Bulletin

RCSLT

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

SUMMER 2024

ISSUE 839

RCSLT.ORG

HEALTH IS FOR EVERYONE

Health inequalities and what SLTs can do

Homelessness: SLTs building connections | Innovation in head and neck cancer services | Powered AAC for people with aphasia | **Ask the experts: multilingual DLD assessments** | **Trauma informed care** | One team's tips for keeping up with new evidence and guidance

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2022 MEMBERSHIP EXCELLENCE AWARDS
Highly Commended
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IN THIS ISSUE

Health inequalities and you

Why should your access to healthcare depend on who you are and where you live?

Our cover story on **page 22** is from the world of homelessness, where people may be affected by multiple inequalities from birth onwards. When working with people affected by homelessness, nothing can be achieved without first gaining trust. Only after that first connection is made can an SLT begin to think about a person's communication or swallowing needs. Author Leigh Andrews is pioneering speech and language therapy in this field, driving change leading to SLTs being embedded in local homelessness teams.

We know that inequalities based on gender, class, your housing situation, ethnicity and many other determinants of health can make a huge difference to outcomes in certain populations. And inequalities can create ill-health while at the same time making it harder for people to access the support they need.

In this issue, we are asking how we can use our professional curiosity to investigate health inequalities and how SLTs can help achieve fairer health outcomes for all.

On **page 32** you can read about how a local service has re-designed their offer to make sure that everyone on their caseload can access care equitably. And on **page 30** we take a look at a new resource that can help you raise awareness of health inequalities.

There are plenty of practical tips and case studies in this issue, so please explore, follow the links to our website and think about ways to put ideas into practice.

> **SLTs can help achieve fairer health outcomes for all**

Also in the summer issue, for anyone wishing to carry out an assessment in another language there is a collection of resources for multilingual children on **page 50**. The authors of our new head and neck cancer guidance look at ways to innovate and develop your service, and some great new resources to help you on **page 46**. Find out about trauma-informed care and how to consider a client's sense of safety and wellbeing on **page 38**.

Derek Munn

RCSLT Director of Policy and Public Affairs
✉ bulletin@rcslt.org

PS our next issue looks at the wider themes of equality, diversity and inclusion (EDI). If you have a practical tip or story to share about EDI, why not email or share with us on social media?

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"Multilingualism is a spectrum … and it is key that the complexity of children's language background is considered in any type of assessment"

EMMA PAGNAMENTA

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SHARE YOUR THOUGHTS ON X @RCSLT #

Talking points

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

LETTER

Social media and SLTs

Our team has been reflecting on the use of social media platforms within continuing professional development (CPD). Whilst there are significant advantages in terms of accessibility, networking and hearing from those with lived experience, we know very little about the quality of posts that SLTs view and we wonder whether we always robustly apply principles of evidence-based practice to discourse on social media (Diehm & Hall-Mills 2023).

We have observed some theories swiftly acquiring considerable traction among SLTs working with autistic children, whilst other well-evidenced interventions are dismissed with an apparent requirement that they should never be offered to families. Such polarised thinking raises concern when we know that no single intervention will ever fit all. These debates are of course not unique to this area of practice or to our profession. Consequently, we suggest an updated social media policy by RCSLT could assist with ensuring reasoned debate and critical evaluation of evidence in this virtual world.

AMY RIDDETT, **DR PENNY WILLIAMS**, **JANETTE CARRASCO**, **DR VICKY SLONIMS**, **ROSIE ASHWORTH**, **AMY WATERS**
Newcomen Neurodevelopmental Service, Evelina London Children's Hospital
✉ penny.williams@gstt.nhs.uk

RCSLT responds:
Evidence-based practice is at the heart of everything we do, and we encourage members to access our tips on critically appraising evidence at **rcslt.info/EBP**.

LETTER

AAC documentary

We are Kate Caryer, award-winning filmmaker and AAC user with cerebral palsy, and Tristán White, videographer. We're producing a feature-length documentary, 'The Power of Unspoken Voices', shedding light on the diverse experiences of AAC users, and raising awareness about AAC's cruciality, empowering nature, and its history and future.

We'd love SLTs to tell their AAC-related stories, plus, any offer of help with research is gratefully received. Also, if you know of an AAC user who may wish to tell their story to the world, please ask them to get in touch! For more about the documentary visit **unspokenvoices.co.uk**.

