WM QRS West Midlands Quality Review Service

NHS

Care of Birmingham's Children and Young People with Speech, Language and Communication Needs

Care provided by Birmingham Community Healthcare NHS Trust Speech and Language Therapy Service

Visit Date: 8th October 2013 Report Date: December 2013

Images courtesy of NHS Photo Library and Sandwell and West Birmingham Hospitals NHS Trust

INDEX

INTRODUCTION

This report represents the findings of the review of the Children's Speech and Language Therapy Service, provided by Birmingham Community Healthcare NHS Trust, which took place on 8th October 2013. The aim of the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The visit reviewed compliance against Quality Standards taken from two documents:

- Royal College of Speech and Language Therapy Communicating Quality 3, 2006
- Supporting Children with Speech, Language and Communication Needs Within Integrated Children's Services: Royal College of Speech and Language Therapy Position Paper, January 2006

In addition, reviewers were asked to look specifically at issues including waiting list initiatives, the role of the service outside of the referred children, the current and on-going service redesign and inter-relations between the Speech and Language Therapy Service and other services within the City.

The visit was organised by West Midlands Quality Review Service at the request of the commissioners of the service; NHS Birmingham South Central Clinical Commissioning Group who commission the service on behalf of the other Clinical Commissioning Groups in Birmingham.

The report also gives external assurance of the care within the Health Economy which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team who reviewed the services. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches although; some do require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS Birmingham South Central Clinical Commissioning Group. It is also noted that the Royal College of Speech and Language Therapy is happy to offer support for any changes that need to take place and have been identified through this review.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff, partner organisations and service users and carers of the Speech and Language Therapy Service, Birmingham Community Healthcare NHS Trust, for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

Return to *Index*

CARE OF BIRMINGHAM'S CHILDREN AND YOUNG PEOPLE WITH SPEECH, LANGUAGE AND COMMUNICATION NEEDS

CHILDREN'S COMMUNITY SPEECH AND LANGUAGE THERAPY SERVICE, BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

BACKGROUND

Birmingham has approximately 319,000 children aged under 19. The population of children age 0 to 14 is high compared to the English average (21.4% in Birmingham compared to 17.7% in England). By 2015 the population of pre-schoolers is forecast to increase by 12%, the population of 5 to 9 year olds by 15% and 10 to 14 year olds by 3%. Nearly 1 in 4 Birmingham children have identified Special Educational Needs (SEN), as defined by being on the SEN Code of Practice, with approximately 90% of these having their needs met in mainstream schools and settings. The SEN population in Birmingham is predicted to rise by approximately 10% by 2021 in line with estimates of population growth. At the time of this review, Birmingham had approximately 293 primary and 78 secondary mainstream schools / Academies, 28 special schools and over 10 Resource Bases attached to mainstream schools, plus private and faith schools.

The Children's Community Speech and Language Therapy Service was commissioned by Birmingham South Central Clinical Commissioning Group (CCG) on behalf of the other CCGs in the city. Since April 2010 the service has been mainly commissioned by health commissioners. A service agreement with Birmingham Local Authority to support the delivery of speech and language therapy to children with Statements of Special Educational Needs in specialist provision (Special Schools and Resource Bases) was withdrawn in March 2010. At the time of the review, speech and language therapy was provided to five schools under a direct contract between the service and the school. The service also provided two days per week speech and language therapy input to Birmingham Children's Hospital and one day per week to support universal and targeted work in Early Years.

The Children's Community Speech and Language Therapy Service is a city-wide service provided across Birmingham. Referrals of children aged 0 to 18 years of age (19 if in Special Schools) in full-time school-based education and registered with a Birmingham GP were accepted. The service was commissioned to work with children with specific speech, language and communication needs and/or feeding and swallowing difficulties. The service was not commissioned to work with children referred solely for diagnosis of written language difficulties such as dyslexia, children with selective mutism with no specific communication disorder, school age children referred for assessment to confirm a diagnosis of Autistic Spectrum Disorder outside of a multi-disciplinary pathway approach.

The Speech and Language Therapy service worked in partnership with a range of other agencies and the wider children's workforce, including contributing to the statutory process of assessment of special educational needs. The service was organised into teams working from a variety of settings:

- Clinics:

  Speech and language therapy support was delivered from 23 health centres (clinics) across the city, organised into six 'clusters'. Each health centre managed a mixed caseload of pre-school and school-aged children and therapy was delivered both in the clinic and in nurseries, children's centres and mainstream schools near the clinic.

