Auditory processing: beyond audiology?
RCSLT Short Courses for 2004

Course 749
Thinking of Returning to Work as an SLT?
Speakers: Gillian Stevenson and Deborah Courtney-Deal
2 December 2004, 10 - 4pm
RCSLT, 2 White Hart Yard, London SE1 1NX

This course is for SLTs who have been out of the profession for a few years, either taking a career break, or working in another field. The course is intended to help SLTs decide whether they want to re-enter the profession, and if so, how they should set about doing so. The course will help intending returners to identify where they may need additional up-dating, and working with the RCSLT will identify opportunities for gaining up-dating knowledge and experience. This course is not suitable for people considering speech and language therapy as a career at the outset.
Booking fee: £30

Course 737
Recruitment methods for non-recruitment professionals: what they didn’t teach you in therapy school
Speaker: Sheila Murray
22 September 2004, 10 - 4 pm
RCSLT, 2 White Hart Yard, London SE1 1NX

This course is suitable for those responsible for recruiting healthcare staff for their department. During the course, you will learn the 10 ways that will increase your ability to find the staff you need, when you need them. You will learn about effective advertising campaigns, networking, open days, employee referral programmes, using agencies and much more to get you started.

Booking fee: RCSLT members £65; non-members £80

Course 722
The role of the clinical specialist in the identification and management of children and young people with pervasive developmental disorders
Speaker: Debbie Onslow
20-21 September 2004, 9 - 4pm
RCSLT, 2 White Hart Yard, London SE1 1NX

Following feedback from course participants attending courses on autism during 2003, we are now offering a two-day course on the identification and management of communication disorders. This course is suitable for SLTs working in paediatrics who are/will be involved in the diagnosis and management of children and young people with ASD via multi-disciplinary settings (real or virtual), mainstream and special schools, and the provision of support for colleagues in the community.
Booking fee: RCSLT Members £130; non-members £160

Course 743
Getting started in research: an interactive workshop on developing practice-based research skills for SLTs
Speaker: Diane Bebbington
5 November 2004, 10.30 - 4pm
RCSLT, 2 White Hart Yard, London SE1 1NX

This workshop is for clinicians and managers with little or no experience of research who are interested in applying existing research and taking forward their own ideas. The workshop will explore the relevance of research to speech and language therapy, help participants clarify areas they want to study and how to access resources, information and skills. The workshop will also look at some of the steps involved in the research process and how to design some small-scale projects.
Booking fee: RCSLT Members £65; non-members £80

Course 740
Thinking of returning to work as an SLT?
Speakers: Gillian Stevenson and Deborah Courtney-Deal
11 October 2004, 10 - 4pm
Classroom 1, Postgraduate Centre, York District Hospital, Wiggington Road, York Y031 8HE

This course is for SLTs who have been out of the profession for a few years, either taking a career break, or working in another field. The course is intended to help SLTs decide whether they want to re-enter the profession, and if so, how they should set about doing so. This course is not suitable for people considering speech and language therapy as a career at the outset.
Booking fee: £30

Booking fees cover refreshments, lunch, course handout materials, and a certificate of attendance. To book your place or find out more contact:
The Short Courses Office, RCSLT, 2 White Hart Yard, London SE1 1NX.

Email: short.courses@rcslt.org
Tel: 020 7378 1200
Fax: 020-7403-7254
COVER STORY:
Auditory processing: beyond audiology?
See page 12 for details

CONTENTS

Editorial and letters

News: Early implementer managers share their AFC experiences; Ruling respects right to treatment; Seminars will lift lid on SLI in education; Chingford club speaks out about aphasia, and more

Survey reveals encouraging trends: The results of the latest SLT recruitment and retention survey: October to March 2003-2004

Auditory processing: beyond audiology?: Should SLTs be involved in the management of auditory processing disorders?

What next for early intervention?: After the closure of Wilstaa, Frances Harris takes stock of what the programme has achieved

Supporting vulnerable communities: What are the challenges when developing groups for vulnerable parents of children with communication difficulties?

Reviews: The latest books and products reviewed by specialist SLTs

Any questions: Your chance to ask your colleagues and share your knowledge

Professional Issues: Caroline Fraser a hard act to follow; Open University announces new degree for assistants; SLTs jump at the chance to influence CQC

Specific Interest Groups: The latest meetings and events around the UK
How are your stress levels?

A recent study by the Health and Safety Executive found that teaching and nursing, both dominated by women, are the most stressful professions in the UK.

The survey revealed that more than three in 10 nurses and four in 10 teachers said they suffer from stress at work, mainly as a result of the demands of their workloads and the increase in the threat of violence that they face in their working lives.

There are a couple of obvious questions from the results of this survey: is speech and language therapy another high stress occupation? If it is, what are the main causes of that stress?

Do you suffer from an excessive workload, caused by too little time, too many clients and too much paperwork? Has the preparation for Agenda for Change had an impact on your stress at work?

And what about the perceived or actual threat of violence in your workplace?

Remember this can come from a number of sources: from clients that may not be able to restrain their physicality; from anxious parents concerned about service provision for their children; it could even come from your health, education or social care colleagues?

And it is not just a question of physical assault. If you feel threatened by another person’s behaviour this is classed as perceived violence and needs to be taken just as seriously.

It will be interesting to see what you have to say on the subject. Please write to bulletin@rcslt.org and let me know.

Steven Harulow
Bulletin Editor

Note:
Please remember that Katy at McMillan-Scott only handles RCSLT’s advertising. For membership enquiries contact the RCSLT membership department, email: membership@rcslt.org or tel: 020 7378 1200

---

LETTERS

Bulletin thrives on your letters and emails
Write to the editor, RCSLT, 2 White Hart Yard, London SE1 1NX
e-mail: bulletin@rcslt.org

Please include your postal address and telephone number
Letters may be edited for publication
250 words maximum

AfC petition
Speech and language therapists in Scotland are keen to raise awareness of Agenda for Change (AfC). As part of this we have raised an e-petition asking the Scottish Parliament to discuss the implications for the profession. This can be viewed and signed at http://itc.napier.ac.uk/e-petition-scot/list_petitions.asp

We urge all Bulletin readers to sign and comment on this online. Although this is a petition to the Scottish Parliament we would encourage all readers across the UK to sign, as this will raise the profile of AfC and speech and language therapy in general.

Nicola Orr and Susan Bannatyne
SLTs

Inclusion is here to stay
I was dismayed but unsurprised to read that delegates attending NASUWT’s conference have deemed educational inclusion to be a ‘disaster’ that does not ‘serve children’s needs’ (‘Inclusion policy a disaster says teachers’ union’, Bulletin, June 2004, p6). I wonder how many SLTs would confess to sharing these sentiments?

However, it is surely not inclusion itself that is failing these children but the combined failure of service providers, professional groups and individual practitioners. We fail them through inadequate coordination of services, insufficient resourcing, inflexible working practices, rigid professional boundaries, lack of shared knowledge and attitudes which value ‘normality’ above human diversity and participation. Inclusion is not simply the buzzword of the day or some new fad. It is here to stay. Like our teaching colleagues, therapists face the challenge of having to reconceptualise their role within inclusive settings and their approaches to intervention ensuring that our practice is not a barrier but a facilitator of successful inclusion.

Kate MacKinnon
SLT, Yorkhill Operational Division NHS Greater Glasgow

Bulletin feedback
I would like to congratulate you on the new look of the Bulletin and Bulletin Supplement. They are easy to read, have maintained the same high quality and look fabulous.

Initially I found the News and

Feature sections of the Bulletin Supplement a little distracting, but now I like the way they give some clinical context to the Supplement.

Name and address supplied
LETTERS

Gastrostomy protocol
At the Typical and Atypical Ageing Conference, on 22-23 April at Guy’s Hospital, I presented a poster on, a clinical protocol for people who may require gastrostomy feeding. I developed the protocol with a clinical psychologist colleague, in our work for Riversdale Early Onset Dementia Service, based in High Wycombe.

The protocol describes an approach to discussing the issues around PEG feeding, including risks and benefits of the procedure, and also considers obtaining an informed decision.

The content of the pack may be generally available, but those who gave their names at the conference asking for further details might like to let me have their email addresses. I plan to contact each one as soon as possible.

Eileen Martin - SLT, Buckinghamshire Mental Health Trust
Email: Eileen.Martin@sbucks.nhs.uk

Review of Basic Verbs
I would like to respond to the comments made in the review of the above in the June Bulletin (p18).

The reviewer commented that the models were all wearing western clothes; few were adults and should have included people with disabilities in order to be inclusive of the wider client group.

We do our utmost to ensure there is a good degree of variety of models shown in our ColorCards so they can be used in a wide number of locations. We have an international market, so it is imperative we do so. Where a set is intended for a particular client group (such as our Pocket ColorCards, which are mainly used with preschoolers) we do try to make sure the models reflect this.

