Bulletin

RCSLT

The official magazine of the Royal College of Speech and Language Therapists

ACTIVE INGREDIENTS

Dosage effects in developmental language disorder

AUTUMN 2022

ISSUE 832

RCSLT.ORG

Evidence-based practice: a collaborative journey | Priority rating scales and voice disorders | Maximising efficiency via quality improvement | **The Neurodiversity Paradigm explored** | Proton beam therapy and SLT | **Spotlight on supervision arrangements** | Stammering: group therapy

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RCSLT

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VICTORIA BRIGGS

Role modelling

Since 1945, the RCSLT's prestigious Honours Awards have been recognising leaders of all levels who have made outstanding contributions that benefit service users and the profession itself. For the past two years, as a consequence of the pandemic, the Honours have been celebrated virtually. While we're all no doubt used to life being lived on screen, it felt like a turning point – and a pretty momentous one at that – to be able to celebrate this year's Honours Awards face-to-face.

I'm sure many of you will have already seen our social media posts from the 2022 **#RCSLTAward**s, which took place in September. We'll be bringing you photos and a round-up of the event in the next issue of *Bulletin* too, but for now we'd like to congratulate all of this year's RCSLT Fellows, and to thank the guests and staff who helped to make the event such a roaring success. It's good to be back in-person with members again.

We're delighted to be joined this issue by Ali Turpie, one of last year's Giving Voice Award winners. In 2020, Ali had a catastrophic stroke that robbed him of his speech. Thanks to a combination of good luck, an indomitable spirit and the interventions of one amazing SLT, Lisa Harris - who also writes for us this issue – Ali is now talking, living life to the full, and serving as an inspirational role model for others. You can read about Lisa and Ali's incredible teamwork on p33.

Other role models we're celebrating this issue include members (and friends) of the UK SLT Pride Network, who represented the RCSLT so spectacularly at this year's London Pride event. If you didn't catch all the joy of the day on social media, then be sure to head to p15 to revisit it.

> **It feels like a turning point**

This issue we also say goodbye to outgoing RCSLT chair Mary Heritage, w*hose Bu*lletin columns over the past two years have documented her unwavering ambition to bring greater diversity and representation to the RCSLT's governance structures. As incoming RCSLT chair Dr Sean Pert notes on p16, thanks to Mary's transformational tenure as chair, he is now poised to preside over the most diverse Board in RCSLT history (see p11 for details of the 2022 Annual General Meeting).

Bulletin will be back with you in January. In the meantime, the magazine has been shortlisted for two prestigious industry awards. We'll be going along to represent the RCSLT there, and would like to extend our thanks to all those members who write for, review, read and respond to *Bulletin* content. Our success is your success, and we couldn't do it without you!

Victoria Briggs

bulletin@rcslt.org
@rcslt_bulletin

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SHARE YOUR THOUGHTS ON TWITTER @RCSLT_BULLETIN

Talking points

Send your letters, notices and talking points to **bulletin@rcslt.org** or tweet **@rcslt_bulletin**

LETTER

Rett syndrome awareness

Have you heard of Rett syndrome? October is Rett Syndrome Awareness Month, and Rett UK will be hosting a range of events and encouraging others to get involved in awareness-raising activities throughout the month – look out for our Twitter Takeover in collaboration with RCSLT Giving Voice on 17 October!

Why not join the Rett UK Communication Professionals Network (**rettuk.org/cpn**) to engage with our new programme for SLTs and get your own copy of the Rett Syndrome Communication Guidelines?

To find out more, contact **Gill Townend**, project lead at Rett UK Communication and Education Support.

gill.townend@rettuk.org
@rettuk

LETTER

National Dysfluency CEN study day

I attended the virtual study day for the National Dysfluency CEN in June to join in with the continuing conversations about the Social Model of Disability.

Firstly, I would thank the CEN for organising such a wonderful and stimulating day. We heard from a range of speakers who presented with real enthusiasm and passion.

I was particularly interested in Dr Hope Gerlach-Houck's latest study around concealment and would encourage anybody interested in this area to check out her research.

LAUREN FLANNERY, SLT and lecturer, University of East Anglia

LETTER

EMST funding

Like many speech and language therapy departments, we have been interested in the growing research in the field of expiratory muscle strength training (EMST) and have been fortunate enough to acquire funding for 20 devices. Consequently, we plan to conduct some small trials with service users with Parkinson's disease, motor neurone disease, head and neck cancer, and stroke.

We wondered if anyone already using EMST in these patient groups would be willing to share their learning.

Please email me if this is something you can help with. Many thanks!

KATIE MINGHELLA, specialist SLT, Airedale NHS Foundation Trust
katie.minghella@nhs.net

LETTERS

In memory

Susan Swann, the RCSLT's Retirement Network director, and a former SLT clinician and manager, sadly died on 26 August. Sue was heavily involved in the development of the RCSLT – including a period of time serving as its information officer – as well as the profession itself. A full obituary will be published in a forthcoming issue of *Bulletin*.

Complex needs in the early years

We're in the process of evaluating our pathway for early years children with complex needs who are at a pre-intentional stage of their communication development. We would be interested to hear from other therapists who could give us information about their local care pathway for this client group. We'd also like to hear from anyone who uses any specific assessments or therapy resources.

DAWN WILSON and **CASSIE MOLLOY**, SLTs, Sheffield
dawn.wilson17@nhs.net
cassie.molloy@nhs.net

Pre-thickened barium products

Are any speech and language therapy teams in the UK currently using pre-thickened barium products (eg Varibar) for videofluoroscopy?

If so, I would be grateful if you would consider getting in touch to discuss how you find them.

KAREN BALDWIN, highly specialist SLT, neuro-oncology
karen.baldwin5@nhs.net

QUOTE OF THE QUARTER

"Speech and language therapists... are among the unsung heroes of the NHS and the education system."

THE BARONESS BRINTON, Liberal Democrat Lords Spokesperson for Health

RCSLT NEWS

New-look careers booklet for prospective SLTs

The RCSLT has launched a brand-new resource to promote speech and language therapy as a career choice.

This pocket-sized handout provides an update to previous RCSLT careers booklets, acting as a tool to promote speech and language therapy as a rewarding and fulfilling career to school-leavers and university graduates alike, as well as those seeking a career change later in life.

The pandemic has led to a wave of interest in healthcare careers across all age groups. By linking through to the RCSLT's rich and comprehensive career webpages via QR code, the handy new booklet directs prospective SLTs to all the information they need about joining the profession.

While the new careers booklet might be small in stature, it's big on both professional inspiration and environmental credentials. With sustainability integral to the RCSLT's new five-year vision, the new format saves on print, paper and our carbon footprint. Made with sustainably sourced, carbon-neutral paper and a built-in biodegradable tag, the new careers booklet is eye-catching, memorable and easy for people to pick up and hang on to.

If you're a member attending a careers promotion event, we'd love to provide you with copies to hand out to the next generation of SLTs.

info@rcslt.org

WHAT'S NEW ON rcslt.org

INCLUSIVE JOURNALS CONTENT

We've introduced a new section on the RCSLT website featuring summaries of the latest research exploring issues related to anti-racism, equality, diversity and inclusion.
bit.ly/3KI8SMF

ASSISTANT PRACTITIONER HUB

The RCSLT assistant practitioner (support worker) hub is now live. It includes information about training and development, and a professional framework and toolkit. There's also a professional network (**bit.ly/3AtPZDH**) for sharing information and ideas.
bit.ly/3psyE83

COVID-19 ORAL HISTORY PROJECT

The RCSLT has been working to build an oral history archive of the COVID-19 pandemic through the eyes of SLTs, student SLTs, and RCSLT trustees and staff. Learn more about the project and its preliminary outcomes now.
bit.ly/3RToVAL

ACCREDITATION UPDATE

The RCSLT's accreditation process, which ensures all pre-registration undergraduate, masters and apprenticeship programmes meet the same standard, has been updated to be more streamlined and transparent.
bit.ly/3RCx7br

NEW NIHR FUNDING CALL

The National Institute for Health and Care Research (NIHR) has launched a major new funding call for research on 'Improving access and use of services for people with speech, language, and communication needs' – an excellent opportunity to address the needs of service users and the profession.
bit.ly/3eoIZ2u

Need to

ROOT by numbers

The RCSLT Online Outcome Tool (ROOT) is an online tool that's been developed to collect, collate and report on outcomes data.

Since its launch in 2016, the ROOT has been used by a growing number of SLTs across the UK and is being continuously developed and updated.

ROOT: the numbers so far AS OF 31 JULY 2022

60,945
outcomes added

67
organisations using the ROOT

44,441
logins

What's new in 2022

- A new ROOT forum in the RCSLT professional networks area with over 50 users (**bit.ly/3OQDc27**)
- New monthly ROOT lunch drop-in surgeries
- A recent ROOT development workshop attended by 30 ROOT users
- The online event *Owning outcomes: outcome measurement to deliver quality services*, attended by 274 participants

Find out more about the ROOT, and how you can use outcomes to support a data-driven approach to care:
bit.ly/3d32rRP **root@rcslt.org** **@RCSLTResearch**

IMAGES: ISTOCK

know

2,161
student members of the RCSLT
AS OF AUGUST 2022

International collaboration

The RCSLT is proud to be an affiliate organisation of the International Association of Communication Sciences and Disorders (IALP), a global organisation that facilitates international cooperation and collaboration in the field of speech and language therapy to improve services and promote the profession.

The UK's own Professor Pam Enderby is IALP's outgoing president and has overseen some fantastic achievements at IALP over the course of her three-year term.

The association is now working more closely with the World Health Organization (WHO), with IALP members actively engaged and contributing to WHO technical groups to ensure the needs of those with communication and swallowing disorders are not forgotten.

IALP is also continuing to work towards its mission of supporting low- and middle-income countries. A new task force on underserved populations has been established, and an upcoming publication from Professor Enderby and Sandra Levey will provide information for governmental health departments, health practitioners and specialists internationally to support access to and development of services for those with communication and swallowing disorders. A mentoring scheme has been established that links those working in low-income countries, where they have limited support, with an experienced clinician who can provide encouragement, guidance and assistance.

IALP has also been working with colleagues from the European Speech-Language Association and Communication Therapy International, and with WHO's 'Rehabilitation in Emergencies' programme to provide support and resources in response to the Ukraine crisis.

Next year will see IALP enter its 100th year with plenty of centennial celebrations in store, including at the 32nd IALP Congress being held in Auckland, New Zealand – visit **ialpauckland2023.org** for more information.

Congratulations to Professor Enderby on an incredible and impactful presidency!

Find out more about IALP at **ialpasoc.info**, and consider becoming an individual member if you're interested in helping with this important work.

NEWS IN BRIEF

Influencing wins

The last few months have seen some big wins when it comes to influencing on behalf of people with speech, language and communication needs.

- The RCSLT, together with Voice21 and I CAN, advocated for crucial amendments to the Schools Bill, to ensure that children are supported in schools to develop their spoken language, and that children with sensory impairments can access sufficiently funded specialist education services.
  Learn more at **bit.ly/3C5oQIx**.

- After extensive engagement from the RCSLT, the National Institute for Health and Care Excellence (NICE) guideline on depression in adults now includes key provisions to support people with communication needs in accessing mental health services.
  Learn more at **bit.ly/3AmvARo**.

- Responding to the consultation on the government's domestic abuse statutory guidance, the RCSLT recommended stronger wording on links between speech, language and communication and domestic abuse, as well as more specificity regarding child victims. We were pleased to see many of the gaps that we identified filled in the final guidance.
  Learn more at **bit.ly/3bVpb5O**.

New IJLCD editorial team members

The International Journal of Language and Communication Disorders has welcomed two new associate editors: Dr Jackie McRae, associate professor and director of research at the Centre for Allied Health at St George's, University of London, and Dr Saloni Krishnan, developmental cognitive neuroscientist at Royal Holloway, University of London. Jackie and Saloni bring huge amounts of expertise in relation to swallowing and child language, respectively.

Supporting NQPs

For newly qualified practitioners (NQPs), transitioning into the workforce can be challenging. The pandemic served to exacerbate those challenges, with many NQPs entering a workforce still dealing with staff shortages and long waiting lists.

The RCSLT has worked with members to develop a set of practical tips to help make this transition easier. The tips are split into those for NQPs themselves and those aimed at their supervisors and managers. The tips cover recruitment, completing RCSLT NQP competencies, induction, learning, wellbeing and more. There's also a sharable infographic format available.

The resources were developed from a workshop held earlier this year, *Supporting our newly qualified workforce: practical solutions for clinicians, managers and CENs*. Many thanks to the NQPs, managers and supervisors who attended and presented at the workshop.

Read the tips for NQPs: **bit.ly/3c62JqJ**
Read the tips for managers and supervisors: **bit.ly/3dKSSax**

Response to government SEND review

The RCSLT has submitted its response to the Department for Education's SEND Review Green Paper – a set of proposals intended to improve the system for children and young people with special educational needs and disabilities (SEND) in England.

As well as our detailed response to the formal consultation, we published a joint policy statement with the Association of Speech and Language Therapists in Independent Practice (ASLTIP), setting out in high-level terms what needs to happen to improve support for children and young people with speech, language and communication needs – and why getting it right for communication is so crucial. We've also published an Easy Read version.

In the statement, we called on the government to take urgent action in six key areas: funding, workforce, joint commissioning, early intervention, accountability and professional development.

The government is expected to respond to the consultation with a delivery plan by the end of the year.

Read the full consultation response and statement at **bit.ly/3pr9oyZ**

Workforce reform programme: career and capabilities framework

The first phase of the development of the UK-wide 'career and capabilities framework' – a part of the wider Health Education England workforce reform programme – has now been completed.

This initial phase included five online discussion events, with contributions from more than 120 RCSLT members covering perspectives from all four UK countries and from students, support workers and practitioners at all career levels. Participants represented a wide range of sectors and settings, including academia, education, independent practice, justice, local authorities, the NHS, private practice and the third sector.

The events included polling and breakout rooms that ignited insightful discussions on how this framework can be effectively developed to support the profession in a consistent, relevant and inclusive manner. Some of the key topics remain under debate in the ongoing second phase of the project, including self-evaluation, practitioner health and wellbeing, scope of practice versus level of practice, and terminology.

Findings from the first phase events have informed the initial draft of the framework, which is currently being shared, reviewed and uplifted with a virtual development group made up of volunteer members from a range of areas. In November, the output from the group's work will be incorporated into the second draft of the resource, before being shared with all members for wider co-creation.

For more information and to find out how you can be involved with this important piece of work, visit **bit.ly/3AsfzIf**

IMAGES: SHUTTERSTOCK

UP COMING

OCTOBER
Black History Month
22 International Stammering Awareness Day

NOVEMBER
20 World Children's Day
24 Carers Rights Day

DECEMBER
3 International Day of Persons with Disabilities
5 International Volunteers Day

DLD Awareness Day

DLD Awareness Day is on 14 October – keep an eye on RCSLT social media for DLD awareness-raising opportunities, including a takeover of the **@RCSLTNI** Twitter channel by members Sinead Marlow and Sarah Wilson.

Leading together in NI

On 17 November the RCSLT Northern Ireland Hub will host *SLTs Leading Together* at the Titanic Centre in Belfast. This event and exhibition will celebrate leadership at all levels, featuring inspirational speakers including Northern Ireland's Minister for Health Robin Swann and the RCSLT's own Kamini Gadhok MBE.

Upcoming RCSLT podcasts

New RCSLT podcasts will be hitting the airwaves this autumn, including an episode highlighting the new assistant practitioner/support worker framework, and one all about the International Communication Project.
Listen at **soundcloud.com/rcslt**

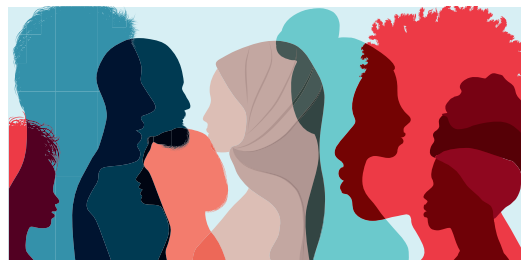
RCSLT Student Day: save the date

RCSLT Student Day is scheduled for 7 December. This annual event is a great learning and networking opportunity, so if you're a final-year student be sure to save the date!

Speech sound disorders guidance update

The RCSLT is about to start an exciting new project updating our guidance and resources on speech sound disorders. Keep an eye on the current projects page at **rcslt.org** for more information and ways to get involved.

AGM to welcome new trustees



This year's RCSLT annual general meeting (AGM) is being held on 6 October. The AGM provides members with an opportunity to look at what the RCSLT and the profession as a whole has achieved in the previous financial year and to vote on proposed resolutions.

This year, the AGM will include the appointment of five new trustees, as well as four current trustees commencing a second term. The RCSLT has been working hard to improve the diversity of the board and, following extensive changes to the recruitment process, we are pleased to be moving forward with a board that more accurately represents the members and communities we serve. We know there is still work to do to meet our equality, diversity and inclusion ambitions, but this is another step in the right direction. Read more about the AGM in the column from incoming Chair Dr Sean Pert on p16.

Find out more about our trustees at **rcslt.org/about-us**

Apprenticeships commence

The first speech and language therapy apprenticeships get underway this autumn, opening up an exciting new route to becoming an SLT.
The first apprentices and their employers are working with the University of Essex to deliver the pre-registration degree via this new route, and we are looking forward to further apprenticeships starting in 2023 at Birmingham City University and the University of Sheffield.
If you're an employer who wants to become involved in supporting an apprentice, check out the RCSLT's apprenticeship guidance or get in touch.

rcslt.org/apprenticeships
berenice.napier@rcslt.org

Want your photo to be featured in the next issue of *Bulletin*? Post your pic on Twitter tagging **@rcslt_bulletin** or using the hashtag **#GetMeInBulletin** and we'll publish a selection of the best

Got something to tweet about?

This issue finds RCSLT members learning, sharing wisdom and raising awareness, plus a special roundup of our first time marching in the London Pride parade.

❤ 2750 likes

1 Anna Rhiannon made a little feathered friend on community visits in North Wales with Betsi Cadwaladr Health Board.
@Anna24127661

2 SLT Georgie Parkinson and her colleague couldn't hide their excitement on day one of the SLT-led voice clinic in Lothian.
@georgievoice

3 SLTs on the Stockport stroke team delivered thickener training as a part of dysphagia education for new stroke nurses.
@Caroline_SLT

4 Fantastic discussions happened between Glenn Carter and Lauren Hopp from **@RCSLTscot** and Member of Scottish Parliament Maree Todd (**@MareeToddMSP**) about the importance of speech and language therapy.

