDS?

17. Speech, Language and Communication Needs (SLCNs) can be primary, such as specific language impairments or a stammer, or secondary and related to other needs like autistic spectrum disorders, hearing impairments or physical disabilities.

18. These needs can include difficulty understanding what people say, difficulty speaking or forming sounds or words, and using language in appropriate social contexts. They can be very severe, for example, when an individual cannot communicate at all without alternative or augmentative communication such as signs or communication aids. They can also be significant, for example, when a child underachieves in class because they are not able to communicate as effectively as their peers.

19. Many SLCNs are identified when the child is very young, perhaps because they are late in starting to talk or because people cannot understand them when they do speak. Others may emerge when the child goes into nursery or primary school, when they start to read, and sometimes even later on when a child is underachieving or becoming withdrawn or frustrated resulting in challenging behaviours.

20. Children and young people may also acquire SLCNs at any time if they have an accident or stroke.

What are the Impacts of Communication Difficulties?

21. **Educational:**
    There is clear evidence that, without early access to the appropriate support from early years and throughout key stages in education, children with communication difficulties will have lower academic attainments.

22. **Social/Emotional:**
    Children with a communication disability are more likely than their peers to find peer interaction and forming real relationships difficult. This puts them at risk of

rejection and isolation. Social isolation has been identified as a risk factor for bullying in children with special educational needs.

23. **Mental Health:**
It is estimated that one third of children with communication problems will go on to develop mental illness if untreated[2]. Often underlying health and medical conditions go unnoticed and undiagnosed in children with communication problems.

24. **Employment:**
The last fifty years have seen a shift in employment patterns, with a move towards service industries, which require sophisticated language, literacy and numerical skills. Without help to develop these skills children with SLCNs will have restricted employment opportunities in later life.

25. The Bercow Report illustrates that there is insufficient understanding of the centrality of speech, language and communication in a child's development and sometimes parents and families themselves fail to recognise the importance it plays in their child's future attainment[3].

What is the Role of the Speech and Language Therapist?

26. Speech and Language Therapists (SLTs) are part of a wider Health and Social Care workforce with responsibility for addressing the needs of children with Speech, Language and Communication difficulties. They are specially trained to diagnose speech, language and communication disorders and have a unique role in the assessment, diagnosis and management of children, young people and adults who have difficulties with communication, and/or eating, drinking and swallowing.

27. Speech and language therapists are statutorily regulated by the Health Professions Council (HPC). The Council maintains a register of all the health

[2] "Life sentence: what happens to children with developmental language disorders in later life?" Clegg, J., Hollis, C. & Rutter, M. (1999) - *Bulletin of the Royal College of Speech Language Therapists*, *571*, 16-18.
[3] The Bercow Report: A Review Of Services For Children With Speech Language And Communication Needs, 2008

professionals it regulates who meet their standards for training, professional skills, behaviour, health, conduct and performance. Speech and Language Therapy is a protected title.

28. Speech and language therapists work closely with parents, carers, psychologists, other health and education professionals and many other agencies. They recognise that the success of intervention requires a team around a child to structure the activities and interaction opportunities of a child's everyday life.

29. In 2006 the speech and language therapy profession produced a position paper entitled "Supporting children with speech, language and communication needs within integrated children's services"[4], which sets out a vision of speech and language therapy to deliver effective support, plan for maximum impact and develop the workforce. Trans-disciplinary working is central, training of others is core and SLT provision must be delivered in partnership with others.

30. This position paper states that: *"SLT services should offer the full range of support for children, including direct intervention where appropriate, while ensuring that overall management includes goals relating to activity and participation, managed by those most relevant to the child".*[5]

[4] 'Supporting children with speech, language and communication needs within integrated children's services' RCSLT position paper, Marie Gascoigne, 2006

[5] 'Supporting children with speech, language and communication needs within integrated children's services' RCSLT position paper, Marie Gascoigne, 2006

AIMS AND OBJECTIVES

Aims:

31. The aim of the Department of Health, Social Services and Public Safety (DHSSPS) is that all children and young people, at risk of or presenting with speech, language or communication needs, will be able to benefit from timely support and integrated services that best meet their needs. We recognise the need for Government departments and agencies to work together in a joined-up manner and to put in place real service improvements across community, health and education settings.

32. This Action Plan will focus mainly on clinical and social care services for children and young people with potential speech, language and communication difficulties. In this context it will also be cognisant of the difficulties experienced in the transition from childhood to adulthood. The Action Plan will consider the particular needs of children and young people in the following groups:
    - 0 – 4 years
    - 4 – 11 years
    - 11 – 18 years
    - 18 – 21 years – transition
    - children and young people in the Youth Justice System.

Objectives:

33. The Department's intention is to produce an Action Plan containing SMART objectives: i.e. Specific, Measurable, Achievable, Realistic and Time Bound. The actions are grouped into four themes:
    - Commissioning and service redesign to maximise outcomes;
    - Supporting and empowering children, parents and carers;
    - Enabling HSC staff to promote early recognition, assessment, intervention, treatment, care and support; and
    - Collaboration between speech and language therapists and teachers and education professionals to enable them to promote early recognition, assessment, intervention and support.

34. Other issues which are addressed are:

- The needs of parents, families and carers;
- New commissioning arrangements;
- Review of waiting times;
- Making full use of existing skill mix;
- Mental health needs and other co-morbidities, including ASD;
- The needs of children with Acquired Brain Injury;
- The needs of children and young people within the Youth Justice System; and
- Integrated models of care which have been positively evaluated.

LEGISLATIVE CONTEXT

35. The Department of Health, Social Services and Public Safety is one of the Northern Ireland Departments created in 1999 as part of the Northern Ireland Executive by the Northern Ireland Act 1998 and the Departments (Northern Ireland) Order 1999. Subsequently, on 1st April 2009, following the creation of six new HSC Trusts, four wholly new regional HSC organisations were brought into being by the Health & Social Care (Reform) Act (NI) 2009:

- The Health and Social Care Board (HSCB);
- The Public Health Agency (PHA);
- The Business Services Organisation (BSO); and
- The Patient and Client Council (PCC).

36. Education and therapy services to children with special needs should be provided in line with current legislation including The Children (Northern Ireland) Order 1995, The Education (Northern Ireland) Order 1996, The Special Educational Needs and Disability (Northern Ireland) Order 2005, The Chronically Sick and Disabled Persons (Northern Ireland) Act 1978, The Disability Discrimination Act 1995 and the relevant Codes of Practice.

STRATEGIC LINKS

37. This Action Plan also draws on a number of other publications. These include:

- The Bercow Report: A Review of Services for Children and Young People (0-19) with Speech, Language and Communication Needs (2008)
- Northern Ireland Commissioner for Children and Young People Reports (2005, 2006)
- Speech and Language Therapy Task Force Report (2008)
- The Bamford Review: Equal Lives (2005)
- Delivering the Bamford Vision (2009)
- Healthy Child, Healthy Future (2010)
- Healthy Child, Healthy Future: Speech and Language Therapy for Children – Information and Referral Guidance (2010)
- Acquired Brain Injury Action Plan (2010)
- Healthy Futures: The Contribution of Health Visitors and School Nurses (March 2010)
- Autism Spectrum Disorder (ASD) Strategic Action Plan (2009)
- Our Children, Our Young People, Our Pledge (2006)
- Developing Services to Children and Young People with Complex Healthcare Needs (2009)
- Standards and Guidance for Promoting Collaborative Working to Support Children with Special Needs (2006)
- Good Practice in Consent: Consent for Examination, Treatment of Care (2003)
- Ministerial Priorities of the Sub-Committee on Children and Young People (OFMDFM)
- Proposed Early Years Strategy (DE)
- A Ten Year Strategy for Children and Young People in Northern Ireland 2006-2016 (OFMDFM)

POTENTIAL IMPACT OF SPEECH, LANGUAGE AND COMMUNICATION DIFFICULTIES ON CHILDREN'S LIVES

38. If a child or young person does not receive the right help in combating their communication disabilities in a timely manner, the risks of that disability having a long-term effect on their future lives is greatly increased. SLCNs can, if left untreated, lead to lower education attainment, behavioural problems, emotional and psychological difficulties, poorer employment prospects, challenges to mental health, and in some cases, a descent into criminality[6].

39. Equally, for those who are already experiencing any of these issues, appropriate therapy provision is essential to mitigate the effects of the SLCN and provide a way out.

