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**Written Evidence to the Parliamentary Review of Health and Social Care**

**Executive Summary**

The Royal College of Speech and Language Therapists (RCSLT) Wales welcomes the opportunity to contribute to the Parliamentary review of Health and Care in Wales**.** Our response below provides background on the Royal College and responds to the eleven key questions raised by the review team. Our key points are highlighted in the bullet points below.

* RCSLT Wales believes that in order to respond to the dual challenge of budget pressures and a rising population with complex needs, it is vital that the health workforce is reshaped and that allied health professionals, and in particular speech and language therapists (SLTs) are used more fully. SLT, as a profession, has developed considerably over recent years to develop public health models and adopt a more consultative, collaborative, outcome focused approach. This is in addition to its specialist role in managing the risk of harm and reducing functional impact for people with Speech, language and communication support needs (SLCN) and swallowing difficulties. The profession has a key role to play in the delivery of new models of care and shifting care from hospitals to community settings.
* Examples of what is working well in the current system include the development of highly successful regional and ‘hub and spoke’ models for some low incidence highly specialist clinical areas, training on values based health care initiatives like therapy outcome measures (TOMs) implemented across all Local Health Boards and the development of a universal, targeted and specialist approach to children’s provision which has led to a more preventative approach, decreased waiting times and more effective use of SLT time. We believe this good practice could be replicated in other areas, in particular, adult services.
* Barriers to improvement include short-term funding, lack of flexibility in the system, silo working and focus on targets and performance measures which do not focus on prevention and empowerment.
* Suggested areas for improvement include increased investment in agile technology and admin support systems to enable efficient, responsive service delivery, shared systems and training across health and social care, factoring in capacity for service review and reducing the barriers to regional working.
* SLTs strongly support the shift to care closer to home and have a key role to play in changing models of care as a workforce adept at working across boundaries as part of multi-agency teams. However, despite evidence of the value of the inclusion of SLTs within multi-disciplinary community teams and the potential opportunities which exist, we are aware that often the role is not specified as part of a dedicated primary care integrated workforce.  In the current model, our services are often provided by small, flexible teams who must meet the competing demands of primary and secondary care, and this can often mean the pressures in secondary care take precedence over opportunities to develop upstream approaches in the community to keep people well and avoid hospital admissions. In order to make changes apace, the balance of professionals employed in primary and secondary care must be carefully explored.

**About the Royal College of Speech and Language Therapists (RCSLT)**

1. RCSLT is the professional body for speech and language therapists, SLT students and support workers working in the UK.  The RCSLT has 15,000 members in the UK (450 in Wales) representing approximately 95% of SLTs working in the UK (who are registered with the Health & Care Professions Council).  We promote excellence in practice and influence health, education, care and justice policies.
2. Recent analysis of the SLT workforce in Wales employed by Local Health Boards (LHBs) across paediatric and adult services indicates 462 full-time equivalent SLTs and Assistants.  The average age of the workforce in Wales is 39 years old.
3. In preparing this response, we have consulted with our members across Wales to ensure that the views of speech and language therapists and assistants are considered as part of this important review.

**Question 1 - Over the next 5-10 years what should Health and Social Care Services prioritise to improve outcomes and best value in health and social care in Wales?**

1. RCSLT Wales believes that in order to respond to the concurrent challenges of budget pressures, a rising population with complex needs and workforce gaps, the priorities of health and social care services should include;
* a focus on keeping people healthier for longer and supporting people to maintain and improve their health and wellbeing – promoting a more ‘social’ model of health. Building resilient communities will be key to the preventative approach and a clear focus on tackling health inequalities.
* a focus on changing models of care for frail, elderly patients with co-morbidities with greater recognition of the role of AHPs in the delivery of new models of care and shifting care from hospitals to community settings**. –** As the Nuffield report has highlighted, there is a need to reshape the health workforce to deliver the care that patients need and alleviate pressures on the health system.  Patients with multiple chronic conditions ‘require a different type of professional who is not tied by traditional boundaries and has a broader range of skills’ ([[1]](file:///C%3A%5CUsers%5CRCSLT_Wales%5CDesktop%5CParliamentary%20Review%20of%20Health%20and%20Social%20Care%20response%20draft%201.docx)).  AHPs are well placed to deliver on this agenda, and their unique skills need to be maximised.
* Workforce planning - Greater consideration of the extension of roles, advanced rolesand progression paths for Healthcare support workerroles as a flexible workforce with short, lead-in training times.
* A focus on the use of technology to facilitate change**.**