5 The speech and language therapy team at **@WyeValleyNHS** have been spreading the word about the importance of oral health and mouth care during **#NationalSmileMonth**.
@LauraBurzioSLT

6 SLT Alexander McMillan shared a glimpse of his day of working in a therapy caravan in the midst of a thunderstorm **#MySLTDay**
@inspiretospeak

7 Members from across the North West participated in a brilliant session sharing and exploring experiences of cultural and ethnic diversity in the profession.
@NWestRCSLTHub

8 Student SLTs Jade, Juliet and Fatimah don't just study together – they also took on the Yorkshire Three Peaks together! Congratulations on smashing the challenge.
@FatimahBH

9 SLT Sue Fenwick Elliott got her steps in as part of **#AHPsActive** with her adorable week-old grandson Jasper.
@sfenwickelliott

PARKINSON'S Excellence Network

How well do you know Parkinson's?

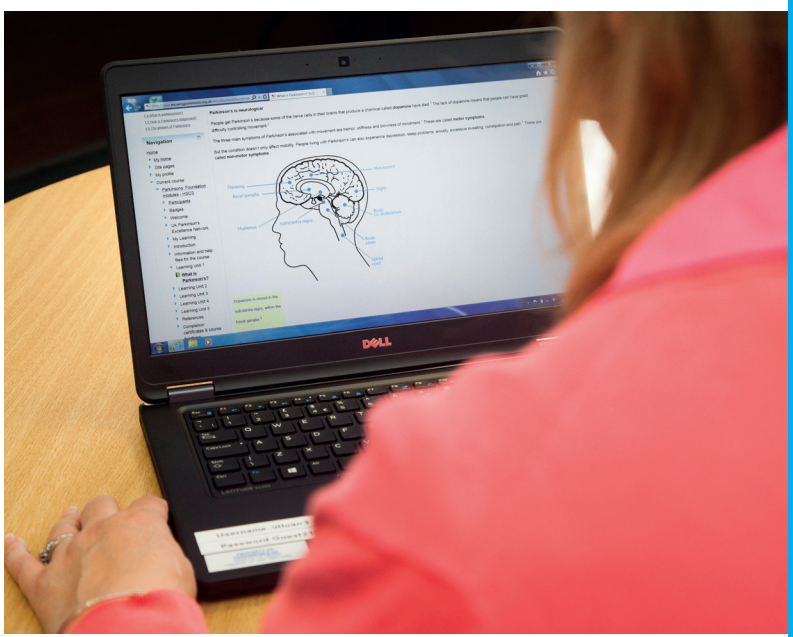
Speech and language therapists can play an important role in helping people take control of their Parkinson's. In the early stages of Parkinson's, a speech and language therapist can be vital in helping someone maintain as much of their communication ability as possible by:

- Developing strategies and exercises to help people with Parkinson's control their volume and speed of speech, breathing, facial expressions and articulation
- Helping with problems related to eating and drinking, such as drooling and difficulty swallowing, potentially suggesting small pieces of equipment and special tools to help
- Recommending tools that support spoken communication or offer a different way of communicating in certain situations, and train a person with Parkinson's, their family and carer to use them.

If you're supporting people with Parkinson's, the Parkinson's Excellence Network Learning Hub can help grow your knowledge and confidence. Discover a range of benefits at **parkinsons.org.uk/learning-hub**:

- Identify the most suitable resources for your role and level of experience using the new learning pathway (tailored specifically to speech and language therapists)
- Learn at your own pace with self-directed online courses
- Save money by choosing from an extensive list of free courses
- Access high quality content, co-created with members of the Parkinson's Excellence Network - a collaboration of health and social care professionals, supported and facilitated by Parkinson's UK to enable better services for people with Parkinson's.

Dive straight in with a 15-minute bite-size course, which provides a background to understanding Parkinson's and discusses specific aspects of the condition that are of direct relevance to professionals working in speech and language therapy. Or explore the more comprehensive foundation modules for health and social care staff, with learning units and activities to help build a more in-depth knowledge and understanding of Parkinson's.



"Armed with the right knowledge we can really make a difference."

CAROLINE BARTLIFF, SPECIALIST SLT

For further information about these courses visit **parkinsons.org.uk/learning-hub**. You can also sign up to the Excellence Network monthly e-newsletter, to hear about new learning opportunities as they become available.

Dr Rowan Wathes, Associate Director of the Parkinson's Excellence Network, said: "These training courses are so important as it is the fastest growing neurological condition in the world.* We appreciate the hard work of everyone in the healthcare sector as they are so vital for people with Parkinson's, who often need a lot of support. In turn, we want to support those working with people with Parkinson's and help them to understand this very complex condition."

*Reference: Dorsey et al, Lancet Neurology, 2018 https://www.thelancet.com/journals/laneur/article/PIIS1474-4422(18)30295-3/fulltext

SLT Pride

On 2 July, the RCSLT, in collaboration with the UK SLT Pride Network, took part in the Pride in London parade for the first time. Members donned their brightest outfits and took to the streets in central London to celebrate.

"Pride means equality for all," said Sara Grummett, a member who attended on the day. "It's important for the RCSLT to be involved in Pride to raise awareness and ensure we are inclusive to all, for all."

SLT Bethan Hill echoed the sentiment: "Having the RSCLT in Pride means showing inclusivity and acceptance to all our queer colleagues and service users. Especially those who aren't in a position to be out and proud".

The UK SLT Pride Network works to support and represent LGBTQIA+ SLTs, support workers and students – an important part of ensuring our profession is diverse and provides an inclusive environment. Jess Davies and Kate Boot, secretary and co-chair of the network, respectively, said it was a privilege to be able to march on behalf of the network, and to meet so many enthusiastic members: "It's a standout moment; one where the RCSLT and the network demonstrate their commitment to enhancing the equality, diversity and inclusion of LGBTQIA+ speech and language therapy professionals. We look forward to the future".

With thanks to the UK SLT Pride Network and to all the members who came to march on the day.

To learn more about the origins and meaning behind Pride, visit **bit.ly/3KYl5XH**

> **Pride means equality for all**
>
> SARA GRUMMETT

Want your photo to be featured in the next issue of *Bulletin*? Post your pic on Twitter tagging **@rcslt_bulletin** or using the hashtag **#GetMeInBulletin** and we'll publish a selection of the best

DR SEAN PERT

Stepping up to the plate

Dr Sean Pert, the RCSLT's incoming Chair, celebrates progress within the profession

I will preside over our most diverse Board ever

In October, I will take up the position of Chair of the Board of Trustees. I will become the first man to occupy the position, and the first openly gay person. With the approval of the membership, I will preside over our most diverse Board ever. This is also the year that saw RCSLT's first official presence at Pride, thanks to the UK SLT Pride Network. Mary Heritage, as outgoing Chair, can be rightfully proud of realising the ambition of attracting trustees and committee members with a range of protected characteristics that more closely reflect our membership and the communities we serve.

We have a range of challenges in the coming years, including responding to the changes to society in response to COVID-19 and the continuing impact on service delivery. Many services are experiencing unprecedented challenges, including long waiting lists and pressures to do more with fewer resources. The RCSLT continues to be responsive to these challenges, supporting members to advocate for hard-to-reach families and service users. We are privileged to ensure that the most vulnerable in society get the help, advice and interventions that they need.

I am constantly impressed and humbled by the efforts of you, our members, in contributing to the RCSLT, as well as your commitment to your service users and the profession as a whole. It is important to remember that *you are the RCSLT*, and that 'college' is not a remote board in London. There are myriad ways of getting involved with your professional body, all of which will also help you to develop transferrable skills that will enhance your career. This applies to all our members – including students, several of whom were involved in the selection panels that interviewed the incoming Board and committee members. From students to retirees, the RCSLT has a place for you. So, if you are unhappy with the way things are, or simply want to feel more involved, why not get in touch and help us to change for the better?

I am proud of the progress we have made so far on improving diversity, and all the amazing work you do on a daily basis. Your contribution really matters. We all strive to constantly improve, and I look forward to helping the profession continue to develop while making diversity an indispensable part of all that we do.

DR SEAN PERT, RCSLT deputy chair
sean.pert@rcslt.org
@SeanPert

KAMINI GADHOK

Collective achievements

In the face of ongoing challenges, the success of the profession lies in supporting each other. **Kamini Gadhok** writes

We are co-producing solutions

The RCSLT's Annual General Meeting on 6 October (see p11) will see outgoing Chair of the Board of Trustees, Mary Heritage, present our annual Impact Report. As we look back over the last year, I want to thank members for their ongoing commitment to the profession, which makes me – and I hope all of you – proud of our collective achievements.

Some of those achievements are highlighted in the Impact Report (see **bit.ly/rcsltagm22**). They include our work on diversity and anti-racism, the sharing of best practice and innovation via CENs and webinars, and our first virtual conference, which made the RCSLT's flagship event more accessible and international than ever before.

The report also highlights how we, as an organisation, have been listening to the challenges faced by members and service users alike. Our Build Back Better campaign allowed us to develop position papers and secure meetings with decision-makers across the UK. We were also successful in securing funding to support much-needed work on increasing the speech and language therapy workforce, establishing improved career pathways, and embedded our commitments to equality, diversity and inclusion.

But I know that this does not help the day-to-day reality and the immediate pressures many of you face. A lack of funding and a shortage of SLTs mean that caseloads are growing. In the face of reduced capacity and member exhaustion, we are continuing to listen to and act on these ongoing challenges, to support the recovery of services and manage the impact of the pandemic.

I am actively involved in many of the meetings being held with members. The listening event for children and young peoples' service leads, held in June, was one such example. We are working to co-produce solutions with speech and language therapy leaders who are keen to share their learning with the profession, as well as working together to influence key decision makers on the need to prioritise the funding of speech and language therapy services and invest in the profession – including clinical and service leadership.

We have been successful in raising our issues through the mainstream and health sector media. While the past few years have been unprecedented in terms of challenge, I continue to be inspired by the leadership and determination shown by the profession. We will continue to work together to support each other and to improve outcomes for our service users. We are all in it together.

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Part of the family

Lucy Rodgers reflects on involving parents in a research project

I set up a patient and public involvement (PPI) group earlier this year after being awarded a public involvement grant from my local National Institute for Health and Care Research (NIHR) research design service. As an early career researcher (ECR), this was both exciting and daunting. The aim of the group, our 'parent panel', was to incorporate the perspectives of parents whose children had accessed early years speech and language therapy into a research proposal.

LUCY RODGERS

Parents and SLTs need to understand each other

Our three online meetings lasted for one hour and spanned three months. I went into the first meeting with myriad anxieties: will the technology work? Will there be awkward silences? However, after our first meeting, it was clear that it would be an enjoyable and valuable learning experience for me, both as a clinician and an ECR.

My number one learning point? Challenge your assumptions. There were certain things I just assumed the panel would agree with me on. For example, I suggested separate clinician and parent PPI groups in the next stage of the project. The panel's response was: "For this to be successful, we need to bring SLTs and parents together!"

By assuming that parents would want their own space to express their views, I had overlooked that, for the project to work, parents and SLTs would need to understand each other's perspectives; only then could we move forward meaningfully.

So, if in doubt, always ask. Which makes it only appropriate to ask Dave, one of our panel members, about his experience.

Why did you decide to take part in the panel?

Dave: To give something back. As a family, we've taken a lot from the speech and language therapy service over the past few years. With the disparity between services across the country, I want to do a little bit to make positive change if I can. It's a way of contributing to what you guys do.

What was it like being a part of the parent panel?

Dave: For me, it was positive because we got Lucy's experience as a researcher and SLT, while networking with other parents in other parts of the country who've had different experiences. The common denominator was speech therapy.

What would you say to SLTs who want to involve parents in a project, but are hesitant about it?

Dave: I think parents with lived experience will give you a perspective that SLTs can't, even if they are a parent themselves. I think that should be embraced... a) it can make them a better SLT, and b) it can help them to treat that person much better, because then they get to be 'part of the family', so to speak.

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ILLUSTRATION: JAMIE WIGNALL

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Not enough hours in the day?

Rachel Magee writes on maximising efficiency by making simple changes

Have you ever thought there just aren't enough hours in the day? Especially when the referrals keep coming and the list gets longer, no matter how quickly you work.

RACHEL MAGEE

Our acute speech and language therapy service had the usual challenges of increasing clinical demands and expectations, with no increase in funding or staffing to meet them. Our team comprised three SLTs, working 8am–4pm, Monday to Friday. Patients were often referred late in the day, which meant frequently having to leave their assessment until the next working day. This resulted in patients not receiving the level of care we wanted to provide. We knew what we needed, but with no increase in staffing capacity, what was the solution?

Our trust has a big focus on quality improvement, with the view that even the smallest change can have an impact. With this in mind, we asked ourselves "why do we all start at the same time?" Yes, there are patients and referrals waiting at 8am, but did we really need three SLTs starting at that time? We considered the impact of staggering our start and finish times. Would that allow us to pick up more 'last-minute' referrals? With three SLTs willing to give it a go, we decided it was worth a try.

We discussed the idea with key stakeholders and soon embarked on a 12-week pilot. We hoped the new shift patterns would result in timelier responses to referrals, reducing the instances of patients having to wait until the next working day for assessment.

We kept the 8am–4pm shift, created new 9am–5pm and 10am–6pm shifts, and took turns working each one. We recorded data about every patient assessed between 4 and 6pm, including the time of referral (so we knew if they would previously have fallen into the 'too late to see' category) and the impact of the assessment.

> **One small change had a big impact on our service**

During the pilot, the number of patients seen on the day of referral increased. This led to fewer patients being kept 'nil by mouth' overnight or at the weekend. There was an increase in the provision of dysphagia and communication care plans for patients who would previously have waited more than 24 hours. This improved patient flow and prevented unnecessary admission of those awaiting assessment. More timely discussions were made around direction of care, appropriacy of non-oral feeding and administration of medications.

Staff across a range of wards and specialities felt the benefit of having an additional two hours to access speech and language therapy advice and assessment. Their feedback was overwhelmingly positive. They were vocal that the new hours be continued – and we agreed! The clinical benefits were clear and the varied shifts also resulted in reduced staff stress and improved work/life balance. Best of all, it was cost-neutral.

Just one small change has had a big impact on our service – how could you create more hours in the day?

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ILLUSTRATION: JAMIE WIGNALL

High energy

Karen Walsh and **Lorna Wilson** on working within a proton beam therapy service

KAREN WALSH

LORNA WILSON

The UK's first NHS-funded proton beam therapy (PBT) service opened in 2018 at the Christie NHS Foundation Trust in Manchester. As key members of the multidisciplinary team (MDT), speech and language therapy and dietetics were extensively involved in setting up and establishing the standards for this national service.

PBT is a type of radiotherapy that uses high-energy protons rather than photons. It is currently commissioned for use in the treatment of some cancers, including head and neck cancer (HNC) (see **bit.ly/3u3XTPQ**). PBT is advantageous for treating tumours in locations where conventional radiotherapy would damage surrounding healthy tissue to an unacceptable level, or where the risks of long-term side effects need to be mitigated. This makes it particularly beneficial for children, teenagers and young adults (TYA), or patients with cancers that are close to the spinal cord, brain, eye or inner ear.

Patients are referred nationally from their local cancer centre. Once funding has been approved by NHS England, the patient is discussed in the weekly proton MDT meeting, enabling a coordinated approach to care and treatment. A 'red-amber-green' prioritisation system ensures each patient's individual needs are met in a timely manner.

Collaboration has led to a greater insight into this cutting-edge treatment

HNC patients are assessed by speech and language therapy and dietetics jointly. Pre-treatment, SLTs assess the patient's swallowing, voice, and communication; during treatment, patients are reviewed in-clinic as appropriate and supported with their goals. Our patients' needs are varied, with some requiring very little input and others needing intensive support from the MDT and higher-level support from psycho-oncology, safeguarding and social services.

Multiple factors – including disease locality, length, and dose of treatment, together with side effects and a prolonged time away from home and support networks – can have a significant impact on the person's physical and psychological wellbeing, quality of life, and their resilience and tolerance of treatment. The MDT consists of clinical and non-clinical members from radiography, physiotherapy, occupational therapy and social work to ensure patients' needs are met holistically. Due to the high number of TYA referrals, TYA staff, as well as addiction specialists and complimentary therapy, are also members of the MDT.

Our team also leads research trials to determine which other cancer diagnoses may benefit from PBT. We are leading the national TORPEdO trial (toxicity reduction using proton beam therapy for oropharyngeal cancer), which will deepen our understanding of the long-term impact of PBT versus standard radiotherapy for oropharyngeal cancers.

This high level of dynamic interprofessional team working has provided many interesting and valuable learning opportunities. Collaboration has led to a greater insight into this cutting-edge treatment and the complexities of unusual diagnoses, while providing cohesive and integrated care to support the patient experience and maximise outcomes. We anticipate many more exciting developments in the future.

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FOCUS ON DIVERSITY

The Neurodiversity Paradigm

Emily Lees calls for a radical shift in how SLTs support Autistic children and adults

EMILY LEES

The 'Medical Model' developed in the 18th century suggests that "disease is detected and identified through a set of symptom descriptions" (Swaine, 2011). It is criticised by Autistic people for its heavy focus on impairment and disorder, implying there is one 'right' way of existing in the world.

We saw a positive shift in models of practice with the introduction of the 'Social Model', which recognises societal barriers within the environment that discriminate against disabled people. Both the Social Model and the Neurodiversity Paradigm advocate for necessary disability supports as outlined in The Equality Act (2010) and focus on improving the environment. However, the Social Model does not fully encapsulate the understanding of neurodiversity and Autism, and still defines people as having 'ability' or 'inability', therefore suggesting people have deficits. The Neurodiversity Paradigm, born in the 1990s by Judy Singer, takes us one step further by recognising the whole diversity of the body-mind experience.

For decades Autistic children have been supported by interventions based on neuronormative sensory, cognitive, attention and language development. Goals are to 'reinforce socially expected behaviours' and 'reduce repetitive behaviours and restricted interests'. Such goals are rooted in the Medical Model and driven by behaviourism. False theories have formed the cornerstones of interventions that stigmatise, disempower and perpetuate the narrative that Autistic children have social impairments. We now have research that shows the opposite, eg Damian Milton's The *Double Empathy Problem* and Catherine Crompton's *Diversity of Social Intelligence* – the first empirical evidence that Autistic people communicate effectively with each other and that, in fact, problems arise when communicating with non-Autistic people. We now know that social skills interventions cause Autistic children to mask and lead to long-term mental health problems. Masking is also correlated with suicide in Autistic adults (Cage and Trixell-Whitman, 2019; Richards et al, 2019).