Prevalence

40. "Speech, Language and Communication difficulties affect more children and young people in Northern Ireland (NI) than any other single condition and are core impairments for many children with a learning, physical or sensory disability". *Northern Ireland Speech and Language Therapy Task Force: Report on Speech and Language Therapy Services for Children and Young People, July 2008*

41. In NI there is a lack of robust quantitative and qualitative research to properly identify prevalence. Therefore regional predictions must rely heavily upon published national research. However, national studies may not be fully comparable due to a number of reasons:
    - The acknowledged higher levels of learning disability in NI; and
    - Children in NI experience relatively higher levels of social and economic disadvantage compared to England, Scotland and Wales[7].

42. In NI the number of children with SLCNs varies according to the criteria used, but it is reasonable to assume there will be at least one child meeting criteria for specialist help in every class in the country (approximately 3 -7% of all children).

[6] The Bercow Report
[7] Overview of the Health and Social Care Needs and Effectiveness Evaluation, DHSSPS DFP OFMDFM

43. The most widely regarded prevalence study in the field has provided a figure of 7.4%[8]. This American epidemiologic study estimated the prevalence of specific language impairment (SLI) in monolingual English-speaking kindergarten children. 7,218 children were screened. Results provided an estimated overall prevalence rate of 7.4%. The prevalence estimate for boys was 8% and for girls 6%.

44. The prevalence of SLCNs in studies of children with co-morbidities such as Autism or Learning Disability is reported to be much higher. The National Autistic Society prevalence information states that "the indication from recent studies is that the figures cannot be precisely fixed, but it appears that a prevalence rate of around 1 in 100 is a best estimate of the prevalence of Autism in children"[9]. All of these children will have communication difficulties as communication is recognised as one of the triads of impairment for diagnosis.

45. The prevalence of communication disorders in learning disability is also much higher. The British Institute of Learning Disabilities state that "estimates suggest that 50% to 90% of people with learning disabilities have communication difficulties"[10].

46. An American study reports that in a population of 242 children with learning disabilities between 8 and 12 years of age enrolled in a school system in Alabama, a speech, language or hearing problem was exhibited by 96.2% (233) of the 242 children studied. Language deficits were found in 90.5%, articulation deficits in 23.5%, voice disorders in 12%, and fluency disorders in 1.2% of the students with learning disabilities[11].

47. The following table gives the population of all children and young people in NI from 0-19yrs per Health and Social Care Trust, and the projected prevalence of SLCNs. As stated above it is reasonable to ascertain that 3-7% of these children

[8] Tomblin, J.B., Records, N., Buckwalter, P., Zhang, X.,Smith, E. & O'Brien, M. (1997) Prevalence of specific language impairment in kindergarten children. Journal of Speech Language and Hearing Research, 4, 1245-1269.

[9] Baird, G. et al (2006). Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). *The Lancet*, 368 (9531), pp. 210-215.

[10] The British institute of learning disabilities Campion House Green Street, Kidderminster

[11] Denise P. Gibbs. Prevalence of Communication Disorders in Students with Learning Disabilities, Journal of Learning Disabilities, Vol. 22, No. 1, 60-63 (1989) DOI: 10.1177/002221948902200111

will have speech, language and communication difficulties, therefore prevalence figures have been calculated accordingly at 7% of the total populations.

Table 1: Trust Child Population Figures - 0-19 yrs per HSC Trust - 2009

Age	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Totals
0-19 yrs Totals*	86,380	121,130	89,460	100,730	84,780	482,480
Prevalence Of 7%	6046	8,479	6,262	7,051	5,934	33,772

**Source: NISRA Registrar General Annual Report 2009 - Population Statistics*

48. The Royal College of Speech and Language Therapists guidance on best practice states that "research has also indicated that up to 62% of children with mental health disorders have speech and language difficulties"[12].

49. The Department of Education has also reported that the incidence of children with SLCNs in NI is increasing. In NI 51% of preschool providers recently surveyed cite speech and language difficulties as the most common difficulty that is evident in children attending preschool provision (DE 2007)[13].

50. The information on the following page has been taken from the Northern Ireland Annual Schools Census 2009/2010, and shows the percentage and number of pupils on the SEN Register and the percentage of the overall school enrolment with speech and language difficulties, in each Education and Library Board area.

[12] Communicating Quality 3: RCSLT's guidance on best practice in service organisation and provision, 2006
[13] DE ETI Special Educational Needs in the pre school sector Review March 2007

Table 2: Percentage of Pupils with S&L Difficulties (Stages 1-5) against Number of Pupils on SEN Register in Each EL Board Area

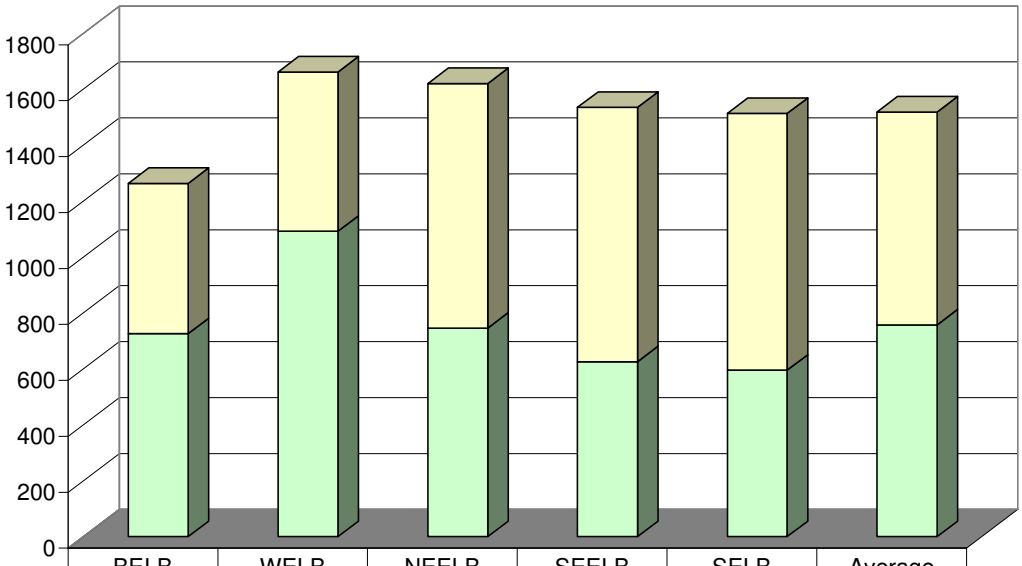
	BELB	WELB	NEELB	SEELB	SELB	Overall
Primary	12.23	16.79	13.50	13.17	15.24	**14.19**
Post Primary	0.97	5.15	3.68	2.19	3.59	**2.93**
Special Schools	32.13	50.16	58.27	50.49	65.25	**48.50**
Overall	**8.75**	**13.96**	**14.24**	**12.79**	**12.90**	**12.36**

Table 3: Percentage of Pupils with S&L Difficulties (Stages 1-5) against Overall School Enrolment in Each EL Board Area

	BELB	WELB	NEELB	SEELB	SELB	Overall
Primary	2.66	4.13	2.80	3.43	3.22	**3.21**
Post Primary	0.22	0.92	0.42	0.36	0.46	**0.47**
Special Schools	32.13	50.16	58.27	50.49	65.25	**48.50**
Overall	**2.28**	**2.95**	**2.30**	**2.50**	**2.10**	**2.40**

Figure 1

Number of Pupils with Speech & Language Difficulties on SEN Register in 2009-10, Split by Stages 1-4 and Stage 5



	BELB	WELB	NEELB	SEELB	SELB	Average
Stage 5	537	569	874	910	918	761.6
Stages 1 -4	726	1092	746	625	595	756.8

Source: 2009/10 Annual Schools Census

Health Inequalities

51. Communication difficulties are more prevalent amongst vulnerable groups and children with additional needs.

52. People with communication difficulties may find it harder to express their needs and communicate effectively with health (and social care) professionals. A lack of effective communication creates a barrier to accessing healthcare and appropriate intervention. This often results in substantial social and health care costs[14] [15]. Communication difficulties can also contribute to the creation or reinforcement of inequalities because of the impact that communication impairment has upon a person's ability to experience the same quality of life as their peers and stay healthy.

53. In the Sure Start Children's Centres Practice Guidance (2006) it states that "there should be additional support available for families that are experiencing particular challenges that mean that their children may be at risk of poor outcomes. Among these families may be: teenage parents; lone parents; families living in poverty; workless households; parents with mental health, drug or alcohol problems; families with a parent in prison or known to be engaged in criminal activity; families from minority ethnic communities; families of asylum seekers; parents with disabled children; and parents with learning disabilities. While these families will not always be in difficulty, child development studies have shown that there is a greater risk that their children may have poor outcomes"[16].

<u>Social Deprivation:</u>

54. A study investigating four year olds in areas of deprivation found the prevalence of speech, language and communication needs of children were as high as 55% (Locke et al, 2002).