- Child Development Centres:

  The Speech and Language Therapy Service was part of the multi-disciplinary team in the five Child Development Centres in Birmingham, supporting children aged 0 to 5 with complex health and education needs.

- Specialist settings: Special Schools and Resource Bases:

  The Speech and Language Therapy Service was based in 21 of Birmingham's Special Schools and in all four Speech and Language Resource Bases.

- Dysphagia: The service had an identified Dysphagia Team.
- The service also input to the citywide Community Child and Adolescent Mental Health Service (CAMHS).

A profiling system was in use, called 'PH@B' which identified a clinical priority level. The aim of this system was to support robust and standardised clinical decision-making and to ensure interventions were targeted to those children and families who required the specific expertise of the specialist Speech and Language Therapy Service and who had adequate support from those around them to make progress. Since April 2013, at the request of commissioners, the 'PH@B' system was being used to manage demand for the service. Threshold criteria had been set based on the individual's total scores on 'PH@B'. Children who did not reach the threshold for therapeutic intervention were given advice and strategies as well as indicators of when to re-contact the service if progress was not made. The average 'Package of Care' was 10 sessions over a 6 month period. As well as 1:1 contact with children and young people, the service supported parents, carers and teaching staff with information, practical resources and strategies to develop speech, language and communication. The consequence of the introduction of 'thresholds' was that the only most severe and persistent cases of speech, language and communication disorder were being accepted. It was anticipated that, because many of these children may need intensive input over several years, the discharge rate and throughput of the service would reduce.

REVIEW VISIT FINDINGS

General Comments and Achievements

All the families and partner organisations who met the visiting team commented on the high quality of care provided by the Speech and Language Therapy Service for individual children and young people. Reviewers were also impressed by the willingness of partners to work with the service and to make their contribution to the development of children's speech, language and communication.

The Speech and Language Therapy Service had worked hard to develop and implement evidence-based clinical tools and both the 'Ph@B' assessment tool and defined 'Packages of Care' were in use. The service had worked with an external, professional expert to validate both the assessment tool and packages of care. These approaches had been used to standardise the care offered across Birmingham. The evidence-base for 'Ph@B' provided the service with a good basis for developing and monitoring outcome measures for the service. The Service had strong professional leadership which was well-respected across the city.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Waiting times**

Waiting times for initial assessment were between seven and eight months and there was a further wait of up to twelve months for therapy. Reviewers were concerned about the length of both waits and that the initial assessment would be invalidated by the time the Package of Care was started.

2 **Involving children, young people, families and partner organisations**

Four workshops had been held to gain views from service users early in the re-design process about how best the SLT resource could be used. Reviewers saw little other evidence of involving children, young

people and families, referring professional staff and other partner organisations in planning and developing the service – or in commissioning. Those who met the visiting team talked about being told about 'thresholds', PH@B and the new referral form rather than having the opportunity to contribute to their development.

3 **Communication and information for children, young people, families and partner organisations**

Many of those who met the visiting team talked about the need for more information and communication from the Speech and Language Therapy Service. Comments included a lack of clarity about who should be referred, the need for referring professionals to have information to give to children and families, a wish for guidance on the advice which should be given during the waiting period, and the need updates about waiting times. A letter had been circulated about the introduction of 'thresholds' but there was little supplementary information for families and referring professionals. A phone line had been set up for families to advise on waiting times.

4 **Referral arrangements**

Referral to the Speech and Language Therapy Service was open to self-referral and referral from all professionals working with children and young people. Criteria for referral were not clearly defined, all referrals received an initial assessment and reviewers were told that only about 30% of referrals went on to therapy. The service was receiving approximately 300 referrals per month and so approximately 200 assessments per month received advice and, if appropriate, onward referral elsewhere. Referrers did not receive feedback about why their referral was inappropriate. 'Did not attend' rates were high. The rate in August was 20% even though the waiting list had been validated and appointments were booked at convenient times but reduced in September. A new referral form had been developed which would make referral criteria clearer and, at the time of the review, this was about to be placed on the Trust website. Supporting guidance, information materials and training were not yet in place. Reviewers concluded that because therapists had become more focussed on 1:1 interventions with those with the most complex needs some of the filters and preventive measures that would have helped to manage demand had been reduced.