What does a Neurodiversity-Affirming SLT look like? The first step is listening to Autistic people through co-production and by honouring the Autistic community's cry of 'nothing about us without us'. We prioritise self-advocacy and empowerment to enable them to advocate for their personal, emotional, learning and sensory needs at all life stages. We honour Autistic styles of communication, such as info-dumping and echolalia. We respect differences in how Autistic children pay attention and play. We presume competence for Non-Speaking and minimally speaking children, and do not gatekeep access to robust augmentative and alternative communication (AAC). We use Autistic children's interests to guide play and learning because their monotropic thinking style means they are much more likely to succeed and learn if they can tap into their interests. We use visual supports as a way of supporting understanding rather than giving demands and instructions. We address the person's sensory processing needs and support their self-regulation. We avoid language such as 'person with autism', 'disorder', 'high/low functioning', 'deficits' and 'impairments'.

Points for reflection: How does your service and practice engage with the Autistic community to uphold their views? Does your practice honour Autistic styles of communication and attention?

REFERENCES
To see a full list of references and further reading on this topic, visit: **rcslt.org/references**

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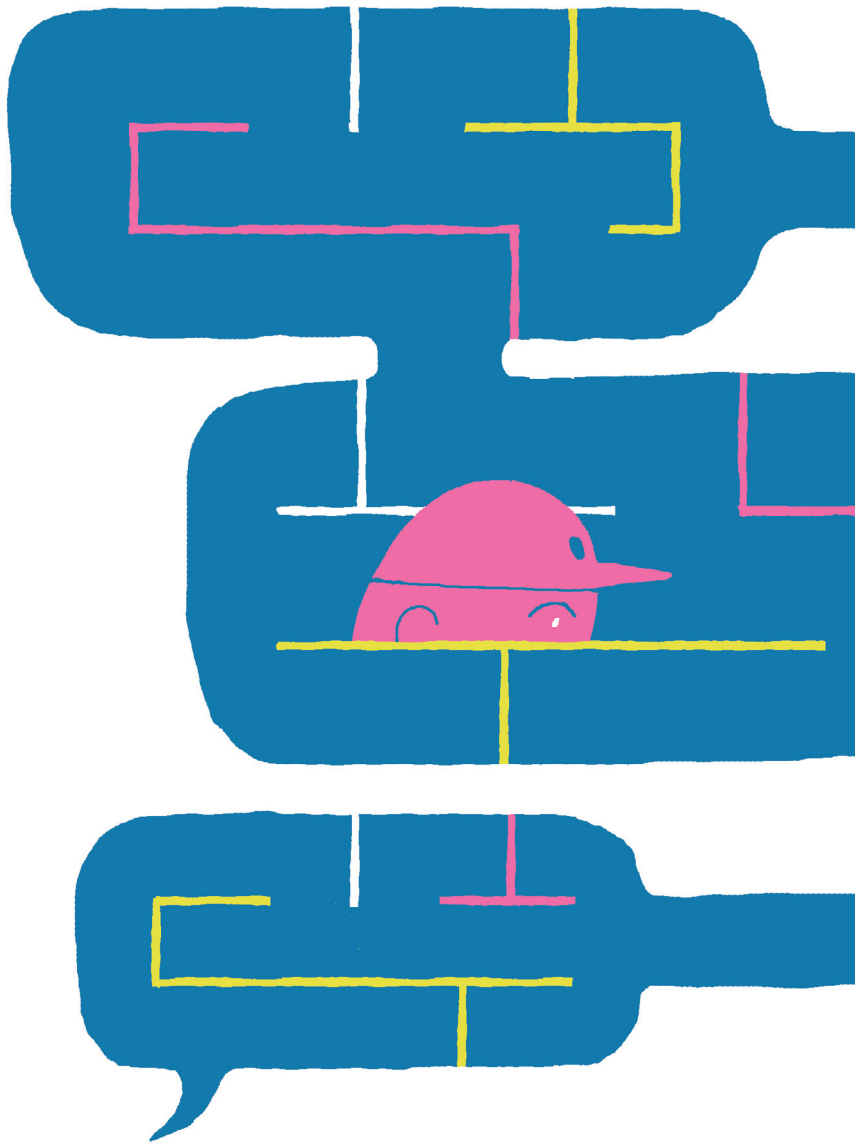
Active ingredients

Dr Pauline Frizelle *and* **Professor Cristina McKean** *examine dosage effects in interventions for children and young people with developmental language disorder*

ILLUSTRATIONS ADAM McCAULEY

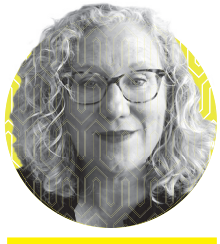


ASK THE EXPERTS

R

ecent developments in our understanding of the prevalence, nature and consequences of developmental language disorder (DLD) have highlighted the need for the provision of effective speech and language therapy. This growing awareness of the scale of the need has coincided with increasing demand, pressures and fragmentation in children's speech and language therapy services. With such scarce resources and such a large need, it is vital that the intervention we offer is delivered with maximum efficiency, in dosages that can bring about change. The number and quality of speech, language and communication intervention studies with children and young people who have a diagnosis or are

DR PAULINE FRIZELLE



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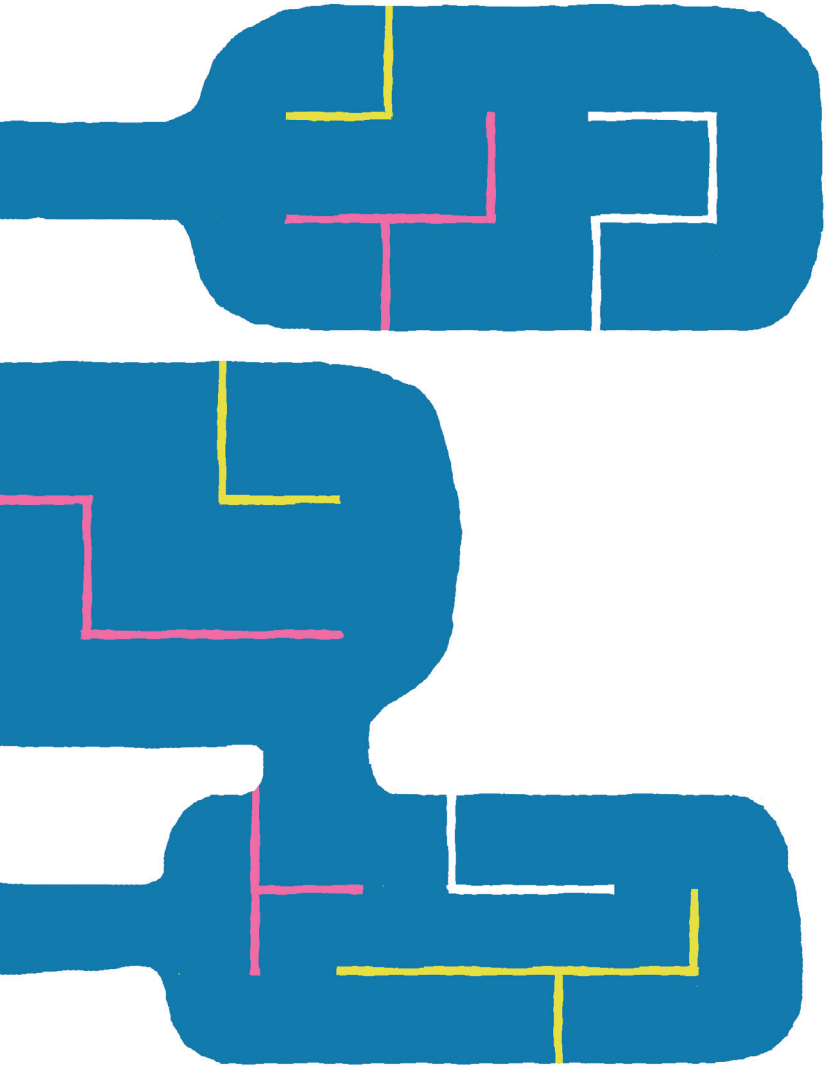

at risk of DLD has increased considerably over the last 20 years. This has led to an increased confidence among practitioners and researchers that our interventions can and do effect meaningful change. However, in order for clinicians to be able to use this evidence in practice, there is a need for precision in descriptions of the key components of an intervention that underlie its efficacy: the 'active ingredients'. This would enable clinicians to replicate interventions in a manner that brings about change and, where necessary, to tailor it to an individual's needs while retaining those aspects which are essential for efficacy. Furthermore, it would enable the profession to robustly challenge service provision in dosages with no realistic chance of success.

> **Our interventions can and do effect meaningful change**

Dosage: a framework to capture intervention

Traditionally, the concept of dosage has been applied to pharmacological interventions, whereby individuals are prescribed a specific amount of a medication, in a particular form, at a given frequency and over a prescribed period of time (eg 500 mg of paracetamol in tablet form to be taken twice daily, for five days). However, the application of dosage to behavioural interventions is much more complex to describe and, consequently, to measure. In 2007, Warren and colleagues proposed five dosage 'active ingredients' to describe interventions. Four of these refer to aspects of the intervention that can be measured quantitively: dose, dose/session frequency, total intervention duration, and cumulative intervention intensity. The fifth is a qualitative characteristic referred to as 'dose form'. Each of these characteristics is defined as follows.

Dose is "the number of properly administered teaching episodes during a single intervention session". For example, the number of times a child is exposed to or produces a target word or the number of models of a specific structure given to or produced by a child. To increase dose, clinicians can increase the dose within the session (eg by increasing the total number of exposures / productions per session), or overall dose by increasing the number of sessions.

Dose / session frequency refers to the number of intervention sessions per unit of time (ie per day, per week, per month); **total intervention duration** is the total period for which the intervention is provided (eg six weeks); and **cumulative intervention intensity** is the product of the previous three components, ie number of exposures/productions per session x session frequency x total intervention duration.

TABLE 1: Components of dose form and their definitions: qualitative active ingredients

Component	Definition	Examples in practice
Techniques	The specific actions/ teaching behaviours thought to effect change	Providing word definitions (vocabulary), recasting, imitation (morphosyntax)
Procedures	The combination and order of technique delivery	Word exposures followed by word definitions (vocabulary); recasting followed by auditory bombardment (morphosyntax)
Method of instruction	The manner in which techniques are delivered, ie with or without explicit instruction (explicit vs implicit)	Word exposures alone (implicit) versus exposures coupled with detailed explicit definitions of targeted words (vocabulary); recasting (implicit) versus recasting with explicit explanation of the grammatical rule targeted (morphosyntax)
Intervention contexts	This has three subcomponents: 1. The activity within which the technique/ teaching behaviour is being delivered 2. Where the activity sits within a child-centred, clinician-directed continuum 3. The degree of variability/uniformity in the linguistic input or materials used	1. Interactive book reading; play-based activities (both can be adapted for vocabulary or morphosyntax interventions) 2. Choosing vocabulary that relates to the child's interests versus developmentally focused vocabulary; integrating syntactic targets into play-based activities using the child's toys versus drill based target games chosen by the clinician 3. Target vocabulary presented repeatedly with little linguistic variation (many examples of few words) or with greater variability (few examples of many words); manipulating noun and verb variability within syntactic models or recasts provided by the clinician

Therefore, a client who receives 36 word-exposures, given three times weekly for six weeks, would have a cumulative intervention intensity of 648. The same cumulative intensity could also be reached by giving 36 exposures once a week for 18 weeks.

The final qualitative characteristic **dose form** was defined by Warren et al (2007) as "the typical tasks or activities within which the teaching episodes are delivered" and extended by Proctor-Williams to include "the commonly used techniques, procedures, and intervention contexts that constitute teaching episodes". In 2021, we further extended this construct to include other active ingredients that we deemed to be missing from the previous definitions (see Frizelle et al, 2021b). The resulting 'dose form' framework to describe qualitative active ingredients of interventions is shown in the accompanying table (left).

What is known about quantitative active ingredients?

Research demonstrates that each of the active ingredients above impact the effectiveness of interventions for children with DLD. However, because research directly comparing one ingredient to another, or manipulating one qualitative aspect of dosage while controlling for all other variables, is relatively rare (Frizelle et al, 2021a), we cannot be definitive about which are the most impactful or efficient dosage components. However, we can extrapolate key points of learning – particularly in relation to quantitative aspects of dosage for vocabulary and morphosyntax interventions – and we outline these below.

Perhaps counter-intuitively, studies show that more is not always better. In a vocabulary intervention, Storkel and colleagues (2017) manipulated the number of word-exposures given to

KEY LEARNING FOR EFFECTIVE INTERVENTION DELIVERY

Using the quantitative classification system presented in this article should help clinicians track aspects of intervention dosage; in particular, to enable the maintenance of high levels of within-session and ideally overall dose.

Defining what constitutes a dose is key to the successful implementation of interventions. For example, for a given intervention, therapists need to decide if a dose is only when the child is required to do or say something or if the input from the therapist is also a dose.

In relation to cumulative intervention dosage, the literature suggests a minimum requirement for children to achieve their goals. For example, 36 word-exposures per session for 15 sessions for vocabulary intervention for 5- to 6-year-olds with DLD.

Overall dose appears to have greater impact on children's learning than the frequency of the treatment schedule. There is tentative evidence that the same results can be achieved in a shorter timeframe if the within-session dose remains the same and reasonably high (eg 24 recasts in 15 minutes versus 24 recasts in 30 minutes).

Weekly or fortnightly sessions are acceptable dose frequency schedules, but only if the dose per session is high. Little and often is also potentially effective, enabling flexibility in scheduling to accommodate parents and or educational practitioners.

More is not always better. Too high a dose can result in diminishing returns, potentially caused by reduced attention, when a target becomes overly familiar. If progress plateaus, we recommend changing intervention targets.

Subtle but simple manipulations of qualitative active ingredients can enhance efficacy, eg:

- varying the referent in vocabulary interventions
- providing auditory bombardment of a target morpho-syntactic structure after recasting
- using explicit teaching at the start of an intervention as children get older (ie 6 to 7 years)
- ensuring all interventions offer children opportunities to produce target forms

There is no magic number for dose or session frequency across language domains. There is sufficient evidence to suggest that SLTs must move away from the practice of delivering a number of pre-determined intervention hours/sessions. Continuing treatment until a child reaches a pre-specified criterion for success aligns more closely with the evidence.

The profession must recognise that removing a child from the classroom or requiring parents to bring children to therapy for interventions that do not provide sufficient dosage to effect change may be unethical.

Service delivery models should be driven by evidence; not by custom and practice.

5- to 6-year-old children with DLD. They found that 36 word exposures was optimal but that, following 48 exposures, fewer children responded to treatment. Diminishing returns were also evident in a morphosyntax intervention on past tense production by Meyers-Denman and Plante (2016). The intervention duration ranged from four to 44 days. The longer children received the intervention the less accurately they produced the verbs. The authors' explanation for these findings relates to deficiencies in processing, such that over-familiarity with material leads to decreased attention (Cepeda et al, 2006).

Based on outcomes from composite language measures (such as the CELF-4), Schmitt and colleagues (2016) found that frequent interventions in which language goals are targeted for short periods (two minutes, 2/3 x weekly) or less frequent interventions targeting language goals for longer (20 minutes, 1x per week or fortnight) have yielded the best outcomes.

The spacing or intensity of interventions is also key to service design. One theory of learning posits that it is more efficient if teaching episodes are spaced over several sessions than if they are more densely concentrated into one or a few sessions. Providing a high cumulative dose provides children with numerous opportunities to encode and re-encode new information (Alt and Plante, 2006). On the other hand, spacing between sessions allows children to consolidate their learning in memory (Archibald and Gathercole, 2006), by building on reactivating partially encoded information with each repetition.

Overall, when cumulative dose is controlled, the literature reports no learning advantage for sessions in a spaced rather than concentrated intervention schedule (eg Storkel et al, 2019). Interestingly, this was also found within session, where the spacing of doses was manipulated (24 recasts in 15 min vs 24 recasts in 30 min) but both conditions yielded similar outcomes (Plante et al, 2019). The manipulation of within-session dose is relatively under-researched and larger samples are needed to validate this finding. However, based upon this current best evidence, the 'number of teaching episodes within-session' dose is potentially more important than the session length or spacing of sessions. If this is shown to be consistently the case, it would provide evidence to support significant changes in how speech and language therapy might be delivered.

Clearly, more research is required; however, there is some key learning that can be applied to practice.

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REFERENCES
For a full list of references visit: **rcslt.org/references**

Get in touch!

The RCSLT wants to hear from members using the evidence around dosage to inform their treatment approach.

Please contact **sarah.lambert@rcslt.org** if you would be happy to share your experience.

The stroke took my speech from me

Ali Turpie *writes about learning to speak again after a stroke*

Building blocks to recovery

Like a lot of teenagers, my 16th birthday was a bit of a turning point. It was also the age I lost my dad to suicide. Since then, I have become a huge advocate for talking about mental health: it's become a topic that is very close to my heart.

In honour of our dad, my brother and I raised £12,000 for the mental health charity Mind, back in the summer of 2018. The success of that definitely gave me the charity bug.

Fast forward to 2020. We were just going into the second lockdown of the pandemic when a good friend of mine lost his girlfriend to suicide. Instantly, I thought of my dad and it made me want to do something.

I've always been very sporty. Although running is not my forte, I decided to challenge myself to run 10k a day to raise money for CALM (the Campaign Against Living Miserably), and while I ran I filmed myself talking about mental health. At first, I was just running and talking, filming and posting it to Instagram. I ran (and walked) with my mum, and we'd just chat about my dad. We'd set the target for £10,000, although never thought in a month of Sundays we'd achieve it. But suddenly people were asking to run with me, my social media following grew, and then ITV News was reporting on it! I ran with people who suffered from depression, someone who suffered with post-natal depression, a suicide survivor – my whole point was that everyone has a problem, and it's okay to talk about it.

> **I want my story to be a little bit of hope for people who have suffered from a stroke**

Stroke

A week after raising more than £12,000 for CALM, I suffered a stroke. Crazy when you think about it. My brother, who was with me at the time, said it was a very, very big stroke. It affected my left hemisphere and my right side, and it totally took my speech from me.

When I lost my dad, I used the experience to raise some money and a lot of awareness. I decided to do the same with my recovery and thought, "I can either let this eat me up, or I can propel myself through it". I knew it wasn't going to be easy, but if you can suffer through the bad days, you can also meet the good ones. For me, it was about either speaking again, or not speaking again.