**Question 2 - What do you value about the service that you deliver now and how could it be made better?**

1. Speech and Language Therapy manages the risk of harm and reduces functional impact for people with speech, language and communication support needs and/or swallowing difficulties.
2. Speech and Language Therapists (SLTs) provide life-improving treatment, support and care for children and adults who have difficulties with communication, eating, drinking or swallowing.  Using specialist skills, SLTs work directly with clients, carers and other professionals to develop personalised strategies.   They also provide training and strategies to the wider workforce; such as teachers and care assistants so that they can identify the signs of SLCN and eating, drinking and swallowing difficulties, improve communication environments and provide effective support.
3. Our members tell us that they value playing an equal role within multi-disciplinary/multi-agency teams and influencing pathways for adults and children. They also highlight the importance of autonomy to retain flexibility which is vital to meet changing needs and priorities.
4. SLT, as a profession, has developed considerably over recent years to adopt a more consultative, collaborative, outcome focused approach, in addition to its specialist role.  For example;
* the development of highly successful regional and hub and spoke models for some low incidence highly specialist clinical areas, such as the cleft lip and palate service based at Morriston Hospital.
* the development of All Wales pathways e.g. early language which clarifies the SLT role at a universal, targeted and specialist level and has led to a focus on outcomes and reduction in waiting times for specialist services (please see further detail in question 3).
* training on therapy outcome measures (TOMs) has been rolled out across all Local Health Boards, as part of values-based healthcare initiatives.
1. It is also recognised that the profession has a growing role within the public health agenda. For example;
* identifying and working to address communication needs in children, young people and vulnerable adults who struggle to understand and express themselves, and help to transform their life chances.
* training and expanding the skills of other professionals in understanding communication needs and the impact of this on physical and mental health, to underpin prevention, ongoing support in the case of developmental difficulties, rehabilitation and end of life.  SLTs train health visitors, primary and secondary care health practitioners, teaching and other education staff, care and nursing staff and families.
1. To support the long-term sustainability of health and social care, there is a pressing need to maximise and utilise the skills of the whole health and care workforce.  It is vital that the skills of allied health professionals (AHPs) and in particular SLTs are used more fully, particularly in the delivery of new models of care as care shifts from hospital to community settings. SLTs already undertake a number of roles as part of primary care teams with the aim of effectively maximising independence and avoiding hospital admission.  For example,
* SLTs provide telephone triage to care homes managing the communication and swallowing problems of those in their care, removing the need for a GP visit. They provide training to care home staff and others in the community to manage decline in swallowing performance from age and disease. SLT intervention is proven to reduce morbidity, mortality and prevent hospital admissions. SLTs have also been developing efficient and effective telehealth solutions in this regard. Evidence from a telehealth project in care homes has indicating savings of £60 on each tele swallowing assessment[[1]](#footnote-1).
* Social return on investment research has highlighted the value of the provision of speech and language therapy for post-acute stroke patients. Every £1 invested in low-intensity SLT is estimated to generate £2.30 in health care cost savings through avoided cases of chest infections.[[2]](#footnote-2)
1. RCSLT believe that there would be significant benefits to innovations from these roles becoming more established within the primary care integrated workforce.  In addition, significant additional opportunities exist to utilise SLTs to support the shift from hospital to community care.  For example;
* providing rapid access to highly skilled dysphagia practitioners at the front door of hospitals or as a referral option for GPs/DNs/Care Homes and ambulance services. This requires highly skilled professionals (Band 6 at a minimum).
* SLTs also provide support to care homes for communication difficulties and are well placed and skilled to support the dementia agenda.  Opportunities exist for SLT/assistant skill mix for triage, education of nursing home staff, risk feeding management and Advanced Care Planning to support hospital admission avoidance.
* SLTs are well placed to deliver assessment for Mental Capacity.
* There is emerging evidence of the value of SLT posts in palliative care.
* The contribution SLT can make to the reduction of isolation and loneliness in elderly people which is more evident in those with communication difficulties[[4]](file:///C%3A%5CUsers%5CRCSLT_Wales%5CDesktop%5CParliamentary%20Review%20of%20Health%20and%20Social%20Care%20response%20draft%201.docx).
1. Despite evidence of the value of the inclusion of SLTs within multi-disciplinary community teams and the potential opportunities which exist, we are aware that too few teams across Wales stipulate inclusion of the role as part of a dedicated primary care integrated workforce.  In the current model, our services are often provided by small, flexible teams who must meet the competing demands of primary and secondary care – and this can often mean the pressures in secondary care take precedence over opportunities to develop upstream approaches in the community to keep people well and avoid hospital admissions.   We would be keen to explore how we can exploit skill mix to ensure the contribution of the profession to primary care clusters and to community care in the long-term.