The main market for Basic Verbs is children, and the models used reflect this. The next set in the series, Familiar Verbs, has a greater emphasis on adult models – over half the set in fact – and includes a young woman with Down’s Syndrome. Many of our models do have difficulties, such as Asperger’s Syndrome and dyslexia but these are not visually apparent. Care is taken to ensure people from ethnic backgrounds, or those with disabilities, are not presented in any way (such as wearing traditional dress) which may suggest stereotyping.

We do not use professional models. They are all volunteers who receive only a nominal payment. We are also restricted by having to shoot photos during school holidays (when children are involved), by who is available on those particular days and by who has not been used in other recent ColorCards sets.

We are always looking for new models, but it is obviously difficult to approach people – particular children with difficulties – and ask to take pictures of them. If any Bulletin readers know of individuals or groups who would be interested in modelling for ColorCards and could travel to Aylesbury, I would be very pleased to hear from them.

Karen Dewick, MRCSLT - Product Developer
email: karend@speechmark.net
Ruling respects right to treatment

A terminally ill man who feared doctors might withdraw his life-prolonging treatment won a landmark case in July ensuring that his wishes will be respected.

Leslie Burke, aged 43, who has cerebellar ataxia and is likely to lose the ability to communicate, brought the case because he was concerned that current General Medical Council (GMC) guidelines left him at risk of having artificial nutrition and hydration (ANH) withdrawn without his consent.

The GMC guidance allows doctors to withdraw ANH when in their opinion a patient's condition is so poor that continuing treatment would serve only to lengthen the patient's suffering.

Mr Burke was concerned that a doctor's decision would be subjective and not coincide with his own decision at the time.

The High Court ruled that if a patient has made a living will or expressed that they would want life-prolonging treatment with drawing life-prolonging treatment won a legal challenge to prevent doctors

Special school parents face prosecution

Parents who set up a special school for children with autism because they felt local schools could not cater for their children's special needs have been threatened with prosecution for failing to send them to a mainstream primary school.

The Step by Step School at Sharpthorne in East Sussex opened in April 2004 and uses a US technique, applied behavioural analysis, to break down tasks and speech into small steps to help children achieve more independence.

The Department for Education and Skills approved the school and it passed its preliminary Ofsted inspection. However, East Sussex County Council insists the education offered by its schools is suitable for the children.

A spokesperson said, “We expect all parents to make sure their children attend school. In these cases the Special Educational Needs and Disability Tribunal has found Step by Step School to be inappropriate.”

The National Autistic Society described the threats as 'unnecessarily aggressive'.

Ask the panel, asks I CAN

I CAN, the charity that helps children with speech and language difficulties, has launched a new online information service on speech and language difficulties. Ask the Panel encourages teachers and other education and health professionals to submit questions on selected topics to a panel of I CAN speech and language specialists. I CAN say their specialists will provide a detailed response within 10 days. Other features include case studies of children with speech and language difficulties, written by their parents, and a resources list to aid teachers in their search for relevant software, magazines and teaching tools. Visit: www.talkingpoint.org.uk
Early implementer managers share their Agenda for Change experiences

Speech and language therapy managers from the Agenda for Change (AfC) early implementer (EI) sites met with representatives from the RCSLT Management Board on 9 August to share information and experiences from the SLT services involved in the AfC pilots.

In addition to sharing learning, the meeting was designed to identify what College could do to further lobby Amicus on behalf of its members and to develop specific guidance for the RCSLT membership.

RCSLT CEO Kamini Gadhok emphasised that the RCSLT does not regard the forthcoming Amicus AfC ballot outcome as a fait accompli.

“Holding this meeting demonstrated College’s commitment to respond to the problems its members are experiencing, and to support them as much as possible,” Ms Gadhok said.

Those present heard that the EI sites have had a range of results for speech and language therapy. While some results were positive and gave rise to optimism, others were less so, and were being reviewed. The managers agreed that differences in the way the AfC process is being implemented locally is contributing to the varying results.

The managers also said it was important to note that the results of the equal pay re-grading are variable across the UK and that this could have some impact on whether the outcomes of AfC are positive for individuals.

The group identified a potential gap in the profile for specialist therapists at band 7 that would be particularly useful for those in community posts. Three of the managers present will work in partnership with Amicus to support the development of the profile.

“SLT managers should get heavily engaged in the AfC process; to become more politically aware.”

The group also established the need for the provision of strong guidance to support individuals both with process and with evidence, specifically around research and development, and knowledge and skills factors.

The group heard that the Joint Evaluation Working Party would review the professional manager profiles. The results of this will be sent out through the RCSLT management networks for comment.

The main advice from the group is that SLT managers should get heavily engaged in the AfC process and find out who they need to influence; to become more politically aware.

In addition, staff should elect an SLT AfC representative and wherever possible should be involved in matching, although the group acknowledged that not all trusts will pay to cover the service while an SLT is on a matching panel. One group member commented that SLTs could lobby for ‘back-fill’ pay where this is not available.

The meeting stressed that it is important for SLTs to do their AfC research. The job evaluation - matching procedures and factor plan are available at:

www.amicushealth.org/archives/000081.html

The specimen job descriptions and person specifications are available at:

www.rcslt.org/#afcjob

Finally, the group re-emphasised that trusts will not accept model job descriptions and it is essential that SLTs re-write the models in their own words.

The RCSLT will send guidance from the meeting to all SLT managers to support them with the AfC process.

Chingford club speaks out about aphasia

Chingford Aphasia Club celebrated its fourth Speak About Aphasia Month (formerly Aphasia Week) in June.

Established in January 2000 by Waltham Forest PCT SLT Catherine Newman and a committee of people with aphasia, the club offers long-term support for people with aphasia and their families. Since then, 36 people with aphasia and 15 family members have attended.

Catherine says, “As a department, Speak About Aphasia Month provides us with a focus to raise awareness of aphasia among our colleagues and in the local community. “Every year we contact the local press, carers groups and health organisations with articles and information. In previous years we have visited a local shopping centre with guidelines for service staff, leafleted all local hospital wards with aphasia information and set up information stalls and displays in clinics and therapy areas.”

For more information on the service, tel: 020 8535 6795.
Managers, take time to pause and reflect

Speech and language therapy managers will have the opportunity to reflect on the major issues impacting on them as leaders within the profession at a major conference next spring.

The organisers of A Time to Pause, on 13-14 April 2005 at Stratford Upon Avon, are looking for presentations (between 20 and 40 minutes in length) and posters around the impact of government policies on speech and language therapy; partnership working; extending and changing roles; models of service delivery and examples of good practice; managing change and individual ‘big issues’.

The keynote speakers, including RCSLT CEO Kamini Gadhok, and Patricia Oakley, Teaching and Research Fellow, London University, will provide a national overview. The organisers are looking for local responses to national issues from a manager’s point of view.

They are not looking for clinical papers as these issues can be followed up at the RCSLT Conference in Spring 2006.

Send abstracts of up to 200 words outlining the key points of your proposed presentation or poster, by the end of September 2004, to Jill Kelly, email: jill.kelly@coventrypct.nhs.uk

Seminars lift lid on SLI in education

The continuing drive to include children with differences and difficulties in learning in mainstream schools has important implications for the speech and language therapy profession.

Speech and language therapists working in educational contexts must seriously reconsider how we understand working and supporting learners with speech and language needs in education and academic learning contexts.

Children who experience difficulties in learning because of speech and language impairment (SLI) represent one of the largest groups of learners with educational difficulties. Research into SLI (also called language and communication difficulties, specific language impairment, language difficulties, disorder or disability) has mainly occurred in the disciplines of medicine, psychology and applied linguistics. There is little to inform practitioners in education how to support these learners.

The Economic and Social Research Council has awarded funding to Deirdre Martin and Carol Miller, from the University of Birmingham’s School of Education, to run a series of seminars to review research findings concerning SLI, and to link it with research in education on language learning.

The aim is to develop a new educational perspective of SLI, with innovative theoretical understandings, research methodologies and teaching and learning practice for researchers and practitioners involved with this group of learners.

The seminars, which begin in October 2004, bring together academic researchers, practitioner-researchers, policy-makers and members of professional and charitable bodies in the different fields of child language disability.

The seminar themes include developing an educational perspective of SLI; research methodologies for the assessment of SLI in educational contexts; approaches to researching curriculum teaching and learning with SLI learners and inter-professional learning with professionals working with learners with SLI.

Outcomes of the series will be a web-based discussion group, a research agenda for SLI in education, and publications for researchers and practitioners.

