



## **The Bercow Review**

Response from Unite (Amicus Section)  
Speech & Language Therapy  
Occupational Advisory Committee

Unite is the largest trade union in the UK, and the third largest in the NHS. Unite (Amicus Section) represents around 100,000 health workers.

This response to the Bercow Review is submitted on behalf of speech and language therapists and speech and language therapy assistants in Unite (Amicus Section). The Union has over 6000 speech and language therapists and speech and language therapy assistants in membership. We therefore represent a relatively high proportion of therapists and therapy assistants at national level.

Our response to this review has been put together by our Speech and Language Therapy Occupational Advisory Committee, the national committee that coordinates the Union's work around the profession. All members of the committee are elected representatives, and all of us are working speech and language therapists or speech and language therapy assistants.

We have worked extremely hard to put together a response to this review that we believe to be both accurate and honest. In December 2007, we carried out a comprehensive survey of all our speech and language therapy or assistant workplace reps. This has given us a detailed picture of what is happening in the profession across the UK (although our focus in this response will be primarily England). Additionally, we circulated a request for specific responses to the review, and the comments we received have been incorporated into this collective response. Our elected representatives on the Occupational Advisory Committee are all in touch with speech and language therapists and speech and language therapy assistants in their own geographical regions, and their accounts and experiences have also contributed to the response we make here.

There has been no contradiction between the feedback we have received from speech and language therapists and speech and language therapy assistants. For convenience, we will refer to both occupational groups here as 'SLTs' or as speech and language therapists.

### **Professional Pride**

It is worth emphasising the tremendous pride that an overwhelming majority of SLTs have in our profession. We believe that there is an intrinsic reward in helping a bewildered child gain communication skills, grow in self-esteem and academic prowess, and make friends. There is the same reward in supporting the parent of a disabled child to understand that communication is not just about '*talking*' or '*not talking*', but that communication is also about vocalisation, facial expression, and body movement. Our colleagues working preventatively gain enormous satisfaction from promoting an understanding of communication not just within individual families but across our wider community. SLTs working with adults share the passionate commitment of almost all

SLTs to respecting individuals, and to maximising the communication skills of every single person with whom we work. We believe that communication is a human right.

The comments from many respondents reflect this pride. Comments included, *'The job continues to be satisfying – intellectually, morally, and as a contribution to the community'*; *'The job is incredibly interesting and rewarding – a vocation'*; and *'The client/patient contact makes it a great job'*. SLTs care about the work we do.

### **A Wider Context**

Unfortunately, the pride and sense of vocation do not give the whole picture. The results of our survey, together with the other information we collected, indicate a profession that is entering a period of significant crisis. We have been genuinely shocked by the data we have collected. Although we received a small number of reports of services that were well-resourced and improving local service delivery, this was not the general experience. The problems reported to us by very many of our colleagues include cuts and redundancies that impact directly on service provision, low morale and poor career prospects, a sharp reduction in training opportunities, a trend towards the loss of specialist posts, and the steady erosion of professional leadership. We are concerned by our findings.

### **Our Response to the Review**

Our response to this review is therefore informed by both perspectives – by our professionalism and commitment, *and* by the wider context of very real difficulties. Of course our members reported differing views and experiences. However, the breadth of the work we have undertaken has allowed the identification of very clear patterns and themes. The experiences we report here reflect the day to day working life of working SLTs.

There is no need for this response to remain confidential.

### **For further information, please contact:**

Gill George  
Chair, Speech and Language Therapy OAC  
c/o Staff Side Office  
St Leonards  
Nuttall Street  
London N1 5LZ

or

Fiona Farmer  
Regional Officer  
Unite (Amicus Section)  
17 South Tay Street  
Dundee DD1 1NR

**5 In my local area, the expertise of school staff and others in the children's workforce (e.g. health visitors, early years workers, children's social workers) to identify and deal with children's language, speech and communication needs is: Excellent/Good/Satisfactory/In need of significant improvement.**

Inevitably the responses from SLTs indicated enormous variation in the skills of the colleagues with whom we work, and the success of joint working to meet the needs of children and their families.

SLTs in educational settings work particularly closely with teachers, teaching assistants, learning support assistants and nursery nurses. Some colleagues have acquired impressive knowledge of speech and language difficulties, and a great deal of skill in working with these children. Others have not – not through any fault of their own, but simply because their training and work experience have not equipped them with these skills. We believe that there is scope for enhanced teacher training that pays more systematic attention to the needs of children with communication difficulties, and more generally to children with special needs. This is vital in an era of inclusion. Every teacher requires the confidence and skills to work with these children. We are unsure of the training available to teaching assistants and nursery nurses, but again there may well be a place for more detailed content regarding the needs of children with speech and language difficulties and children with special needs.

It is a shame that learning support assistants are often now employed to meet the needs of one child in one school, and may have little opportunity to develop their knowledge and skills over time. In the past, LSAs were employed by Education Authorities and had opportunities to transfer their skills readily between different posts. Over time, the level of skill of LSAs could become very impressive indeed. This is now harder. We would welcome a review of the basis on which LSAs are employed, and the introduction of core training for every LSA.

A challenge for SLTs in school settings is that they may be put under pressure to maximise the time spent on face to face contacts – sometimes at the cost of training of school staff. The pressure may come from SENCOs and Head Teachers, and strong professional leadership from within SLT is necessary on occasion to resolve this.

We are beginning now to hear reports from SLTs in a range of settings that a drive for face to face contacts is coming from commissioners within the NHS. Training, liaison and the like are not readily seen as valuable. This is a new development, but one that concerns us. If the trend becomes established, this will affect our ability to provide an effective service in schools. SLTs have a centrally important role to play in developing the skills of education staff through training. This will inevitably be harder if they are to be judged solely on the basis of numbers. (We would have the same concerns when it comes to working with children with complex needs, or children where there may be significant social concerns. *Management* of these cases, with an emphasis on strong communication between professionals, is as important, and sometimes more important, than direct contact). SLTs have told us, '*I have to justify my existence*', and '*I find the target driven culture of the NHS demoralising*'. We believe the need for training extends to commissioners and non-clinical managers within the health service.