55. Therapists working within Sure Start projects report high numbers of children being identified as requiring SLT provision who have been discharged due to non -attendance at community clinics (Did Not Attend / DNA).

[14] Snow and Powell Developmental Language Disorders and Adolescent Risk
Current Issues in Criminal Justice 16(2) Australia (2004)
[15] Jerome et al 2002, Young et al 2002, Johnson et al 1999
[16] Sure Start Children's Centres Practice Guidance, Department for Education and Skills and Department of Health, 2006

56. This finding has also been substantiated by the findings of a recent International Development Fund (IDF) project in the Colin area of West Belfast. The Colin area has a population of approximately 20,000, of which approximately 30% are aged between 0 and 15 years. The area falls within the 20 most deprived wards in Northern Ireland, and the local clinic reported high rates of DNAs.

57. The Colin Speech and Language Therapy Service provided a universal and targeted school-based speech and language therapy service to pupils in the Colin area in order to:

- Improve access to the Speech and Language Therapy Service within the Colin area;
- Improve the identification and support for children with speech, language and communication difficulties;
- Develop a model of collaborative practice between therapists, education staff and parents; and
- Increase education staff's knowledge and skills in identifying and supporting children with speech, language and communication difficulties.

58. The project improved outcomes for both children and the community, with results showing that 52% of children were discharged at the end of P1. SLT has also become embedded in classroom practice, and pre/post assessment has been improved. There is also improved access to services (2 week waiting time).

<u>Minority Groups:</u>

59. Health inequalities disproportionately affect ethnic communities. Individuals with communication disabilities from these communities may therefore need additional help to assist with bilingual input.

<u>Learning Disability:</u>

60. The Equality Commission NI Report: 'The accessibility of health information for people with learning disability' states that "many people with a learning disability will have specific communication needs which may affect access to information about individual health issues and information about health services or options available to meet health needs".

61. The Equality Commission maintains that the lack of knowledge about communication disability among staff is the main barrier to enabling this group to access appropriate health and social care, combined with a lack of support and training to enable them to understand the communication needs of people with learning disability.

Young Offenders:

62. There is now an acknowledged evidence base to support the finding that SLCNs are prevalent amongst young offenders and young unemployed men:
    - Clegg et al. (1999) showed that a third of children with speech and language difficulties develop mental health problems with resulting criminal involvement in some cases;
    - A 2003 Polmont Young Offenders Institute (YOI) survey found that 70% of young men had significant communication problems;
    - 66-90% of young offenders have low language skills, with 46-67% of these being in the poor or very poor range (Bryan et al. 2004);
    - This area of difficulty is likely to cause them significant problems, in particular, in formal settings, such as police interviews, court, job interviews and so on (Lanz, 2009);
    - Many young offenders lack understanding of their communication difficulties and may not know that they have misunderstood or may present as surly and uncommunicative (Bryan, 2009);
    - Half of the UK prison population has been identified as having literacy difficulties and Home Office studies have shown that around 35% of offenders only have speaking and listening skills at a basic level[17].

63. Research shows that speech and language therapy targeted at improving the language skills of individuals can significantly reduce the number of them who go on to offend[18]. A national study carried out in 2001/2002 showed that the recidivism rates were reduced by as much as 50% for individuals who

[17] Davies K. et al (2004) An evaluation of the literacy demands of general offending behavioural programmes, Home Office Findings 233
[18] Bryan, K. Prevalence of speech and language difficulties in young offenders in the International Journal of Language and Communication Disorders, 39, 391-400. (2004)

received targeted speech and language therapy to improve their oral language skills in their first year after release[19].

64. The Youth Justice Agency in partnership with the Royal College of Speech and Language Therapists held a conference entitled 'Locked Up and Locked Out: Communication is the Key' at the University of Ulster on 30 June 2009. The link between offending and communication difficulties was well illustrated and recent research and practice improvements in the UK were highlighted.

65. As a result a paper was put to the Criminal Justice Board to ask the relevant agencies (PSNI, Public Prosecution Service, NI Court Service, NI Prison Service, the then NIO, Probation Board for NI and YJA) to adopt a common framework approach to the issues of learning disability and communication difficulties. The need to liaise and consult widely was accepted as an imperative.

66. In September 2009, a Multi-Agency Steering Group (MASG) on Learning Disability, Learning and Communication Difficulty (LDLCD), was formed by the NIPS following a Penal Reform Trust report "Know One Knows" into the prevalence and response to offenders who may have a learning disability and/or a learning difficulty. Membership is drawn from all the criminal justice agencies (NIPS, PSNI, PPS, NI Court Service, PBNI and the Youth Justice Agency). The Department of Education and HSC Trusts are also represented, along with a number of voluntary sector bodies.

67. The Multi-Agency Steering Group on Learning Disability, Learning and Communication Difficulties covers the following main areas:
    - Awareness raising within agencies and across the system;
    - The development of common early identification tools which will include common definitions and be a reliable source of evidence;
    - Improving the flow of information, as appropriate, within and between agencies;

[19] Moseley, D et al. *Developing oral communication and productive thinking skills in HM Prisons* (Learning and Skills Research Centre, 140. 2006)

- Making reasonable adjustments to policies and practices to better meet the needs of persons with learning and communication difficulties;
- Provide staff training on areas relating to learning and communication difficulties to equip staff to interact more effectively in day to day contact with this vulnerable group.

SECTION 2: CURRENT SERVICE PROVISION

WORKFORCE PLANNING

TRAINING AND DEVELOPMENT

SERVICE IMPROVEMENT

SECTION 2: CURRENT SERVICE PROVISION

WORKFORCE PLANNING

68. The following table provides a breakdown of the Speech and Language Therapy workforce for children and young people as of December 2010.

Table 4

Qualified SLTS		**NHSCT**	**BHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**
1	WTE SLT permanently funded posts for 0-18.11 years in children's teams	60.8	53.43	37.19 **	37.71	30.95 ****
2	WTE vacancies in above permanently funded posts 0-18.11 years in children's team	4.5	4.14	0	3.18	1.6
3	WTE temporarily funded posts for 0-18.11 years in children's teams	0.6	4 *	0	0	0.17
4	WTE vacancies in above temporarily funded posts	0.4	0	0	0	0
5	WTE staff on maternity leave	4.46	1	2.72	1.5	3
6	WTE staff on career break (CB) / secondment (sec)	1.5	1.47	1.55	0	1
7	WTE supernumerary staff in posts	0	0	0	0	0
SLT Assistants / Technical Instructors		**NHSCT**	**BHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**
1	WTE SLTAs permanently funded posts for 0-18.11 years in children's teams	10.793	7.78	6.99	4.5	8.92
2	WTE vacancies in above permanently funded posts 0-18.11 years in children's team	0	1.2	0	0.3	0
3	WTE temporarily funded posts for 0-18.11 years in children's teams	0	0	1.47 ***	0	1
4	WTE Vacancies in above temporarily funded posts	0	0	0	0	0
5	WTE staff on maternity leave	1.4	0	0	0	2
6	WTE staff on career break (CB) / secondment (sec)	0	0	0	0	1
7	WTE supernumerary staff in posts	0	0	0	0	0
Admin and Clerical Support		**NHSCT**	**BHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**
1	WTE A&C staff permanently funded to support Head(s) of Service	0.8	0.2	0.5	0.24	0.2
2	WTE A&C staff permanently funded to support above posts *****	5.96	2.54	2.51	4.78	6.1

* There are also 1.66 SLTs in Surestarts in Belfast area for which the Trust does not have lead responsibility
**Plus 3 working in ASCET Multidisciplinary Team
***0.67 Extended schools project plus 0.8 Surestart (fixed term contracts)
****Surestart = 1.52, West Team = 3.32, ASD Team = 2.0
***** includes staff in m/d teams as well as core service, but does not include staff supporting head(s) of service.

TRAINING AND DEVELOPMENT

69. Speech and language therapy is a graduate profession. DHSSPS commissions the undergraduate BSc Honours course for Speech and Language Therapy in Northern Ireland. The course is situated at the University of Ulster at Jordanstown (UUJ) and has availability for 30 places per academic year. Following graduation, speech and language therapists are eligible for registration with the HPC.

70. Following graduation there is a range of post –graduate development opportunities available through the Beeches Post-Graduate Centre for Allied Health Professions and both Queens University and UUJ, with opportunities up to Doctorate level. This allows for the continuing professional development required within the profession to maintain professional registration with the HPC. There are also considerable opportunities for research and development through the R&D Office at the Public Health Agency.

SERVICE IMPROVEMENT

71. Health service provision for children with SLCNs has improved significantly over the past number of years, with patients and speech and language therapy services having benefitted from substantial investment in elective care reform.