Deirdre Martin and Carol Miller
School of Education, University of Birmingham
Email: d.m.martin@bham.ac.uk
Survey reveals encouraging trends

Debby Rossiter presents the results of her latest SLT recruitment and retention survey: October to March 2003-2004

The fourth Bulletin survey has been undertaken during a relatively settled period for speech and language therapy, with the 2000 regrading well established and increased student numbers coming through into the profession. However, with Agenda for Change (AfC) on the horizon and the likelihood that many of the gains under regrading may be lost, the high response rate (82%) reflects the profession’s continuing concern about recruitment and retention (R&R) issues.

During the six-month survey period, 225 NHS trusts placed advertisements for 933 posts. This figure was slightly down on 2001/02 (969). Forty-seven posts were re-advertisements and were not included in the analysis, leaving a total of 886 posts.

Nearly four fifths (79%) of posts were advertised as full time and 21% as part time; however the flexibility demonstrated by managers in previous surveys continued, with inducements offered to increase the range of applicants, including bands one or two, according to experience, on a full- or part-time basis, flexible working and school holidays.

The number of new posts increased to 15% from 8% in 2001/02. In this survey a specific question was included in addition to information from the advertisement, which will have added to the accuracy of the total. The number of new posts (131) is significant since it outstrips the number of new student places established as a partial solution to the profession’s R&R problems. Nine per cent of posts were based outside the NHS. This was a slight drop from 2001/2002 (11%) and the majority of local education authority posts are now advertised jointly or in cooperation with local PCT services.

The percentages of paediatric and adult neurology posts both increased slightly at the expense of posts in learning disability. The share of adult neurology posts has risen from 18% in 1999/2000 to 26%.

Within these major specialisms, areas such as hearing impairment and paediatric dysphagia are now recognised sub specialities, reflecting the increasing breadth of the SLT’s role.

At the time of the 2001/02 survey (Rossiter 2002a,b), speech and language therapy regrading had recently been completed and the number of posts advertised above spine point 33 had risen from 5% to 17%. After a further two years’ consolidation, this figure has increased to 20%. That is one in five posts in 2003/04 as opposed to one in 20 in 1999/2000. The increase in higher banded posts can now be clearly demonstrated to have had a significant effect within the salary structure and career development of the profession.

Questionnaires were sent out regarding 532 posts over a period of 14 weeks to ensure equal numbers with the previous survey. The 82% response rate meant I could analyse a wealth of data from 438 posts. The core questions have remained the same over the four surveys, but this year SLTs were asked whether new posts were created with additional funding, and also about the availability and use of locums.

Overall, there has been an improvement in recruitment since the last survey; the percentage of posts filled has risen from 41% to 51%. However, when examined in more detail, the distribution across the spine is uneven, with two spikes at both the bottom and top end.

Band 1/2 posts up to spine point 25 had a 64% success rate, but over 80% of these were filled by SLTs qualified for less than one year. Indeed, several posts were offered and then turned down by candidates in what was a buyer’s market. The encouraging figure reflects the increasing number of students now coming into the profession and increasing the capacity for filling junior posts. This is qualified by the number of posts that managers had deliberately downgraded in order to capture this larger market. At the other end of the spine, band 3/5 posts had a 66% success rate. Not only were they more likely to be filled; there were nearly twice as many applicants for these posts (an average of two).

It seems likely that the increased salary and career structure offered by regrading has

---

**Table One: Percentage of Posts Advertised by Major Speciality**

<table>
<thead>
<tr>
<th>Speciality</th>
<th>1999/00</th>
<th>2001/02</th>
<th>2003/04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric</td>
<td>40%</td>
<td>45%</td>
<td>50%</td>
</tr>
<tr>
<td>Adult Neurology</td>
<td>20%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Mixed</td>
<td>30%</td>
<td>20%</td>
<td>15%</td>
</tr>
</tbody>
</table>
Recruitment and retention surveys have started to bear fruit. The success rate for band 2 posts, which contain the clinical powerhouse of the profession, remains depressed at 46%. A third of advertised posts received no applications at all.

Choice remained limited with a mean of 1.3 applicants across the spine (range 0-13). The 13 applicants were for a therapy manager’s post and the next highest at seven were for an adult new graduate post and a band 3 post.

Over the survey period, changes in the work of SLTs have become apparent. Advertisements for posts specialising in autism and learning disability have reduced and remain the most difficult to fill at 32%. Not only this, but locum cover was rare (27%) and many of these posts had lain vacant for many months. The recent survey by James and Money (2004) is timely, as the profession needs to review the organisation and promotion of learning disabilities services to ensure the vital contribution of speech and language therapy is maintained.

The Sure Start scheme continues to grow, a further 50% of posts advertised were new and recruitment was easier at 54%. A quarter of these appointments were internal, thus stretching other aspects of the paediatric service. More positively, hearing impairment, previously a small field and difficult to recruit to (20% in 1999/2000), is expanding significantly and over 60% of posts in 2003/04 were filled. Adverts for acute paediatric dysphagia increased in 2003/04, perhaps reflecting the number of significantly pre-term babies who may need SLT intervention.

Regional differences have not changed significantly, although London and the South East, with 46%, continue to advertise far and away the greatest number of posts. Recruitment was most successful in Scotland at 64%, London was unchanged at 56%; however, the success rate in the South East increased from 31% to 49%.

Overall, the profession continues to become ‘less experienced’. Of the 217 posts where years post qualification were mentioned for successful candidates, 68% had been qualified for five years or less, up from 61% (2001/02). As in the previous survey, there are worrying extremes of experience; of two candidates appointed to spine point 26-28 posts; one had been qualified for less than a year, the other for 20 years.

The number of locum agencies advertising in the Bulletin has steadily increased over the years of the survey from six to 10. This increase in locum activity was reflected in the questionnaire responses. Excluding new posts and those vacant for less than a month, 38% of posts had locum cover, while 62% did not. The reasons for this were not specifically requested, although several managers commented on the lack of availability of locums. This is supported by a reverse situation in London, where 65% of posts had locum cover as opposed to 35% without. Where there was locum cover, 41% of locums had been in place for over three months and 29% for over six months.

Of the 438 posts, 49% had been vacant for (at least) four months, nearly a third had been vacant for more than six months and 12% had been vacant for over a year. The mean vacancy period was six months (range 0-48 months). This suggests the Department of Health’s three-month vacancy figures of 3.8% (194 posts in March 2004) are an underestimation.

Until recently, speech and language therapy has recruited mainly overseas trained therapists often working to support travel around Europe. Unlike other therapy colleagues, SLTs have mostly been employed directly by the NHS. This loyalty is changing; 40% of the therapists providing locum cover were UK-trained and with locum agencies offering superior rates of pay and similar terms and conditions to their NHS colleagues, this drift will increase, with its resulting destabilising effect on speech and language therapy services.

Recruitment and retention in SLT is still a major problem but there are some
a stabilising effect and ensure that SLTs have the right level of knowledge, skills and experience before taking on more senior posts.

For those of us who have been in speech and language therapy for the long haul and who have always campaigned for a decent career structure, the survey shows the real gains made under the current regrading. The number of posts advertised above spine point 33, which represented the old clinical and middle management 'glass ceiling' before SLT regrading, has now risen from 5% (1999/2000) to 20%. Analysis of the posts advertised shows an even spread between clinical specialism and managerial responsibility, particularly within band 3.

This may all be lost under AfC. If the majority of these posts are capped at band 7, as appears likely from the early implementer sites, then the scale of the downward shift can be seen. Top of band 7 is £34,417, closely equivalent to the current spine point 36 of £34,086. Some five years and two regradings later, the profession would have moved precisely three points up from the old glass ceiling of spine point 33. It is to be hoped common sense will prevail and profiles within band 8 will be more widely used as AfC rolls out nationally.

One of the major lessons from these repeated surveys has been how much market forces have shaped speech and language therapy services across the UK. I have no reason to doubt that over the next few years they will do the same for AfC. The decisions made at implementation are unlikely to remain set in stone and over the next few years managers will need to decide within normal budgetary constraints at what grade posts need to be banded, both in terms of service needs and developments. They will also need to ensure that where possible, posts have some chance of being filled. For the morale of the profession, however, it would be good for these decisions to be based on the full range of profiles available and reflecting a valid career structure, rather than cobbled together with recruitment and retention premia and other inducements in order to attract staff.

Needless to say, with yet more change in sight, the survey will be repeated in 2005/06. I thank all the managers who continue to respond in such numbers to my ever-lengthening questionnaires and in particular Jenny Sheridan who helped send them all out.

Debby Rossiter - SLT manager, Kings College Hospital
email: Debby.Rossiter@kingsch.nhs.uk

References:

Auditory processing: beyond audiology?