TRISTAN WHITE, AI Consultant and **KATE CARYER**, Founding memeber of the Unspoken Project CIC
✉ tristan.white@gmail.com
✉ kate.unspoken@gmail.com

BIOFEEDBACK POST STROKE

I am looking to make contact with SLTs who are using biofeedback with dysphagia patients post stroke. In particular, I'm interested in what equipment and software you are using. Maggie Lee Huckerbee's Bisskit software isn't currently available in the UK so I'm looking for recommendations for alternatives.

KATHERINE WATSON SHORT, Clinical Specialist SLT, University Hospitals Dorset
✉ katherine.watson-short@uhd.nhs.uk

LETTER

Reducing the use of thickeners

Thank you for the article by Lizzie King in the Spring *Bulletin*. As a team of Adult Learning Disability SLTs we take a highly personalised approach to eating, drinking and swallowing (EDS) assessments, interventions, and the use of thickened fluids, and it was great to read this analysis supporting our approaches.

However, we're increasingly having difficulty sourcing the specialist cups that are often a vital tool in reducing thickener use for adults with learning disabilities, particularly those that support a reduced flow rate or limited bolus size such as the Reflo or Drink-Rite cups. These cups seem to be either impossible to purchase or prohibitively expensive for our service users – we wondered if any readers of *Bulletin* might have any advice, as we can't be the only team experiencing these difficulties, particularly as we all strive to reduce use of thickener in line with the latest position paper.

JO CLARKE, Specialist SLT, Leeds and York Partnership NHS Foundation Trust
✉ joclarke@nhs.net

QUOTE OF THE QUARTER

> "Hearing the real-life accounts of SLTs is always inspiring but it's also a stark reminder of the sheer volume of eating, drinking and swallowing challenges patients face."

PIPPA COTTERILL, Head of RCSLT Wales

Keeping the conversation going

Lots of you shared your thoughts and ideas about the last issue with one another on social media! We love to see readers sharing our content, so tag in #RCSLT.

Great article in @RCSLT *Bulletin* this season about building partnerships with individuals and their communication partners when thinking about AAC (Skills for building partnerships, page 21). Meaningful relationships are key to collaborative and person-centred care.
Jess Rodgers, SLT
@jrodgersSLT

To avoid doom scrolling, my Saturday morning routine is catching up on *Bulletin*. Great to (finally) read this article from @AuDHD_SLT@jbmdavies (Ripple effect, page 34) and to see @ RCSLT giving guidance on LGBTQIA+ affirming work environments. I'm so looking forward to using this tool!
Lilias Jeffery, SLT, West Midlands
@Lilias_Jeffery

A great article about neurodivergent SLTs in this month's @RCSLT bulletin by @pollydSLT (Workplace=our place, page 47). Thank you for sharing your experiences and amplifying ND voices.
Lucy Holohan, SLT @LucyHolohan

Such a fantastic article in @RCSLT #Bulletin about the SLT role with patients with Cog Comm Disorder (Communication is everything, page 44). The perspectives of professionals embedded throughout were so thought-provoking and the whole thing was just an all-round great read. Would highly recommend!
Lauren Bell, Consultant Neuro SLT, Judith A Scholefield & Associates
@laurenbell_slt

Yes #RCSLT refreshing to see resilience/wellbeing acknowledged as something we do not do for ourselves but to keep us serving others, and not being asked of employers to provide for us ('Steel yourself', page 18).
Kat Lewis, Highly Specialist SLT, Acute Clinical Lead @KatLewis_SLT

WHAT'S NEW ON rcslt.org

DEMENTIA

The RCSLT has updated guidance for SLTs working with people with dementia. In addition to the guidance pages, there is a a new position paper highlighting the benefits of providing an adequate SLT service. Plus public guidance highlighting the challenges which people with dementia can have around communication and eating, drinking and swallowing.

rcslt.info/dementia-guidance

AAC GUIDANCE

Updated guidance about the role of speech and language therapy in working with augmentative and alternative communication (AAC) has now been published. The guidance was coproduced by those with lived experience and with SLTs from across the UK.

rcslt.info/AAC-guidance

SERVICE INNOVATIONS IN HEAD AND NECK CANCER

The RCSLT has collated examples of how head and neck cancer SLT teams are innovating in a patient-centred way, featuring a range of example service structures and clinical initiatives. Turn to page 46 to find out more.