72. The NICCY Reviews of Speech and Language Therapy provision in 2005 and 2006 resulted in additional funding of £1m in 2006/07 to help address the issues raised in the reviews. This funding was baselined from 2008/09.

73. An additional £4m funding was also provided to Trusts in 2006-07 and 2007-08 to establish multidisciplinary teams for children and young people, and was incorporated into baseline figures from 2008/09. Speech and language therapists are recognised as an essential component of those teams.

74. Finally, the Health Minister secured an additional £0.2m of service development investment in 2009/10 under the Comprehensive Spending Review, which has now been baselined.

75. At 30 September 2010 there were 422 (355.9 WTE) Speech and Language Therapists supporting children and adults in the Health and Social Care sector in Northern Ireland, as well as 69 (54.2 WTE) SLT assistants.

76. As part of service improvement, the Department issued a regional Priority for Action (PfA) target to standardise the access criteria across its services in relation to Allied Health Professional (AHP) services. This requires Health and Social Trusts to ensure that, from March 2010, no patient waits longer than 9 weeks from referral to commencement of AHP treatment, including speech and language therapy; a reduction from 28 weeks in 2008. The most recent information available indicates that at 31 December 2010, 106 people had been waiting for longer than 9 weeks for a speech and language therapy appointment. Health and Social Care Trusts are working on reform programmes and implementation plans in order to meet these targets and address assessment and waiting times.

77. Additionally, the Department commissioned Business Consultancy Services within the Department of Finance and Personnel to help improve the commissioning and planning of HSC Trust speech and language therapy services. A scoping exercise has recently been completed, which may inform future service improvement and redesign. This scoping exercise assessed the different demands and delivery mechanisms required from SLT services to children and young people between 0 and 21 years.

SECTION 3: THE WAY FORWARD

COLLABORATIVE WORKING

THE IMPORTANCE OF PREVENTION AND EARLY INTERVENTION

CARE PATHWAY

TRANSITIONS

PRINCIPLES OF BEST PRACTICE

TRANS-DISCIPLINARY WORKING

NEXT STEPS

SECTION 3: THE WAY FORWARD

78. Previous sections have detailed the scale and nature of the issues involved in Speech and Language Therapy provision, and provided an outline of the service improvements carried out to date in terms of investment, staffing levels and waiting times. This section sets out the guiding principles to be used in the further development of services.

COLLABORATIVE WORKING

79. Collaborative, integrated working across statutory and voluntary providers (including health and social care, education, criminal justice, etc) is essential within universal and targeted services to secure effective early support, identification and intervention at all stages in the development of children and young people.

80. In this respect, many models of good practice already exist in Northern Ireland, which demonstrate excellent examples of collaborative working. These should be reviewed and developed on an ongoing basis.

81. The successful delivery of the envisaged holistic support service, which places the child firmly at the centre and which will provide early and effective intervention, will require some redesign in the delivery of speech and language therapy services. Teachers and other staff in educational settings will require further multidisciplinary support and advice from the SL service to ensure children experiencing speech, language and communication difficulties are not only identified early but related educational strategies can be put in place in the classroom to support SLT intervention.

82. The Department of Education has recently issued the policy proposals which have emerged from the Review of Special Educational Needs (SEN) and Inclusion. The policy proposals, as contained in the Department of Education's consultation document *Every School a Good School: The Way Forward for SEN and Inclusion*, reflect the vital importance of joined up working between all professionals in delivering the services for children who require additional support

in learning. A factual summary of the responses to the consultation will issue in Spring 2011 and will help inform further development of policy options surrounding multi agency working. This work will involve further engagement with DHSSPS (and Board and Trust colleagues) and the Department of Employment and Learning (DEL).

THE IMPORTANCE OF PREVENTION AND EARLY INTERVENTION

83. The Child Health Promotion Programme, delivered within Northern Ireland through Healthy Child, Healthy Future (2010), provides a framework for connecting the range of different policies and spheres of activity that support children and young people's health and development in the early years and beyond (Hall & Ellimann, 2003).

84. The universal service is provided to the total population of children and young people aged 0-19 years, irrelevant of need. Even where children receive additional resource e.g. those who are 'Looked After' or with special educational needs, they are still entitled to a universal service.

85. Essentially a universal service is one where a number of contacts are made with children and families to identify health need, through both screening and surveillance and, where necessary, early intervention to mitigate the potential early negative impact of any physical, social or emotional factors.

86. Where early intervention is unable to address need, escalation to a more progressive level of intervention should be considered.

87. In relation to the development of speech and language, parents are supported by health visitors to understand and support the developmental needs of their child (e.g. through play, reading, etc) as they grow and develop and to identify the normal range at each stage within the preschool years. Whilst formal screening of all children is not recommended for speech and language delay, where there is concern, screening will be undertaken and referral to speech and language therapy services made as appropriate. SLTs work closely with health visitors to

develop their skills to identify and support those children at risk of speech, language and communication difficulties.

88. Other factors influencing normal development are important and an increasing evidence base outlining the importance of secure relationships early in life, and of early attachment and good parenting, indicates that early identification of such issues are effective in helping to prevent damaging patterns of behaviour being established. Investing in a preventative approach through early intervention will result in positive outcomes not only in terms of conduct, behaviour, and lifestyle but also in the long term emotional health and well-being of children and young people.

89. The Public Health Agency recently published Information and Referral Guidance on Speech and Language Therapy for Children, as part of the Healthy Child, Healthy Future guidance. This is a training and information resource which supports and reinforces a collaborative approach between speech and language therapists, referrers and parents in the identification and management of children with developmental SLCNs. The aim of the document is to revise and enhance referrers' skills in identifying children's SLCNs. It will provide referrers with additional information to enhance their management options for the child; provide referrers with information to deliver health promotion messages regarding SLC development; and will present referral guidance for children presenting with SLCNs.

90. It is recognised that children and young people with SLCNs may benefit from the use of communication aids. Currently, assessments for these aids are carried out at the Communication Advice Centre (CAC) at Musgrave Park Hospital. Further work is required to scope current provision to support future decision making in this area.

CARE PATHWAY(S)

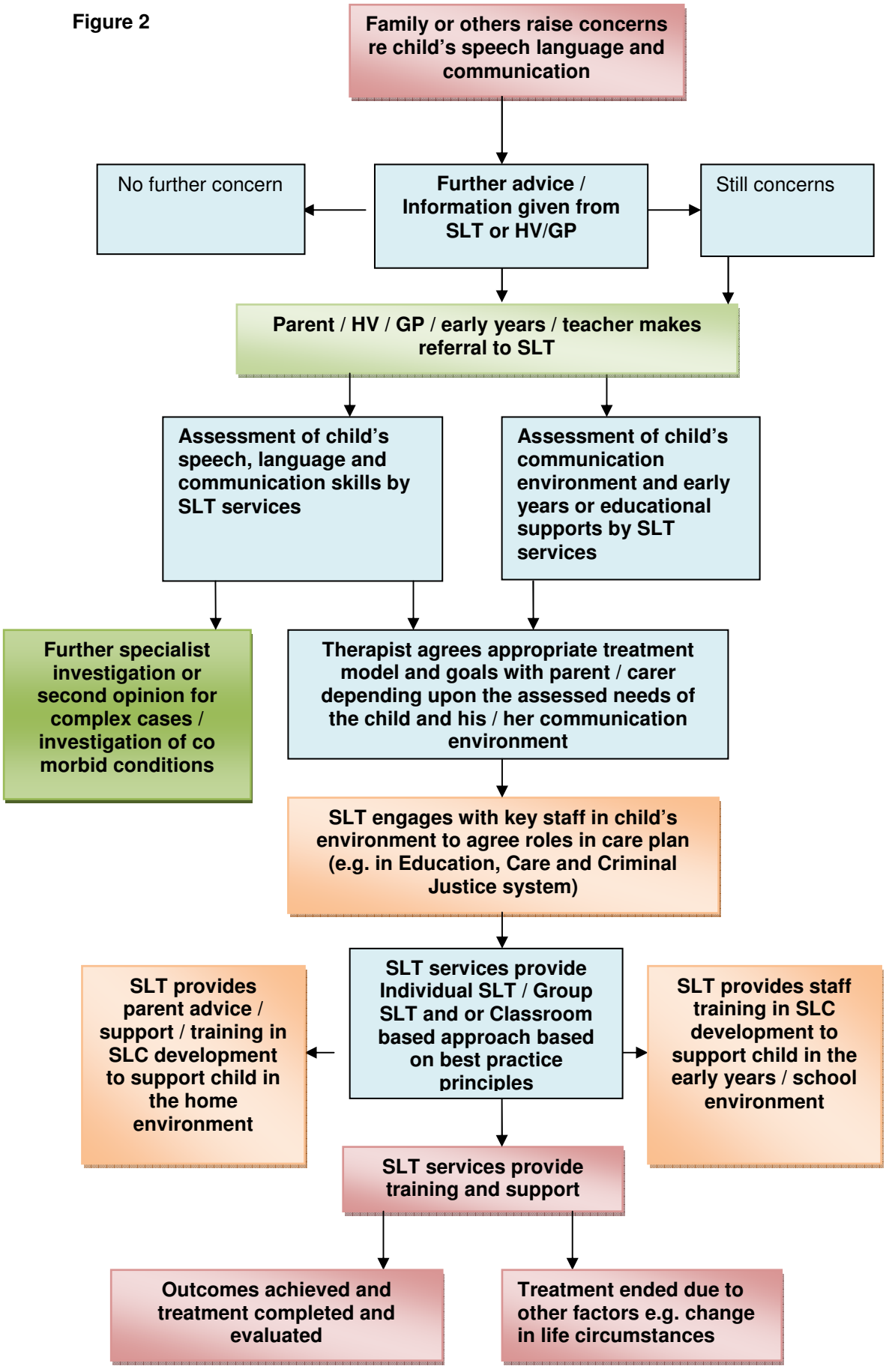
91. It has been agreed that there is a need for a generic care pathway to aid health professionals in making decisions about how to manage the care of children and young people who present with speech, language and communication needs. It should be noted that this generic care pathway is intended to be a tool for guidance, and can be modified, added to or adapted for use with different client groups with specific needs.