Dilys Treharne asks whether SLTs should be involved in the management of auditory processing disorders

Experts in the field cannot agree a consensus definition of auditory processing disorder (APD or CAPD). One simple working definition, however, is that APD is what an individual does with what their ear transmits. But does this suggest it is an audiologist’s problem?

Consider David, a seven-year old who had had speech and language therapy for a considerable time. He had made progress in the development and use of language but his phonological system was still extremely restricted. As a result, David was largely unintelligible and his self-esteem was so low that he avoided speaking. When he did speak he mainly used single word responses.

David’s SLT referred him to the Sheffield University APD clinic. His peripheral hearing was normal. Central auditory processing tests indicated he had a number of difficulties associated with APD. These were addressed. No further speech and language therapy was offered. When his communication skills were reviewed a little over a year later, his phonological system had matured and although he was still shy, his language was appropriate for his age. David is typical of the younger children referred to the clinic.

Aja represents another group of children. She was referred at 11 years of age with a history of early speech and language delay in the pre-school period, for which she had received sessions of therapy and a home programme. Although she was discharged before starting school, her mother was not happy with this as she felt that something was not right. Aja struggled throughout primary school having particular difficulty with reading and spelling. Her parents took her to the Dyslexia Institute for an assessment and they diagnosed borderline dyslexia – with some symptoms, but not enough to make a firm diagnosis.

Her IQ, as measured by the Wechsler Series of Intelligence Scales for Children, was at the 75th centile, so she was a bright child. The lessons she took to improve her reading and spelling had little effect.

On transfer to secondary school Aja’s problems multiplied and she complained of not being able to hear what her teachers were saying. Aja’s GP eventually referred her to an ENT consultant. No peripheral hearing loss was found and she was referred to the APD clinic at Sheffield University. Assessment showed a number of APD features.

Aja could not separate auditory streams, which meant background noise was as loud as the speech she was supposed to be following.

In addition, Aja had a short processing memory and difficulty in maintaining her attention on auditory tasks. She was only able to process short chunks of information at a time and her attention to auditory stimuli ‘detuned’ frequently, resulting in gaps of information. At the age of three the problem resulted in delayed language development. At home, where Aja had her mother’s attention for much of the day, and there was ample opportunity for good interaction in a relatively quiet situation, Aja was able to develop sufficient language for conversational purposes.

Educationally and socially she just coped at primary school because groups were relatively small and she was able to follow other children when she failed to understand instructions. Her problems became more apparent as she neared the end of primary school, and reached a head after one term at secondary school. She began to lose friends because she was unable to understand the nuances and ambiguities that form a large part of the social chat of the 11 plus age group, and so appeared immature and naïve. She failed to record her homework requirements accurately and even when her parents could identify the task required, it took a whole evening to complete a short written piece. Not surprisingly, Aja’s self esteem plummeted and she tried to avoid school.

Aja’s APD was managed by transferring her to a school that used a visual teaching method; priming her auditory system with an auditory stimulation programme; working on specific areas of deficit in her language processing and teaching her identify techniques to enable her to manage her processing difficulties.

Aja will always have an auditory processing difficulty, but appropriate intervention and management has enabled her to pass one GCSE a year early and she is preparing to take a full set of subjects in the coming year.

Consider David and Aja are representative of the APD referrals received each month. In some, the problems seem to be more firmly based in language processing. In others, there are clear auditory processing difficulties underlying the language deficit. In yet others, such as Aja, superficial competence in conversational language masks an underlying weakness, which shows in literacy and other learning problems.

Commonly found presenting features include difficulty hearing in background noise, the need for frequent repetition of instructions, problems with sequencing sounds and verbal concepts, poor sequential memory and short processing memory, poor pattern and prosody perception and difficulty in carrying out motor and language tasks together. Not all of these difficulties are present in each child or adult and many of them can occur in other conditions. There is high co-morbidity with autistic spectrum disorders, attention deficit hyperactive disorder, dyslexia and language disorders.

As early as 1973, Tallal and Piercy...
identified auditory problems as possible causes of specific language impairment (SLI). Although there are criticisms of Tallal’s early work, her findings have been replicated and evidence of other auditory deficits in SLI (Stollman et al, 2003) and associated disorders, such as dyslexia (Stackhouse and Wells, 1997), have been reported. Conversely, some researchers have found no evidence of auditory deficits. However, there are many variants of SLI. No doubt a considerable number of these individuals have multiple processing difficulties.

Cacace and McFarland (1998) were unable to support the concept of a modality specific disorder, as they were unable to locate adequate research on multi-modality processing.

Bernstein and Stark (1985) followed 29 children with SLI and found that although most had shown auditory deficits on first testing these had disappeared four years later. They concluded that poor auditory perception in early childhood may be implicated in persisting language deficit even though normal processing may in time develop. Early identification of auditory difficulties is therefore crucial if an attempt is to be made to improve processing in time to reduce the effect on language.

Most models of language processing include an indication of pre-language processing of the auditory signal, such as the discrimination of speech as opposed to non-speech stimuli (Stackhouse and Wells, 1997). Many streams of sound surround the listener and he/she must separate the target sound from the irrelevant streams. Speech versus non-speech is one means; location, rhythm patterns and pitch perception are others. The latter are also important for processing syntactic structure, and pitch for identification of phonemes and intonation. The ability to retain a sequence or pattern of sound and to recognise rapidly changing sounds are necessary to recognise words and process sentences.

Competence in these can be improved with appropriate environmental modification, auditory stimulation programmes (Treharne 2002a,b) and specific task training. Remediation must, of course, take into account the integration of auditory processing with the processing of other modalities. Improved pre-language processing should lead to more successful language therapy. Much the same argument can be applied to children with literacy and learning difficulties, many of which may be rooted in weak language skills.

Clearly, more research is needed to explore the nature of the processing problems in children with language and learning difficulties. APD can also occur in adults either as a problem from childhood or with late onset, perhaps as a result of trauma. In the UK we have been slow in embracing the discussions and developments surrounding APD. However, it is an intensely fascinating field that is wide open for research.

**References:**


Treharne DA. A pilot study to investigate the efficacy of The Listening Program in the management of auditory and verbal information processing disorders. 2002a (http://www.advancedbrain.com/article_intro.asp)

Treharne DA. From sceptic to convert, the objective way. Speech and Language Therapy in Practice. 2002b Winter 2002.

**Notes:**

- The names of the children in this article have been changed.
- Any SLTs interested in forming an auditory processing disorders in children and adults interest or study group contact Dilys Treharne.
What next for early intervention?

Twenty years on from the start of Sally Ward et al’s research, Wilstaar has closed. Here, Frances Harris takes stock of what the programme has achieved.

Early promotion of language skills dominated the programme at the second Sure Start conference in June. For parents, there were babble groups, cartoons to show how 0-12 month old babies learn to communicate, and videos of parents talking about how to help children learn language. I also learnt about a new vogue for baby signing to accelerate a baby’s expressive skills. The drive behind Sure Start is the philosophy of early, preventative, community interventions, and the belief this will improve the development of children for school. I came away from the conference thinking that we really want it to work, but maybe we don’t know for sure which parts work, and for which children. Early interactions. Acceleration. This rings bells with Sally Ward’s work on the Ward Infant Language Screening Test Acceleration and Remediation (Wilstaar) programme. This set out to offer a parent-child interactive approach to promoting language development in infants showing signs of potential language delay or disorder.

Ward’s early intervention programme was born out of many years of clinical observations and experience. She recognised the importance of adult-child speech patterns and the significance of adequate stimulation, in particular the quality and appropriate quantity of auditory input. Her detailed intervention programmes set out a systematic description of appropriate play activities designed to promote vocal interactive patterns for parent and infant.

The Wilstaar intervention programme was only offered to ‘at risk’ infants. Ward’s screening questionnaire, given by health visitors at the eight-month check, targeted those infants with reduced response to auditory stimuli, and/or reduced babble. Ward (1992, 1999) reported on the Manchester children first screened and then treated using this approach. The mean age at screening was 9.3 months (range eight to 21 months) and the average intervention period was four months. The main outcome was recorded in terms of improved language scores, to within the normal range, and reduced referral rates to SLT services. The key findings were that by the age of three, 95% of the treated children were ‘within normal limits’ for their language scores, compared to 15% of a control group. By the same age, none of the treated children had been referred to speech and language therapy, compared to 30% of the control group.

Ward (1999) acknowledged some of the methodological weakness in the study, including the assessors’ awareness of the child’s group status, loss of subjects, and the difficulties of finding adequate measurement scales for the 0-3 years age group. The core difficulty of measurement remains unresolved: the Receptive Expressive Emergent Language Scale (REEL) is not a standardised measure, and determines ‘language ages’ rather than standard scores. Ward used REEL because of the lack of any other established benchmark assessments at that time.