I'm a big believer in fate. I had my stroke on 10 December and, by Boxing Day, I was in my first speech and language therapy lesson. I did it all with my mum by my side. She was militant and did everything in her power to help me. One day, my mum got a call from my fiancée's mum, Bev, who was on holiday at the time. Bev told my mum she'd met someone on holiday who was best friends with an SLT called Lisa Harris. Fate!

Lisa was truly amazing throughout my recovery. She knew that I saw it as my job to learn to speak again. It wasn't a bad recovery, and I think that's because I accepted straight away that I would have to learn to speak again. As soon as I came to terms with that, I started building the blocks to learn. Of course, it was frustrating! But I also got frustrated with things before I had the stroke. There were tears and days when I really didn't want to do the work, but I persevered. I knew that, even with hard work, the real healer was time.

I don't think I'm special, I truly don't. I just did it day by day, and this is the outcome: I'm not fully recovered and I won't be until I decide I am. I want my story to be a little bit of hope for people who have suffered from a stroke and people who are working with those who have. Time just takes time.

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An extraordinary recovery

SLT **Lisa Harris** reflects on her work with **Ali Turpie,** a service user who's been on an incredible journey

It was December 2020 and we were in another phase of lockdown. Ali, at the age of 28, had suffered a stroke just before Christmas, leaving him completely unable to talk. At that time, due to Covid restrictions, he was alone in hospital, valiantly trying to communicate with basic sign language to his girlfriend on FaceTime. His mother was told it was unlikely he would speak again.

I have worked as an SLT in neurorehabilitation for nearly 30 years. In that time, no case has ever been the same - from the level or type of injury to the brain, the cognitive ability and personality of the patient, to the variables of the life they live and the family and friends that surround them. But all of these factors combine to play a part in recovery.

Ali had had a very serious stroke, but the damage appeared to be limited to his speech centre. He was severely expressively aphasic and apraxic, but he still maintained a good intent to communicate. He could make some sounds but had no meaningful speech. His receptive ability was relatively intact, with only mild difficulties, and he was cognitively able.

Intensive therapy

On discharge from acute care Ali had an excellent start in the Bradley Neurorehabilitation Unit in Woking. He was fortunate to have intensive speech sessions there, working initially on his sound repertoire and starting to build syllables into meaningful words. After his short stay there, he and I started remote work together on Boxing Day bank holiday – he was certainly keen! Daily intensive hour-long sessions were held on Zoom. This was a relatively new way of working at that time but, through the process, we found it was just as effective as being face-to-face in a clinic room.

Ali was young and perhaps that meant he had greater plasticity on his side. Personality-wise, he was positive from the start, and incredibly determined. Determination of course does not directly aid recovery – especially if an injury is very serious – but it does mean that someone may work tirelessly on their treatment, trying to make new neural connections repeatedly, day in, day out, for as long as cognitive fatigue will allow.

Daily, we worked on building words; initially CV, then CVC to CCVC, focusing on common, high-frequency words that he could try and use outside of the sessions. 'Repetition, repetition, repetition' was the initial name of the game, trying to find pathways and maintain them. Over weeks we built up to commonly known phrases and, gradually, to Ali constructing meaningful short sentences himself.

REFERENCES
To see a full list of references visit: **rcslt.org/references**

Alongside this we worked on intensive single word-finding activities, initially for common nouns and then verbs. There was intensive semantic work, processing through the whole language centre, starting to push the word-searching to find more abstract and lower frequency words. Within months we were working on sentence-level responses to questions and discussions, and multisyllabic words. Using online apps, Ali was able to practise independently outside of our sessions. He recorded his Zoom sessions so that he was able to review them and do them again if he chose to.

Ali's speech in recovery was initially highly telegraphic and monotone and he struggled with multisyllabic words. But as each month went by his fluency started to improve, which gave him the motivation needed to keep working hard.

Cognitive fatigue was a significant factor for Ali and, of course, support and explanation are needed on this topic so that a patient and their family can understand why they may be struggling on one day more than another. Too much cognitive fatigue and a patient can feel overloaded and limited in ability to respond at that time. With an understanding of the variables that will lead to greater cognitive fatigue comes more personal control of it, and balancing activity around it so that the patient may be more able when they choose to be. But also knowing that they have not 'gone backwards' is very important mentally, and that it is just the effects of fatigue on a vulnerable system.

Progress

From the beginning Ali shared his progress and treatment sessions on Instagram, to provide support for others who may be in the same boat; it led to a tidal wave of support and encouragement. He raised more awareness of aphasia and apraxia in one year than I have done in 30 (indeed, he won an RCSLT Giving Voice award for it!). Of note was the extraordinary support of his close-knit circle of family, friends and colleagues who were so keen to work with him, support him and truly get behind him in every way. We know that support and understanding from family, friends and the workplace can have a significant impact not only on a person with aphasia's recovery, but also on their wellbeing.

When people understand aphasia (which of course they may never have heard of before) and the variables that can affect it, they are better able to tailor their own communication style to support someone. We know that taking the time to work with someone's communication circle and to provide the knowledge and tools needed for them to understand and support the person with aphasia and apraxia can improve the opportunity for a patient to communicate and feel supported and facilitated to take part in communication, aiding inclusion and communicative connection and confidence. They may then engage in more communication, enabling them to continue to practice their speech and language processes outside of a session.

Ali shared his progress and treatment sessions on Instagram

Some examples of tools that can help:

- providing more time to respond
- making space for them to speak in a group conversation
- facilitating word-finding where appropriate
- use of forced alternatives rather than open questions
- slowing their own speech down
- using shorter sentences
- repetition, sometimes with different words
- using total communication, such as writing, drawing or gesture to support communication
- maintaining eye contact, respect and speaking directly to the person
- helping the person to stay relaxed and calm, reducing pressure if possible
- reminding them of a topic of conversation or what they have said if they have become focused on finding a particular word and lost their thread.

Ali's progress snowballed slowly but surely. By May 2021 he had caught the attention of ITV News and was able to be interviewed. At that point his speech was still very telegraphic, but he was able to take part in a two-way conversation using sentences with full content. He continued to work intensively and by August 2021 he was able to return to a very supportive work setting, while still continuing weekly speech and language therapy sessions to work on high-level language goals.

Speech for Ali during his recovery has always felt effortful, and although far less so now, he still finds this at the time of writing. Many patients may present to the world as 'fully recovered', but what the listener observes and what the patient experiences internally may be two different things. For a person who has had or still has aphasia or apraxia, the effort required to speak can continue to feel draining. While sometimes barely discernible to a listener, speakers often feel like their speed of response is akin to walking through treacle; too slow for the speaker, and an ease-of-communication barrier causing ongoing cognitive fatigue. Language is a high-level process of course, and its recovery complex.

Ali has made an extraordinary recovery. He has accomplished a great deal and his story is inspirational and encouraging to many. I admire his determination enormously, and his strength of character and positivity are second to none. However, unfortunately, as we know, these traits can exist in other people whose recovery may not be so successful. We simply do not yet know at the outset how well a patient will recover.

We were delighted that all the variables came together in Ali's case to enable him to have a very successful recovery. In this case, the use of intensive treatment, its frequent repetition at the level of impairment, and tight goal-setting, alongside supportive communication, worked well. An unrestricted period of treatment meant that we could continue working together until a recovery plateau had been reached, which is of course unusual and very fortunate. But with the use of technology and a supportive family, an intensive programme can be offered to others more easily. Initial spontaneous recovery will also have played a part.

At the time of writing, we are now 15 months post-onset and recovery has slowed down; but, even now, Ali is making incremental improvements in his fluency, word-finding and speed of processing. He remains as determined as ever.

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Facing the fear

Emma Chambers *looks at the benefits of a group approach to therapy for young people with dysfluency*

In 2019, Medway Community Healthcare launched intensive group therapy sessions for young people aged 10–17 who stammer.

Research shows that as young people reach their teenage years, stammering can have a significant impact on individuals' social interaction, confidence, self-esteem and identity (Cook and Howell, 2014). They are more likely to be perceived negatively by peers or teased/bullied (Blood et al, 2011), and there is an increased risk of social anxiety disorder developing in adulthood (Iverach et al, 2000).

Within our service, we found young people often did not know anyone else who stammered, which increased the feeling of being 'different' from their peers. They often voiced a strong desire to try and 'control' their stammer or 'avoid' situations that required speaking in front of others – for example, reading out loud in front of the class, meeting new people or giving presentations. Following training at the Michael Palin Centre on secondary-age children who stammer, we identified that group therapy showed the potential to address many of these issues for young people on our caseload, and could improve therapy outcomes (Fry et al, 2014).

REFERENCES
For a full list of references visit: **rcslt.org/references**

Pilot scheme

We launched a pilot scheme for a one-week intensive stammering group. This aimed to help young people to meet others who stammer, increase understanding of their own strengths, and support them to take small steps towards facing any anxiety linked to talking.

The local youth centre provided a free venue that created a more social and relaxed atmosphere compared to our usual healthcare setting. We scheduled the first group in the Easter holidays, for two hours a day, Monday to Friday. We invited young people, aged 10–17 years old in our stammering service, and anyone who had been discharged in the previous year. Eight boys signed up from across the age range.

Group activities

Using a solution-focused model, participants created a 0–10 'best hopes' scale (Nicholas, 2015) for what they wanted to achieve in the group. Personal goals included: 'to be more confident talking to new people', 'to be able to ask for help at school', 'to meet new people' and 'to speak to someone I don't know'. Throughout the week, they participated in activities to support these goals using both identification and desensitisation activities, including:

- What we know about stammering
- Facebook survey to ask the public how they feel about people who stammer

IMAGE: ISTOCK

Stammering can have a significant impact on social interaction

- Using comfort scales to develop awareness of anxiety levels in different situations
- Developing individual stammering 'icebergs' and sharing these with family/friends
- Using voluntary stammering to reduce sensitivity
- Discussing safety behaviours and avoidance of situations/words
- Developing awareness of negative automatic thoughts and challenging this through positive thinking and 'being kind to ourselves'
- Considering what makes a good communicator
- Using 'speaking circles' to face the fear of speaking in front of others.

The group established its own group rules, with just one rule added by the therapists: 'It's OK to stammer'. At the end of the week, the young people completed a 'speaking circle' with the parents to answer questions the parents had posed earlier in the week. Participants, staff and parents used a 'positivity wall' to provide positive feedback to each other throughout the week. Participants also had the opportunity to write or record a video message to themselves to keep them on track after the course.

Post-group review

We saw the participants for an individual review in clinic two to three months after the course. Next steps included the option of discharge on a plan, further individual therapy or attendance at the next group in the summer.

Five of the eight participants opted for the follow-up group, with two returning for additional individual therapy sessions. One opted for discharge on a plan.

At the follow-up group, three new boys joined the five returning participants. During this group, they continued to build their confidence with talking as well as working on desensitisation activities, such as 'teaching a peer their stammer'. The participants further developed their understanding of the 'vicious cycle', recognising negative automatic thoughts versus positive thinking. They started to develop skills in building individual 'small steps plans' to work towards their personal talking goals. They also briefly explored modification activities in the form of direct speech management strategies, including slow talking, pausing, soft contacts and use of the 'slide' (starting the word slowly and picking up speed as you go).

Positive outcomes

We measured outcomes from both groups informally through the participants' 'best hopes scales' and participant/parent feedback. All participants spoke confidently in front of the parents at the end of the week and moved up their best hopes scales, with several reaching the top of theirs. All the parents and young people identified that they had increased their confidence in talking as a result of attending the group and were 'likely' or 'very likely' to recommend the group to others. The young people commented that 'the speaking circle', 'meeting new people' and 'being more confident' had helped them to achieve progress.

Nathan, aged 13, who attended both groups, said: "The group has helped me a lot because the last time I came here it really improved my confidence and coming here again has improved it more. It's made me believe in myself... I've met new people and it's made me more confident. I've spoken more than I ever thought I would be able to. Thank you for making me 'me' again".

The mother of Cameron, aged 11, who attended both groups, said: "This group is so important for the young people that attend. They are equipped with so much knowledge, which not only empowers them, but helps them to understand what's happening to their body when they stammer. It's lovely to see them connect with others who really understand what they go through".

Following an informal evaluation of this pilot, we determined that the results of group therapy showed potential promise for this age group. These results are in line with outcomes seen in the literature, suggesting this may be a useful approach to add to our future service delivery. We are therefore planning to continue to monitor outcomes from these groups and develop further controlled evaluation methods.

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Tips for talking

Catherine Davies, **Nicola Waddington** *and* **Sara Winfield** *on bringing together research and practice*

In 2018, the Leeds children's speech and language therapy team launched a creative project to support their parent training with accessible online materials. Although the information provided was based on clinical practice, it didn't originally stand on an explicit research base. As practitioners, families and researchers came to use the materials, it became clear that academics had something valuable to offer by integrating the current evidence to substantiate the advice and suggestions provided.

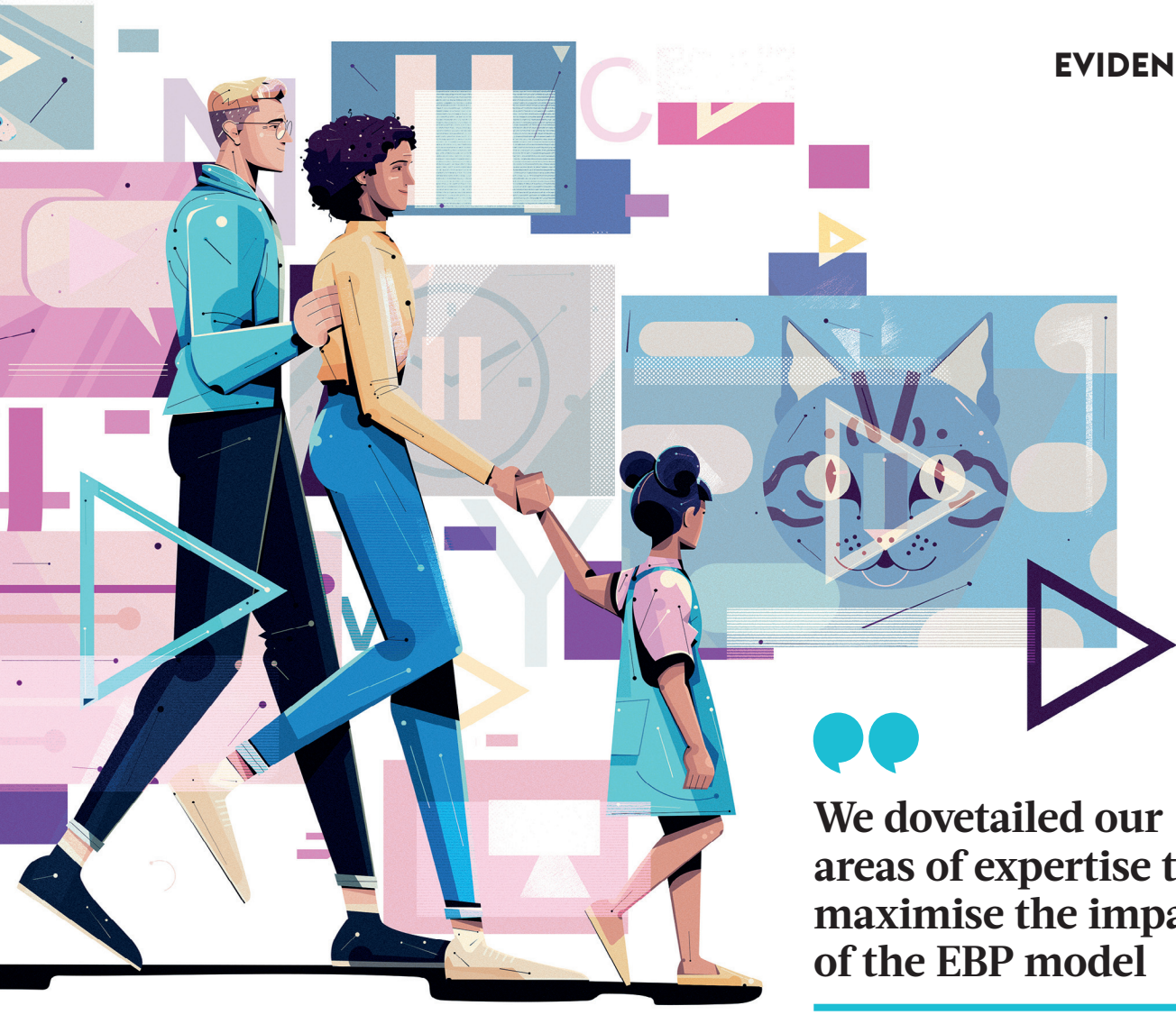
One barrier to effective evidence-based practice (EBP) can be a lack of a network between researchers and practitioners. However, Leeds Local Authority hosts the multi-agency Communication and Language Steering Group, which comprises a wide range of expertise, including clinicians and academic researchers. Through this group, we – Sara (specialist SLT), Nicola (clinical lead for children's speech and language therapy) and Catherine (professor in language development at Leeds University's Child Development Unit) – combined our expertise into a new EBP project.

Our project embodied the model of EBP that integrates clinical expertise, service users' priorities, and peer-reviewed, scientific evidence. Through a series of meetings, we agreed a plan of action and negotiated how this work would fit into our schedules.

We had many conversations about the challenges of EBP, and – crucially – how to resolve them. We clarified the sometimes opposing aims of our respective professions, faced some difficult questions about the art versus science of speech and language therapy, and ultimately dovetailed our areas of expertise to maximise the impact of the EBP model within the context of community working.

These are our reflections on the collaborative EBP journey.

REFERENCES
For a full list of references visit: **rcslt.org/references**



ILLUSTRATIONS: JOE WALDRON

> We dovetailed our areas of expertise to maximise the impact of the EBP model

The SLT view: Sara

The focus of our early language parent training workshop was 'Top Ten Tips for Talking' – a series of strategies for supporting early language development that SLTs recommend to parents following a referral for early language difficulties. In the workshop, the top tips were described and discussed, and parents encouraged to identify one new strategy to try with their child. Illustrated paper copies of the tips were provided for parents to refer to.

In 2018, we surveyed parents on their preferred ways of receiving advice or information online. The majority favoured short animations, so the tips were developed into a series of 12 short clips. These were launched in 2019 for National Children's Day, supported by health visitors and early education practitioners who signpost families to the resources as soon as a concern with language development is identified.

As part of an evaluation of community-level support for early language development, Nicola discussed the animations with our Communication and Language Steering Group. This offered an opportunity to cross-check our practice with the evidence base. We formed a working group with Catherine, who offered invaluable support with accessing and appraising the evidence behind the top tips. The parameters were set: the research had to be gold-standard: ie peer-reviewed, valid and reliable.