**Question 3 - What do you see as working well, and are there examples of innovation and good practice that could be replicated?**

1. We wish to highlight a number of examples of good practice, which could be replicated and scaled up to increase impact.
* Services developed and led by AHPs in contrast to historically medically-led teams.

For example, video fluoroscopy clinics run by SLTs and radiographers, Fibre optic endoscopic evaluation of swallow clinics run by SLTs, cancer rehab clinics run by SLTs, nurses and dieticians.

* Joint working within MDT clinics

Speech and Language Therapists are most effective when working as part of a multidisciplinary/agency team, where they are on an equal footing with other professionals and can influence the pathway for the benefit of the adult or child. Good examples include head and neck cancer and palliative care.

* **Managing swallowing problems in residential care**

There are over 22,000 older people living in residential care in Wales[[7]](file:///C%3A%5CUsers%5CRCSLT_Wales%5CDesktop%5CParliamentary%20Review%20of%20Health%20and%20Social%20Care%20response%20draft%201.docx).  Between 50-75% of nursing home residents have dysphagia.3  SLTs have a key a key role to play in supporting the management of communication and swallowing problems of those in care homes, removing the need for a GP visit.  They provide training to care home staff and others in the community to manage decline in swallowing performance from age and disease, which reduces morbidity, mortality and prevent hospital admissions.

The Community Resource Teams in Cardiff and Vale University Health Board includes 7 speech and language therapists.  The SLTs, working in partnership with other health and social care professionals and the Wales Ambulance Service Trust (WAST), have recently taken part in an important project which investigated the root causes and possible solutions tailored to supporting Nursing and Residential Homes in the Cardiff area. The project identified a pilot home as a high service user of WAST and ensured targeted advice and staff training was put in place. Following provision of support and staff education in the pilot home, initial data analysis has been very positive. Data has been collected against the pre-intervention criteria and comparisons made:

* The average number of OOH calls has reduced. From Jan16 to Nov16 the average was 9 a month, from Dec16 to Feb17 the average was 5.
* The average number of WAST Incidents has reduced. From Jan16 to Nov16 the average was 16 a month, from Dec16 to Feb17 the average was 11.
* The average number of WAST Responses has reduced. From Jan16 to Nov16 the average was 20 a month, from Dec16 to Feb17 the average was 15.
* The average number of EU Attendances has reduced. From Jan16 to Nov16 the average was 11 a month, from Dec16 to Feb17 the average was 8.
* The average number of Emergency Admissions has reduced. From Jan16 to Nov16 the average was 4 a month, from Dec16 to Feb17 the average was 2.
* The average EU Duration has reduced. From Jan16 to Nov16 the average was around 18hours30mins, from Dec16 to Feb17 the average was around 12hours30mins.