Although the 'PH@B' tool was evidence-based, robust and detailed, it involved collection of a large amount of information which then had to be inputted by therapy staff. Reviewers considered that this may not be a good use of therapy time, especially for children whose needs were unlikely to meet the 'threshold' for therapeutic intervention.

5 **Multi-disciplinary review and learning**

Staff who met the visiting team were not aware of, and did not appear to receive feedback from, regular departmental governance meetings. As a result, staff may not have been learning from complaints, incidents and positive feedback. Some complaints were being addressed to commissioners and it was not clear that they were being combined with feedback made directly to the service. Arrangements for multi-disciplinary review and learning within the service and with partner organisations did not appear to be in place.

6 **Staff well-being**

Many of the issues identified in this report combined to make reviewers concerned about the well-being of staff within the Speech and Language Therapy Service. The pressure of long waiting lists, waiting list initiatives and the introduction of 'thresholds' had all been stressful for staff. Clinical supervision was available through 'non-managerial clinical supervision groups' within the speech and language therapy service. This appeared to be on request rather than a formal, regular process.

Further Consideration

1 Although the management structure had changed over the preceding few years, reviewers considered that the ratio of senior to junior staff was high. This should been seen in the context of the case mix of the

service and its concentration on those children with the most complex needs but, even so, reviewers considered there was potential for a greater role for band 5 and 6 therapists. Reviewers also suggested that the service should develop a clearer understanding of its capacity, possibly through the use of central scheduling. The specialism mix in the band 7 and 8a posts may also benefit from review. The service had little administrative and clerical support and therapy staff were inputting data on their assessments and activity. This may not be the best use of senior therapists' time. The more senior roles had the potential to fulfil an invaluable role in service development and liaison with other agencies but, at the time of the review, their time was focussed on 1:1 interventions.

2 Work to reduce 'DNA' rates was underway, including texting before appointments. Reviewers supported continuation of this work. Sending copies of appointment details to schools and health visitors may also be helpful (as well as communicating after the appointment).

3 Reviewers were told that the risk register combined the risks of long waiting times and the impact of 'thresholds'. It may be helpful to separate these two items.

4 Considerable staff time could be released if the 'PH@B' tool was simplified, especially for those who do not meet the 'threshold'. Also, at the time of the visit, children were often having a second 'PH@B' at the start of their therapy and when the Package of Care had been agreed. Streamlining these processes may be helpful in ensuring best use is made of staff time.

5 A range of work will be necessary if the service is to continue to attract students and newly qualified staff. Addressing staff well-being (see above) will be important in ensuring students and newly qualified staff have a positive experience of work in the service.

6 Significant work on capacity and demand had been undertaken but reviewers considered that further work of this sort may be helpful. In order to achieve sustainable, short waiting times for assessment and therapy reviewers suggested that consideration is given to both a) streamlining referral arrangements and b) skill mix changes. A further capacity and demand study may then be helpful.

7 If it is to move away from providing only highly specialised interventions to a broader remit, in line with national guidance and evidence of best practice, the service will need to a) have a clearly defined range of packages of care which it has the capacity to deliver well, b) work with potential referrers to ensure these packages of care meet their needs and c) take full advantage of opportunities to promote these packages of care through formal and informal mechanisms. In designing and promoting their 'offer' the service should take full cognisance of the public health agenda, especially for Early Years, the Healthy Child Programme and 'Call to Action'. The change from the current position of long waiting times for highly specialised interventions to a responsive service providing the full expected range of services will not be easy. Senior staff in particular will require mentoring, support and time for service development if this is to be achieved. Draft legislative changes may lead to an increase in the level of need that education commissioners will be expected to meet. Independent providers are likely to respond positively to these opportunities and there is a real risk to the reputation and future of the service if it is not quickly in a position to respond positively.

8 Personal Development Reviews were carried out by someone who worked in same clinical area or by the individuals' line managers. The links between Personal Development Reviews and managerial supervision could be clearer. Reviewers suggested that annual reviews should be undertaken by line managers and someone with relevant clinical expertise together.

9 Specific suggestions from the visiting team which may be of interest to both the service and its commissioner include:

a. An advice line and /or advice sessions aimed at reducing the number of referrals and increasing the proportion that go on to meet the thresholds for access to the service. This would have the added benefit of providing support for other professionals.

b. Screening of referrals with advice, but no assessment, for those that clearly do not meet the 'threshold' criteria.

c. A health needs assessment, in particular to quantify the 'gap' between the service currently commissioned and the level which would meet the needs of Birmingham children with speech, language and communication needs, should be undertaken. This work should aim for a shared understanding of whether this 'gap' could filled by additional services commissioned by schools or whether the core service commissioned by health (and education) should expand. This work should include looking at the effectiveness and long-term benefit of providing services to those in the 'gap'.