In pre-school settings, SLTs have historically worked very closely with health visitors. We have depended on health visitors to identify at an early stage the children who seem to have delayed or disordered language skills, or wider developmental difficulties. We have

relied on health visitors, and on nursery nurses based within health visiting teams, to reinforce advice given by SLTs around communication or eating/drinking.

In recent years, there has been a sharp shift in health visiting services to targeted rather than universal provision. The focus is on families identified as 'in need', and routine developmental checks are no longer done, or are done before developmental problems become apparent. The challenge is that many children with speech and language disorders or problems such as autism do not live in families that are readily identifiable as being 'in need'. There is therefore a strong reliance on parental report of problems. We have not looked at this systematically, and we have no data on this – but anecdotal evidence suggests later identification and later intervention for at least some children with significant difficulties.

Again this is anecdotal, but we are aware of specialist dysphagia SLTs who are receiving more referrals for children of two, three or four years with behavioural eating disorders. There is a strong suspicion that poor parental understanding of weaning contributes to unhelpful patterns of behaviour becoming established. The decline in universal health visiting provision makes it less likely that parents will receive appropriate advice about weaning at the time it is needed.

We believe that there is an evidence base to support early intervention for children with speech and language difficulties, and this very obviously requires early identification. We also value the wider public health and preventative role of health visitors. We would support the restoration of a universal health visiting service, and the expansion of the qualified health visitor workforce needed to implement this. We would also welcome the recruitment of more nursery nurses within health visiting teams, *not* to replace health visitors, but to enhance their work. Our view is that adequately resourced health visiting teams have an important role to play not just in supporting and reinforcing the work of SLTs, but around related issues such as promoting parenting skills, developing play skills, and identifying child protection concerns.

**6 In my local area, access to speech and language training for school staff and others in the children's workforce is: Excellent/Good/Satisfactory/In need of significant improvement.**

We have covered the wider issues around this in our response to Question 5. We support I Can's call for effective workforce development programmes.

**7 In my local area, access to training and development opportunities for speech and language therapists is: Excellent/Good/Satisfactory/In need of significant improvement.**

This is an area where we have exceptionally strong concerns. Of the respondents in our survey, 53% reported that training and continuing professional development opportunities were worse than in the past.

We also asked SLTs if they were required to pay for their own training. We found that 51% of our respondents paid for their own training, wholly or in part.

It seems likely that this situation arises from the wider financial difficulties in the NHS over the last two years. In some Trusts, training budgets have been completely deleted. In others, the training of AHPs has not been seen as a priority at a time when finances are tight. Where training budgets remain, block contracts with universities or other training providers typically cover the higher volume training required by nursing staff, but not the specialist courses needed by SLTs. We have been told of non-clinicians making decisions on access to training where the response is determined solely by cost, with little or no understanding of the long term needs of the service. The loss of training opportunities has been a major contributory factor in the growing demoralisation of SLTs.

Our view is that CPD is essential if we are to maintain high quality service delivery to our clients. SLTs have told us of the heroic attempts being made at local level to support CPD through the use of journal clubs and the like. We do not believe that ad hoc in-house arrangements can adequately equip developing specialists with the new skills they need, nor maintain a robust and up to date evidence based approach from experienced colleagues.

Many SLTs cannot afford to pay for their training. Even one day courses are costly if individual therapists are expected to pay (for example, the typical £130 for one day I Can courses). More specialist courses cost a good deal more: for example, the £435 for a three day Hanen course (It Takes Two to Talk or More Than Words); while a specialist five day dysphagia course would cost around £600. Specialist courses are frequently not held close to an SLT's home, so money for hotel accommodation and transport must also be found. Some SLTs will be able to afford this substantial expenditure, but many others will have family or financial commitments that make this a simple impossibility.

The Health Professions Council, the body regulating SLTs, requires a minimum level of CPD to maintain registration. Some SLTs have expressed concern to us that they are finding it increasingly difficult to meet HPC requirements.

We have had a small number of reports from SLTs who not only have to pay for their own training, but who are also now expected to take annual leave to attend courses or SIGs. This is so disgraceful that it is difficult to comment.

The strong risk over time is that we will drift into a 'dumbing down' of the profession, as knowledge and skills levels gradually decline. We believe this to be unacceptable. Money for training should be ring-fenced within NHS budgets. The training of AHPs should be seen as no less important than the training of doctors and nurses. Professional managers should (and often do) make robust challenges to the loss of training budgets, while strategic managers must recognise the importance of CPD in maintaining long term service quality.

**8 a) Set out your views on the workforce in your local area, including people who work in the health and education sectors, as well as others in the children's workforce. (E.g. the role of school staff and the role of speech and language therapists. What training and development opportunities are available? Is recruitment and retention an issue? Can some children's speech, language and communications needs met by professionals other than speech and language therapists?)**

Can communication needs be met by professionals other than speech and language therapists? Of course. SLTs have long since moved away from a medical model where children are taken out of their environment, 'theraped', and given back when they have been made better. As a matter of routine, SLTs in an education setting work with teachers and LSAs but recognise that it these staff, rather than the SLT, who will be responsible for implementing communication goals on a day to day basis.

In many settings, SLTs work closely with SLT assistants, bilingual co-workers and other support staff. We work with health visitors and nursery nurses. Many SLTs work in multi-disciplinary teams where there is a high degree of joint working, with professionals sharing goals and working collaboratively on whatever priorities have been agreed with a child's parents. The move of the last few years towards 'joined up thinking' and integrated service delivery has been an important step forward in the care provided to disabled children and their families.

However, we do not believe that SLTs can be *replaced* by other staff. We note (and agree with) the work of RCSLT on competent practice (CQ3). SLTs do far more than assess clients or implement communication/ dysphagia goals in a mechanistic and pre-determined way. We are skilled professionals who combine a high level of theoretical knowledge with strong personal communication skills, a thorough knowledge of the healthcare and education settings in which we work, a framework for decision making, the ability to challenge and critically appraise our own practice, and a set of values which revolve around respect for individuals and their autonomy. We are proud of our profession and our professionalism. We believe that we are uniquely placed to play a leading role in working with individuals with communication difficulties, and in promoting an awareness of communication in wider society.