Pleasingly, most of the research aligned with the advice we gave. However, there were some areas of disagreement. For example, one of the tips advised caregivers to reduce questions. Although we agreed that questions are important in language acquisition, my practitioner view would be to limit questions in favour of commenting, eg by using the five finger rule: backing each question up with four comments. However, the published research suggested that questions are a powerful way of supporting language growth through turn-taking and increased complexity. In line with this, we removed this animation from circulation and updated it with advice on the most supportive ways of asking questions. We shared this updated evidence widely with our teams.

A further disconnect emerged over our advice around dummy use. As a practitioner, I would always advise limited dummy use, especially when a child is playing or talking. However, we discovered scant high-quality evidence to support our advice, which raised two important questions. How would we manage the lack of research evidence for this type of fundamental advice? Should we always expect there to be research evidence behind it? In a landscape of limited funding, published research into the effects of, for example, dummy use on language may not exist. Data gathered from our clinical work suggests that these approaches work, but more carefully controlled evaluation is required to confirm our clinical observations.

It has been great to work with Catherine to see things from a different perspective, and to find a way through the evidence together and create as much common ground as possible.

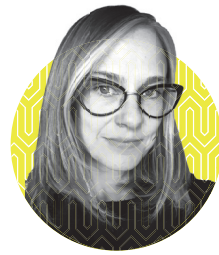
The clinical lead view: Nicola

Developing the Top Ten Tips for Talking animations was an interesting project from the perspective of a clinical lead. To ensure a successful service improvement outcome, it was important to involve service users at the start of the project. We asked parents/carers to complete a survey about how they would access digital resources. Around 70% of the 162 responses indicated a preference for animations, available online. Service users also contributed during the development stage by commenting on the content, imagery and pace of the animations. To date, the animations have been viewed over 20,000 times. We have received positive reviews from parents, and other speech and language therapy services have contacted us to ask about the development process and for permission to use our animations.

Another supportive factor was the collaboration with the university. Catherine was able to review the literature, assimilate the science, and summarise the evidence base in an accessible way. It is unlikely that this collaboration would have occurred had Catherine and I not both sat on the Communication and Language Steering Group, hosted by Leeds City Council.

We are delighted that the supporting evidence for the Top Ten Tips for Talking has now been uploaded to our website so that it is accessible to all. We will continue our partnership to review the evidence base on an ongoing basis.

The research view: Catherine Davies



When I discovered the Top Ten Tips for Talking, I was impressed by its eye-catching, user-friendly format and was excited to contribute my time, knowledge and access to research to the advice that practitioners offer on a daily basis. I hoped that by providing the science behind the tips, caregivers and practitioners would better understand and remember the ideas and put them into practice more easily. From my employer's perspective, engaging with practitioners was a great way to meet a university's impact agenda.

Tracing the links between the speech and language therapy strategies and published research on language development was painstaking and interesting work. To support advice to 'get down to your child's level', I cited studies showing the power of eye contact and joint attention in lexical and pragmatic development. On 'giving choices', I wrote about mutual exclusivity. This is a powerful process in vocabulary learning: if a child hears a familiar word, eg banana, and a new one, eg sushi, while they can see an object they know (the banana) and one they're not familiar with (the sushi), they work out that the new word must relate to the new object. This label-object link then manifests as a new word in the child's repertoire. On 'follow your child's lead', I summarised data on the benefits of contingent talk; the simple act of talking about what the child is focusing on. Studies show that responding contingently helps word learning.

However, as I collated and evaluated the evidence base, a couple of the tips stood out as more controversial as they did not align with the research evidence. Although I knew resolving the divisions would be challenging, being able to provide the data behind the advice felt like important work.

One tip advised carers to reduce the number of questions they asked their child. Knowing that two of the most important aspects of caregiver talk are turn-taking and

language complexity, it seemed odd to avoid using questions, which can be a powerful way of achieving both. Sara cited materials from the Hanen Centre suggesting that questions can cause a child to say less rather than more. Over several conversations with research colleagues and with Sara, part of the conflict seemed to stem from the clash between individual- versus population-level observations, or what appears to work for one child in the therapeutic world, versus what works for children more broadly in research. A client in a clinical setting will show idiosyncrasies that reflect their unique experiences resulting from the interplay of multiple, individualistic factors – and that may include difficulties processing questions. This contrasts with the methodologies used in the bank of publications that evidence the supportive role of questions in developing complex syntax and more diverse vocabulary. Sample sizes used in these studies can reach into the hundreds and can mask subtle individual differences in the aggregation. The contradiction between an individual client and a representative sample was not easy to resolve, but we found a way by encouraging parents to give their children more time to respond to questions, so that questions are supported rather than avoided.

Our experience neatly demonstrates one of the main arguments for adopting EBP: the advantages it brings are precisely because there are disparities between clinical practice and research evidence. By finding ways of bringing research and practice into alignment, while acknowledging the very different ethos of each profession, we engaged in genuinely transformative work. As a researcher, I have a sharper sense of priorities for both practice and research, and the critical importance of collaboration. Through this *Bulletin* piece, as well as at events, we continue to demonstrate this symbiosis.

Our advice to researcher-practitioner collaborative teams:

- Start small: a short conversation can reveal quick wins for stubborn problems.
- Facilitate dynamic interprofessional partnerships that can challenge current practice and be responsive to clinical needs.
- Ensure that interprofessional teams working on collaborative projects have complementary skills and a respect and understanding of each other's roles, eg in service users' values or critical analysis.
- Ensure that the team has 100% clarity of vision for the task at hand and for each other's expectations, including division of labour, timeline, and in the setting and reviewing of outcomes.

See the Top Ten Tips for Talking animations and evidence base at: **bit.ly/3P8emvO**

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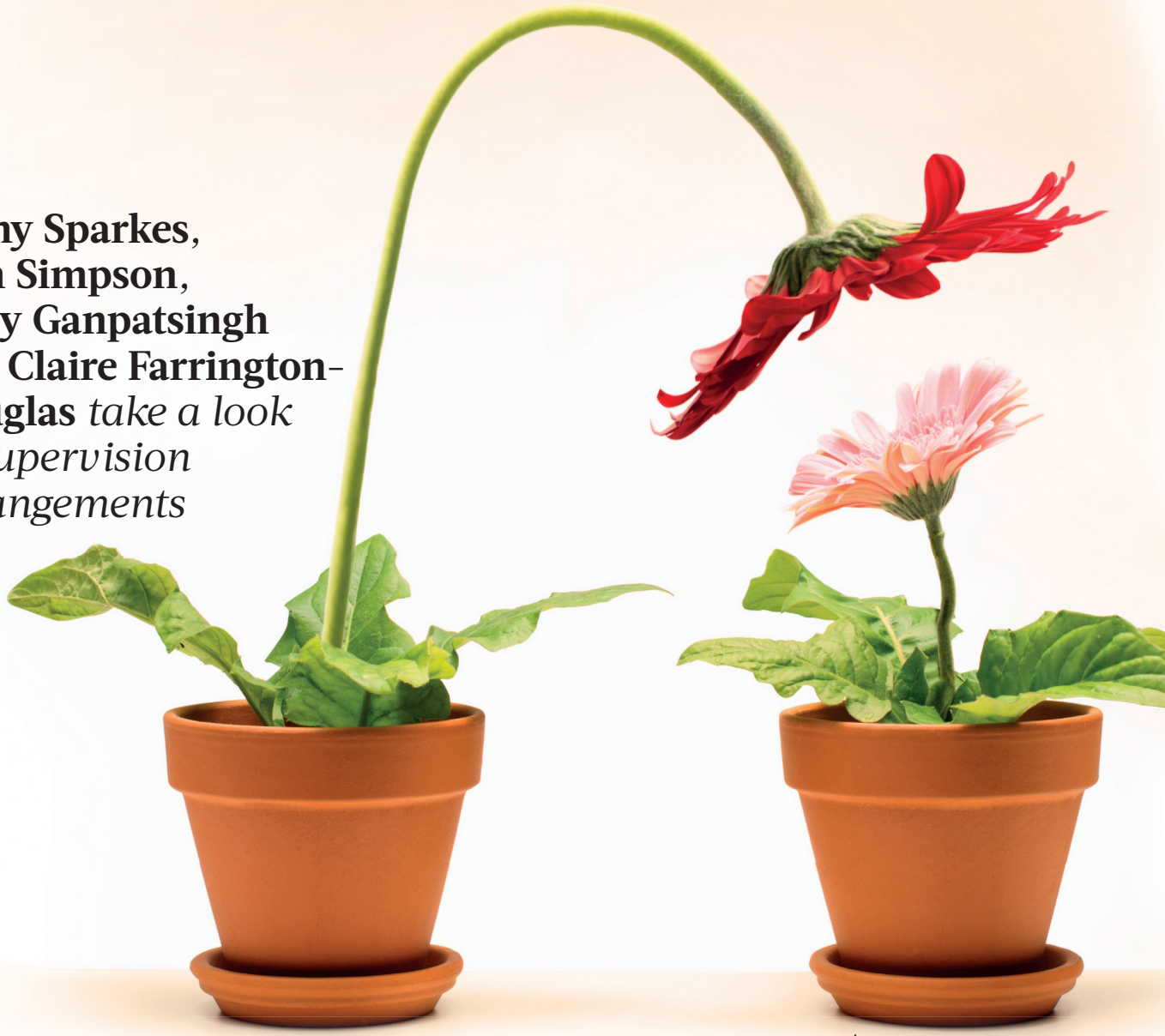
Cathy Sparkes, Sam Simpson, Mary Ganpatsingh *and* **Claire Farrington-Douglas** *take a look at supervision arrangements*



Breathing new life into your supervision

When we look back over the supervision experiences from our professional lives, we may recall some positive relationships. As a student, it may have been a particularly supportive practice educator. NQPs may have had a professional supervisor whose approach was especially encouraging, while SLTs working at bands 6, 7 or 8 may have had an inspiring supervisor they wanted to emulate. Equally, we may have had some less

positive experiences, such as infrequent supervision, no supervision at all, or supervision of a low quality. No matter our overall experiences, we will have been influenced in some way by supervision.

Some of us have been fortunate to have worked in a department, service or practice with a robust pro-supervision culture, committed to providing high-quality supervision. But others may have witnessed a philosophy of settling for what was being offered (whatever the quality or quantity), with little or no encouragement to seek alternatives. As we have developed and become more senior or specialist, we may have encountered a narrative that promoted a more diverse supervision culture or, by contrast, one that perpetuated the belief that the more experienced we are, the less supervision we need.

Whatever our experiences, we might do well to remind ourselves of the RCSLT best practice guidance (2017):

"Supervision is the formal arrangement that enables an SLT or assistant practitioner to discuss their work regularly with someone who is experienced and qualified. It is an essential component of a good quality speech and language therapy service that is able to respond to service users and identify and manage risk. Supervision is critical to the delivery of a high-quality client service through accountable decision-making and clinical practice, the facilitation of learning and professional development and the promotion of staff wellbeing.

"Although supervision is strongly associated with training at a pre-qualification level, it is equally relevant to qualified SLTs at all stages in their career as it plays a central role in the maintenance and ongoing development of their knowledge, skills and practice. [...] Both managerial supervision and professional supervision are important at all stages of your career without exception."

We invite you to pause and reflect on your supervision history and current arrangements and to use our suggestions to either validate what you have in place or consider alternative options.

Your reflections might bring to light that you:

- are working in an organisation where there is no one senior enough or working in your specialism that is a good fit for you.
- have moved away from the nhs into independent practice and have no one easily accessible to supervise you.
- want to find a supervisor outside of your organisation who can offer additional or alternative reflective space.
- find yourself in a service that does not prioritise supervision.
- value a short-term arrangement with someone in a related profession to support development in an area of growing interest.

But where do we go to find a new and different supervisor? We've pulled together some ideas to help.

We invite you to reflect on your supervision history

Peer support

Peer supervision – either 1:1 or in a group – is where two or more practitioners with similar levels of experience, or working at a similar grade, meet for professional supervision. You could find someone working in the same specialism or a different one – there are benefits to both. Peer supervision is advantageous because it's cost-neutral; it offers the chance to practise your own supervisory skills, gain honest feedback and deepen peer connections. Additionally, when peer relationships are formed across different services, it can provide insight into alternative models and approaches, which can then be applied to your own client group.

Online supervision

Online working has become a lot more popular as a result of the pandemic, creating possibilities to access people outside of your locality or even your country. This way of working widens your pool of potential supervisors, meaning you can access someone who you may have wanted as your supervisor, but who was previously inaccessible.

REFERENCES

For a full list of references visit: **rcslt.org/references**

Self-funding

Independent practitioners have to fund their own supervision (unless deciding to adopt a peer supervision model). If you are working for the NHS or another organisation, you can also choose to fund your own external supervision. Paying for your own supervision provides the freedom to find a supervisor who meets your specific needs at a given point and/or forms part of a balance of supervisors if you require more than one.

Group supervision

Group supervision is an opportunity to gather two or more people at the same or different grades, with a clear and shared focus. This group could be made up of people from one discipline or several disciplines. It may be facilitated by a supervisor, or you may take turns to facilitate within the group. Attention needs to be paid to the ratio in accordance with the RCSLT guidance (2017). Group supervision can complement 1:1 supervision.

Funding from your organisation

You may find yourself working for an organisation in which there isn't anyone suitable to provide the supervision you need. Some trusts and organisations will fund external professional supervision for you. It is always worth discussing with your senior/head of service why you might need to access external supervision and who might be appropriate.

Find a local SLT

If you are working independently, you could approach a local SLT; for example, a former colleague, someone you know who works in the NHS, an

IMAGE: GETTY

independent therapist who is known to you or who has been recommended, or alternatively someone you have made a link with via a network group such as the Association of Speech and Language Therapists in Independent Practice (ASLTIP) or a clinical excellence network (CEN).

Cross-specialism and cross-discipline supervision
As you become more experienced, you may decide that you would like supervision from a practitioner working in a different specialism, or even a different profession (a psychologist, social worker or counsellor, for example). This may be for all your supervision needs or just occasional supervision, perhaps alternating with your regular supervisor. As your career progresses, it can be helpful to widen the net to access different supervisory styles and approaches. An important consideration here is to discuss which regulatory body the supervisor is under.

Creative cost-neutral solutions
Other creative ideas include exchanging supervision services with neighbouring NHS trusts. For example, therapists can offer a block of therapy hours to gain experience in an area of specialism in exchange for a supervision session or peer supervision opportunities can be created across trust boundaries.

Duration of supervisory relationships
There are many benefits to building a supervisory relationship over the long term; however, as part of a balanced set of arrangements, it can also be useful to set up short blocks of supervision. This could be with someone who shares a particular interest to talk over specific issues or development areas.

We hope this article encourages you to take stock and reconsider your supervision needs and arrangements going forward.

We are currently developing an online register of high-quality supervisors – visit **bit.ly/3uJ9h4Q**. We welcome you to get in touch with any feedback or to share your own creative supervision practices.

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THE IMPORTANCE OF SUPERVISION

Supervision is key to health and social care governance. With reference to Regulation 18 in the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*, the Care Quality Commission (CQC) highlights that healthcare staff must receive the supervision necessary for them to carry out their role and responsibilities. SLTs are regulated by the Health and Care Professions Council (HCPC), which similarly highlights, in the *Standards for Proficiency for Practice* (2014, p8), the need for registrants to: "understand the importance of participation in training, supervision, and mentoring". Crucially, the importance of supervision in relation to practitioner self-care and public safety has become increasingly apparent throughout the COVID-19 pandemic due to the increased demands on practitioners and more lone working practices (Martin and Snowden, 2020).

The benefits of supervision are multiple and far-reaching. For practitioners, regular supervision can provide a supportive environment in which to discuss concerns and explore uncertainties, which can help to alleviate workplace pressures such as stress, anxiety and burnout. It can also improve confidence and job satisfaction by allowing individuals to reflect on achievements and affirming areas of positive practice.

Additionally, supervision can help to create a more supportive, caring and positive working environment, as it provides a space for regular communication, problem-solving and increased team working. When carried out regularly, supervision can help to build working relationships and create a culture of honesty, critical appraisal and learning across the organisation. As well as supporting staff, supervision can have a positive impact on service users by safeguarding and raising practice standards and can contribute towards increased quality of care and service outcomes.

UK SLT co-authors in international peer-reviewed book:

Dysphagia: New Advances

IQoro is increasingly being adopted by SLTs across the NHS and in independent practice. Natalie Morris, SLT and director of *The Feeding Trust CIC*, has integrated IQoro training into her clinical practice.

"I work as the director of Integrated Therapy Solutions, leading an award-winning therapy team who specialise in providing inter-disciplinary treatment for children and young people (CYP) with neuro-developmental disabilities. I am also founder of The Feeding Trust, a not-for-profit community interest company that runs a feeding clinic for CYP with paediatric feeding disorders.

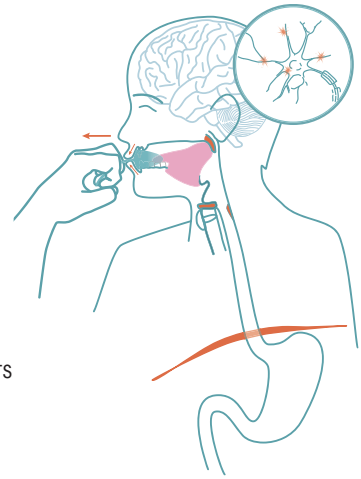
A key patient group for us is those with Cerebral Palsy (CP) who often have multiple challenges, and we have often found saliva control to be a persistent and debilitating problem. NICE guidelines for management of saliva control in CP offer few options for therapists. The only treatment options after considering compensatory strategies – such as positioning – are drug therapy or surgery. Many medications routinely prescribed for saliva control are not licensed for use with under 18's.

Exploring IQoro

The lack of alternative therapies led me to explore IQoro neuromuscular training, which had shown evidence in previous scientific studies of supporting swallowing, particularly with adults who have post-stroke dysphagia. I embarked on a practice-based evidence project, using a case series design, and this evidenced positive and encouraging outcomes for improving swallowing and saliva control when using a goal attainment scaling approach with a group of individuals with CP. I wanted to share my experience and evidence with others. I was delighted to be offered the opportunity to collaborate with renowned Swedish associate professor, Mary Hägg, who invented IQoro. Between us we authored a chapter now published in the InTechOpen scientific journal: https://www.intechopen.com/online-first/79510.