Return to *Index*

COMMISSIONING

Concerns

1 Reviewers were concerned by the 'gap' between the highly specialised interventions being commissioned at the time of the review and the level of service that would meet the needs of Birmingham's children and young people with speech, language and communication needs. Reviewers considered that a significant group of children who would benefit from speech and language therapy interventions did not have access to this therapy. Reviewers were also concerned about the almost complete lack of education funding for speech and language therapy services and advised that new draft legislation, if implemented, would increase the expectation of education funding for children with Special Educational Needs which included speech, language and communication needs. The 'core' service commissioned for Birmingham residents was significantly less than that commissioned in the areas represented on the reviewing team.

2 Reviewers were concerned about the implications of the 'gap' in commissioning of speech and language therapy services for child safeguarding, in particular the situation where children with communication problems do not meet the 'threshold'. Safeguarding issues may not be identified because their communication issues are not being addressed.

3 Joint commissioning arrangements were not yet in place for speech and language therapy services and, although some progress had been achieved, 'co-commissioning' arrangements did not appear to be achieving progress at an appropriate rate, as shown by the issues raised in this report.

4 Contrary to NICE guidance, speech and language therapy input to the diagnostic process for children aged over five with possible Autistic Spectrum Disorder was not commissioned.

Further Consideration

1 The service specification did not include measureable outcomes. New output measures had been agreed and August data were available. It may be helpful to consider the development of agreed outcome measures for future monitoring of the service.

2 Specific suggestions from the visiting team which may be of interest to both the service and its commissioner include:

a. An advice line and /or advice sessions aimed at reducing the number of referrals and increasing the proportion that go on to meet the thresholds for access to the service. This would have the added benefit of providing support for other professionals.

b. Screening of referrals with advice, but no assessment, for those that clearly do not meet the 'threshold' criteria.

A health needs assessment, in particular to quantify the 'gap' between the service currently commissioned and the level which would meet the needs of Birmingham children with speech, language and communication needs, should be undertaken. This work should aim for a shared understanding of whether

this ‘gap’ could filled additional services commissioned by schools or whether the core service commissioned by health (and education) should expand. This work should include looking at the effectiveness and long-term benefit of providing services to those in the ‘gap’.

Return to *Index*

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Katrina Coley	Children's Speech and Language Therapist Team Leader	Leicester Partnership NHS Trust
Nicola Corbett	Head of Registration and Compliance	Coventry & Warwickshire Partnership NHS Trust
Rebecca Cross	Service Manager: Health Partnership, Children and Young People's Service	Bristol City Council
Karin Evans	Head of Children's Speech and Language Therapy, Northern Division	Staffordshire and Stoke-on-Trent Partnership NHS Trust
Janet Harrison	Speech and Language Therapy Service Manager	Leicester Partnership NHS Trust
Sarah Jones	Clinical Lead for Paediatric Speech and Language Therapy	Heart of England NHS Foundation Trust
Petrina Marsh	Head of Dept. Children's Therapies	Sandwell & West Birmingham Hospitals NHS Trust

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sue McIldowie	Quality Manager	West Midlands Quality Review Service

Return to *Index*

APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varied depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No but', where there is real commitment to achieving a particular standard, than a 'Yes but' – where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Children's Community Speech and Language Therapy Service	28	9	32

QRS Number	Standard	Number/ Ref in document	Met Y/N	Reviewer Comment
1	All SLTs access an appropriate form of clinical supervision at least once every 12 weeks.	* 14 Section 5.3.3 p.106	N	The definition of clinical supervision being used was not clear. There was a Trust clinical supervision policy but it was not clear if this was being implemented. Reviewers were told that staff who wanted to could access non-managerial clinical supervision groups within the speech and language therapy service. This appeared to be on request rather than a formal process with oversight of staff participation. It may also be helpful to consider clinical supervision from outside of the service for some staff.
2	The service supports the monitoring of clinical practice through managerial and clinical supervision, staff development review and personal development plans.	* 17 Section 5.3.5 p.115	N	Personal Development Reviews were carried out by someone who worked in same clinical area or by individuals' line managers. The links between Personal Development Reviews and managerial supervision were not clear.