We asked several questions about the recruitment of SLTs in our survey of speech and language therapists, and a number of colleagues made separate comments around this area, asking us to feed them into this response.

Recruitment has become a challenging area for SLTs. We are used to thinking of ourselves as a 'shortage profession', but this view has become simplistic. The financial crisis of the last two years has made it extraordinarily difficult for newly qualified SLTs to find employment. We have further work to do on the data from our survey, but an initial impression from our respondents is that well under a half of Trusts will be recruiting newly qualified therapists this year. This scenario leaves large numbers of newly qualified SLTs competing for a small number of jobs. Comments made to us include, '*We are snowed under with applicants*'; '*Many applicants for very few posts*'; and '*We are getting over fifty applicants for each post*'. We have been told of qualified speech and language therapists applying for assistant posts and even for admin and clerical posts in speech and language therapy departments, because they are so desperate to get a foot in the door.

This is indicative of a level of workforce and financial planning at national level that is simply unacceptable. There is a waste here of the public money spent training these individuals; there is a great disservice to the SLTs who have worked hard for four years only to end up with no employment; and, above all, there is a disservice to the clients who desperately need the professional support that these colleagues could offer. The lack of stability in the NHS over the last two years has been immensely damaging.

Ironically, our respondents told us that it is very difficult to recruit more experienced SLTs. This is not a universal picture, and some Trusts continue to have significant numbers of applicants for middle ranking Band 6 posts, and for specialist posts at Band 7 and 8. Anecdotal evidence suggests that recruitment to specialist posts is easier in London, for example. However, the more common picture is that recruitment has become difficult. Respondents have commented, *'The jobs market is awash with newly qualified therapists but it's hard to find more experienced SLTs'*; *'Harder to recruit to middle grades'*; and *'Recruitment is poor – AFC has created stagnation'*.

The reasons behind this situation are likely to be complex. The financial problems in the NHS are certainly one reason. There is less money for new posts at all levels, and posts that fall vacant are not necessarily filled. In some cases, specialist and professional manager posts have been lost through redundancy. These issues will be covered more fully in our response to Question 8b. The lack of vacant posts across the career structure contributes to a lack of movement and the 'stagnation' to which one of our respondents referred.

Another reason is the relatively new 'Agenda for Change' pay structure across the NHS. This led to higher initial pay for newly qualified SLTs, but to slower career progression (certainly in urban areas, where career prospects have been extremely good in the past). At more senior levels, some of our most experienced therapists lost a great deal of money, and are on pay protection. This will be lost if they change jobs. Senior posts have also been affected by a very clear 'grade drift' downwards. SLTs in many of these posts managed to achieve good initial outcomes for themselves as individuals, but posts are being downgraded when they fall vacant, and new posts with a similar level of responsibility are being offered at lower salaries. The overall effect of this is that our senior specialist SLTs are tending to remain in their current posts to safeguard their salaries. The lack of movement at the top of the profession 'ripples down', and again contributes to a relatively static situation. Managers cannot recruit *and* SLTs seeking promotion cannot find a suitable post in the part of the country where they are based.

This is undoubtedly a complex picture, with regional variations, and likely variations between urban and rural areas. We hope to do more work around this issue. However, what is clear is that many, many SLTs now regard their career prospects as poor. Comments to us included, *'Not enough jobs, not enough career progression'*; *'Difficult to gain any promotion'*; and *'Only likely to progress if filling dead man's shoes'*.

We asked SLTs if they would recommend speech and language therapy as a career. We were concerned to find that over a third would not. One SLT who would recommend this as a career said, *'Yes – but only if someone is not particularly ambitious'*. Another commented, *'I have always been passionate about both the profession and the NHS, but I would advise any prospective new entrant to consider their career options very carefully'*. This last contribution perhaps sums up the current dilemma for many SLTs. We retain our overwhelming commitment to our profession and our clients – but we find ourselves in an increasingly difficult situation.

On a different note, we wish to comment on the role of Portage. Portage is a home visiting service for pre-school children with special needs. This is a service that in our experience is viewed very positively by parents. Portage supports even the children with the most profound disabilities in making developmental gains, and allows parents to focus on how their child is *progressing* rather than on what he or she cannot do. In many areas, SLTs and Portage staff work closely together, with each enhancing and supporting the role of the other. We are aware of substantial geographical variations in the provision of Portage. Our view is that this is an immensely valuable service that should be offered with a greater degree of consistency.

**8 b) What are the important workforce issues to address? (E.g. Where improvements could be made and by whom. Do the different professionals all have the expertise and ability to identify and address children's speech, language and communications needs? Are their sufficient numbers of the different types of professionals needed to work with children with speech, language and communications needs? What steps should Government take to make improvements and what should be done at a local level?)**

Recruitment of and career progression for SLTs are significant workforce issues, as we have outlined. There may be no easy solutions to these, but we would welcome willingness from the Department of Health and/or NHS Employers to recognise the problems and explore solutions in partnership. The difficulties affecting us will not be unique to SLTs.

Our survey identified a concerning collapse in the morale of SLTs. We asked SLTs if their morale was 'Higher', 'Lower' or 'About the same' compared to the year before. A shocking 63% of respondents told us that their morale was lower. Only 2% reported higher morale, while 35% said that things were about the same. When almost two thirds of respondents identify that their morale is lower now than it was a year ago, this indicates to us a significant problem.

The reasons given by our respondents were varied. We have already outlined the loss of CPD opportunities and the strong perceptions of poor career progression. There is no doubt at all that these have affected morale.

We touched in our response to Question 8a on the wider issues around cuts and redundancies. These are of central importance. Of our respondents, 36% reported that compulsory redundancies had been implemented by their employer. An extremely high proportion, 78%, told us that posts had been reduced through other means, such as voluntary redundancy, vacant posts being frozen and vacant posts being deleted. Job cuts have affected SLT departments very directly, with 61% of respondents telling us of SLT posts being deleted over the last eighteen months.

In other cases, posts were eventually filled – but were delayed for long periods (between three months and a year) before permission was given for them to be advertised.