There is significant scope to replicate this model in other locations requesting support or identified as High Service users by WAST. Key to the model is the multi-disciplinary approach with SLTs at its core.

* **The Universal/targeted and specialist model for Children’s services**



The above model has been very successful in improving children’s SLT services in Wales and could be equally as useful for adult services, e.g. dementia care.

* **Therapy Outcome Measures Implementation (TOMs)**

All SLT services in Wales are implementing training in TOMs as part of values based healthcare initiatives.  Person-centred outcome measures such as TOMS report the impact services have on people, look at the gains in activity, participation, impairment and wellbeing. TOMS is a valid and reliable measure to facilitate benchmarking to inform efficiency and effectiveness improvement plans.

TOMS can be used across all SLT services to measure outcome against a variety of goals:

* Comfort (Palliative care): Relieving pain and increasing comfort
* Adjustment: increase the patient’s readiness for change or acceptance of their current condition
* Improvement: improve skills/condition or ability but not to within normal limits
* Resolution (cure): improve skills/condition or ability to within normal limits
* Participation: to enable patient to be actively participating more in their daily life
* Stabilisation: to maintain or reduce rate of deterioration/loss of function
* Prevention: prevent or reduce the risk of future harm
* Investigation: assessment to decide if there is something that SLT can do to help service user manage the risk and impact of their condition.

**Question 4 - What do you see as the barriers to improvement and how could these be overcome?  What stops change from happening?**

1. Funding – Ring-fenced funding being too restrictive to support projects that would add real value. Funding can often be highly restrictive both in terms of criteria and timing which impacts on realistic implementation planning. Short –term funding also leads to issues retaining high-quality staff and ensuring development of services. It would be helpful if short-term funding, timetables and how funding were devolved were reconsidered in light of these comments.
2. Capacity - SLT is a relatively small, predominantly female profession**.** Part-time working is widespread, and maternity leave cover is an ongoing consideration.  Our members tell us that there is little flex in the system to allow time to focus on improvement work, the creation of development roles and research capacity.  All elements which would support both the sustainability of services and effective succession planning.  Where budgets have been more flexible, we have seen the development of strong, agile teams which have driven service improvement. For example, Cardiff and Vale Community Resource Team as highlighted in the example in question 3.

1. Targets- Targets can be an effective way of driving change in services, but these need to be highly sensitive to ensure improved outcomes.  There is an inherent risk that such a focus leads to an industry of measurement, perverse incentives ad barriers to improvement.  We would be in favour of further refinement of performance measures for areas such as stroke to ensure best use of resources across adult services. It would also be beneficial if future targets/performance measures could have a greater focus on prevention and empowerment.

1. Silo working - SLTs work across education, health and social services.  A major challenge remains communication barriers between different sectors and divisions which can frustrate attempts at greater multi-agency working.  IT solutions which cross boundaries must remain an ongoing priority.  We have been closely involved in the development of the Welsh Community Care Information System and are hopeful that the pilots will be successful.