QRS Number	Standard	Number/ Ref in document	Met Y/N	Reviewer Comment
3	The service has a strategic and systematic approach within each clinical team to establish an evidence-based resource as the basis for provision of clinical care, organisation of services and service development.	* 23 Section 5.3.6 p.116	Y	The PH@B framework and clearly defined Packages of Care were in place. This Standard was therefore met for clinical care and these tools had been used to develop a standardised approach across Birmingham. The introduction of 'thresholds' had changed the cut-off at which speech and language therapy services could be accessed. The evidence base for the thresholds was not clear. Reviewers considered that the thresholds were set so high that children who would benefit from speech and language therapy interventions would not be able to access the service.
4	The service has a system to collect information for service management purposes and to meet contractual obligations. Information is collected on a consistent and regular basis.	* 24 Section 5.3.7 p.118	Y	Required commissioning data had been agreed with commissioners and data for August 2013 were available. The agreed dataset comprised output data and it may helpful, in future, to consider using some of the outcome data which will be available from PH@B for service monitoring.
5	The service has sufficient and appropriate resources to support the principal functions of the service.	* 29 Section 5.4 p.124	N	Reviewers were not able to confirm that the service had appropriate resources to support its principal functions. The service had sufficient resources for the provision of the very specialist service but national guidance and legislation is that the service should be commissioned to meet the level of need identified, which will be much greater than the level commissioned. The service had no Local Education Authority funding and commissions from only 5 of Birmingham's schools. Agreements with individual schools appeared to be based on links with one therapist, rather than an agreement for support from the service as a whole.
6	The service has a mechanism for on-going monitoring of staff workloads.	* 35 Section 5.4.3 p.134	Y	A clear and transparent system for monitoring staff workloads was in place. Reviewers did not see a shared understanding of capacity and demand and the service's capacity to maintain waiting times once waiting list initiatives have been completed was not clear. Commissioners did not have an understanding of capacity available and the impact of this on waiting times and unmet demand.

QRS Number	Standard	Number/ Ref in document	Met Y/N	Reviewer Comment
7	The urgency or priority of referrals is determined in a systematic and equitable manner. Prioritisation systems are evidence-based as far as possible and clearly documented.	* 36 Section 5.4.3 p.139	Y	This Standard was achieved through use of the PH@B tool. Dysphagia referrals were then prioritised for initial assessment but other referrals were seen in the order that they were referred. Prioritisation took place after initial assessment (but see main report for concerns about the validity of the initial assessment when waiting times are so long). The new referral form will enable better triage of referrals.
8	The service involves service users in the evaluation and development of services.	* 46 Section 5.7 p.168	N	Four workshops had been held to gain views from service users early in the re-design process about how best the SLT resource could be used. Head teachers who met the visiting team had not been involved in the development of the tool or the new referral form and did not have mechanisms for evaluating and influencing the development of the service. Reviewers saw no evidence of involvement of children and young people in the evaluation and development of services.
9	Where there are gaps or shortfalls against standards in the service, there is clear evidence that the service is taking steps to develop and improve the service.	* 50 Section 6.2.3 p.190	N	There was evidence of the service addressing long waiting times. A second waiting list initiative was about to start and waiting lists had been validated. The gap between the service being provided and the level of need for evidence-based interventions had not been quantified and there was not a clear action plan to address this shortfall. The service was, however, taking part in city-wide strategy discussions which may, in due course, progress the issue. Representatives from referring services who met the visiting team had a general perception that access to the service was reducing. Reviewers were also concerned by some evidence of over-referral because waiting times were so long. For example, "The problem may resolve but we refer anyway because by the time they are seen it will be clear if they need the intervention."
10	The service has a strategy in relation to health inequalities and is able to demonstrate actions taken to reduce these inequalities.	* 51 Section 6.2.3 p.190	N	Reviewers saw no evidence of the service addressing health inequalities. The response to referrals was completely standardised and, as a result, may be increasing inequalities. Reviewers were particularly concerned about the limited Local Authority commissioned speech and language therapy input to the Early Years' Service.