The loss of SLT posts has had a significant impact on service delivery, and this will be covered in our response to Question 9. However, job loss and the pressure of unfilled vacancies have also had practical implications for staff, and have contributed substantially to increased workloads and stress for many SLTs. We were told, *'Some aspects of the job are rewarding, but our resources are being stretched further and further'*; *'We all love our jobs but we feel ineffective because of increasing demands and decreasing staff levels'*; and *'We're constantly asked to do more with fewer resources'*. With remarkably few exceptions, this really did emerge as the prevailing picture. Exactly two thirds of SLTs told us that their workloads were bigger than they had been eighteen months before. Only 3% of SLTs told us that they had a smaller workload.

In over a third of Trusts, there is now a sharply reduced use of locums to cover vacant posts, maternity leave, and long term sickness. Again, this adds to the pressure on SLTs, as they are expected to cover the same workload with fewer staff. The reduced use of locums is driven by financial restrictions at Trust level. However, we also note that the use of locums was reported by almost a half of respondents to be about the same. In

a very small number of Trusts, it was possible to identify an increased use of locums; this was typically to cover posts that it had not been possible to recruit to.

An issue that has caused real and obvious distress to many of our respondents is the constant reorganisation that now affects primary care in particular. Many SLTs who have contacted us have recently gone through major reorganisations or mergers arising from Commissioning a Patient-Led NHS. Others are being affected by organisational change as Primary Care Trusts consolidate or extend the separation of commissioning and provider services. While this may sound like jargon, the change and insecurity for SLTs (and other health workers) are very real indeed.

Comments from SLTs included, *'A tremendous sense of insecurity with the development of provider services as business units'*; *'Currently the service is under review so stress levels are high'*; and *'Due to a current service reorganisation, jobs are being put at risk and most people in SLT are uncertain about their future jobs and pay'*. Some of the SLTs who sent us their comments reported in quite bleak terms about their personal despair and their lack of confidence in the future of the NHS.

Other stressors for SLTs include pay and the increased use of fixed term contracts.

This year's below-inflation pay award has caused very real anger. We believe that health workers work hard and with real commitment, and that we deserve pay that at least keeps pace with inflation.

The use of fixed term contracts, typically for a year, is causing very real stress and insecurity. We are opposed to the use of fixed term contracts unless there is a clear and identifiable need for these (such as covering maternity leave). We did not ask a specific question about short term contracts, but the information volunteered by respondents suggests that some Trusts are now using these fairly routinely. There will be at least two reasons for the use of fixed term contracts. One will be the tendency for service delivery to be determined by the availability of one-off 'pots of money', rather than through stable core funding. The other will be the continuing financial and organisational uncertainty in the NHS. Posts on fixed term contracts are easier to delete should the need for further cuts arise. This approach cannot enhance strategic service planning.

So what steps should the Government take? We have covered the need for ring-fenced funding for CPD. We would like to work with the Department of Health or NHS Employers on developing an enhanced career structure for SLTs. We would like pay that keeps pace with inflation. Above all, we would like funding for core services that is stable and sufficient, and we would like to see an end to constant organisational change.

SLTs care passionately about the services we provide, and about the NHS and the values of the NHS. We would like the Government to actively support the work we do. If that is not possible, the greatest wish we have is that the Government will leave us alone and let us get on with supporting our clients.

## **9 For health and education services in my local area, meeting children's speech, language and communications needs is: A high priority/one of many competing priorities/Not a priority/A priority for health only/Education only**

At national level, this is a mixed picture. Most speech and language therapists work in the NHS, and all but one of our responses (in the survey and our separate request for information for this review) came from SLTs employed by the NHS. That is therefore the main focus of our response here.

Our experience is that there is a very direct link between the resources allocated to an SLT service, and the ability of that service to meet the speech, language and communication needs of children.

We are aware of a small number of areas where SLT services are expanding, with the creation of new initiatives and new posts. Waiting lists have decreased and therapy services have improved. In one of those areas, health and education have a pooled SLT budget, and a shared service that works in an impressively seamless way.

This is not, however, the typical picture. Across the NHS, very many Trusts have experienced financial difficulties over the last two years. Although we asked about this, it was difficult to unpick from our survey results what proportion of our respondents worked in Trusts that had a current deficit. It was clear that at least a half worked in organisations that had been in deficit in the previous or current financial year, or in Trusts that had implemented major cuts for financial reasons. Policies such as 'top slicing' have had an impact on financial resources even where Trusts have not been in deficit. A little oddly, one Trust was reported as 'awash with money' following the return of top-sliced funds.

Inevitably, there has been an impact on SLT services arising from a situation of financial cutbacks. There is no question that SLT services have had to compete with other clinical services for scarce resources. We were told by 75% of survey respondents that cuts had had an impact on service provision. SLTs told us both of their distress at this situation and the consequences for service delivery. References were made to '*vast cutbacks*' and being '*grossly under-funded*'. There were several examples of the contracts of Sure Start SLT contracts ending, but the posts (and the work) simply being deleted rather than mainstreamed into core services. Repeated comments were made about increased waiting lists. We were told, '*Increased waiting lists, increased workload on staff, increased complaints*'; '*Very very major impact – we are not able to provide the same quality of service as previously*'; and '*This has been a tortuous reorganisation that has left everyone struggling*'.

We know of one Trust where the waiting time for children to be seen is now eighteen months. We know of another where mainstream school services to close to 1000 children are provided by 2.5 wte SLTs. We do not regard either as an acceptable situation, for SLTs or for children and their families.

Several SLTs told us of the introduction of a prioritisation system, with children categorised into 'High priority', 'Medium priority', 'Low priority'. Of course we have no objection in principle to prioritisation – *if* clinical needs are met. However, these are systems that are driven by scarce resources rather than need. There is a clinical risk if 'low priority' children receive little or no therapy input at the time they need it. For some of these children, their difficulties will resolve spontaneously, and there will be no long term consequences at all. Other children, though, will start school with unresolved

speech and language difficulties, with attendant consequences on their academic attainment, self-confidence, and ability to form friendships.