92. The care pathway described in this section relates to the child or young person's journey from referral to discharge. It is understood that the speech and language care pathway is embedded in a wider integrated care pathway for all children and young people with speech, language and communication needs. Health Visitors, early years workers, teachers and paediatricians all play an important role in the early identification of children with SLCNs. Currently the DHSSPS is working with speech and language therapists to develop an agreed care pathway model. Speech and Language Therapists believe that it is equally relevant to have an SLT supporting a child with a complex disability as it is to be involved in the preventative work aimed at a general population.

93. The development of this care pathway work will be led by the Public Health Agency in collaboration with the relevant agencies.

Generic Care Pathway – Placing the Child and Parent at the Centre of Care

Figure 2



Speech and Language Therapy Interfaces With Child Populations

94. The following diagram demonstrates that SLTs work at all levels of need within child populations, including:-

95. **Level One:** Base Population - where children and families typically self-refer and access universal and community resources as part of everyday life;

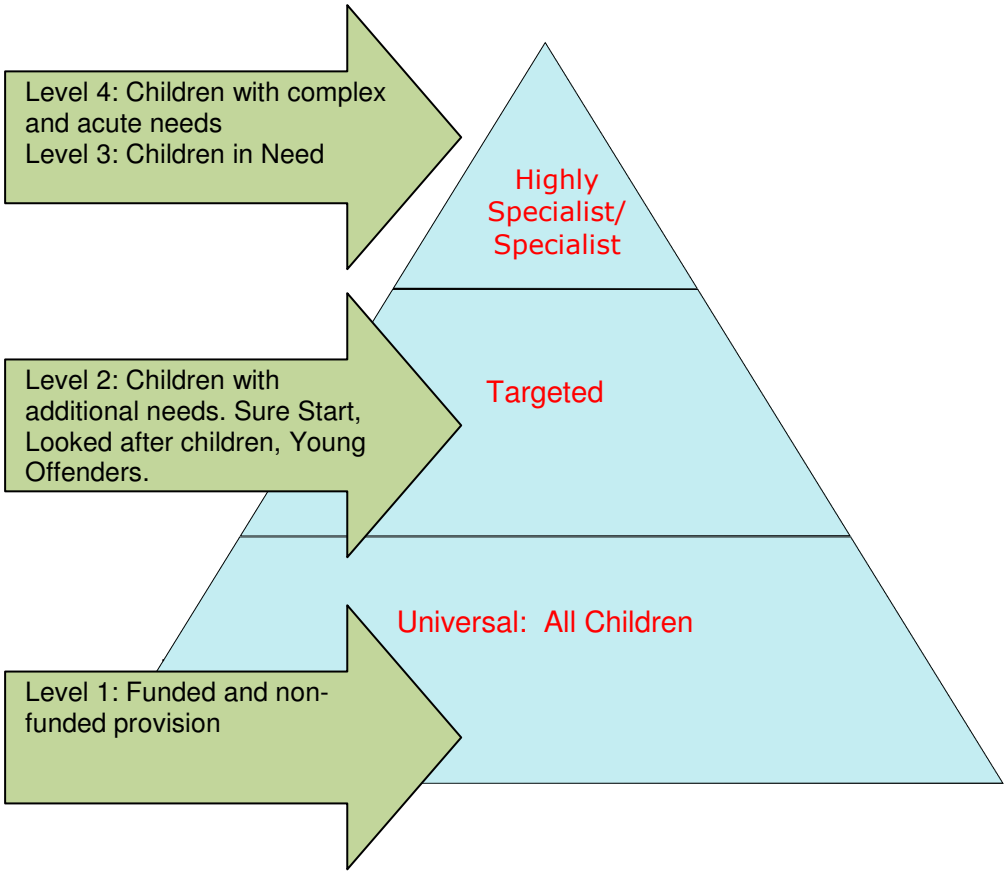
96. **Level Two:** Children with Additional Needs - where some children and families are offered enhanced assistance from universal and other services such as Sure Start;

97. **Level Three:** Children in Need - where children have been identified as children in need including disabled children whose families may require additional services;

98. **Level Four**: Children with Complex and Acute Needs - where children experiencing the most acute, intense or complex difficulties because of health, disability or vulnerability due to their family situations will normally be provided with coordinated support and intervention that may involve a multi-agency response.

99. The model is based on the Thresholds of Need Model (DHSSPS, 2008), *Understanding the Needs of Children in Northern Ireland (UNOCINI)*. Working within this model secures an effective and co-ordinated approach to assessment and identification of needs within integrated children's services.

Figure 3 **SLT Interfaces with Child Populations**



Care Pathway – Contributory Work

100. As a result of the Priorities for Action (PfA) target to reduce waiting times for Allied Health Professions (AHP) services, a range of regional work streams were identified and taken forward by the AHP Reform Network.

101. The network is facilitated and supported on a regular basis through the Performance Management and Service Improvement Directorate (PMSID) at the HSC Board.

102. Initial discussions clarified that each Trust had various pathways, access criteria and means of delivering services for each group of patient. It was felt that this represented an inequity of access across the region.

103. Through a speech and language subgroup (on which all HSC Trusts are represented), the network has defined the access criteria and care pathways and typical patient journey for paediatric cases and adult neurology cases.

104. The care pathways are based on a clinical decision-making approach with clear decision and action points identified along the pathways which also detail the discharge criteria for each patient group.

105. Agreement has been reached that each Trust will accept the care pathway model as developed by the subgroup and replicate these locally.

106. There is currently ongoing work on establishing the demand and capacity of each of the current services and pathways, and the capacity requirements that a new model of service delivery might require.

107. The outcome of this work will further inform the commissioning of services.

108. In conjunction with the regionally agreed care pathway and access criteria, each Trust is also undertaking baseline assessment and developing action plans in relation to the basic steps in the systems and processing of referrals, including the centralisation of registration of referrals, prioritisation of referrals, capacity planning, booking processes, application of appropriate Did Not Attend / Could Not Attend (DNA/CNA) Policy.

TRANSITIONS

109. It is widely recognised and accepted that the transfer and transition periods are "vulnerable" stages of a young person's development, a reality acknowledged by the Hall 4 Report[20].

110. There are two key stages within a young person's educational process:
    - Transfer is the transfer to pre-school, from pre-school to primary education, from primary to post primary and moving between different environments;
    - Transition is the process of moving from post primary to one of the following – Further Education; Higher Education; Training and Employment; Unemployment; and Adult Day Care Services.

[20] Hall 4 Report DHSSPS Nowling, M. (eds) Dyslexia, Speech and Language: A Practitioner's Handbook. 2nd Edition, Whurr Publishers (2006)

111. The processes of Transfer and Transition can also include the transfer and transitioning between other environments such as residential, supported living and respite services. Transition, whether big or small, regular or infrequent, can impact on an individual with SLCNs and every service and new environment needs to meet this challenge to ensure that the individual is properly supported. It is also important to ensure that appropriate information on what services are available at Transition is available to parents and young people themselves as part of Transition planning.