QRS Number	Standard	Number/ Ref in document	Met Y/N	Reviewer Comment
11	There are clear and up-to-date written policies on admission to and discharge from speech and language therapy services for referred individuals.	* 52 Section 6.2.4 p.190	N	A new referral form was about to be put on Trust website. Referring agencies who met the reviewing team were not aware of the new referral form and said that they were not clear about the criteria for referral to or discharge from the service.
12	There are clear written pathways for each speech and language therapy care group that reflect and anticipate the needs of clients, many of whom have enduring, complex and multiple health and social needs.	* 54 Section 6.3.1 p.196	N	Packages of Care' provided clear written pathways for those children and young people who met the 'threshold' criteria for acceptance by the service. Pathways were not in place for children and young people with needs requiring speech and language therapy intervention but who were not able to access to the service. Pathways were also not in place for preventative and public health work with groups where such needs could be anticipated.
13	Clinical care standards are linked to the published research evidence-base and consensus views on best practice.	* 56 Section 9.2 p.419	Y	This Standard was met for the care provided by the service. Additional clinical care standards would be needed if the service was appropriately commissioned for both preventative and interventional work.

QRS Number	Standard	Number/ Ref in document	Met Y/N	Reviewer Comment
14	Any speech and language therapist (SLT) working with children should: • Identify the speech, language, communication or eating/drinking needs of the child as part of, or with reference to, the appropriate multidisciplinary team (this does not imply a static membership, more the team of relevant professionals for the individual child) • Identify the functional impact of these needs • Consider the most appropriate context for support ie. which settings are most relevant to the child and their family • Identify the contribution of the speech and language therapist as part of the wider team working with the child to meet the child's needs – including the full range of options from advice to colleagues through setting up programmes to direct intervention where appropriate.	** 1 Page 15	Y	This Standard was mostly met by PH@B. The Speech and Language Therapy Service also contributed to multi-disciplinary teams in Child Development Centres. Advice to colleagues was not easily available. The comment made to reviewers was "Referrers are delighted when one child gets through the threshold - partly because then they can have a conversation with a speech and language therapist about other children.' The service model in place at the time of the review did not allow for advice and guidance prior to referral. This may have been contributing to the increasing referral rates and did not help other professionals working with children to maximise their contribution to speech, language and communication development.
15	Services should offer the full range of support for children, including direct intervention where appropriate, while ensuring overall management includes goals relating to activity and participation, managed by those most relevant the child.	** 2 Page 15	N	Only very specialised direct interventions were commissioned.

QRS Number	Standard	Number/ Ref in document	Met Y/N	Reviewer Comment
16	The RCSLT regards trans-disciplinary working as central to work with children. The RCSLT supports the exploration of SLT roles within trans-disciplinary models and the development of new models that maximise the contribution of SLTs while ensuring that the specialist contribution to the system is recognised as essential. Emerging key worker roles and lead professional roles are also central to this model of working if it is to be successfully implemented for the benefit of children and their families.	** 3 Page 16	N	No evidence of trans-disciplinary working was apparent. Representatives from other agencies who met the visiting team also indicated that this was not happening.
17	Training of others, including parents, should be viewed a central activity for SLTs to maximise impact for the child and their family.	** 4 Page 17	N	This Standard was met for children and young people who met the 'threshold' although observation (face to face coaching) was the only option available. There was no systematic sharing of knowledge with those who were working with children and young people who do not meet the 'threshold'. The Birmingham Co-commissioning Group had a good 'Communication Friendly Schools Programme' but this was optional. Reviewers considered it likely that schools which already had a good understanding of communication needs would be likely to buy into this programme whereas those without this understanding may not. This may serve to perpetuate and increase health inequalities. An Early Language Development Programme was also in place but this may not always be appropriately used.
18	Service planning for children with speech, language, communication or eating/drinking needs should always be in partnership with other agencies.	** 5 Page 17	N	Reviewers were told of several groups which were meeting. Representatives of partner agencies who met the visiting team did not consider that they were involved in service planning, for example, they had not been consulted on the new referral form and would have appreciated the opportunity to comment.