Our feedback from SLTs has identified the beginnings of a trend that causes us quite significant concerns. While this applies still in a minority of Trusts, it is a new development that has not been seen in the past. SLTs have told us of the loss of specialist posts – the posts that are most costly. We know, for example, of the deletion of a specialist post to support children with specific language impairment in mainstream school; the deletion of a specialist post working with children with special needs in school; and the deletion of a specialist dysfluency post. We do not believe that the loss of specialist posts can possibly be in the interests of children. A busy generalist therapist with a large caseload will find it challenging to provide careful individualised support to children with more complex needs. In our survey, 31% of SLTs reported the loss of specialist posts within their own department.

Even where specialist posts remain intact, specialist services may be affected detrimentally due to other cutbacks. We were contacted by an SLT from a specialist AAC service, providing support to children (and adults) with very severe communication disabilities. Their own service remains intact, but cutbacks in surrounding Primary Care Trusts mean that there are insufficient SLTs at local level to provide ongoing support. Children receive specialist assessment, specialist advice, and may be supplied with costly high technology communication aids – but are unable to use those aids effectively in school or within their families, as adequate local SLT support is unavailable.

We note that children with relatively low-incidence needs often have difficulty in accessing appropriate specialist services. It is uneconomic for many Primary Care Trusts to provide a highly specialist service for children with acquired brain injury, for example, or for the slightly greater number of children with moderate or severe hearing loss. These children have significant communication needs, but those needs are not best met by generalist therapists. We believe that provision for these children may well be best provided at regional level, with whatever ring fenced funding arrangements are required to ensure an adequate service.

Historically, speech and language therapy services have been led by a Head Speech and Language Therapist – someone who still works as a clinician or who has many years experience working as a clinician. This has meant clinically informed decisions around issues such as service development and the funding of CPD. Where job cuts are made or posts deleted, the Head can at least seek to minimise the damage to service provision.

A relatively new development – and one that concerns us – is that Head SLT posts are being deleted in service reorganisations. We know of a number of recent cases where experienced SLT managers have been made redundant, or have left and not been replaced, and we believe this group of staff to be at significant risk in the future. These posts are replaced sometimes by Therapies Managers or AHP Managers from a different professional background, and (less often) by general managers with no direct clinical experience at all. In our own survey, 20% of respondents told us that they no longer had a 'Head of SLT' in their own service.

Our view is that this leads to a significant loss of accountability. Important decisions on the strategic direction of services, the funding of specialist posts and so on may be made by someone with limited clinical knowledge. Day to day decisions on funding of CPD are more likely to be made purely on cost grounds, with little understanding of the clinical importance of (expensive) specialist training. There is a risk that generic service

managers will feel more remote from the consequences of their decisions. We value our professional management. We believe that the best model for local service delivery is for SLT departments to be headed by experienced SLT clinicians, with additional management training.

It is important to differentiate the roles of a professional manager (a leader at the level of service management) and a professional lead (providing expert clinical leadership and knowledge). Both are, of course, professional leadership roles. In many SLT departments, these two roles have been combined, and this frequently works very well. In other SLT departments, the roles are separate. A professional lead - who need not be a manager - provides clinical support for local therapists, keeps in touch with recognised best practice in the profession, and advises on the clinical implications of operational and strategic decisions.

We regret that the professional lead role is being eroded, in a process very similar to that affecting professional managers. In our survey, 17% of replies indicated the loss of a professional lead role. In practical terms, this means the loss of the person best placed to advise on how to provide high quality clinical care.

Taken together, the erosion of professional manager and professional lead roles create a significant risk. Professional leaders are able to influence policy direction based on the needs of the client. We know that commissioners at local level may have a poor understanding of speech and language therapy. We know that managers from a different professional background may not have a detailed understanding of the profession. This is not about blaming colleagues for a lack of knowledge, but simply accepting that no one can be an expert in everything. Without professional leadership, decisions may be taken that are damaging to service delivery. Without an experienced clinician who can monitor and interpret changing best practice, and provide skilled clinical support to local SLTs, there is a danger of a gradual deterioration in the quality of therapy provided.

We are proud of our professionalism. Professionalism should not be a dirty word, and should not be seen as an overhead.

## **10 Health and education services work well together to provide these services: All or most of the time/Sometimes/Rarely**

It is profoundly important that we get this right. We are well aware of the strong links between speech and language difficulties and academic failure, and the high incidence of speech and language problems amongst young offenders.

We did not survey this area, but responses to our request for contributions to this review suggest a mixed picture.

One of the best examples of good practice that we have come across is of a service where budgets have been pooled, and the service is managed (from within health) in a department with strong professional and clinical leadership. This has completely overcome the sterile arguments about who should pay for the support of which children. There are, however, many other geographical areas where these disputes continue. Arguments over funding will tend to mitigate against the creation of a 'joined up' service to support children with communication needs.

We have been told by several therapists of good working relationships at school level, but of frustration in developing effective service provision at a more strategic level. In some cases, ongoing work has been severely disrupted by reorganisation (of health or education departments). In other cases, SLTs have told us of a lack of understanding or support from education managers. Comments include, *'I have become disillusioned by higher management who tell us how to streamline our department for more efficient output. We are made to sound like a factory, but a good therapist takes time to learn about individual families and to support their individual needs. This takes time - but in the long run proves to be more beneficial in terms of time and therapy outcomes'*. Others have commented on a lack of cooperative working and on needless duplication of services.

We accept that many geographical areas will have achieved strong joint working at this strategic level, but this does not help the children who happen to live in the wrong place. We would welcome clearly defined minimum standards for the provision of therapy in school settings, and clearer arrangements for funding.

There are, of course, positive examples of SLTs employed directly by education and working solely in educational settings. We know of other examples where SLTs employed by education have experienced repeated problems around a lack of clinical supervision, no CPD, and a strong feeling of being isolated from the support of wider health networks. We know of many, many examples where SLTs providing services into schools have had their clinical judgement over-ridden by a SENCO or Head Teacher, and have needed support from outside the school setting in order to act in the best interests of the child.