112. Given the importance of transitions in the health and social care sector, there are a number of multi-agency initiatives underway which are considering transitions planning for children and young people with disabilities. For example, in June 2009 the Department launched the document *Developing Services to Children and Young People with Complex Healthcare Needs*, which highlighted service developments to be taken forward under the aegis of a Regional Inter-agency Implementation Group (RIIG).

113. Reference Groups were established to drive specific areas of work forward. The Transition Reference Group aimed to develop a regional response to the transition issues faced by young people with complex healthcare needs by hosting three workshops to look innovatively at developing a regional response to 4 key issues identified by young people and parents: the implementation of a regional transition care pathway; information and mode of delivery; commissioning (how packages continue); and medical issues.

114. Delegates at the workshops agreed to set up a Regional Interagency Transitions Group with representation from child and adult services, young people and parents to lead work, which will include but not be limited to:

- Agree Terms of Reference for Regional Transitions Group;
- Carry out a scoping exercise in each HSC Trust to determine the pathways used and the information given to families. The information from the scoping exercise should be reviewed by a regional group and a regional framework agreed;
- To commission and implement a Regional Integrated Care Pathway for Transition;

- Encourage the formation of multi-agency transition groups at HSC Trust level and ensure meaningful participation from professionals and young people/families;
- Identify professional responsible for Transition at HSC Board, HSC Trusts and DHSSPS.

Transitions Planning in Schools

115. Transitions planning is equally important in an education setting. Factors such as the language of the curriculum, the variety of subjects and the challenges of secondary school can present major difficulties to the post primary school age child. Coping with a new school, new subjects, travel, different teachers, and making new friends can lead to feelings of isolation.

116. The Code of Practice on the Identification and Assessment of Special Educational Needs and the Supplement to the Code of Practice, which are issued by the Department of Education under Article 4 of the Education (NI) Order 1996, require an Education and Library Board to produce a transition plan at the first (and subsequent) Annual Review of a statement of special educational need following the young person's 14th birthday.

117. This education Transition Plan draws together information from a variety of sources, including the young person, his/her parents, the school and any other professional involved with the young person. It aims to plan coherently for the change when a young person moves from school to adult life.

118. Parents of children with SLCNs report that they would benefit from timely information regarding the availability of services that will meet the needs of their child at transfer and transition. The involvement of a speech and language therapist in the transitions team would also be of benefit to the child or young person.

PRINCIPLES OF BEST PRACTICE IN MODELS OF SERVICE DELIVERY FOR CHILDREN WITH SPEECH, LANGUAGE AND COMMUNICATION NEEDS

119. Services should provide equitable access to effective and efficient SLT provision for children with speech, language, communication, feeding and swallowing needs.

120. It is recognised, however, that there are a range of models of service delivery which have developed and which are appropriate in different contexts, e.g. cultural or geographical, and are relevant and appropriate depending on the client group and at the different stages in a child's life.

121. However, the overriding principles of any model of service delivery should reflect the following:

<u>Models should:-</u>

- Be provided in line with professional standards and guidelines of practice to ensure the highest quality of speech and language therapy provision whilst maximising resources;

- Ensure the appropriate range of skills and competencies are available to address the needs of children with SLCNs;

- Work in partnership with the child, their family and other professions and agencies to reduce the impact of the SLCNs;

- Anticipate and respond to the needs of children who may experience speech, language, communication or swallowing difficulties;

- Be provided in a range of working contexts e.g. domiciliary, community clinics, hospitals, child development centres, schools (mainstream & special schools / units);

- Be integrated across health and social care, education and other agencies in both commissioning and delivery of services;

- Reflect a tiered approach to service provision with universal, targeted, specialist and highly specialist levels as appropriate;

- Enable timely and appropriate access to speech and language therapy services in line with the regional access criteria;

- Be provided in line with the N.I regional care pathway models (range of client groups);

- Reflect uni, multi and trans-disciplinary models of service delivery as appropriate.

TRANS - DISCIPLINARY WORKING

122. A trans-disciplinary approach is an integrated model of working to ensure that the holistic needs of the child are met.

123. Within this model of working the child and his or her needs are placed at the centre of the team. Professional skills and expertise are developed amongst members when adopting this approach and specialist core individual professional skills are enhanced. This subsequently enables therapy aims from other professional groups to be integrated into a child's therapy session through joint goal setting, thereby ensuring the delivery of a comprehensive programme. For example, a physiotherapist may deliver a programme to enhance a child's gross motor skills, whilst incorporating concept development to address a child's language difficulties following support and guidance from the Speech and Language Therapist within the team.

124. For example, the Public Health Agency and HSC Board are leading in developing a review of AHP support for children with special needs in both special schools and mainstream education. This will examine equity of access to AHP services for children with special needs, and encourage partnership working with the education sector and parents, along with the development of a tiered model of therapy provision.

NEXT STEPS

125. The Public Health Agency / Health and Social Care Board will be responsible for driving the implementation of the Action Plan over its two-year life cycle. The Department will consider 1 April 2011 as the start point for implementation and will require six monthly progress reports thereafter.

SECTION 4: ACTION PLAN

HOW TO READ THIS ACTION PLAN

ACTION PLAN

SECTION 4: ACTION PLAN

HOW TO READ THIS ACTION PLAN

Four Themes

126. The Action Plan seeks to improve speech and language therapy services to meet the assessed needs of children and young people, families and carers. The plan is made up of key actions, a timetable for completion, the associated outcomes and the benefit of each action for children and young people and their families.

127. The Action Plan is organised around four themes:
    (a) Commissioning and service redesign to maximise outcomes;
    (b) Supporting and empowering children, parents and carers;
    (c) Enabling HSC staff to promote early recognition, assessment, intervention, treatment, care and support;
    (d) Collaboration between speech and language therapists and teachers and education professionals to enable them to promote early recognition, assessment, intervention and support.

Task Force Recommendations

128. The Speech and Language Therapy Task Force Report included a number of recommendations based on the findings of the Task Force. These recommendations were grouped into five key areas:
    1. Strategic Policy, Planning and Commissioning;
    2. Partnership and Collaborative Working;
    3. Delivering Equitable and Effective Models of Service Delivery;
    4. Education and Training; and
    5. Workforce.

129. These areas and the recommendations they cover have been carefully considered during the drafting of this Action Plan. All actions detailed in the following Action Plan will state in the final column which of the key areas above they correspond to, numbered 1 to 5.

Speech, Language and Communication Therapy Action Plan

2011/12 – 2012/13

Key Themes

A Commissioning and service redesign to maximise outcomes;

B Supporting and empowering children, parents and carers;

C Enabling HSC staff to promote early recognition, assessment, intervention, treatment, care and support;

D Collaboration between Speech and Language Therapists and teachers and education professionals to enable them to promote early recognition, assessment, intervention and support.

Theme A – *Commissioning and Service Redesign to Maximise Outcomes*						
Action Plan Point Ref No.	**Key Actions and Service Needed**	**For Action By**	**Outcome Required**	**Timetable for completion and key milestones**	**Benefits**	**Task Force 1-5**
A1	Agree commissioning framework for SLT for children and young people up to age 19. Incorporate care pathway approach and principles of best practice intervention models.	HSCB/PHA in collaboration with HSC Trusts, Primary Care, and voluntary/ community and education sectors Criminal Justice System (CJS) Royal College of Speech and Language Therapists (RCSLT)	Service planners should have an agreed understanding of care pathway approach and agree assessment tools and standards	September 2011	Promotion of equality of access to service provision and seamless care	1, 2, 3

A2	Agree care pathway(s) for speech and language therapy. Key elements to include: • Awareness raising • Information provision • Early intervention • Agreed referral criteria • Clinical prioritisation • Principles of Best Practice intervention • Involvement in treatment planning / goal setting • Agreed discharge criteria • Self management / parental and educational support • Provision for timely re-entry into SLT services for patients who are subject to medium and long term reviews.	HSCB/PHA in collaboration with HSC Trusts, Primary Care, and voluntary/ community and education sectors CJS RSCLT	An agreed understanding and sharing of a generic model of treatment/care that supports early intervention, and the involvement of parents and educational providers An understanding of goal setting and the respective roles of individuals, parents, staff and educationalists, where appropriate.	From April 2011 onwards	Early intervention and improved outcomes for children with a speech, language and communication need. Promotion of self management and information provision to assist parents and staff in ongoing management of the child with a clear understanding of predicted goals and outcomes.	1, 2, 3, 4, 5