Wilstaar was taken up by nearly 100 health organisations in the UK, Ireland and Western Australia. Health services using Wilstaar looked for a gain in terms of service delivery efficiencies as much as a gain in infant language scores. Two controlled studies and several service audits have examined the efficacy of Wilstaar (see table 1).

The Leeds controlled study did not set out to replicate Ward’s methods. In particular, it used the Wilstaar screen on children at the age of seven months and gave supplementary written advice to the control group.

The conclusion of the larger Kenilworth replication study was that by two and three years of age both the intervention and the control groups had improved mean language scores. There was no significant difference between their group mean scores. Further, by the age of three, 16% of the intervention children and 19% of the control group had been referred for speech and language therapy.

In each service audit, researchers compared a cohort of screened infants for their later referral for therapy, according to whether they had been given the Wilstaar intervention or not. These studies all report improved child language scores immediately after intervention. However, they also report high screen fail rates (23-38%) and a fluctuating false positive rate (2.8-11.3%). Their key finding was that by the age of four, between 4% and 27% of the children receiving the Wilstaar intervention had been referred again for speech and language therapy. This led to the conclusion that Wilstaar was not consistently effective.

The use of referral rates as an outcome measure relates to the service delivery focus. However, a later referral does not necessarily mean a failed clinical intervention. The referral may not be appropriate: it may not be due to language delay/disorder (for example, in a child now showing phonology problems), and it may be unrelated to earlier treatment (for example, post head injury). According to your view of the nature of language delay/disorder, those referred who do have persisting language delay could be those with a genetic component to their difficulty. It could be appropriate to work with these children in a layered way, with successive interventions at different ages. By contrast, the children successfully treated...
(and not referred) could be those for whom an interactionist intervention such as Wilstaar resolves their mild to moderate degree of language delay. From a service delivery point of view, however, a referral could mean a failed intervention because it means Wilstaar is an add-on rather than a replacement mode of delivery.

Many Wilstaar users refer not to language scores and referral rates but to other benefits of the approach, including the increased confidence of parents to interact with their children; the widening of access through home visits; the opportunity for therapists to promote early communication skills and joint working with health visitors. It is these outcomes that were mentioned by recent users of Wilstaar programmes at a London study day in September 2003. Parental feedback from the study day and the studies listed is generally very positive.

Ward identified that targeted care to at risk infants was not only clinically desirable, but within our reach. She set out an agenda for identification and targeted intervention that still applies today. Sure Start programmes using Wilstaar have much to add to our understanding of its impact.

Early intervention has a tremendously strong appeal. However, in the field of language delay, we have not yet demonstrated conclusively that early is better. Ward herself recognised this (1999) and published her work as part of this clinical debate. We have shown that Wilstaar can make immediate gains, but these may fade over the rest of the preschool period. What is apparent is there may be social/personal and political benefits to earlier intervention that encourage our profession to move towards an early intervention stance.

Current challenges include:

- **Measurement of early language skills**: the well-documented variability in normal language development means reliable and valid measurements need further work. American researchers have been developing a parent-reporting approach (the MacArthur Communicative Development Inventories) for early language skills, which is now being adapted for UK use.

- **Timeliness of intervention**: a shift from early intervention towards ‘timely’ intervention could see children with different clinical presentations treated at different stages of development.

- **Risk profiles**: Whitehurst and Fischel (1994) set out the notion of a risk profile. This combines the infant’s age, type of language delay, environmental and genetic/family factors into a composite concept of risk. This approach looks for high-risk children rather than targeting one subtype of delay or a single age group.

### Table One: Studies of Wilstaar

<table>
<thead>
<tr>
<th>Type of study</th>
<th>Location</th>
<th>Total number screened</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled trial</td>
<td>Manchester</td>
<td>1,070</td>
<td>Ward, 1999</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E: 60</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>C: 59</td>
<td></td>
</tr>
<tr>
<td>Replication, randomised</td>
<td>Kenilworth</td>
<td>597</td>
<td>Evans and Jones, 2004*</td>
</tr>
<tr>
<td>controlled trial</td>
<td></td>
<td>E: 24</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>C: 36</td>
<td></td>
</tr>
<tr>
<td>Controlled study, Wilstaar</td>
<td>Leeds</td>
<td>254</td>
<td>Sutton and Tapper, 1999*</td>
</tr>
<tr>
<td>based. Not a replication</td>
<td></td>
<td>E: 13</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>C: 9</td>
<td></td>
</tr>
<tr>
<td>Service audits, no control</td>
<td>Epsom</td>
<td>2,896</td>
<td>Oakenfull et al, 2001</td>
</tr>
<tr>
<td>group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Belfast</td>
<td></td>
<td>1,231</td>
<td>Coulter, 2003*</td>
</tr>
<tr>
<td>Bournemouth</td>
<td></td>
<td>2,710</td>
<td>Awcock and Habgood, 1998; Hall, 2000</td>
</tr>
<tr>
<td>Slough</td>
<td></td>
<td>486</td>
<td>Alderman and Beaupain, 2002*</td>
</tr>
<tr>
<td>Western Australia</td>
<td></td>
<td>2,295</td>
<td>Marshall, 2004*</td>
</tr>
</tbody>
</table>

E: experimental group of at risk infants (screen true positives) given the Wilstaar programme
C: control group; of at risk infants not given the Wilstaar programme
* not yet published

---

**Frances Harris**

SLT, Sure Start speech and language development project, City University, London

email: fharris@citysurestart.freeserve.co.uk

**References**


**Acknowledgements**

Thanks to Deirdre Birkett for her comments and to the cited authors who generously shared their work.
Supporting vulnerable communities

Mary Elton and Suzanne Harvie discuss the challenges when developing groups for vulnerable parents of children with communication difficulties

The first Sure Start projects involving SLTs in Edinburgh started in 2000. Part of the project included group work with vulnerable parents on early parent/child interaction skills. We used You Make The Difference (YMTD), the Hanen community-based preventative programme where parents develop ways to facilitate their child's communication. Each group taught us something new and challenged our preconceptions, for example of young parents. One seemingly vulnerable but very competent 17-year mother said, “I hate when people shake their heads when I'm pushing my bairn in the buggy.”

Written and verbal feedback from parents and staff about the groups was generally very positive. However, parents did not always say what they thought at the time. One parent who initially gave positive feedback later said the course was patronising because she already had children.

Despite the project's apparent success it was clear a group of parents was not catered for. The YMTD programme did not offer the support needed for helping children with significant communication difficulties. Similarly, parents from areas of social and economic need, with children on the SLT caseload, often did not attend the It Takes Two to Talk Hanen programme for parents of children with language difficulties.

It became clear that parent groups were not always 'in tune' with these vulnerable parents' cultural backgrounds. Van Kleeck (1994) said, “The goals of such programmes are solidly grounded on parent-child interaction. However, these studies have focused almost exclusively on white, middle class families. Therefore, the goals reflect underlying values and beliefs that are not shared by all cultural groups.”

Growing recognition of this fact by specialists working on early communication has resulted in studies in the cultural differences in parent-child interaction and the importance of taking these into account when working with parents.

For example, Girolametto et al (2002) found differences in parent-child interaction between mothers of late talking toddlers in Italy and Canada. Italian mothers talked more quickly and used more utterances, but used fewer imitations and interpretations of their children's attempts to communicate. The children's communication was not adversely affected; it mirrored the parent's communication style.

According to Girolametto, “Suggestions to reduce talkativeness and increase interpretations may be at odds with cultural expectations and may meet with resistance.”

We felt the need to develop a group that was more sensitive to parents of children with identified communication difficulties who come from areas of social and economic need. The Hanen Centre gave us permission to use some of their ideas and material, for example the use of the observe, wait and listen concept, in a simplified form. We also spent time with parents whose children were receiving speech and language therapy at child and family centres. We discussed their children's progress and asked a series of questions to tap into their own communication experience and find out what they valued in parent-child interaction:

what have you noticed is best at helping your child to communicate?

thinking about your family, friends and people living in your area, have you noticed anybody who is particularly good at talking with kids? What did they do?

think back to your childhood. Do you have any good memories of an adult playing and talking with you? What did they do?

Many of the approaches valued by the parents are intrinsic to Hanen principles, for example careful listening to children; implying, using gestures; slowing down conversation and interpreting children's sounds. Some parents mentioned approaches that were at variance with accepted parent-child interaction programmes. One Pakistani woman identified her mother as the key person in her childhood and said she valued her calm step-by-step formal teaching approach. Many parents also emphasised humour and fun as being essential ingredients to good adult-child interaction.