Children do not exist solely to be educated. They are human beings who have feelings, play games, make friends, deal with conflict; who function in families and wider communities. IEPs are a very small part of life! We strongly believe in the importance of a holistic approach to assessment and intervention for children with communication needs, and we believe that SLTs are uniquely placed to provide this support.

We also believe in the importance of maintaining speech and language therapy as a single profession. Paediatric and adult therapists have a common theoretical understanding of communication, together with shared vision and values about respect

for our clients. Of course we work in different ways, and with different people, but our own clinical experience is that a neonatal feeding specialist and a paediatric therapist and an adult therapist have far more that unites us than divides us. Any rigid separation between paediatric and adult therapy would be to the detriment of both groups.

There will be local circumstances that support a variety of models, but we feel that the best home for a majority of SLTs is within the NHS, with professional management from within our own profession. We regard health as a 'wellness' service – not fixing what is wrong, but working to promote physical, social and psychological wellbeing. Educational achievement is part of this broader picture. We would oppose any future organisational form that sought to move the employment of SLTs into education on a large scale, as we believe this would threaten our clinical autonomy, our clinical supervision, and our ability to provide therapy within a holistic framework. Joint working can be achieved through an understanding that communication is a joint responsibility, and through standards, shared budgets, and a shared commitment to deliver for children and families. There is no requirement for changed employment status.

**11 a) Set out your views of the strategy to deliver to speech, language and communications services in your local area. (E.g. Is there strategic leadership from service heads? Are steps being taken to bring services closer together or to integrate them? Are formal arrangements in place to ensure effective commissioning and delivery of services? Are there agreed local plans and/or targets?)**

In many areas, the strategy has become one of survival. Service delivery revolves around delivering 'efficiency' savings or overt cuts, or stretching resources further to cover for posts that are not going to be filled. This is not the fault of professional managers, who typically do their best to minimise the harm to services – but this is, sadly, the reality now for many SLT departments.

Professional managers have also become adept at constructing bids within 24 hours for pots of money that appear intermittently and with no notice, and that last for only a year. This is not a useful way of providing services on a planned and coherent basis – but making snap judgements about how to win funds and use a year's worth of money effectively certainly requires a sound knowledge of the profession.

The erosion of professional leadership is an issue we have already covered. Without professional leadership, *strategic* leadership necessarily becomes a good deal harder.

Many of those who responded to our survey praised their professional managers – not a universal picture, but a common one. Perspectives of the senior NHS managers implementing reorganisation, cuts or redundancies were starkly different. Comments made to us included, *'Decisions are being taken by people who understand nothing about clinical services and care even less'*; *'Management is no longer by SLTs so there is a lack of local and clinical knowledge – leading to poor decisions'*; and *'A tremendous sense of uncertainty with the development of provider services as 'business units' – I have no faith that the senior managers leading this have the skills needed'*.

Professional leadership matters. So do adequate resourcing and organisational stability.

Integration is affected by contradictory pressures. The variability of joint working between health and education has been touched on. There have been a number of immensely valuable initiatives around support for disabled children – such as 'Together from the Start', 'Early Support', and the 'National Service Framework for Children Standard 8'. There is a recognition in these of the multitude of appointments attended by many of these children, the pressures placed on parents and carers, and on the need for *integrated* care, putting children and families at the heart of designing and delivering packages of care. Services have responded – for example, through the development of key worker schemes, and closer working between professionals to ensure joint appointments and shared goals wherever possible. While there is a long way to go, things have improved in many geographical areas.

However, the move towards the privatisation and fragmentation of public sector services makes integration much harder. In the future, a child may receive services provided by education, by a privatised provider of respite care, by a different privatised provider of social services funded OT, by several acute NHS providers, by a privatised SLT provider, by a separate privatised physiotherapy provider.... Each of these providers will have separate management structures, and separate policies and priorities. Providing integrated care necessarily becomes more difficult. We do not believe that this level of fragmentation is in the interests of children with complex needs.

Market testing is about breaking up existing provision. We are in a period of very rapid change, and great uncertainty for staff and clients. The impact on the morale of SLTs – and other NHS employees - has been profound. SLTs have told us of their fears for the future, their uncertainty over who their future employer might be, and their uncertainty over whether or not they will remain in employment.

Unite (Amicus Section) opposes privatisation of the NHS. Our strong belief is that privatisation is not in the interests of patient care. We are committed to the NHS as a public sector organisation. Many SLTs 'go the extra mile' on a daily basis, and we do so because we believe in the values and ethos of the NHS. That commitment is not necessarily transferable to a privatised speech and language therapy company, where the emphasis is on maximising profit

What is the definition of effective commissioning? For SLTs, who have an obvious interest in preserving our jobs as well as our professionalism, it is being commissioned, and being supported in providing high quality evidence based care. For commissioners, it may be the purchase of a cost effective service, with lots of face to face contacts from newly qualified (cheap) SLTs providing apparent value for money. A service can superficially look good, and can be measured and monitored and demonstrated as 'good' – but that does not ensure that the therapy provided is of the quality that children with speech and language difficulties deserve.

**11 b) How could strategic leaders strengthen delivery of speech, language and communications services? (E.g. What would need to be done in respect of service structures and operations? Would priorities have to change? What levers might bring about change?)**

The importance of professional leadership has been emphasised. Without professional leadership, we will lose strategic decision making at local level.

It may sound like a bizarre comment, but an exceptionally important change would be to restore health care to a position of importance within the NHS. It is possible now to read page after page of Board papers that discuss business units and units of production at length, but that are quite divorced from the needs of patients or the wider community. There are consequences to running the NHS as a series of competing small businesses. The language *and* the priorities of NHS decision makers become those of the business world.

From a speech and language therapy perspective, we would welcome a national strategy around communication, and minimum national standards for the provision of speech and language therapy support for children with communication needs. This *national* strategic approach is currently lacking.

**12 In my experience, resources are used mainly to provide: support for children in their early years, support for 5-11 year olds, support for 11-16 year olds, support for children with the severest speech, language and communication needs, support for children with low level needs, speech and language units, outreach work, information for parents, other**

The approaches taken by individual services have varied. The emphasis, in our experience, is consistently on pre-school children, and sometimes on pre-school *and* primary age children. Some services have mainstreamed Sure Start services successfully; others have effectively dropped a preventative approach by deleting these posts. Other services have responded to financial pressures by cutting specialist posts, thereby reducing services available to the children with the most severe speech and language disorders (or with wider disabilities). Others again have prioritised service provision to the extent that children with a lesser level of need no longer receive a service.