**Question 5 - What could be improved in current systems or in your area of work, and what needs to happen to enable change?  What would be the benefits in terms of improved outcomes?**

1. Members have suggested a number of potential areas for improvement.
* Increased investment in technology and admin support systems to enable efficient, responsive service delivery.
* Shared systems across health and social care, and other systems that can communicate with each other (e.g. across health and education).
* Shared training and development across organisations.
* Embedding audit and systematic service review to support continual improvement.
* Factoring into capacity the time for staff to audit and review their service and practice is needed, also time to participate in clinical supervision.
* Increased capacity to ensure workforce stability is adequate for variation due to maternity/sick leave/vacancy slippage through improved workforce planning/access to locums.
* Genuine integrated pathways with focus on what the patient needs at each stage and who is best to deliver it.
* Fewer barriers to working regionally, less competitiveness in the system, and more of a focus on what is effective and efficient for patients.
1. RCSLT also believe that there would be significant benefit in looking at new models of care using prudent healthcare principles, one example of which may be Care Aims which has been adopted by a number of Speech and Language Therapy Services.  The main benefits identified by services and teams using it are that the model offers:
* a standardised way of capturing and communicating clinical reasoning
* a clear and comprehensive way of demonstrating clinical effectiveness
* a systematic way of supporting and demonstrating clinical reflection
* an ability to focus resources where they can make the most difference by being outcomes driven and not demand led
* a sound framework for managing caseloads and workload
* a framework to support service design, planning and evaluation

**Question 6 - What needs to change to ensure that co-production or co-design is routine in health and care services and that people are better able to stay healthy or manage their condition?**

1. RCSLT believes that genuine co-production should be at the heart of improvements in health and care services.  Person-centred, dignified, safe and effective, patient experiences are dependent on effective two-way communication, whether face to face or written, between service providers and actual or potential service users. Nearly 20% of the population will experience communication difficulties at some point in their lives[[9]](file:///C%3A%5CUsers%5CRCSLT_Wales%5CDesktop%5CParliamentary%20Review%20of%20Health%20and%20Social%20Care%20response%20draft%201.docx).  For example, one third of stroke survivors experience aphasia (a language disorder caused by brain injury and consensus across several sources of evidence indicates up to 8/10 mental health service users will have speech, language and communication difficulties or needs (SLCN) - that is a permanent or transient difficulty understanding the spoken and/or written word and/or expressing themselves effectively verbally, non-verbally and/or In writing.  There is a need to ensure that service providers are aware of the impact of SLCN on service users’ ability to access and/or benefit from services.  In addition, at an individual level, systems need to be in place to support those with communication and/or cognitive difficulties to make decisions about their care.  For example, training, tools and knowledge regarding how to sensitively and appropriately involve people with SLCN in discussions.  SLTs have specialist knowledge of this area and should be an integral part of multidisciplinary teams.

**Question 7 - Do you agree that the strategic direction of developing primary, community and social care in local communities is the right approach to better meeting the needs of particular populations?**

1. As we have highlighted earlier in our response, we strongly agree that a shift from acute care to care closer to home is required. However, this key step change will not be achieved without strong support at all levels, significant movement of resources to the primary and community sector, developing skills within primary care (a generalist workforce with specialist skills) and investment in supporting technologies.  AHPs have a key role to play within early intervention and prevention services and priority should be placed, as a key pillar of the strategic direction, on fostering a multidisciplinary workforce which harnesses these unique skills.

**Question 8 - To what extent should services and processes be standardised across Wales, to achieve the right balance between national level and local decision making and allow room for innovation?**

1. There is significant scope for the development of all-Wales clinical pathways to ensure the best use of evidence and resources.  Opportunities for networking and sharing good practice are key and as budgets tighten, time and expenses for such activities must be protected to ensure continued improvement. However, a balance must be struck between a focus on ensuring equity of services through standardisation, structures for benchmarking, comparing outcomes and sharing good practice and giving services the freedom to meet the needs of local populations.   For example, SLT services delivered in rural Powys operate on very different models to those based in urban, ethnically diverse areas and while key principles and outcomes should be transferable, flexibility should remain in terms of models of delivery.  Workforce training should take account of these differing needs to ensure the future staff are equipped with the skills to work within diverse communities.