QRS Number	Standard	Number/ Ref in document	Met Y/N	Reviewer Comment
19	Service planning should take account of the most functionally communicative and socially appropriate environment for effecting change.	** 6 Page 17	Y	This Standard was covered by the 'Packages of Care'. Dysphagia work took place in an appropriate environment.
20	There is a need to define the parameters of an appropriate advisory needs-based and dynamic approach to supporting children which integrates the concept of skill mix both within the profession and across professional boundaries. The term 'consultative' model should be replaced by a more accurate description of the service being delivered. The RCSLT supports the need for research to further define and investigate the impact of approaches,which rely on the implementation of speech and language therapy advice by others.	** 7 Pages 18 and 19	N	At the time of the review the services' resources were being targeted to children meeting the 'threshold' and the service had reduced consultative approaches. This resulted in less formal contact across professional boundaries and less informal liaison and support.
21	Service structures should reflect the changing context. Highly specialist, principal and consultant therapists need to use time to train, develop, coach and mentor less experienced therapists, who in turn need to be given the opportunity to work with all caseloads. The most specialist need to focus their skills on the strategic developments within their specialist area.	** 8 Page 20	N	The skill mix of the Speech and Language Therapy service had a relatively high proportion of more senior staff. There were neither enough less experienced therapists nor a balanced case mix to allow this Standard to be met.

QRS Number	Standard	Number/ Ref in document	Met Y/N	Reviewer Comment
22	The RCSLT recommends that within each local authority area there needs to be an SLT professional lead for children, who can interpret national policy and ensure partnership working occurs in terms of integrated commissioning of speech and language therapy provision, strategic planning and operational delivery. This professional lead should ideally be a member of key strategic multi-agency planning groups and be empowered to make key strategic decisions on behalf of local speech and language therapy services. The role of professional lead should also provide a focal point in terms of professional standards for all speech and language therapy provider services both within statutory and non-statutory provider organisations (including independent practitioners).	** 9 Page 20	Y	Good professional leadership was evident. The professional 'message' to strategic multi-agency planning groups about the nature of the service being commissioned, in particular the impact of 'thresholds', did not appear to be being heard by health or education commissioners.
23	The role of the SLT must be seen within the context of the specialist and wider workforce. Commissioners need to be aware of the unique contribution of SLTs across the population base.	** 10 Page 21	N	The role of the speech and language therapist appeared to be seen by commissioners as only within the context of specialist interventions. The speech and language therapy service, while wanting the wider role, were behaving in accordance with commissioners' requirements. Other professionals who met the visiting team recognised that 'communication is everybody's business' but did not see this reflected by the behaviour of the speech and language therapy service.

QRS Number	Standard	Number/ Ref in document	Met Y/N	Reviewer Comment
24	Managers and service leads should work together with their allied health professional (AHP) colleagues as well as colleagues from education and social care, in the development of new roles, in particular the development of consultants/specialist advisory posts and cross agency posts.	** 11 Page 22	N	Operational lead and clinical leads within the Trust met regularly but reviewers did not see any evidence of regular, wider meetings with education and social care. The Trust's Head of Inclusion Services was planning to use learning from other services in the re-design of speech and language therapy services.
25	Management opportunities across agencies and across professional boundaries should be developed.	** 12 Page 23	N	Reviewers saw no evidence of this.
26	The RCSLT supports the development of placements that offer student therapists a full range of opportunities as part of their practice-based learning and this would include working as part of trans-disciplinary teams.	** 13 Page 23	N	The service model in place at the time of the review made it difficult for this Standard to be achieved. Some staff reported that they did not have adequate capacity to supervise students, possibly because of the impact of waiting list initiatives. This issue could have long-term implications for recruitment into the service. One member of the SLT team within the Trust worked alongside SLT colleagues from other divisions to work with the universities to promote and deliver effective student placement experiences.
27	Speech and language therapists working with children should undertake continuing professional development (CPD) activities across health, education and social care in order to develop knowledge and skills that will prepare them for cross-agency roles. The RCSLT values CPD activities that are not limited to the health context.	** 14 Page 24	N	See main report in relation to continuing professional development. Reviewers did not see any evidence of speech and language therapists actively being prepared for cross-agency roles but Birmingham did not have any cross-agency roles for which staff could prepare.

QRS Number	Standard	Number/ Ref in document	Met Y/N	Reviewer Comment
28	The challenges of the changing context mean that business and entrepreneurial skills sets will become more relevant for senior managers. Excellent communication and negotiation skills should also be developed by all speech and language therapy service leads as part of a portfolio of leadership competence.	** 15 Page 24	Y	Although senior staff reported that they were developing these skills, reviewers commented that they appeared to be caught up in the current service model and waiting list difficulties. The stress under which staff had been working for some time (see main report) may have hindered their ability to develop business and entrepreneurial skills and to actively promote the service. Strict adherence to the commissioned service model was also limiting their access to formal and informal marketing and promotional opportunities.

Return to *Index*