So what should be happening? The challenge in many areas now is that resources are restricted and diminishing still further. This leaves uncomfortable choices to be made about which group of children will suffer. The obvious alternative would be adequate funding for speech and language therapy provision, with priorities determined by clinical need and the development of a robust evidence base. National standards for speech and language therapy provision could help to ensure that SLT departments are not seen as a soft target for cuts, and could set out core standards for meeting the needs of *all* of these children. There must be some degree of flexibility in any national approach, as positive change comes about through innovation. We support a national approach, but not one that is completely prescriptive.

More generally, we have seen (and we support) the recommendations of I Can's 'The Cost to the Nation' paper.

**13 b) Describe how you think resources at both national and local level should be used. (E.g. should more resources be directed towards early intervention? What kind of investment offers best value for money in terms of improving children's outcomes?)**

Our view is that there is a growing evidence base for a preventative approach. We welcome the pilots of intensive nurse led early intervention packages in the UK, based on the work of David Olds. We would, of course, not wish this approach to be at the cost of a universal health visiting service. We support the use of an early preventative approach to speech and language difficulties, and note the work of Sure Start and the more focused approaches of 'Talk to Your Baby', 'Talk to Me' and the like. We wonder if there is scope for further research to refine our understanding of what elements of these packages are most effective.

There is also now a strong evidence base for early intervention, for those children who have developed speech or language difficulties, and for children with wider disabilities. I Can's report summarises the research evidence well. We support these early intervention approaches. Again, we suggest there may be potential for further research to refine early intervention work.

We note the association between delayed language skills and social deprivation. While we are supportive of intervention to meet the communication needs of these children, we would also wish to see policy initiatives from the Government that go further in tackling the underlying causes of inequality and disadvantage. We also regret the sharp reduction in free or highly subsidised nursery places in council nurseries in many areas. Where language delay is related to a lack of play opportunities and language stimulation at home, nursery placements can be remarkably effective in achieving positive change for children. Unfortunately, nursery places are frequently prohibitively expensive. We are pleased by the commitment made in the Children's Plan to offer free part-time nursery places to 20,000 two year olds in the most deprived parts of the country – but this will not benefit the two year olds who live outside these areas.

We feel very strongly that neither preventative nor early intervention approaches are enough to meet the needs of every child. Specific language impairment or autistic spectrum disorders, for example, cannot be 'made better' by either approach – although early intervention can be immensely beneficial for these children and for their families. Our view is that children with more severe and persistent speech and language difficulties must have access to long term specialist support, to meet their changing needs as they grow up. This should include support for secondary aged children where this is necessary. We are aware of the evidence of a high social and financial cost if the needs of these children are not met. Quite apart from the cost issue, we believe there is a moral imperative to provide support to these children.

We oppose an approach to speech and language therapy provision that is based purely on what is cost effective and what provides value for money. This issue becomes stark when we consider children with the most profound and complex disabilities. Improved survival rates of very premature babies have led to a sharp growth in the population of these children. For many of these children, it is very apparent that they will never become economically active members of society. Nor are they likely to go out and commit crimes, or behave anti-socially, as many of them are not independently mobile. This must not in any way diminish their right to therapy support, to communicate as effectively as they can, to eat and drink without distress, and to have the best possible

quality of life. Our ability to support these very vulnerable individuals is a measure of the society in which we live.

We note that speech and language therapy has failed to establish the strong tradition of research that exists in, for example, clinical psychology. Clinical psychologists will typically undertake research as part of their own training and professional development – but the work that they do adds to the knowledge base of the profession. In our own profession, this is less well established. We would like to see a greater emphasis on research, and the creation of posts or a career structure that more readily allow SLTs to combine clinical work and research. We believe that this would strengthen our use of evidence based practice.

#### **14 In my local area, lines of accountability in all services are: Clear, Clear on some issues, Not clear**

The reality of much of the NHS, particularly primary care, is that things are now a complete muddle. The Commissioning a Patient-Led NHS reorganisations were required to deliver cuts in management costs. Additionally, many Primary Care Trusts merged as part of this process. Service manager posts were deleted in many of these restructures. Commissioning a Patient-Led NHS has often been accompanied by or succeeded by further reorganisations to reduce costs or to consolidate the commissioner-provider split. These changes are continuing.

The pace of change has been so great that it becomes quite unclear who takes strategic decisions, and sometimes even who manages services on a day to day basis. Accountability is really very weak.

SLTs have also told us of the lack of clarity around commissioning. We have been told that SLTs don't know who the commissioners are, how they take their decisions, and how they are held to account for those decisions. We don't know either. There is certainly a great deal of work around data collection and reference costing, but this does not relate readily to the provision of health care.

Comments to us include, *'At the level of service delivery, we often feel we are at the whim of whoever has the next idea'*; *'As yet it is unclear how commissioning will work in the health community (or even who those commissioners are)'*; and *'The people in management did not listen to our concerns about service development or the impact of how restructuring will affect our clients. They have not given us any confidence in their management, and they clearly do not understand how we work or what we do'*.

This cannot be a context that is supportive of high quality speech and language therapy provision. These are national issues, and they require a change of policy at national level.

## **15 In terms of improving children's outcomes, service standards are: Excellent, Good, Satisfactory, In need of significant improvement**

We know of services where SLT provision is excellent. One SLT told us, *'The service is expanding. We have been given additional resources to employ basic grades and more specialist staff, and this has transformed the quality of our service to pre-school and school aged children'*. We regard this service as showing what is possible with adequate resources and committed professional management.

There will be other services that are getting by just fine. The cuts in SLT departments do not apply everywhere. Not every SLT who has contacted us has reported a collapse in their career prospects or morale.

However, there are many SLT departments that have experienced harsh cuts, and it is these services in particular where standards of therapy have become unacceptably poor.