The chapter pulls together information on multiple domains relating to swallowing: the physiological stages of the swallow, how the parallel neurological processes drive them, and how neuromuscular training treats swallowing disorders. IQoro is introduced and explained as a neuromuscular training device. The evidence focusses on three internationally published studies, as well as my own case studies, and the results of a service evaluation which has been conducted by SLTs in an NHS setting in Devon.

The service evaluation was funded by the South West Academic Health Science Network and showed positive results in improving chronic dysphagia in adults with acquired swallowing disorders. Through the systematic use of IQoro as a treatment method, the SLTs achieved significant outcomes including: some patients regaining an oral diet after enteral feeding and some patients managing more challenging food textures and thinner fluids.



Neuromuscular training has shown success as a treatment option for some individuals with swallowing difficulties. Contributing to, and co-authoring, a peer-reviewed internationally published article has been a fantastic learning experience for me and I would encourage other SLTs to participate in practice-based evidence projects to evaluate their own experiences with IQoro as a therapy tool".

- Natalie Morris

IQoro is available on NHS prescription in the UK

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Fast track or routine?

Anne Pijper *and* **Marion Alston**

explore priority rating scales for service users with voice disorders

The ear, nose and throat (ENT) speech therapy department at the Royal National ENT and Eastman Dental Hospital in London has a high rate of referrals of patients with benign laryngeal and airway disorders. The department is based at University College London Hospital and has eight SLTs specialising in ENT speech therapy. It operates a closed referral system and only accepts referrals from internal ENT and head and neck surgeons.

With the increasing growth of waiting lists, prioritisation of treatment is an ever-present pressure for hospital services. It has been recognised that approaches to prioritisation can differ between clinicians and managers and that, on occasions, "clinicians [can] experience… a threat to their autonomy, to their professional ideals and to their desire to perform their job in a professional way" (Skirbekk et al, 2017).

Prioritisation should be guided by "the principles of fairness, openness, transparency and basing action on evidence" (Prasad et al, 2006) and "criteria by which priority is given to patients [should be] explicit" (Tudor Edwards, 1999).

While it is imperative to consider a multitude of factors for diagnosis and treatment of voice disorders, it is necessary to be selective when choosing what to include in a robust triage system. A priority decision must allow for an equal comparison between patients (Hutchings and Mitchell, 2021).

Bearing these aspects in mind, and based on clinical experience and departmental consensus, the following parameters have been included in the department's priority rating scale for benign voice disorders:

- ENT severity rating
- ENT diagnosis
- Patient's occupation
- Total voice handicap index (VHI) score
- Phonosurgery planned/taken place.

Scoring

Each patient referred to the department is triaged and receives a score based on the above parameters, with a possible total score of 15. For each parameter, except surgery, a rating scale of 0–3 is used. Those with an overall score of 10 or more are prioritised for assessment and seen as a matter of urgency. See table 1 for examples of ratings.

Severity: Reporting of severity of the condition corresponds with the overall GRBAS (Grade) rating of dysphonia (Hirano, 1981) where 0=normal voice, 1=mild dysphonia, 2=moderate dysphonia and 3=severe dysphonia.

Diagnosis/lesion: Diagnosis/lesion is provided by the surgeon after viewing the larynx. The allocation of a severity rating for the type of lesion or diagnosis was agreed upon by members of the ENT speech and language therapy team. Rating decisions were based on a number of factors, such as potential for speech and language therapy to effect change, timeliness of intervention, impact on the voice and desire to avert surgery.

REFERENCES

To see a full list of references visit: **rcslt.org/references**

Prioritisation of treatment is an ever-present pressure for hospital services

TABLE 1: examples of ratings

Severity	None	Mild (eg intermittent dysphonia)	Moderate (eg persistent dysphonia)	Severe (eg aphonia)
Lesion/ diagnosis	Globus Normal larynx	Chronic cough Nodules Reflux	Muscle tension dysphonia Vocal fold palsy	Inducible laryngeal obstruction Vocal fold haemorrhage
Occupation/ vocal load		Gardener Paediatric scholar Retired	Doctor/nurse/ AHP Hairdresser Sales assistant	Actor Call centre worker Teacher
Voice handicap index (VHI)	0-19	20-49	50-79	80-120
Surgery	None			Pre-op / Post-op Direct laryngoscopy +/- surgery External blunt trauma

Occupation: The impact of a dysphonia on the ability to perform a particular role has important consequences for prioritising the treatment of patients (Fritzell, 2009; Roy et al, 2004). The score is based on the patient's main occupation.

Initially, scores for certain occupations were agreed upon by department members and were heavily influenced by the perceived vocal load of the occupation. As time went on, many different occupations were added and assigned a rating based on departmental consensus. It became evident that other factors (eg loss or potential loss of earnings, psychological impact of unemployment, social isolation) should also be considered. To this end, in 2015, our department devised a questionnaire that was disseminated to voice specialists (ENTs, SLTs and voice scientists) worldwide and received 170 responses. The questionnaire aimed to obtain a consensus on ratings of the impact a dysphonia/laryngeal disorder on various work roles. The results of the questionnaire informed modifications to the scoring of the occupation category (Pijper and Alston, 2015).

Voice handicap index (VHI): Before using the current scale, prioritisation for treatment was solely based on patient perception as measured by the VHI (Jacobsen et al, 1997). All patients scoring 80 and above (out of a total 120) were fast-tracked.

Using the VHI alone as a method of prioritisation was leading to anxious patients accessing treatment prior to other patients who had valid reasons for being prioritised, but didn't have a high VHI score. It was clear that additional factors needed to be included to yield a more balanced tool, hence the incorporation of the other listed parameters.

Surgery: Patients score 0 if there is no planned surgical intervention. They score 3 if they have had, or are about to undergo, exploratory direct laryngoscopy (under anaesthetic) with or without phonosurgery. They also score 3 if they are listed for an 'in office' procedure (eg vocal fold injection).

Those who have received external blunt trauma to the larynx also receive a score of 3, regardless of whether or not they have had surgery.

We've used this scale since 2004 and it is periodically reviewed and updated. It includes both a surgeon and service user perspective and provides a documentable, accountable and transparent record of how prioritisation decisions are reached, reducing the potential for pressure being unfairly placed on the SLT by service users, surgeons or management. Departmental audit and experience have found it adaptable and robust, and we believe that it ensures we are seeing the right people at the right time.

If you would like to trial this system in your department and would like to have the full list of occupations and lesions devised in our department, please get in touch.

ANNE PIJPER, principal SLT (ENT) and **MARION ALSTON,** highly specialist SLT (ENT), the Royal National ENT and Eastman Dental Hospital
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Finding the balance

Wendy Best *and colleagues explore the importance of valuing different designs in intervention research*

At the core of speech and language therapy practice are clinical decisions about which intervention is appropriate for each person, given their goals and pattern of strengths and needs. Evidence-based practice (EBP) guidelines encourage us to look to the research literature to support this clinical decision-making. These same guidelines also provide suggestions on which kinds of research provide the 'best' evidence. Until recently, they have overwhelmingly promoted the view that the 'best' evidence comes from (high-quality) randomised controlled trials (RCTs) and the highest level of evidence has been accorded to systematic reviews and meta-analyses of RCTs.

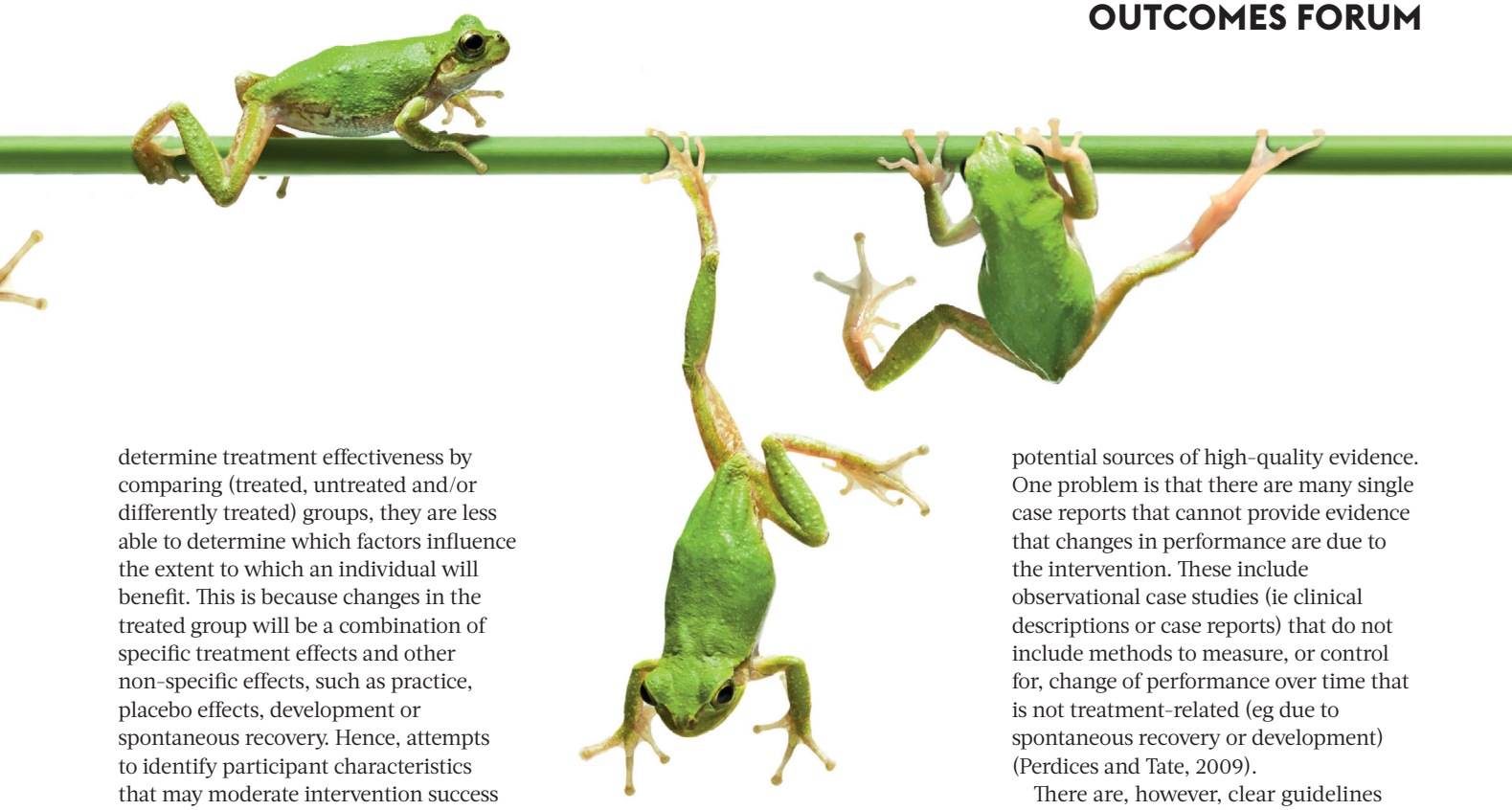
REFERENCES
To see a full list of references, visit:
bit.ly/Bulletin References

However, there have long been concerns that RCTs may not always provide all the answers (Howard, 2016). Here, we make the case for valuing evidence from well-controlled single case designs. To quote one SLT responding to a survey (reported alongside fuller exploration of RCTs and single case experimental designs in Best et al, 2019):

"I think SLTs should take more confidence in the single case study design as a useful research tool. I find this research evidence more informative as it translates more readily into clinical practice."

Importantly, and inherent in their design, the outcomes of RCTs apply to groups rather than individuals. Even if an intervention shows a significant benefit in an RCT, this is only true on average: not every individual in the group may benefit. Hence, while another 'acceptably similar' group may also benefit on average, an individual client cannot be guaranteed to improve (eg Cohen et al, 2004). This is problematic particularly when there is heterogeneity in the disorder, as in many health conditions, including communication disorders. For example, in research into trigger profiles for migraine, analysis of individual profiles (n-of-1 analysis), rather than the group average, revealed a high degree of inter-individual heterogeneity: the percentage of patients with unique trigger profiles was high (74%) and therefore the group average profile was not applicable to the majority of individuals with migraine (Perris et al, 2016).

Returning to intervention; because RCTs



determine treatment effectiveness by comparing (treated, untreated and/or differently treated) groups, they are less able to determine which factors influence the extent to which an individual will benefit. This is because changes in the treated group will be a combination of specific treatment effects and other non-specific effects, such as practice, placebo effects, development or spontaneous recovery. Hence, attempts to identify participant characteristics that may moderate intervention success in an RCT is limited because individuals are likely to be influenced by confounding factors to different degrees. Furthermore, the comparison/control conditions used influence the conclusions that can be drawn.

Single case experimental designs

Within medicine, these problems in identifying individual patterns from RCTs have led to the suggestion that, in order to determine the effectiveness of intervention for an individual, single case investigations are required. Moreover, it has now been recognised that evidence of the highest strength can be obtained at the level of the individual with appropriate methodology. The Oxford Centre for Evidence-Based Medicine (2011) places systematic reviews of randomised trials or n-of-1 trials at the top of the hierarchy of evidence for an intervention's effectiveness. Additionally, the new Medical Research Council framework for developing and evaluating complex interventions (Skivington et al, 2021) highlights the importance of going beyond whether an intervention works to consider wider questions including the context and resources.

This research should be considered a key source of high-quality evidence in its own right

In our field, there are many well-conducted intervention studies that use single case experimental designs (SCEDs). We use the term SCED broadly to encompass different designs that maintain experimental control in a single case or case series intervention study (eg Howard et al, 2015; Rvachew and Matthews, 2017).

Given the characteristics of RCTs outlined – particularly the lack of ability to predict an outcome for an individual – it is unclear why SCEDs remain overlooked as potential sources of high-quality evidence. One problem is that there are many single case reports that cannot provide evidence that changes in performance are due to the intervention. These include observational case studies (ie clinical descriptions or case reports) that do not include methods to measure, or control for, change of performance over time that is not treatment-related (eg due to spontaneous recovery or development) (Perdices and Tate, 2009).

There are, however, clear guidelines regarding SCEDs that enable investigators to be confident that changes are due to the intervention (eg Franklin, 1997; Howard et al, 2015; Rvachew and Matthews, 2017). Designs include, for example, crossover, multiple-baseline and withdrawal/reversal. Importantly, they monitor changes in performance across structured intervention and no-intervention phases and treated and untreated items or tasks. While there is no control group, each participant acts as their own control, with replication within participant. The designs enable us to establish a causal relationship between intervention and response in each participant (Rvachew and Mathews, 2017). Furthermore, results from SCEDs can be combined to provide insights as informative as those from systematic reviews of RCTs (eg Sze et al, 2020) and can be included in meta-analyses (eg Roberts and Kaiser, 2011).

Findings from SCEDs are sometimes criticised on the grounds of limited generalisability to other individuals. However, they can enable exploration beyond whether the treatment works, to why it works. Specific hypotheses can be made regarding the 'active ingredients' of

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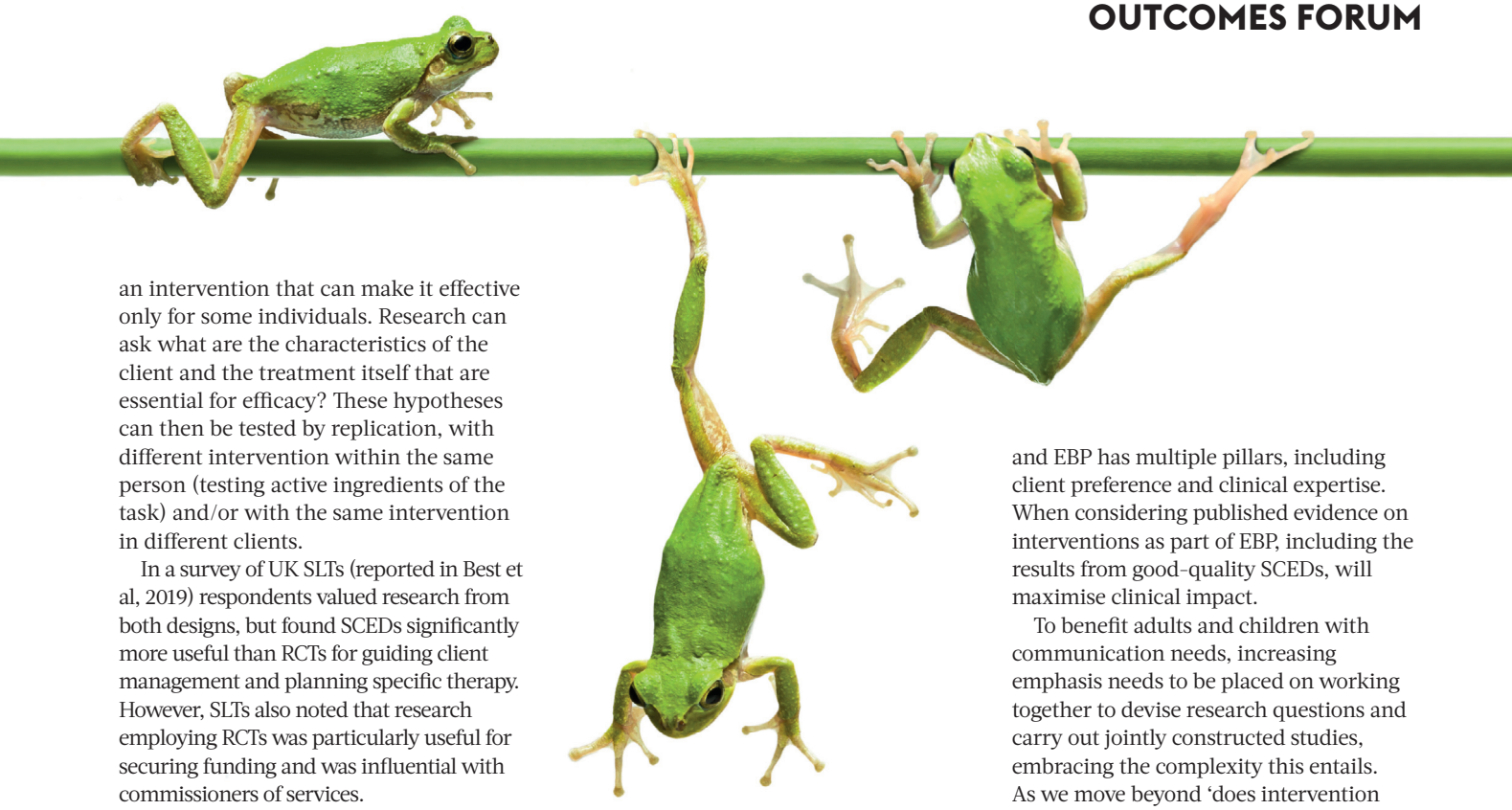
TABLE 1: A comparison of RCT and SCED research designs for evaluating the effectiveness of interventions with people with communication disorders (adapted from Best et al, 2019).