A3	Scope SLT services in Northern Ireland.	Commissioned by DHSSPS in collaboration with HSCB / PHA HSC Trusts SLTs DFP	Service level is determined and areas identified for possible improvement.	March 2010 **Action completed**	SLT services are streamlined and work more efficiently.	1, 2, 3, 5
A4	Agree service redesign to reflect a tiered approach to service provision: • Universal • Targeted • Specialist; and • Highly specialist; as appropriate to needs of patients, and families.	HSCB/PHA in collaboration with Health Visitors / school nurses within HSC Trusts, Primary Care, and voluntary/ community/independent and education sectors RCSLT	Promotion of early intervention and up-skilling of staff relevant to the level of specialist intervention required	December 2011	Health promotion, intervention and detection of "red flags" at earlier stages of intervention. Assessment appropriate to need.	1, 2, 3, 4, 5
A5	Standardise speech and language therapy input into Sure Start schemes.	HSCB/PHA in collaboration with HSC Trusts, Primary Care, and voluntary/ community and education sectors	Enhance child development and early recognition and support for children in need.	December 2011	Promotion of health and wellbeing; reduction in inequalities.	2, 3

A6	Develop innovative approaches to reduce "Did Not Attend" (DNA).	HSCB/PHA in collaboration with HSC Trusts, Primary Care, and voluntary/ community and education sectors. May link with GAIN audit programme.	Audit of DNAs and causes of delayed or late referral. Promote models of interventions which improve access to SLT services and reduce DNAs, especially for hard to reach children and families.	March 2012 and beyond	Assist the child, parents and family to achieve goals and improve outcomes.	1, 2, 3
A7	Develop a Partnership Agreement between HSC Board / Public Health Agency and the education sector which identifies the respective responsibilities of each sector to promote speech, language and communication development, and to support a principles-based approach to speech and language therapy interventions.	HSCB/PHA in collaboration with HSC Trusts, ELBs and education sectors and community and voluntary sectors.	Promote speech and language development.	March 2012	Promote wellbeing, and social inclusion for the child, young person and their family.	2, 3

A8	Develop a speech, language and communication care pathway for children and young people who are not in education, training or employment and for Young Offenders.	HSCB / PHA in collaboration with HSC Trusts, education, employment and youth justice organisations / agencies, RCSLT.	An agreed understanding of the linkage with the generic care pathway; a nominated lead to promote coordination of care planning, for those with a SLC need.	March 2012 and beyond	Improved outcomes for individuals, promotion of social inclusion and enhanced "life chances".	1, 2, 5
A9	Reduce waiting times from 13 weeks to 9 weeks for patients from date of referral to first treatment.	HSCB / PHA HSC Trusts	That no one waits longer than 9 weeks from initial referral to treatment.	From April 2010	Patients are guaranteed to begin treatment within 9 weeks and undue delays are avoided.	1, 3
A10	Develop audit criteria to promote and enhance the quality of service provision. Criteria to be agreed but could include: - provision of individual care plan; - best practice models of provision; - reasons for discharge; - Customer satisfaction.	HSCB/PHA in collaboration with HSC Trusts, Primary Care, may link with GAIN audit programme.	Agreed information provision to inform commissioning and development of services.	From March 2012	Promotion of quality services.	2, 3, 4

A11	Scope unmet need in relation to individuals with SLCNs in the Criminal Justice System.	HSCB / PHA / SEHSCT in collaboration with NIPS and CJS.	Data to inform decision making in CJS.	From March 2012	Facilitate intervention and improved outcomes for young people in CJS.	1, 2, 3
A12	Standardise data collection for speech and language therapy information.	HSCB/PHA, HSC Trusts	Standardised data available to be used in planning and commissioning of services.	March 2012	Reliable information is used to inform decision making.	1, 2, 3, 5
A13	Scope current provision of communication aids for children and young people.	HSCB/PHA, HSC Trusts	Data to support future decision making regarding the provision of communication aids.	From March 2012	To maximise the benefits of new communication aids for children and young people.	1, 2, 3

Theme B – *Supporting and Empowering Children, Parents and Carers*						
Action Plan Point Ref No.	**Key Actions and Service Needed**	**For Action By**	**Outcome Required**	**Timetable for completion and key milestones**	**Benefits**	**Task Force 1-5**
B1	Promote early development of speech, language and communication through working with parents. Roll out of early years support material, for example, Bookstart.	HSCB/PHA, Health Visitors within Trusts and Primary Care in collaboration with RCSLT, as well as community, voluntary, independent and education sectors	Encourage parental interaction with child to promote early speech, language and communication development.	Ongoing March 2012	Part of universal services, linked to Health For All Children (Hall and Elliman, 4th Edition), delivered locally through Healthy Child, Healthy Future (2010), to support children and young people's health and development.	2, 4
B2	Amendment of Parent Child Health Record to promote earlier identification of child development concerns.	HSCB/PHA in collaboration with HSC Child Health Promotion Programme in NI.	Earlier identification of "red flags" to support parents to identify concerns regarding child development milestones.	October 2010 **Action Complete**	Part of universal services, linked to Health For All Children (Hall and Elliman, 4th Edition), delivered locally through Healthy Child, Healthy Future (2010), to support parents in the health and development of their child.	3, 4, 5

B3	Agree HV actions, where there is parental concern about speech/language/communication development, in line with Healthy Child, Healthy Future: Speech and language therapy for children – Information and Referral Guidance, for use prior to HSC referral.	HSCB/PHA Health Visitors and SLTs within HSC Trusts, in collaboration with Primary Care, RCSLT and voluntary/ community sector.	Earlier engagement with child and parents where concerns have been identified.	December 2010 **Action Complete**	Earlier intervention and appropriate referral.	3, 4, 5
B4	On entry into primary school, a health appraisal will identify concerns regarding speech, language and communication and refer appropriately.	As above School nurses within Trusts.	Earlier engagement with child and parents where concerns have been identified.	31 December 2011	Earlier intervention and appropriate referral.	2, 3, 4, 5
B5	Where need has been identified, discuss and agree treatment plan with parents / carers with agreed outcomes and respective responsibilities of staff, child and parents/families/carers and educationalists, as appropriate.	HSCB/PHA HSC Trusts Speech and language therapists and assistants, child, parents and educationalists.	Realistic treatment goals and greater understanding of treatment plan.	From March 2011	Promotion of a collaborative approach to intervention. A nominated support worker should be known to the child and family and the education sector, where appropriate.	2, 3, 4, 5

B6	Seek written consent of parents/child/young person to share treatment plan and actively encourage sharing of it with other sectors such as nursery, school, college, youth offender establishments, in accordance with DHSSPS guidance in Good Practice in Consent (2003) and the Data Protection Act 1998.	HSCB/PHA HSC Trusts Speech and language therapists and assistants, child and parents.	Greater collaboration and involvement of parents, families and other sectors.	March 2012	Promotion of a collaborative approach to intervention in the interests of child or young person.	2, 3, 4, 5
B7	Harmonise existing sources of information for children, young people, parents and carers, ensuring they are evidence based, can be maintained and aligned with best practice, and periodically evaluated.	HSCB / PHA HSC Trusts ELBs RCSLT Voluntary and community organisations.	A central resource, targeted at children, young people, parents and carers, in user friendly language to assist and encourage self management and involvement.	March 2012	A one-stop-shop approach to the provision of web-based information which can be regularly updated and maintained.	2, 4

B8	Develop standards for communication practices for parents and therapists in a school setting.	HSCB/PHA HSC Trusts SLTs and assistants, parents and teachers RCSLT Afasic.	Agreed standards for dissemination to schools and parents.	From March 2012	To ensure standardisation of best practice across region.	1,2, 4, 5

Theme C – *Enabling HSC Staff to Promote Early Recognition, Assessment, Intervention, Treatment, Care and Support*						
Action Plan Point Ref No.	**Key Actions and Service Needed**	**For Action By**	**Outcome Required**	**Timetable for completion and key milestones**	**Benefits**	**Task Force 1-5**
C1	Review of the training and update available for health visitors within training and 'In-Service Education' programme provision regarding Speech and Language development and subsequent steps to improve speech, language and communication. Recognition of co morbidities and potential impact on communication and behaviour, e.g. moderate acquired brain injury.	HSCB/PHA in collaboration with HSC Trusts, and including Nurse education providers through the University of Ulster and Nurse Education Commissioning Consortia.	Harmonisation of Health Visitor training package and information tools. Earlier detection of hidden co morbidities.	March 2011 (through introduction of updated Child Health Promotion Programme) Training programme for students undertaking Health Visitor training – 31 March 2011 ongoing thereafter	Improved awareness among HVs and school nurses and support to children and parents. Timely re-entry into service to ensure appropriate intervention.	2, 3, 4, 5