Most parents interviewed did not identify their own parents as people who interacted best with them when they were young; grandparents, siblings and friends featured as important interaction figures. Some of the parents found it hard to recall their childhoods, while others recalled in lively detail: “My mum always played with me in the house. I had dolls. I would put the dolls in bed and say to my mum, 'Right, I'm away to the bingo, watch that one at the end, she's trouble.' She entered into the fun. I'd come back and ask about the babies and she'd say they were all fine except that one at the end. She'd got no tea.”

From their feedback, it was clear that not all parents held the same views and it is wrong to assume parents living in the same area hold the same values. We did not develop any set approaches as a result of the questionnaire but concluded we needed to be sensitive and flexible with each group.

After interviewing parents with learning difficulties whose children attended one centre, we planned a simple support group to help them encourage communication in their children.

The group had a shaky beginning and patchy attendance meant we had to cancel two of the six sessions. Despite this, the centre was keen for us to persevere and the two final sessions were well attended with parents arriving on time and two

Mary Elton and Suzanne Harvie discuss the challenges when developing groups for vulnerable parents of children with communication difficulties.
additional parents joining the group. The new members were the grown-up daughters of one of the parents already attending the group. One of these women was a key figure in her family and was closely involved in the care of one of her mother’s children. This reflected what we had observed in our questionnaire - complex family support networks with siblings often playing a key role in raising children.

The parents called the group ‘Chatterbox’. The group sessions included an introduction, including sharing ideas and experiences in helping children who are late talkers; taking time to observe, wait and listen, and adjusting to a child’s level of communication and using praise.

The parents responded best to videos of local children with communication difficulties, although they found discussing what they had seen very demanding. They also learnt well through games and role-play, which gave them an opportunity to laugh, especially at the SLTs. We kept written material, explanations and discussions to a minimum and we did not undertake a written evaluation with the parents at the end of the group because written questionnaires would have delivered single word responses. Instead, we asked key workers to find out from parents what they had learnt and what they thought about the group. It was hard to predict the group’s learning outcomes and we found parents sometimes had different ideas about what they were learning than we had intended. One parent said they had been learning about how to put on a child’s coat, although she also said that we had been talking about listening to children. Overall, they enjoyed the group.

Our own evaluation was mixed. We were frustrated about the short duration of the course. We felt parents needed more support than we were able to give them and were disappointed that we were not able to include parent-child interaction video sessions. Although the parents enjoyed the course we thought we had had minimal impact on their interaction with their children. This group of parents, with a complex combination of learning difficulties and social need require longer term support to change parenting patterns.

However, we felt we must be doing something right as attendance increased towards the end of the groups. Part of the reason for this success was our continued encouragement for parents to attend through weekly reminders, phone calls and the constant support from key workers. Surprises for the children at the end of each session, provided an extra incentive for parents to attend.

We continue to work on developing groups for vulnerable parents of children with communication difficulties. Adjustments we have made include using a support worker from the local community and this has been very successful.

References:

Acknowledgements:
Thanks to Hailesland Child and Family Centre where the group was held and to Joanna Bull, SLT, who was previously involved in the project.
**Book Reviews**

**Multicoloured Mayhem**  
Jacqui Jackson  
Jessica Kingsley, 2003  
£12.95  
ISBN: 0-34075-896-1

Jacqui, a single parent of seven children, believes her four sons reflect the multicolours of the autistic spectrum. She introduces her family, gives a case history of each boy and shares her perspectives of autistic spectrum disorder (ASD), attention-deficit/hyperactivity disorder, dyslexia, dyspraxia, sensory integration dysfunction and the labels often associated with autism. She leaps from one topic to another commenting that this reflects the mayhem of her household and how ASD affects the whole family.

Determined to reduce the disabling aspects of ASD, Jacqui researched many approaches and describes those she finds helpful. The book has practical advice concerning health and safety, medication, family outings, and coping with adolescence.

Therapists and parents will find this a thought-provoking book. It challenges how professionals interpret behaviour, physical condition and developmental history to reach diagnostic criteria. It reminds professionals of the difficulties parents experience in discovering what makes their child different from others. Most parents will find this a worthwhile book. While some may be full of admiration for Jacqui, others might be daunted by her energy and commitment. Some will certainly question some of her approaches and statements.

**The Brain Injury Workbook, Exercises for Cognitive Rehabilitation**  
Trevor Powell, Kit Malia  
Speechmark, Headway, 2003  
£33.95  
ISBN: 0-86388-318-4

This book, based on group activities for adults with acquired brain injury, contains therapy resources and educational handouts. The authors suggest they would be equally relevant for individual therapy sessions.

The book has six sections covering: brain injury information, memory, thinking skills, executive skills, improving insight and emotional adjustment. Each contains discussion and quiz sheets, questionnaires and exercises.

The information sheets referring to specific impairments are very helpful with simple explanations for medical terminology. However, they contain a large amount of information and would need simplifying for very severely impaired clients, but are sufficiently detailed to be useful for family members or training care staff and assistants.

The exercises in the memory, thinking skills and executive skills sections provide gradually less support for the client or group. The final sections on insight and adjustment provide useful ideas for reflection and group discussion.

Some activities would not be appropriate for all groups or individuals; however the authors acknowledge this in the introduction.

**Dysphagia Screening, A Training Resource Pack**  
Lucy Rodriguez, Merida Borrelli  
Whurr, 2003  
£75.00  

This book, based on group activities for adults with acquired brain injury, contains therapy resources and educational handouts. The authors suggest they would be equally relevant for individual therapy sessions.

In addition to identifying patients with dysphagia, I would expect a screen to identify those patients that do not require input. However, the screening training I currently do is limited to post acute stroke patients. This pack is intended to have a wider remit.

The pack will certainly benefit anyone planning to introduce screening training, saving hours of preparation time and ‘reinventing the wheel’. Even if you have been training for some time you are likely to find it a useful addition.

**BOOK OF THE MONTH**

Lucy Rodriquez, Merida Borrelli  
Whurr, 2003

This is for SLTs who train nurses in screening for dysphagia. It is a comprehensive competency-based pack containing: a training manual and course outline, including practical advice for course organisation; a rigorous schedule for competency testing; well referenced and appropriately pitched resource materials to challenge and interest registered nurses; sample record sheets and certificates.

The training is aimed at E-grade nurses and above. It recommends patients passing the screen be given normal fluids and pureed diet only and advises automatic referral to the SLT team for full assessment. The authors explain the rationale for this, but some may feel the approach overly cautious.

**CONTENTS: READABILITY: VALUE:**  
*****  *****  *****

**CLARE BAILEY - Senior SLT, Community Neurological Rehabilitation Team, City and Hackney Teaching PCT**

**READABILITY:**  
*****

**VALUE:**  
*****

**CONTENTS:**  
*****

**JULIA SCOTLAND - Clinical Specialist SLT, Mid Sussex PCT**

**READABILITY:**  
*****

**VALUE:**  
*****

**CONTENTS:**  
*****

**LUCY ABEL - Chief SLT (Adults), Isle of Wight NHS Healthcare Trust**

You can order any of the titles on this page or any other current therapy title from

**bookmark5@tiscali.co.uk**

**There are no delivery charges for RCSLT members**

(0117) 9561671
SLTs jump at the chance to influence CQ3

It is no surprise that SLTs are jumping at the opportunity to be involved in the development of Communicating Quality 3 (CQ3); professional guidance and standards to support the provision of high quality speech and language therapy services.

As the context for service provision has changed in health education, social care and the voluntary sector, so the need to develop CQ3 has grown.

The profession needs a document to reflect speech and language therapy provision in all its complexity.

Despite the challenging nature of the task, the proposal for the outline content of the document has been widely welcomed by practitioners.

The recent CQ3 roadshows across the UK have engaged SLTs, SLTAs and other stakeholders in commenting on the possibilities for the structure, content and format of the new publication. We thank those who took part.

The wide-ranging views expressed by those attending have been included in planning for the document and have refined the thinking in several key areas.

The list of stakeholders has been extended and we have developed a staged process for their involvement. This will involve a degree of self-selection and invitations to representatives of user groups and carers to ensure a good representation of the views of communication-impaired individuals.

We will invite stakeholders to select how they would like to be involved, including developing the document or commenting on its draft form.

We will also use e-groups to develop the content of each section. While some of the groups will be client-specific, others may describe input towards a care pathway.

In this way, CQ3 will serve the needs of commissioners, who tend still to commission on the basis of client groups, as well as representing broader principles of therapy services and pathways of care.

It is not too late to take part in the process. Details of the proposed scope of CQ3 are now available on the RCSLT website. Email: bridget.ramsay@rcslt.org to express interest or for a nomination form.