Research design issue	Randomised controlled trials - group RCT.	Experimentally controlled case series/single case designs – SCEDs.
Scientific/ clinical understanding	Widely accepted as 'gold standard'. Range of well-established designs and analyses.	Less well understood. Range of designs and analyses available.
Experimental control	Established through a control group. The similarity between control and intervention conditions affects the conclusions that can be drawn.	Established in several ways, eg, baseline testing, control items, modalities or tasks. Participants act as their own control.
Comparison of effectiveness between interventions	Comparisons are usually between groups, e.g., intervention group type 1, intervention group type 2 and control group.	Comparisons are made across phases of treatment/no treatment/different treatments, and/or treated/untreated items, within an individual or across a case series, allowing specific conclusions about appropriate intervention(s) for an individual.
Applicability to individual participants	If a significant difference is found, this is in the group average; the intervention may not benefit all those who are treated.	Findings are applicable on a case-by-case basis. Results are analysed for each participant separately.
Detailed profiling	Usually not possible, given group size necessary for a fully powered study and cost.	Use of in-depth assessment to profile participants communication needs and strengths is feasible and common.
Generalisation to others	Findings are generalisable to others who meet the entry criteria for the study. As the findings are based on group means, they may not generalise to a specific individual.	Findings apply to those included in the study. Replication may extend the results to others with similar communication profiles.
Heterogeneity	Variability inherent in communication disorders means identifying relevant variables and matching groups can be problematic. Heterogeneity may be statistically addressed by using large samples.	Variability inherent in communication disorders and in intervention outcomes can be exploited to allow conclusions linking outcome to the nature of individual profiles across case series of intervention studies.
Selective reporting and publication bias	Some variability: null outcomes have been reported. Risk of bias scales increasingly used.	Potential for vulnerability in SCED studies. However, null findings for an approach or individual often reported in the context of a comparison between approaches/individuals.
Random assignment	Participants are randomly assigned to different groups, a requirement for good RCTs.	Randomisation is important and achieved in various ways, e.g., items may be randomly assigned to intervention and control conditions, intervention order may be randomly assigned.



an intervention that can make it effective only for some individuals. Research can ask what are the characteristics of the client and the treatment itself that are essential for efficacy? These hypotheses can then be tested by replication, with different intervention within the same person (testing active ingredients of the task) and/or with the same intervention in different clients.

In a survey of UK SLTs (reported in Best et al, 2019) respondents valued research from both designs, but found SCEDs significantly more useful than RCTs for guiding client management and planning specific therapy. However, SLTs also noted that research employing RCTs was particularly useful for securing funding and was influential with commissioners of services.

Table 1 (left) summarises and contrasts some key strengths and weaknesses of RCTs and SCEDs. Clinicians should always be aware that peer review is not infallible. Poor-quality studies of both types still appear in the literature and claims that go beyond the strength of the data or design are common.

So, where does this leave us? A clinically informative research question is 'what works for whom and under which conditions?' We suggest that a SCED-case series is well able to answer this through systematic investigation of the effectiveness of treatment, and variability in outcomes, across a series of individuals, with detailed profiling of clients' strengths and difficulties. This research should be considered a key source of high-quality evidence in its own right, rather than a stepping-stone on the way to an RCT. SCEDs can provide a window on causal relationships between intervention and response in each participant.

To be clear, RCT research is, and will continue to be, crucial. Well-conducted RCTs can provide useful evidence and this design will certainly continue to be influential for policy and practice. There are now studies that use RCTs with designs that also enable full analysis at the level of the individual (as in design 9 in Ebbels, 2017, eg Best et al, 2021; Smith-Lock et al, 2015).

To benefit adults and children with communication needs, increasing emphasis needs to be placed on working together

Our aim is to question the automatic supremacy of RCTs and encourage researchers, clinicians, policy-makers and funders to value other approaches to establishing clinical efficacy, especially well-designed SCEDs. The clinical decision-making of SLTs is multifaceted and EBP has multiple pillars, including client preference and clinical expertise. When considering published evidence on interventions as part of EBP, including the results from good-quality SCEDs, will maximise clinical impact.

To benefit adults and children with communication needs, increasing emphasis needs to be placed on working together to devise research questions and carry out jointly constructed studies, embracing the complexity this entails. As we move beyond 'does intervention work?' and the limitations of RCTs become more widely understood and acknowledged, we need to be equipped with a range of evidence that is clinically informative including building a shared understanding of how positive, intervention-induced change can occur and which intervention components are key to that change for those with different communication profiles.

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Member benefits

The RCSLT awards grants to members to benefit the profession and boost CPD. **Victoria Harris** takes a look at what's involved

The RCSLT offers minor grants to its members of up to £800 that are aimed at benefitting the profession as a whole or enhancing members' own professional development. The grants are awarded three times a year by the Minor Grants Panel, which comprises RCSLT committee members and staff. In addition, the Catherine Renfrew Grant of £600 for overseas travel is awarded biennially by the RCSLT. The Catherine Renfrew award was paused in 2021 due to Covid travel restrictions, with the plan to award in 2022 and 2023 consecutively if travel remains open.

Minor grants

Minor grants awarded to support an individual's continuing professional development (CPD) can be used in a variety of ways. Examples include:

- attending conferences and professional gatherings.
- certain specialised training, particularly short courses.
- research into speech and language therapy.
- the purchase of specified equipment and/or books (normally to a maximum of £100).

In 2022 the grant level was increased to £800

You can use minor grants across the four pillars of practice: clinical, research, leadership and education. The RCSLT may decide to meet applications in full or in part (to a maximum of £800). This may depend on the number and quality of applications received.

Recent improvements

In 2020, the Minor Grants Panel streamlined the grants application process for members and updated the application form. Scoring criteria were also introduced for the panel (which is available to applicants to ensure transparency, see **bit.ly/3RoxM0n**). Application forms are now anonymised when they are sent to panel members to rule out any potential bias.

In April 2022, the grant level was also increased from £500 to £800 to reflect the reality of higher costs.

Minor grants: deadline for applications 2022/23
13 October 2022
24 February 2023
16 June 2023
13 October 2023

Catherine Renfrew Grant

This award honours the memory of Catherine Renfrew (1901-2002), who worked as an ambassador to the profession by raising the profile of speech and language therapy around the world. Catherine's overseas travel meant a great deal to her and enabled her to forge many friendships and connections.

This award gives an SLT the opportunity to follow in her footsteps by networking internationally and broadening the horizons of speech and language therapy.

The award of £600 (recently increased from £500) can be used to help fund a visit to a course or conference outside the UK and outside the therapist's country of employment. It aims to help the continuing professional development of the SLT, enabling them to forge links worldwide and share information with the global speech and language therapy community.

The award winner has to have been an RCSLT member for two years prior to application, and for a year after the funded trip takes place.

Catherine Renfrew Award: deadline for applications 2022/23
13 October 2022
13 October 2023

More information on applying for RCSLT grants, along with application guidance and upcoming deadlines, can be found at **bit.ly/RCSLTgrants**

VICTORIA HARRIS, RCSLT head of learning
victoria.harris@rcslt.org

MINOR GRANTS: CASE STUDIES

Anne-Marie Anderson was awarded a grant for CPD in education

I'm very grateful to the RCSLT for a £500 grant. I used the grant to partially fund my first module in an e-postgraduate certificate in professional and higher education at Queen Margaret University, Edinburgh. The module focused on assessment for learning and comprised three units: assessment for learning, feedback and leadership.

I work as an SLT in a community hospital for NHS Ayrshire and Arran, a clinical tutor at the University of Strathclyde, and I'm currently on secondment as an AHP practice education lead for NHS Education Scotland. The module benefitted me in all three roles.

I have used my new knowledge and skills to improve my feedback to students and discuss with students how they can learn from assessment for learning techniques (eg self-assessment, reflection, peer feedback). I have evaluated my tutorial and student practice educator sessions following these changes and students have responded positively. I have also reflected on my leadership in education and this has allowed me to recognise and develop my leadership skills, in my NHS Education Scotland role in particular. An unexpected benefit of this course is developing creative methods of delivering education. I can now use the graphic design platform Canva to design posters and materials for Twitter.

I found the process of applying made me consider in depth not only what the study was going to achieve for me personally, but also how it was going to impact my practice and benefit the profession. I would advise prospective applicants to set aside some time to look over the form and gather the necessary additional information that may be required before beginning the application process.

Laura Mizzi was given a grant towards a leadership course

A minor grant from the RCSLT meant that, alongside three other sources of funding, I was able to complete my master's degree in leadership in health and social care.

In terms of applying, I would suggest that applicants read the guidelines in advance of completing their application form. My experience of sitting on the Minor Grants Panel was that it could be quite frustrating when people didn't take the time to follow the guidelines. We're all volunteers on the panel, and it meant our jobs were made harder as it took us longer to read each application.

Grants are a benefit of your RCSLT membership to help with your CPD. Have a think about what you could do with a grant and give it a go – you never know what the outcome might be, and don't take this member benefit for granted!

COURSE LISTINGS

Elklan Total Training Packages: SLD
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Cost: £510 pp ex. VAT
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michelle@elklan.co.uk
www.elklan.co.uk/Training/Tutors/#Tutor

The SHAPE CODINGTM system: Part 1
13 October, self-paced online course
Designed to teach spoken and written grammar to school-aged children with developmental language disorder (DLD). Three accredited courses are available for SLTs and those working within education.
Tel: 07557 440603
training@moorhouseinstitute.co.uk
www.moorhouseinstitute.co.uk/courses

Elklan Total Training Packages: Vulnerable Young People
14-20 October, 2-5pm, online
Cost: £510 pp ex. VAT
These courses equip SLTs and teaching advisors to provide accredited training to practitioners in a range of settings. Each Total Training Package covers all you need to run the course.
michelle@elklan.co.uk
www.elklan.co.uk/Training/Tutors/#Tutor

Elklan Specialist Training Package: Supporting Children and Adults using AAC
4, 11 and 18 November, 9am-12.30pm, online
Cost: £235 pp ex. VAT
This course equips SLTs to provide accredited training to staff supporting users of AAC, including power-based and person-based communication aids. It covers all you need to run the course, 'Supporting Children and Adults using AAC'. Presented by the author Andrea Lee.
michelle@elklan.co.uk
www.elklan.co.uk/Training/Tutors/Specialist_Training_Pack_-_AAC

The SHAPE CODINGTM system – Practical Applications
17 and 24 November 2022 or 18 and 25 May 2023, online
Designed to teach spoken and written grammar to school-aged children with developmental language disorder (DLD). Three accredited courses available for SLTs and those working within education.
Tel: 07557 440603
training@moorhouseinstitute.co.uk
www.moorhouseinstitute.co.uk/courses

Elklan Total Training Packages – ASD
18-24 November, 9am-12pm, online
Cost: £510 pp ex. VAT
These courses equip SLTs and teaching advisors to provide accredited training to practitioners in a range of settings. Each Total Training Package covers all you need to run the course.
michelle@elklan.co.uk
www.elklan.co.uk/Training/Tutors/#Tutor

Elklan Total Training Packages: Various ages
0-3s: 18-24 November, 2-5pm
5-11s: 6-12 January 2023 and 17-23 March 2023, 2-5pm
11-16s: 3-9 February 2023, 2-5pm
3-5s: 3-9 March 2023, 2-5pm
Post-16s: 3-9 March 2023, 2-5pm
Cost: £510 pp ex. VAT
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A 0-3s top-up day, for tutors who have completed the 3-5s TTP, will be help on 10 March 2023, 9.30am-4.30pm (£250 ex. VAT).
michelle@elklan.co.uk
www.elklan.co.uk/Training/Tutors/#Tutor

Elklan Total Training Packages – Complex Needs
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Cost: £510 pp ex. VAT
These courses equip SLTs and teaching advisors to provide accredited training to practitioners in a range of settings. Each Total Training Package covers all you need to run the course.
michelle@elklan.co.uk
www.elklan.co.uk/Training/Tutors/#Tutor

Adult Dysphagia Training –Theoretical Course
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1 week intensive course for SLTs working on dysphagia competencies to provide theoretical knowledge in assessment and management of adults with dysphagia.
4 days theory, 1 day practical – inpatient setting.
Contact: Annie Byrne-Stevens or Jess Sin.
Tel: 0207 288 5546
annie.byrne-stevens@nhs.net
Jessica.sin@nhs.net

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19 and 26 January 2023 or 15 and 22 June 2023, online
Designed to teach spoken and written grammar to school-aged children with developmental language disorder (DLD). Three accredited courses available for SLTs and those working within education.
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www.therapy-links.co.uk/training

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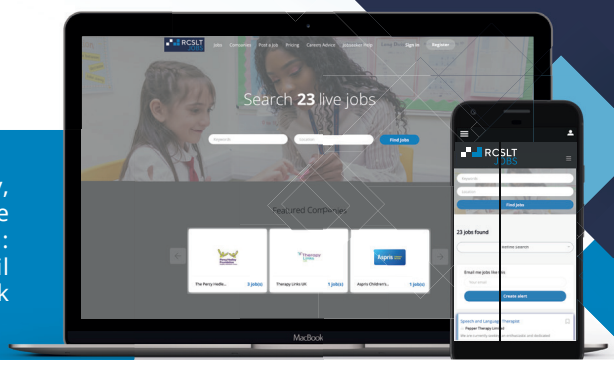

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Susie WILLIAMS

Specialist SLT (stroke)

Hello, my name is Susie. I lead the speech therapy team on the stroke unit at Ipswich Hospital.

Ever since I was a student SLT, I've been interested in academic research. When I graduated, I threw myself into clinical work, as I enjoyed working with patients and families. I always tried to base my practice on the best available evidence but found myself asking clinical questions for which there weren't always clear academic answers. I thought that the door to a research career had closed: I wasn't in a position to give up work and self-fund a PhD. But then I discovered it was possible to train as a clinical academic, completing research alongside and inspired by my clinical work.

> **I discovered it was possible to train as a clinical academic**

I applied for a Health Education England/National Institute for Health Research integrated clinical academic internship, which funded release time so I could complete 48 days of study leave. During this time, I completed a 20-credit module in research methods at the University of East Anglia. I learnt about qualitative and quantitative research, critical appraisal, and how research can be applied to clinical practice. I also completed a scoping review examining the academic literature in my area of interest (aphasia), where I successfully identified research gaps.

The rest of the time was flexible. At first, this was daunting, but I quickly identified learning opportunities. I used the time to attend inspiring online conferences and apply for the British Aphasiology Society (BAS) Special Award for Jargon Aphasia to research the support needs of carers of people with jargon aphasia. I was matched with a mentor, Sarah Northcott, who helped me to form my ideas into action, while the other allied health professionals on the internship provided me with peer support. My manager, team and the hospital library also offered useful advice and encouragement. I reached out by email to academics, who have been universally warm and supportive.

Completing the internship alongside my clinical work during the pandemic had its challenges. The internship was paused for three months when the pandemic was at its height and all the content was delivered online, which allowed me to study flexibly. Getting the balance right between direct clinical work, managerial work and research is something that I will work on going forward.

My funding application for the BAS Special Award was successful and I'm now working on my first primary research study. I'm being supported by academics I met during the internship and supported by my trust. I've also started a Pre-Doctoral Clinical Academic Fellowship to continue my research journey and answer some more of those burning questions.

susie.williams2@esneft.nhs.uk
@SusieWSLT

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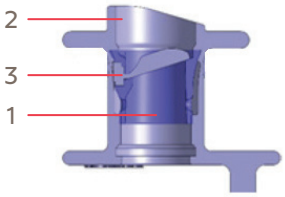

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Dharinee HANSJEE

Senior lecturer and programme lead

At the time I started considering a career in speech therapy in 1980s apartheid South Africa, the degree was gradually being opened to non-white candidates. The university took on their first Black students for the programme the year I joined.

On completing my degree, the country was going through political unrest. I took a job at a hospital in Soweto, which was not only a violent place to work, but also the largest hospital in the Southern Hemisphere at that time, with a 3,000-bed unit. I worked with parents and children in language workshops and cleft palate clinics, saw adolescents for stammering, did neuro and stroke assessments, and fitted hearing aids. My time at this hospital was a humbling, inspiring and culturally rich experience.

> I was grateful for my spiritual upbringing

In 1998 my husband and I decided to spend some time abroad. We landed in England on a bitterly cold day, and I began locuming in NHS trusts and schools, assimilating to the new culture, processes and systems. I was grateful for my spiritual upbringing and for learning meditation at a young age, which brought moments of calm during this time.

My first substantive role was in Bath at a brain injury unit, and I worked in both speech and language therapy and audiology in quaint country hospitals and community establishments all around Somerset. I was used to being the only person of colour at local SLT meetings but was comfortable in my own skin.

We moved to London in 2006, where I worked on a stroke unit and developed an interest in advocacy. In 2009 I started my leadership journey, with a master's in Advanced Practice Leadership at King's College London. But finding roles was a challenge. I was working as a clinical lead but couldn't get on to the next step of the management ladder.

As senior leadership positions were proving difficult to find, I added to my career pathway by taking on a Care Quality Commission specialist adviser role, guest lecturing, and research activity. Over the years, I saw the cumulative benefit these additional roles had on my clinical practice.

During the pandemic, I found that running and taking time to replenish the spirit helped me to balance work and family life. I also took on a part-time senior lecturing position at the University of Greenwich, while continuing to work in the NHS.

The increased focus on equality and diversity following the death of George Floyd was a poignant moment for me. I joined the RCSLT anti-racism subgroup for higher education institutions to help move this agenda forward. There is significant learning to glean from the global SLT community. When there is cultural humility, there is greater understanding of the barriers and enablers and, as a profession, we have a long way to go, but we are transitioning.

I'm delighted to now be the programme lead for the speech and language therapy BSc offered by the University of Greenwich and Canterbury Christ Church University, and remain deeply grateful for opportunities to influence and develop our profession.

d.hansjee@greenwich.ac.uk
@DharineeHansjee

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Anne, Lead SLT Sure Start, Belfast

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In Memory

Bulletin *remembers those who have dedicated their careers to speech and language therapy*

Anne Coburn
1943–2021

Anne was a much-loved friend and colleague who worked for more than 25 years as a paediatric SLT. Born in London, Anne studied at Brunel University before training at the National Hospital's College of Speech Sciences. Anne joined us in Ealing in 1989 as the clinical lead for the early years team, staying until her retirement in 2008. Her compassion for families, children and staff meant that she was well-liked and respected by everyone she worked with. Retirement brought her new adventures: Anne travelled the world and enjoyed a busy social life. Her motto, "Look after your health, your family and then you can do a good job", seems even more relevant than ever.