C2	Training and awareness-raising for general practitioners on “red flags” regarding child development milestones and subsequent steps to improve speech, language and communication. Recognition of co morbidities and potential impact on communication and behaviour, e.g. moderate acquired brain injury.	HSCB/PHA HSC Trusts NIMDTA GPs RCSLT	Additional information for GP practices and enhanced training. Earlier detection of hidden co morbidities.	March 2012 and ongoing	Improved awareness among general practitioners on speech, language and communication development and assistance to parents. Timely re-entry into service to ensure appropriate intervention.	2, 3, 4, 5
C3	Analysis of late referral of children with speech, language and communication difficulties to SLT services.	HSCB/PHA in collaboration with HSC Trusts and Primary Care. May link with GAIN audit programme.	Additional information to assist HSC staff to promote earlier recognition of needs; better engagement with parents; reduction in DNA rates.	March 2012	Better outcomes for individual children and young people through earlier recognition and referral and systems redesign, where appropriate.	1, 2, 3, 5

C4	Undertake a workforce analysis of SLT skill mix within the context of the Allied Health Professionals Strategy.	DHSSPS HSCB/PHA HSC Trusts	A strategic vision for AHPs, to include SLTs.	April 2012	An appropriately skilled workforce to enhance timely intervention for children, parents, families etc.	1, 3, 5
C5	Include Speech and Language Therapist in Transitions teams within HSC Trusts.	HSCB/PHA HSC Trusts	Increased trans-disciplinary working and SLT involvement in transition planning. Timely information provided to parents and clients prior to transition re availability of services.	March 2012 onwards	SLCNs are equally considered in transition planning, ensuring better outcomes for children and young people during and after transition phase.	1, 2, 3
C6	Trusts will seek to ensure in their registration and monitoring of non-statutory early years services that providers are aware of the indicators of SLCN's in children and young people and also how to refer to SLT services for appropriate intervention.	HSCB/PHA in collaboration with HSC Trusts	Improved awareness of SLCNs in non-statutory early years settings.	March 2012	Improved early identification of SLCNs in non-statutory early years settings.	1, 2, 3, 4

Theme D – *Collaboration between Speech and Language Therapists and Teachers and Education Professionals to Enable them to Promote Early Recognition, Assessment, Intervention and Support*						
Action Plan Point Ref No.	**Key Actions and Service Needed**	**For Action By**	**Outcome Required**	**Timetable for completion and key milestones**	**Benefits**	**Task Force 1-5**
D1	Initiate discussions with training organisations around inclusion of understanding of child development and the relevance of speech and language to learning within undergraduate teacher training courses and Further Education childcare courses.	DHSSPS in collaboration with other government departments and Education providers.	Enhanced understanding and awareness by teachers **and other care providers** of child development milestones.	From December 2010 Initial discussions completed	Improved understanding of child development and the relevance of speech and language to learning in undergraduate teacher training **and other relevant childcare courses.**	1, 2, 3, 5
D2	Develop information and awareness-raising materials for use in pre-school, primary, post-primary school, special school and young offender settings, taking into account current best practice and existing materials.	Regional SLT Group In collaboration with HSCB / PHA, HSC Trusts, community, voluntary and education sectors.	Consistency of information to educational professionals.	March 2012	Increased awareness of SLCNs in pre-school, primary and secondary school settings.	2, 4, 5

D3	Recognition of transition planning as an integral part of the written care plan for the child / young person as appropriate for their need.	HSCB/PHA HSC Trusts Primary care Education sector and community services.	Seamless and integrated service delivery at critical points of transition.	December 2010 ongoing	Improved health, wellbeing and life chances.	1, 2, 3
D4	Teachers and SLTs respect and understand each others' roles and work in a trans-disciplinary manner, sharing knowledge and skills to ensure that delivering education and therapy needs is the responsibility of both teachers and therapists to encourage maximum participation of the child.	HSCB/PHA HSC Trusts SLT staff in collaboration with school principals and staff. DHSSPS to engage with DE.	Integration of individual care plan into educational curriculum in classroom setting.	March 2012 ongoing	Improved outcomes for children and young people and improved communication between education professionals and SLTs.	1, 2, 3, 4, 5
D5	SLTs input into the Individual Education Plan of children with SLCNs, including appropriate support strategies.	HSC Trusts SLTs School Principals DHSSPS to engage with DE ELBs	Increased understanding of need to practice integrated working.	Ongoing	Improved professional practice and outcomes for children.	1, 2, 3

D6	To introduce appropriate training for nursery school and P1 and P2 teachers and SLTs to enhance learning and development outcomes for children with SLCNs.	HSC Trusts in collaboration with ELBs.	Development of existing collaborative working practices.	Ongoing	Improved professional practice and improved outcomes for children.	1, 2, 3, 4
D7	Senior management of the school and SLT managers should ensure that collaborative working is promoted and provide clarity to the joint working of teachers and therapists.	HSC Trusts in collaboration with ELBs School principals SLT Managers SLTs	Development of existing collaborative working practices.	Ongoing	Improved professional practice and improved outcomes for children.	2, 3
D8	Continuing Professional Development of all staff is required to support the development of collaborative working for the benefit of children with SLCNs.	HSC Trusts in collaborations with ELBs SLTs School principals	Further development of existing skills.	Ongoing	Continued staff development and benefits for children.	2, 3, 4, 5

D9	Review, update and extend DHSSPS/DE document Standards and Guidance for "Promoting Collaborative Working to Support Children with Special Needs" to support the number of children with SLCNs in the education sector.	HSCB/PHA in collaboration with relevant organisations and agencies, including education, training and youth justice sectors	Improved collaborative working practices.	From April 2012	Improved outcomes for children.	1,2,3,4

APPENDIX 1

ACRONYMS

A & C	Administration and Clerical
AHP	Allied Health Professional
BELB	Belfast Education and Library Board
CYPFP	Children & Young People Funding Package
DEL	Department of Employment and Learning
DENI/DE	Department of Education in Northern Ireland/Department of Education
DFP	Department of Finance and Personnel
DHSSPS	Department of Health, Social Services and Public Safety
DNA/CNA	Did Not Attend/Could Not Attend
DOJ	Department of Justice
EHSSB	(legacy) Eastern Health and Social Services Board
ELB	Education and Library Board
GAIN	Guidelines and Audit Implementation Network
GP	General Practitioner
HALL	Health for All Children

HPC	Health Professions Council
HSC	Health and Social Care
HSCT	Health and Social Care Trust
HV	Health Visitors
IDF	International Development Fund
IEP	Individual Education Plans
LCG	Local Commissioning Group
LDLCD	Learning Disability, Learning and Communication Difficulty
MASG	Multi-Agency Steering Group
NEELB	North Eastern Education and Library Board
NHSSB	(legacy) Northern Health and Social Services Board
NICS	Northern Ireland Civil Service
NICCY	Northern Ireland Commissioner for Children and Young People
NIMDTA	Northern Ireland Medical and Dental Training Agency
NIO	Northern Ireland Office
NIPS	Northern Ireland Prison Service
OFMDFM	Office of the First Minister and Deputy First Minister

PBNI	Probation Board of Northern Ireland
PfA	Priorities for Action – Issued annually by DHSSPS
PHA	Public Health Agency
PMSID	Performance Management and Service Improvement Directorate
PPS	Public Prosecution Service
PSNI	Police Service of Northern Ireland
RCSLT	Royal College of Speech and Language Therapists
R & D	Research and Development
(R)HSCB	(Regional) Health and Social Care Board
RIIG	Regional Interagency Implementation Group
SEELB	South Eastern Education and Library Board
SELB	Southern Education and Library Board
SEN	Special Educational Needs
SHSSB	(legacy) Southern Health and Social Services Board
SLC	Speech, Language and Communication
SLCNs	Speech, Language and Communication Needs
SLI	Specific Language Impairment

SLT	Speech and Language Therapy
SLTAs	Speech and Language Therapy Assistants
SLTs	Speech and Language Therapists
TIs	Technical Instructors
UNOCINI	Understanding the Needs of Children in Northern Ireland
WELB	Western Education and Library Board
WTE	Whole Time Equivalent
YJA	Youth Justice Agency
YOI	Young Offenders Institute

APPENDIX 2

Project Team Membership

Chair - Dr Maura Briscoe	DHSSPS
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Heather Crawford	SEHSCT / RCSLT
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Rachel McKenzie	HSCB
Debbie Gladwell	DE
Shona Graham	DE
Irene Murphy	DE
Janice McHenry / Alan Patterson	NIPS
Bill Lockhart / Paula Jack	YJA
Valerie Young	SELB & WELB
Ceardha Morgan	NICCY observer
Patricia Blackburn	DHSSPS
Pauline Mulholland	DHSSPS
Angela McLernon	DHSSPS
Michael Sweeney	DHSSPS
Taryn Gray (administrative support)	DHSSPS