Kath Williamson and Caroline Pickstone

AGM features legal issues

RCSLT members are invited to attend this year's annual general meeting and study afternoon in Durham on Thursday, 30 September. Details have been sent to all members by post, including instructions on proxy voting. This year’s afternoon study session will feature legal experts discussing medico-legal topics for SLTs:

Consent, negligence and extended scope
Malcolm Khan, from the University of Northumbria’s School of Medical Law, says, “As a professional SLT you are expected to maintain certain legal standards of care in looking after your clients. You are also expected to respect the personal autonomy of those clients. A knowledge of the law on consent is essential. Underlying both these areas is the realisation that your clients’ human rights must be respected.”

Education law and tribunals
Janet O’Keefe and Melinda Nettleton will look at the legal framework in which SLTs work, including cover current legislation, legally binding regulations and case law relating to children with special educational needs (SEN), the statementing process and SEN, and disability tribunals. They will also focus on areas that occur frequently in tribunals as matters of professional dispute, and will also look at professional complaints and how these are dealt with in the context of expert witness evidence.

Remember to send your confirmation of attendance to Bridget Ramsay, RCSLT, 2 White Hart Yard, London SE1 1NX by 20 Sept.
Open University announces new foundation degree for assistants

Assistant level healthcare practitioners will soon be able to study a new Foundation Degree in Health and Social Care: Assistant Practitioner.

The award, which begins in England in October, is part of a government initiative to open up opportunities for unqualified staff within the health and social care workforce.

The award will be delivered in the workplace, is multi-professional and will be especially attractive to those working at an assistant level alongside a range of allied health professions.

It is mapped against the key frameworks and competencies within the modernisation agenda in order to facilitate progression both into and out of the award.

The programme involves academic study along with supervised practice. While there are no formal entry requirements, the award is only open to students who are sponsored by their employers.

Responsibility for students’ learning is shared between their employer and the Open University, who will provide the study materials, organise tutorial support and manage the assessment procedures. The employer, subject to the university’s approval, will manage the practice learning mostly within the student’s existing workplace.

Students remain in employment while they study and employers are required to give them the equivalent of half to one day a week study leave per academic year. The amount of study leave depends on the stage of the programme and the credit transfer arrangements due to previous learning/qualifications.

Students who have undertaken in-house schemes of the appropriate level and/or vocational qualifications may either be exempt from part of the programme or be able to take an assessment only option. For further information, email: shsw-foundation-degrees@open.ac.uk

The new degree will be especially attractive to those working at an assistant level.

Join the RCSLT Education and Workforce Development Board

The RCSLT Education and Workforce Development Board provides strategic leadership on policy relating to the commissioning of training for the future SLT workforce and ensuring that pre- and post-registration courses are appropriate for SLT workforce needs at the start and throughout a career.

The RCSLT is looking for representation from each of the devolved countries for 2004-2006 and is seeking applications from senior managers (for one position) and from SLT academic staff (one each to represent Wales, Ireland and England).

For an information pack contact Bridget Ramsay: email: bridget.ramsay@rcslt.org, tel: 020 7378 3001.

The deadline for receipt of applications is 22 September, 2004.

Engage in the Health Foundation’s £3 million quality initiative

The Health Foundation has launched a £3 million initiative to engage healthcare professionals in projects to improve the quality of patient care in the UK.

The Engaging with Quality programme will support professional organisations that share an interest in building clinical leadership to achieve quality improvement. The initiative aims to engage clinicians in clinical quality improvement projects that will achieve measurable improvement in clinical care processes and/or outcomes; identify effective strategies for improvement that can be replicated and spread, and increase the capacity for clinical quality improvement within the healthcare system.

The Health Foundation is looking to fund projects that aim to improve the quality of clinical care by using evidence-based interventions. Two types of project will be funded through the initiative: those that include all elements of the quality improvement cycle and those that build on the measurement and reporting processes provided by current quality improvement systems, such as national clinical audits.

The Health Foundation will give preference to proposals that reflect national priorities, make a significant impact on the health of large groups of the population and are associated with high total costs to the public purse.

Eligible organisations include professional associations for allied health professionals, specialist societies, and other healthcare alliances. Organisations can apply independently or in partnership.

The deadline for outline proposals is 8 October. A shortlist of applicants will be invited to submit detailed plans by the end of November, and decisions will be made by the end of 2004. Visit the Health Foundation’s website at: www.health.org.uk, Email enquiries to: engagingwithquality@health.org.uk
Caroline Fraser: a hard act to follow

Caroline Fraser retires as RCSLT Chair and from mainstream speech and language therapy this month after 40 years of dedicated service to the profession. Here we celebrate the life and work of an inspirational individual.

Caroline completed her DipCSLT at the West End Hospital for Neurology and Neurosurgery (later embraced by University College, London) between 1961-64.

“I was taken with the idea of this young speech and language profession, applied for a college place and have never once regretted my decision,” she wrote in 2002.

Caroline started working in 1964, as the only SLT in a school for children with epilepsy in Surrey.

“This was a very isolated job,” she recalled. “I had to seek out colleagues in other areas in order to keep up to date. There were very few SLTs around at that time and we had to stick together.”

In 1967, Caroline moved to San Francisco and worked in a rehabilitation centre before finding her way back to the North East in 1969 and her first experience of the NHS. There was no service for learning disabilities or neurosciences at that time, so Caroline got involved in both and together with a few dedicated colleagues began to establish services for Stockton, Middlesbrough, Hartlepool and Redcar.

“It was a hard fight,” she added. “There was no career structure and no financial rewards for setting up these services. The rewards were in creating services for people who we knew had communication problems.”

In 1979, Caroline started to work full-time in Middlesbrough. By then, there was an SLT career structure and she became chief therapist. Between 1981-84, she worked in Australia, taking the opportunity to complete a Masters degree in linguistics. She returned to Middlesbrough as District SLT and became more involved in working with other health professions – a situation that is taken as read today but was much less usual 20 years ago.

“A big step for me was when the trust decided to put all the allied health professions into one clinical support directorate that I managed from 1993,” Caroline said.

**Extracurricular activities**

Caroline’s ‘extracurricular’ activities with the RCSLT are legend and will ensure her name enters the annals of the profession. Caroline was an RCSLT regional councillor, from 1993 to 1998 and chair of the Regional Councillors Committee between 1996 and 1998. She was also chair of the working party that revised Communicating Quality 2 in 1996.

In 1999, Caroline received RCSLT Honours for her ‘outstanding contribution to the profession’, the same year she joined the task group of the National Service Framework for Older People - Acute Hospitals and Palliative Care. From 2000-2002, she was RCSLT Deputy Chair and, of course, she has been an able Chair of Council from 2002 until the present day.

In August, Caroline attended the 26th World Congress of the International Association of Logopedics and Phoniatrics in Brisbane on behalf of the RCSLT to sign an agreement with the professional organisations of the USA, Australia and Canada. This will establish the mutual recognition of credentials and will allow an easier movement of SLTs between those countries, something that Caroline has long championed for.

On the eve of her retirement, Caroline’s enthusiasm remains, “I wish I was starting out again as I will never lose my passion for speech and language therapy. It has been such a significant and worthwhile part of my life.”

**Tributes to Caroline**

“It has been a great pleasure to work with Caroline Fraser. She has been a most conscientious chair who always took great interest in new ideas. I very much hope she will continue to be active in furthering the aims of the RCSLT. She will be a hard act to follow and will be very missed,” Sigmund Sternberg.

“Caroline has been a driving force for the profession and it has been a delight to work with her at the RCSLT. She will be greatly missed and we know that her contribution will continue long after she has retired,” RCSLT CEO Kamini Gadhok.

“One of Caroline’s many strengths is her ability to focus not only on the needs of the profession and the professional body but also on the clients we serve. This led to her forging and strengthening links with groups and organisations outside the College to the benefit of members and clients alike,” Shirley Davis, past RCSLT Professional Director.

“Caroline has been a friend and colleague for almost 30 years, and has been an inspiration to me to many others. She is clear thinking, strategic when necessary but with compassion overlaid, and a great advocate of speech and language therapy at all levels, at all times,” Margaret Lines, head of speech and language therapy, Middlesbrough PCT.