KAREN BENEDYK and **AMI MATHU**

Mary Cordle
1949–2021

Mary began her career in 1970, developing expertise in AAC and dysphagia, and authoring a publication for carers of children with cerebral palsy. An enthusiastic SLT, Mary was innovative, open to discussion, and generous in sharing knowledge. In the 1980s, she worked in Birmingham with children with complex needs before taking a break to raise her children. From 2000 to her retirement in 2009, Mary worked in the child development centre at Walsall Healthcare NHS Trust, where she was a wonderful ambassador for the department and the profession. Friends and former colleagues were greatly saddened by her death and our thoughts are with her husband, children and grandchildren.

HEATHER HALLETT

Anne Lowry
1937–2021

Anne was universally acknowledged as a wise and special SLT and manager. For many years she was the sole SLT on the island of Jersey, having arrived in the early 1960s from Belfast via Leicester, where she trained. Setting up the service in Jersey from scratch, Anne held the entire caseload for the adult and paediatric population of the island. She quickly earned the respect of colleagues and grew the team into a large, diverse service, which she managed until retirement in 1999. Anne was always able to put people at ease with her intuition, genuine interest and Irish charm. After retiring, she continued to work as a bereavement counsellor. Unshockable, kind and never judgmental, she will be sorely missed.

JENNIFER SHORT

Maria Farry
1947–2022

A wonderful friend and colleague: small in stature, big of heart, kind, thoughtful, loyal, courageous and tenacious. Proud to be an SLT, Maria was fully committed to the development of the independent sector of the profession. She was the driving force behind the formation of ASLTIP in 1988, with the aim to support therapists working independently and ensure high standards in the sector. In 2006, Maria was awarded an RCSLT Honours Award for her contribution to the profession. In her memory, ASLTIP has created the 'Maria Farry Award for Outstanding Contribution to SLT'. She will be sadly missed.

JOAN HADDICK, GERALDINE WOTTON and **ASLTIP COLLEAGUES**

In the journals

Nonverbal oro-motor exercises

This study aimed to determine if nonverbal oro-motor (NVOM) exercises are an efficient intervention for articulation difficulties.

The 122 participants were typically developing 4-year-olds. All participants were assessed at baseline to determine the number of 'non-produced sounds', and designated as having 'moderate' or 'severe' difficulties based on this number. Each category was then evenly distributed across the control and experimental groups. The experimental group received 30-minute interventions in small groups, twice a week for three months, using 20 NVOM exercises.

On re-evaluation, both groups showed fewer non-produced sounds, but there was no statistically significant difference between the groups. Similarly, there was no difference identified between the two groups in analysis of different phonemes or in relation to the severity of the articulatory difficulty.

The authors conclude their results "indicated that these exercises are not useful for the acquisition of sounds in typical speech development" and they suggest that "some interventions in speech therapy are based more on tradition than on scientific foundation and should be reconsidered".

DR ANNE BREAKS, consultant SLT, Evelina London Children's Hospital

Parra-López, P., Olmos-Soria, M. and Valero-García, A.V., 2022. Nonverbal Oro-Motor Exercises: Do They Really Work for Phonoarticulatory Difficulties? *International Journal of Environmental Research and Public Health*, 19(9), 5459.

Therapy allocation and funding for DLD

This study reports findings from a survey by a European Union network that explored differences in service delivery and the funding of speech and language therapy services for children with developmental language disorder (DLD).

The survey was completed by 5,024 participants across 39 European countries. Further analysis into the use of direct, indirect and mixed interventions, and their relationship to funding available (public, private or mixed) was carried out.

The results revealed that direct therapy was the most widely applied model in most countries for children with DLD, and there were more cases than expected receiving private funding. For indirect therapy, fewer than expected received private funding and more than expected received public funding. For mixed therapy, fewer cases than expected received private funding.

The authors discussed their findings and concluded, "it is not simply the type of funding which matters but also the health, educational and care context within which the therapy is delivered". And further, that factors other than evidence-based practices, practitioners' experience and patient preferences drive choices in therapy. More research is needed to gain a better understanding of factors affecting the choice of therapy.

LAUREN FLANNERY, SLT and lecturer, University of East Anglia

Knudsen, HBS et al (2022) Allocation and funding of Speech and Language Therapy for children with Developmental Language Disorders across Europe and beyond. *Research in Developmental Disabilities*, (121), 104139

Narrative discourse in aphasia

This study suggests it is beneficial to measure thematic units in spoken discourse analysis.

Seventeen bilingual (French-Canadian) individuals with aphasia completed the spoken picture description from the Western Aphasia Battery at three time periods following their stroke: 0 to 72 hours (acute phase), 7 to 14 days (subacute phase) and 6 to 12 months (chronic phase).

The participants had various types and severities of aphasia. Their descriptions were analysed in terms of thematic informativeness (number of thematic units (TUs), number of TUs per minute and number of TUs

This section highlights recent research articles that are relevant to the profession. Inclusion does not reflect strength of evidence or offer a critical appraisal. Your own critical appraisal is advised when following them up.

Get help navigating and understanding research papers from the e-learning module 'Research under the spotlight', designed specifically for RCSLT members and accessed via **rcsltcpd.org.uk**.

A journal club is a great way to get together with other professionals to consider evidence relevant to your practice. CAHPR has some top tips for making this a success: **bit.ly/3OYTpCk**.

Repetitive transcranial magnetic stimulation

A meta-analysis investigating the efficacy of repetitive transcranial magnetic stimulation (rTMS) found that it can effectively accelerate the improvement of swallowing function in patients with post-stroke dysphagia.

The review was designed and implemented based on the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) guideline. The databases of MEDLINE (PubMed), Cochrane Library, Embase, Web of Science, CNKI and Wangfang were searched for randomised controlled trials (RCTs) of rTMS to treat dysphagia after stroke.

After screening and assessment, 11 RCTs involving 463 patients met the inclusion criteria for meta-analysis. This analysis demonstrated a significant effect for rTMS on post-stroke dysphagia when combined with traditional swallowing exercises.

A more significant improvement was seen with increased stimulation frequency, though the authors caution of a need for more RCTs in this area in particular. No significant difference was observed based on stimulation site (affected vs unaffected hemisphere or bilateral stimulation).

The authors conclude that, "overall, rTMS can effectively promote the recovery of swallowing function in patients with post-stroke dysphagia".

SONIA MALLON, acting stroke lead, Hywel Dda Health Board

Wen, X et al (2022) The Effectiveness of Repetitive Transcranial Magnetic Stimulation for Post-stroke Dysphagia: A Systematic Review and Meta- Analysis. *Frontiers in Human Neuroscience*. 16:841781

per utterance), as well as a number of microstructural variables, such as mean length of utterance (MLU), number of words per minute and percentages of semantic and phonological errors. Findings included positive correlations between TUs and MLU in the acute phase and a general language impairment severity measure in the acute and chronic phases. The authors consider that TUs are quick to score and can capture long-term changes in abilities. They consequently suggest that "thematic informativeness... constitutes an interesting path to explore as a routine clinical evaluation".

RACHEL CLARE, SLT

Brisebois, A et al (2022) A longitudinal study of narrative discourse in post-stroke aphasia, *Aphasiology*, 36:7, 805-830

NEW: inclusive practice journals roundup

A new regular feature on the RCSLT website has been launched, comprising summaries of three key research papers relevant for the profession on topics related to anti-racism, equality, diversity and inclusive practice. Summaries are accompanied by a short commentary and considerations of the implications of the research.

The first instalment summarises the following articles:

- Ricks, TN et al (2021) Undoing Racism and Mitigating Bias Among Healthcare Professionals: Lessons Learned During a Systematic Review. *Journal of Racial and Ethnic Health Disparities*.
- Sim, W et al (2021) The perspectives of health professionals and patients on racism in healthcare: A qualitative systematic review. *PLoS ONE*, 16(8): e0255936.
- Yu, B et al (2022) Making Race Visible in the Speech, Language, and Hearing Sciences: A Critical Discourse Analysis. *American Journal of Speech-Language Pathology*, 31, 578–660.

Implications include the need for all SLTs to be aware of unconscious bias and unchecked racism in practice and policy. Furthermore, critical appraisal and careful evaluation of training materials and professional standards would be a valuable exercise, to ensure the profession is acknowledging issues of racism and avoids alienating professionals of colour.

Read the first instalment at: **bit.ly/3Jijzix**

Contact **katie.chadd@rcslt.org** to get involved.

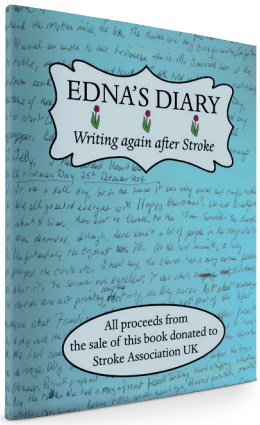
Book reviews

Books and resources reviewed and rated by *Bulletin* readers

✪✪✪✪

Edna's Diary: Writing again after stroke

AUTHOR: Edna Miles
PUBLISHER: Sam & Sam Cambridge, 2021
PRICE: £5.00



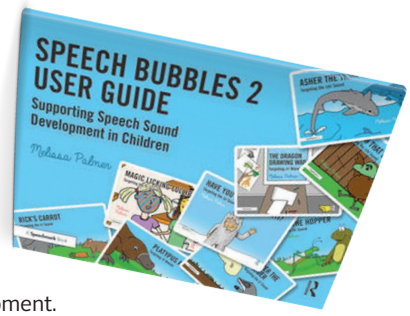
Edna's Diary is a charming collection of diary entries that beautifully demonstrate that wit and charm supersede the devastating effects of a stroke. The book works as an inspiration to any stroke survivor and should be shown to anyone struggling with the rehabilitation marathon that lays before them. Edna writes about the mundane intricacies of everyday life, making the reader laugh out loud with her portrayals of her friends and family.

SONIA MALLON, stroke specialist SLT, Hywel Dda Health Board

✪✪✪✪✪

Speech Bubbles 2 (Picture books and guide)

AUTHORS: Melissa Palmer
PUBLISHER: Taylor and Francis, 2021
PRICE: £49.99



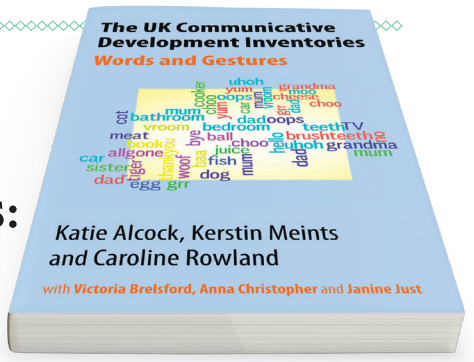
Melissa Palmer's books are a handy, easy-to-use tool for SLTs or families working on speech sound development. There is a very accessible user guide and a set of engaging stories with eye-catching illustrations that are suitable for use in-clinic or for homework tasks. I have been using the books in-clinic recently as an auditory bombardment activity with some reluctant participants who have responded well, moving swiftly from listening to the stories to making consistent attempts at the target sounds. A good addition to any community clinic.

ALEX WORMALL, specialist SLT

✪✪✪✪

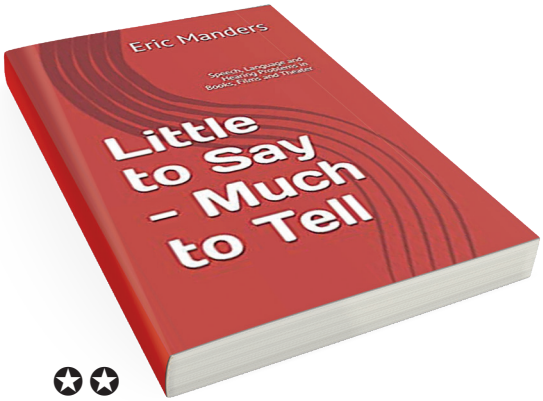
The UK Communicative Development Inventories: Words and Gestures

AUTHORS: Katie Alcock, Kerstin Meints and Caroline Rowland
PUBLISHER: J&R Press, 2020
PRICE: £24.99



This book describes the development of an inventory of words and gestures used and understood by children aged eight to 18 months learning British English in a monolingual environment.
The list can be photocopied from the book or a download accessed via a link in the book. Many families would be able to complete this independently or could be supported to access the information. Norms are available for parent report of use of gestures, comprehension and production of single words.
It was interesting to read about the process of the development of the questionnaire and inventory. This could be a useful adjunct to the assessment of young children's early communication development.

SALLY MORDI, SLT, clinical lead for autism, Barnet, Enfield and Haringey Mental Health NHS Trust



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Little to Say – Much to Tell: Speech, Language and Hearing Problems in Books, Films and Theater

AUTHOR: Eric Manders
PUBLISHER: Independent Publishing, 2021
PRICE: £14.48

This book is essentially a compilation of books, film and theatre productions that portray communication difficulties. It is divided into chapters focusing on specific types of difficulties, including aphasia, stuttering, mutism and deafness.

It is not clear what the purpose of the book is or who it is aimed at. Each book or film listed is described but there is very little evaluation or critical comment given. There is a short concluding chapter which highlights that the portrayal of communication difficulties in the media can be both negative and positive, and that some of these publications can provide a useful tool to help in improving understanding of communication difficulties.

I think the main value of this book is in using it as a reference list for further reading, either for increasing your own insight or to support those you work with. For example, there are several children's books listed which may be a valuable resource for those working with children and young people. There is also an extensive list of books and films focusing on dysfluency, which could potentially provide a basis for further exploration and discussion within a therapy context.

JENNY TAYLOR, specialist SLT, NHS Ayrshire and Arran

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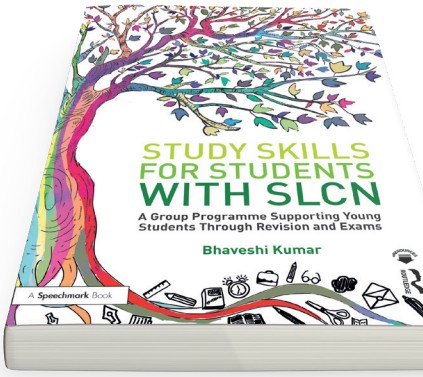
Study Skills for Children with SLCN

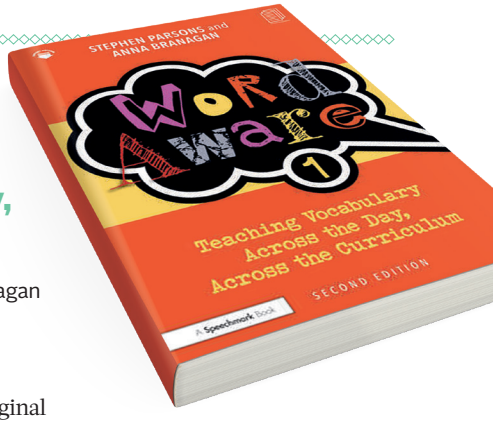


AUTHOR: Bhaveshi Kumar
PUBLISHER: Speechmark Books; Routledge, 2020
PRICE: £20.99

This is a resource aimed at supporting students with speech, language and communication needs (SLCN) to learn how to study. Learning how to study is a complex skill and it's very positive to see a resource tackling this.

The book is practical and contains background information and 10 well-defined study sessions, complete with resources and worksheets. It will be useful for primary-aged children, and could be adopted to cover those in secondary education. While the book contains lovely resources and ideas, imagination and innovation are needed to deliver it in an engaging way and compete with the computerised resources many children are used to.

LAUREN DRAKE, highly specialist SLT



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Word Aware 1: Teaching Vocabulary Across the Day, Across the Curriculum

AUTHORS: Stephen Parsons and Anna Branagan
PUBLISHER: Routledge, 2022 (2nd edition)
PRICE: £35.99

Word Aware 1 is a revised edition of the original *Word Aware* book, including updated online resources. It can be read alongside *Word Aware 2* (early years) and *Word Aware 3* (teaching vocabulary in small groups), which may be the most useful tool for teaching assistants to use. *Word Aware 1* takes a much broader look at vocabulary learning, focusing on a whole-school approach. While it's been written for the primary age range, it can be adapted and used with older children with significant needs.

This book is aimed at literacy coordinators, SENCos and SLTs and offers a great combination of practical activities and a robust evidence base for each stage of vocabulary learning. Resources cover getting excited about words, moving on to teaching words and, finally, independent word learning.

There is a focus on implementing this in the classroom at all ages and curriculum areas, alongside working closely with families to reinforce the importance of vocabulary learning at home. It's clearly been tried and tested in a range of schools, with helpful, detailed examples included of the impact this approach has had for vocabulary learners. Its written style reignites the passion that we all, as a profession, have for word learning.

SONIA SIVYER, highly specialist SLT and lecturer

Where next?

Want to delve further into the topics explored in this issue? We've compiled a list of related RCSLT guidance and resources to help you deepen your understanding

Get involved

No matter your role, area of expertise or time commitments, there are plenty of ways to get involved with the RCSLT's work:

- Establishing an LGBTQIA+ working group: **bit.ly/3QwZCXH**
- Workforce reform programme: **bit.ly/3A3akhW**

View all current opportunities to get involved at **rcslt.org/get-involved**

DON'T FORGET

Key resources on the RCSLT website

- The new careers promotion booklet: **bit.ly/3QzC8kV**
- Tips for newly qualified practitioners (**bit.ly/3c62JqJ**) and their supervisors (**bit.ly/3dKSSax**)
- Keep on top of the latest news and announcements: **rcslt.org/news**

Read

HEAD AND NECK CANCER

- Information and resources: **bit.ly/3A1ZZCR**

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DEVELOPMENTAL LANGUAGE DISORDER (DLD)

- Guidance: **bit.ly/3A8k5v2**

STAMMERING

- Dysfluency guidance: **bit.ly/3c1YFIb**

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RCSLT PODCASTS

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RCSLT WEBINAR RECORDINGS

Many of our webinars are recorded with subtitles and made available after the event, so you can catch up on any you've missed. Recent webinars include:

- Owning outcomes: outcome measurement to deliver quality services: **bit.ly/3T1P7gI**
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References: 1. Bolivar M et al. Neurogastroenterol Motil. 2019; e13695.
2. Oudhuis L, Vallons K, Sliwinski E. Clinical Nutrition Supplements, 2011; 6(1): 18 (OP043).

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