We have mentioned already the service where children wait 18 months to be seen. We know of another service where the wait time for an initial assessment or school visit is up to a year. We have commented on the service where 2.5 wte SLTs provide a service to almost a thousand children. We have commented on the loss of specialist posts – with examples known to us including SLI, special needs in mainstream school, voice, dysphagia, AAC, and dysfluency. We have mentioned the loss of a preventative approach in some areas. We have noted the introduction of prioritisation systems that leave children with unmet needs.

Services provided on this basis are unlikely to improve children's outcomes particularly well.

We do not believe that these standards of service provision are acceptable. We most certainly do not blame the SLTs who deliver these services. It is heart breaking for SLTs to find themselves trapped in a system where they cannot deliver adequate care. SLTs have told us of their very real distress, with several disclosing that they have been reduced to tears by their work situation.

The need for change has become urgent.

**16 Evidence to show standards and children's outcomes are improving is: Collected and shared regularly, Available for some aspects, but not others, Not available**

When we began collecting data on what was happening in the profession, we had no idea of just how bad things were. We knew that there were problems, but we had not guessed at how serious or widespread these were.

We suspect that the Directors and Assistant Directors in the Trusts we have surveyed are busy writing reports for Commissioners or the Board to tell them how well things are working, and how easy it has been for staff to implement new ways of working. It is remarkable how services can be cut, but somehow manage to get better and better.

Therapists have told us that senior managers do not recognise or value the work done by SLTs. They have told us of the need for *'major cultural change'* and that *'planning must involve listening to those delivering the service'*. We agree. We seem to be in an Alice in Wonderland world where politicians and NHS decision makers tell us everything is wonderful – but clinicians tell us that things are getting worse and worse. This makes no sense. Data collection must be meaningful, and strategic decision makers must seek to engage with the staff who deliver services.

## **17 At national level, lines of accountability are: Clear, Clear on some issues, Not clear**

We do not feel that there is a great deal of clarity around lines of accountability at national level. RCSLT sets overall professional standards, while the HPC regulates the profession. When it comes to defining clinical priorities and standards for service delivery, there is little guidance. Voluntary sector organisations such as I Can, Scope and the National Autistic Society provide support and guidance on good practice, but there is no requirement that this is implemented at local level.

The Children's NSF and the Children's Plan pay little attention to communication.

It is likely that the absence of clearly defined standards for speech and language therapy provision has contributed to the damaging cuts we have seen in the last two years.

We regard the Bercow Review as an important opportunity. We know that things aren't good enough. We know that the life chances of children are being affected by inadequate services. This review gives us the opportunity to put things right.

We support this review. All the SLTs we have spoken to support this review. We support I Can's call for a clearly defined national approach to meeting the needs of children with communication disabilities. We hope that any recommendations arising from this review will pay due attention to wider issues in the NHS.

## **18 Central Government's contribution to raising standards is: Clear and helpful, In need of strengthening, Not clear**

Sadly, we believe that the Government's recent contribution has been a negative one. We have outlined the reasons for this in our detailed responses to the questions in this review.

SLTs are now contending with poor pay, constant reorganisation and insecurity, job loss, and cuts in training. They feel unsupported by senior managers. *'Disillusioned; Under-resourced; Uncertain'* is a comment to us that reflects the experiences of many SLTs.

It is not possible to divorce speech and language therapy from the context in which it is delivered. The decisions being made around the NHS are political ones. We hope for some significant policy changes.

**20 What are the important steps needed to improve standards? (E.g. What level of standards should be achieved (give examples)? What should be the role of Government departments and national regulators or inspectorates?)**

We are strongly supportive of a national approach to meeting communication needs. We do not believe it would be helpful for us to give 'off the cuff' suggestions on what level of standards should be achieved. Our belief is that careful, considered work should take place before any national standards are defined.

We believe in the importance of evidence based practice. We hope that any national approach will seek to incorporate recognised best practice, from expert clinicians and from voluntary sector organisations. We do not wish to see a prescriptive approach that excludes innovative practice. We believe that SLTs have the skills and commitment to drive forward any new national approach, and to be at the heart of delivering improved support for children with communication disabilities.

Any national approach should have formal backing from the Government, and the funding to make it work. Without these, new recommendations will carry little weight. Perhaps a communication strategy could be incorporated into the NSF for Children.

The HPC, as the body that regulates SLTs, has in our view played little useful role in promoting professional standards. The emphasis of the HPC seems to be primarily on 'policing' individuals. In some cases, the treatment of these individuals seems to have been unfair. We regard the HPC as a poorly run organisation. There have been countless problems reported by SLTs in maintaining their registration, because the HPC mislays letters, does not answer its telephones, imposes arbitrary charges, and fails to communicate essential information. We are not impressed by this organisation.

## 21 Do you have any further comments?

- *The service is expanding. We have been given additional resources to employ basic grades and more specialist staff, and this has transformed the quality of our service to pre-school and school aged children.*
- *In 30 years of NHS practice I have never known a time when staff are so demoralised, frustrated, depressed and generally stressed out by the constant demands, not just to do with our caseload, but the systems which leave us feeling watched, monitored and totally unsupported at every turn.*

There are choices here. Which model do we want? Which model will support us in meeting the needs of children with communication disabilities?

If we use existing best practice as a model, our profession will grow, develop, and provide the best possible care for children with speech and language difficulties.

If we continue down our current route, the future for the profession looks bleak. The decline of speech and language therapy as a profession will have a detrimental impact on the provision of services to the children we support.

Almost two-thirds of the SLTs we have spoken to reported lower morale than a year ago. Over two-thirds told us that they 'often' saw their colleagues affected by stress. These cannot be regarded as trivial concerns.

The needs of speech and language therapists are not particularly surprising. We need organisational stability, within an NHS that we can be proud of. We need job security. We need fair pay, and recognition for the work we do. We need managers who understand what we do, and who understand the clinical consequences of their decisions. We need training and opportunities for professional development. We need speech and language therapy to offer a career, not just a job.

Above all, we need to believe that the services we offer make a difference. The sorts of cuts that are now taking place are an insult to the professionalism of speech and language therapists.

There are fundamental problems. We need fundamental change.