“Caroline understands better than most the necessity of engaging people – all people. She displays a warmth of personality and genuine interest in the opinions of others, whatever the background, clinical expertise or standing in the community. It's been a pleasure to watch her in action,” Graham Williamson, consultant head of speech and language therapy, Sedgefield PCT.
Specific Interest Group notices

Adults with a learning disability (Northern Ireland) (I15)
13 September 2004, 9.30 - 11.30am
The role of a college adviser, speaker Roslyn Wilson; AGM
Laganview Conference Centre, Lagan Valley Hospital, Lisburn
Contact: Suzanne Smith, SLT, Muckamore Abbey Hospital; Cynthia Robinson SLT, Edgecumbe Training and Resource Centre

Voice and laryngectomy SIG (E4)
16 September 2004, 1.30pm registration
Histology of the voice pathology and what we hear, speaker John Rubin (consultant ENT surgeon)
Grayham Fraser Lecture Theatre, Royal Ear Nose and Throat Hospital, Grays Inn Road, London
Members free/non-members £7/students £5. Fee for year £20
Contact: Chris Payten or Marion Alston, tel: 020 7915 1315, email: marion.alston@royalfree.nhs.uk

Hertfordshire SLI SIG (E37)
20 September 2004, 1 - 4.30pm
Using shape/colour coding with language disordered children. Presentations by therapists using these approaches in therapy
Postgraduate Centre, Lister Hospital, Coreys Mill Lane, Stevenage (Junction 8, A1M)
Members free/non-members and students £2 Contact: Mary Smith, tel: 01767 227660, email: maryt.smith@nltworld.com

Yorkshire paediatric dysphagia SIG (N16)
20 September 2004, 1.30pm
Videofluoroscopy and preterm babies. Topics to include course feedback
Tadcaster Health Centre
Contact: Sue Craig, tel: 01274 365461 or Angela Hunter, tel: 01924 483909

Central SIG - Emotional and behavioural difficulties in school age children (C23)
21 September 2004, 1.30 - 4pm
Inaugural meeting: sharing good practice. Please bring examples of/suggestions for working with children with EBD and speech and language difficulties
Centenary House, Heritage Park, Albert Terrace Road, Sheffield, S6 3BR
Free for inaugural meeting
Contact: Ann Birks, tel: 0114 2276182

SE SIG Deafness (L12)
22 September 2004, 1.30pm
AGM and Update on cochlear implants. Speakers, London cochlear implant centre teams
Grayham Fraser Lecture Theatre, Royal Ear Nose and Throat Hospital, Grays Inn Road, London
£5 membership per year, now due £2 non-members/£1 students Contact: Pippa Wilson, tel: 020 7915 1315, email: pippa.wilson@royalfree.nhs.uk

SLTs Working in Child Development Centres SIG (UKRI 3)
22 September 2004, 10 - 4pm
AM: Research projects relating to speech and language therapy, speaker Sarah Chandler, Regional Development Officer for Contact-A-Family: Working With Parents, speaker Catherine DeHaas PM; Case study around suck, swallow, breathe synchrony (based on the MORE principal), speaker Heather Bates. Bring three items to either suck or blow
Room B626, Baker Building, Perry Barr Campus, UCE. Directions available at: www.uce.ac.uk
Members £15/non-members £20/students £5
Contact: Fiona Wilson, tel: 01302 366666 ext 3854

Scottish brain injury SIG (S10)
23 September 2004, 9 - 3.30pm
Executive function in brain injury, speakers Jonathan Evans, Liz Hutt, Ian Green
A.K. Bell Library, Perth
Members £20/non-members £25
Contact: Catherine McGee, tel: 0141 201 1441/2115

Oxford voice and laryngectomy SIG (E31)
29 September 2004, 12.30 - 4.30pm
Liaison and networking: AGM; Counselling in SLT, speaker Caroline Thompson; Psychology Forum (bring cases for discussion), speaker Dr Anita Farrell, consultant clinical health psychologist, Northampton Nurses’ Seminar Room, Radcliffe Infirmary, Oxford
Members free/non-members £7.50
Contact: Elaine Coker/Penny Taylor, tel: 01604 545737

South West Thames SIG in developmental speech and language impairment (E15)
6 October 2004, 7.45 for 8pm
Social stories – some practical strategies, speaker Diana Ennis, outreach teacher, Linden Bridge School
The Meath School, Brox Road, Ottershay, Chertsey, Surrey
Members free/non-members £5. Annual fee £10
Contact: Vera Grant, tel: 020 8977 4175 (evenings), email: neildgrant@aol.com

Trent dysphagia SIG (C17)
6 October 2004, 9.30 - 12.30pm
Bronchial auscultation and laryngopharyngeal reflux, speakers Jane Shaw and Sam Sharp
SLT dept, City Hospital Nottingham
£5 - limited places available
Contact: Moira Shaw, tel: 0115 9709221

National SIG in Disorders of Fluency (UKRI 6)
11 October 2004, Registration 9 - 9.30am
Case Studies in Stammering and AGM. Speakers Win Ashton, Ali Biggart, Liz O’Connell and Sue Rant. The day will include work with a pre-school child, school age child, teenager and adult client
Friends Meeting House, 173 Euston Road, London
Members free/non-members or renewing members £20/students £10
Contact: Jane Fry, tel: 020 7530 4239 email: jane.fry@nhs.net

SIG Speech and language difficulties in secondary education (C19)
18 October 2004, 2 - 5pm
Transition: obstacles and opportunities
Health Education Room, New Parks Health Centre, St Oswords Road, Leicester
Non-members £2
Contact: Carol Reffin (SIG Secretary) tel: 0116 5454670

Child Development Centres (South East Region) (UKRI 3)
20 October 2004, 9.30 - 4pm
SLT intervention on the neonatal unit, speaker specialist SLT Gillian Kennedy; Developmental consequences of prematurity, speaker consultant neonatologist Enitan Ogundipe
RCSLT, 2 White Hart Yard, London, SE1, INX
Members free/non-members £7/students £5
Membership fee £10 due
Contact: Tina Arnold, SLT, Cheyne Child Development Service, Chelsea and Westminster Hospital, 369 Fulham Road, London SW10 9NH

Lancashire dysphagia SIG (N27)
4 November 2004, 1.30-4.30pm
Northwest work-based dysphagia competency course, speakers Salty Boyes, Sarah Wallace, Sue M’Cormick
North Manchester General Hospital, Crumpsall, Manchester M8 5RN
Members £2.50/non-members £5/students £1
Contact: Liz Jones, tel: 01704 383763, Elizabeth Scanlan, tel: 01695 598302

SIG Dysphasia Therapy (E24)
12 November 2004, 9.30-4pm
How to meet the communication needs of people with aphasia, speaker Alex Stirling Principles and practical ideas for supported conversation in all settings,
RCSLT, 2 White Hart Yard, London, SE1, INX
Cost: Members £25/non-members £35
Contact: Diane Walton, tel: 020 8940 6456

LOCAL GROUPS

SLUG Surrey Local Group
21 September 2004, 7.45 for 8pm
Title to be confirmed SLTs, SLTAs, non-practising SLTs and students are all welcome
Casselden Centre, Dorking Hospital
£2
Contact: Ann Adams, tel: 01737 768511 ext 6090 (work) or 01737 843378 (home)

To advertise your RCSLT registered SIG event for free send your notice by email only in the following format:

- Name of group and registration number
- Date and time of event
- Title of event and speakers
- Address of event
- Costs
- Contact details

Send to: bulletin@rcslt.org by the first Monday of the month before publication. For example, by Monday 2nd August 2004 for the September Bulletin.

To advertise in the Bulletin Supplement quick look dates (£24 for one insertion, £40 for two insertions) contact Katy Eggleton, tel 020 7878 2344, email: katy@mcmslondon.co.uk

www.rcslt.org September 2004 bulletin 23
All bookings & enquiries regarding advertising in the Bulletin have now changed.

For any advertising information or to make a booking for the 1st October Bulletin – deadline for booking & copy 10th September, midday – please contact Katy Eggleton at TG Scott Healthcare on Tel: 020 7878 2344 or email katy@mcmslondon.co.uk

As of the 1st July issue advertising rates and procedures have changed slightly, below is a quick look rate card, but for more information please contact Katy on the details above.

### Display

<table>
<thead>
<tr>
<th>Size</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full page</td>
<td>£1650</td>
</tr>
<tr>
<td>Half page</td>
<td>£1100</td>
</tr>
<tr>
<td>Quarter page</td>
<td>£800</td>
</tr>
<tr>
<td>Eighth page</td>
<td>£450</td>
</tr>
</tbody>
</table>

All rates are inclusive of colour and are subject to VAT

### Column Widths

<table>
<thead>
<tr>
<th>Size</th>
<th>Size in mm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Page</td>
<td>248 x 185</td>
</tr>
<tr>
<td></td>
<td>297 x 210</td>
</tr>
<tr>
<td></td>
<td>303 x 216</td>
</tr>
<tr>
<td>Half Page</td>
<td>248 x 90</td>
</tr>
<tr>
<td>Vertical</td>
<td></td>
</tr>
<tr>
<td>Horizontal</td>
<td>120 x 185</td>
</tr>
<tr>
<td>Quarter Page</td>
<td>120 x 90</td>
</tr>
<tr>
<td>Eighth Page</td>
<td>60 x 90</td>
</tr>
</tbody>
</table>

Inserts are dependent on size and weight please call for an exact quote.