rcslt.info/service-models

NEW AI RESOURCES PAGE

The use of AI in speech and language therapy assessments and management is an evolving area with a lot of potential as well as risks and challenges for SLTs to consider. The RCSLT has collated a list of resources to support members with their understanding of AI in relation to learning, research and policy.

rcslt.info/ai-resources

Need to

VoiceBox winner announced

Congratulations to Gordon of Cockenzie Primary School in East Lothian, who is the winner of the VoiceBox 2024 Scotland competition. The RCSLT's national joke-telling competition for primary school children was designed to raise awareness of the fun and importance of communication. It offers a light-hearted and inclusive way for pupils to develop their communication skills and build their confidence and self-esteem. Our finalists told their jokes in front of members of the Scottish Parliament and a judging panel at the national final in the Scottish Parliament in June.

Gordon received a £100 toyshop gift card voucher, plus £500 worth of Collins Big Cat books for his school. Finalists also received £100 worth of HarperCollins books. Glenn Carter, Head of RCSLT Scotland, said: "Humour has the power to connect us, underscoring the importance of speech and language in our lives."

Gordon's winning joke was: **"Why did the donkey go to the shops? Cause he had hee haw in the hoose!"** Why not try it out? You can tell your audience that hee-haw is Scots slang meaning 'nothing'.

IJLCD-RCSLT student prize

Hayley Wilde from Leeds Beckett University is the winner of the International Journal of Language and Communication Disorders (IJLCD) student writing prize 2024. Her project used think aloud protocols to find out how assistive technology affects writing for people with aphasia.

know

75% of people living with dementia in the UK who have communication or swallowing difficulties improve with speech and language therapy

Get Inspired: new RCSLT leadership training

The new RCSLT leadership programme, Inspire, is now open for applications from members who are new to a leadership role, or looking forward to moving into leadership in the next year. Inspire is a bespoke learning experience designed around the needs of SLTs to create a new generation of future healthcare leaders.

To be truly effective, leaders need to build a toolkit of knowledge, skills and behaviours that will set them and their organisations up for success. The RCSLT programme offers support in understanding how your leadership behaviours affect the culture and climate you, your colleagues, and teams work in, and addresses operational and strategic objectives. It has been developed in collaboration with Real Healthcare Solutions Ltd.

To apply, you will need the support of a line manager, or a mentor for independent SLTs if possible. We welcome applications from members of any age, gender, ethnicity, sexual orientation, faith or disability. The deadline is 8 July 2024, and successful candidates will be announced 2 August.

To find out more visit
rcslt.info/inspire

NEWS IN BRIEF

SLTs in the justice system

RCSLT has mapped where SLTs are working across the justice system, to better understand the breadth of the SLT workforce and identify any gaps in provision.

The results show that most SLTs in the justice system work with children and young people. Most are at band 7 and the majority work part time. Over two thirds of posts are permanent but 20% of teams have vacancies, and there is huge variety in post funding.

RCSLT is doing more analysis to support future commissioning and workforce development in justice provision.

New RCSLT awards

The annual RCSLT Awards have been revamped with a more inclusive nominations process and eight new categories. Previously the Giving Voice awards, the new awards recognise the achievements of members and celebrate those who have championed the profession and made a difference to the lives of service users. New categories include developing the profession, excellence in research, and fostering equality. Fellowships and honorary fellowships continue to be awarded for contributions in all areas of the profession.

Winners will be announced in the autumn awards ceremony.

New health inequalities resources

If you need to raise awareness of the SLT role in health inequalities among stakeholders and peers, you can now access downloadable graphics containing evidence-based information. The new resource is based on the NHS England health inequalities programme, Core20PLUS5 but can be used anywhere in the UK. For more details about the resources turn to page 30.

Find out more
rcslt.info/health-inequalities-resources

CORE20PLUS5

New workforce education and training programme

The RCSLT is starting a new programme to enhance SLT education and careers, with funding from NHS England. The programme aims to ensure SLTs feel confident in their roles, with opportunities to develop their careers through education and training, ultimately promoting retention and workplace satisfaction.

The programme will encompass all four nations and the programme team aims to engage with SLTs from the entire UK.

The new programme will include projects designed to benefit members working in all sectors, from students to consultants. Some key initiatives include conducting a curriculum review and updating the professional development framework. We will be working with education leaders to develop resources for teachers, advisors and career changers. There will be a review of the newly qualified practitioner and preceptorship process, and plans for improving post registration opportunities. It will also be finding innovative ways to reduce waiting times for children and young people.