**Question 9 - What do you understand by prudent health and social care?  What steps are needed to ensure the principles are embedded in routine practice?**

1. SLTs are committed to embedding the principles of prudent health and social care. We understand the key concepts of prudent health care to be;
* achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
* care for those with the greatest health need first, making the most effective use of all skills and resources;
* do only what is needed, no more, no less; and do no harm.
* reduce inappropriate variation using evidence-based practices consistently and transparently.

1. Strong national leadership is required to embed these principles and an honest discussion with the public with regards resource, the need to deliver health and care differently and greater expectations on the public’s role within their own healthcare.  Application of these principles supports professionals to operate at the ‘top of their licence’ but will depend on strong governance arrangements to facilitate delegation and investment in alternative approaches

**Question 10 - What do you understand by integration and what steps are needed to further integrate services?**

1. Our members have a particular interest in the effective integration of health and social care.  Approximately 40% of SLTs work in intermediate care services.  SLTs work at all stages of the care pathway – from primary to secondary to tertiary care; from universal to specialist level services; from prevention to rehabilitation and reablement to end of life care.  The profession has a key role in services for all major clinical priority groups – dementia, frail elderly, stroke, cancer, learning disability, mental health.  SLTs deliver integrated and effective community services, focusingon early intervention and rehabilitation which support people to live morehealthily in their own home for longer.

1. Members are well aware of the importance of the enactment of the Social Services and Wellbeing Act and the Wellbeing of Future Generation Act. We understand effective integration to mean the development of a multi-disciplinary workforce able to work in partnership with individuals, carers and families and a collaborative culture which emphasises team working and the delivery of co-ordinated, person-centred care. A number of factors would support increased integration including;
* a fundamental review of data collected by both agencies in order to streamline and consider how information may be effectively shared (Due to the current separation of data between health and social services, we currently lack information at a national level on our input into social care which hinders the ability of staff to realistically plan and respond to need).
* an emphasis on supporting changes in culture, values and behaviour to support greater integration, supported by a national NHS Wales and social care workforce education and training plan.
* greater evidence of joint working arrangements developed including pooling of resources, training and performance management, shared systems and service reviews
* a shared vision in health and social care and a commitment to a long-term funding plan
* a shift within planning and service provision to models which are preventative and which maintain wellbeing and independence.

**Question 11 - What actions are needed to ensure services have a sustainable workforce for the future that matches the strategic direction?**

1. To create a sustainable workforce for the future, there is a need to ensure greater promotion of the wide range of health and social care professions, including SLT among young people and older people seeking a career change. Currently, there is little time and monies set aside for such promotion work which is key to creating a local pipeline of workforce supply. This should be combined with a focus on accessible training and progression routes for people without academic qualifications, in addition to high-quality undergraduate and postgraduate training.
2. Members also highlight the need for Wales to be confident to look beyond its own boundaries when considering workforce needs. Diversity will be key moving forwards and the continued sharing of ideas from other parts of the UK and the world.

1. The SLT workforce is well aligned with the future direction of travel in terms of the focus of the profession on providing preventative health care in local communities, multidisciplinary team working and the delivery of integrated care.  These are increasing areas of focus within the undergraduate training course. However as described earlier in our response, despite evidence of the value of the inclusion of SLTs within multi-disciplinary community teams and the potential opportunities which exist, we are aware that often the role is not specified as part of a dedicated primary care integrated workforce.  In the current model, our services are often provided by small, flexible teams who must meet the competing demands of primary and secondary care, and this can often mean the pressures in secondary care take precedence over opportunities to develop upstream approaches in the community to keep people well and avoid hospital admissions. In order to make changes apace, the balance of professionals employed in primary and secondary care must be carefully explored.

**Further Information**

1. For further information on this response or any aspect of RCSLT’s work, please contact:

**Dr Alison Stroud**

**Head of Wales Office**

**029 2039 7729/**alison.stroud@rcslt.org

**References**

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2. Matrix Evidence (2010). An Economic Evaluation of Speech and Language Therapy – Final report. London:Matrix Evidence [↑](#footnote-ref-2)