A new RCSLT team has been recruited to work through these projects so please do reach out for more information and look out for updates on RCSLTs website, social media and in *Bulletin*.

✉ Contact **william.christopher@rcslt.org**.

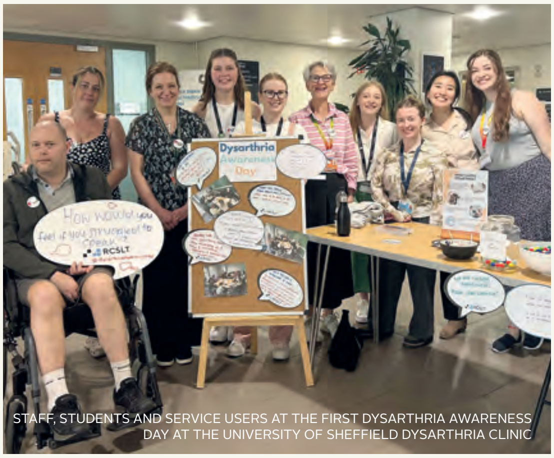
RCSLT at Pride 2024

Carrying the RCSLT banner at Birmingham Pride on 25 May, members marched to celebrate the LGBTQIA+ community. Pride is an opportunity for togetherness and joy, as well as an important platform to voice the inequalities that still exist. The SLT Pride Network aims to support and represent all LGBTQIA+ speech and language therapy professionals.

🔗 Find out more **uksltpride.wordpress.com**

First Dysarthria Awareness Day

The first Dysarthria Awareness Day was launched on May 10 this year, by clients, student SLTs and staff from the University of Sheffield. The event was inspired by discussions with clients at the university's in-house dysarthria clinic about low public knowledge of the condition. Clients reported experiencing misconceptions and discrimination due to their speech. For example, some people they met treated them as though they were drunk, less intelligent or no longer able to participate in conversations.



STAFF, STUDENTS AND SERVICE USERS AT THE FIRST DYSARTHRIA AWARENESS DAY AT THE UNIVERSITY OF SHEFFIELD DYSARTHRIA CLINIC

At the launch event, the team engaged with visitors to raise awareness and understanding. Most people had never heard of dysarthria, underscoring the ongoing need for advocacy and education to bridge the knowledge gap and better support those living with dysarthria.

Sheffield student SLTs Dana Lillie, Lucy Anderson, Ellie Jenkins, Amy Swan and Daisy Humphries told us: "Watch this space for future dysarthria awareness initiatives!"

UP COMING

JULY
South Asian Heritage Month
1 Research Appreciation Day

AUGUST
7 Playday
27 Makaton International Awareness Day

SEPTEMBER
30 National NonSpeaking/Nonverbal Awareness Day

Anti-racism training

A research project is taking place at the University of Essex over the coming year to evaluate the feasibility of a new 'active anti-racism for SLTs' programme of learning. This work builds upon the RCSLT's resources used in the previous profession-wide anti-racism workshop. Members of the RCSLT anti-racism reference group will serve as 'trainers' for their local teams and networks, who will trial the package.

Research Champions workshop

The 2024 Research Champions workshop is taking place on 12 September. Join us to build connections within the research community, get the latest research updates, and hear about RCSLT's latest areas of focus. To find out more about becoming an RCSLT Research Champion and joining the workshop contact:
✉ **research@rcslt.org**

Future supply of therapists

A recent report commissioned by the Department for Health and Social Care showed an increase in need combined with resource pressures leading to lower care quality and patchy provision. The RCSLT will be working to improve support for children and young people through quality standards and systems guidance for commissioners, and addressing training and wellbeing across the workforce.
🔗 **rcslt.info/SLT-support**

Call for rehabilitation services

The RCSLT has joined 36 organisations in the Community Rehabilitation Alliance to write to leaders of the main political parties asking them to invest in community-based rehabilitation services. Rehabilitation could help address many of the challenges facing health and care by reducing multimorbidity and enabling more people to stay independent, work and enjoy social activities. Support us on social media **#RightToRehab**.

RCSLT Connect events launch

RCSLT Connect, our series of UK-wide member engagement events, officially launched on 12 June with RCSLT Connect Wales. The event 'One Wales, One Profession' at Metropole Hotel Venue and Spa in Llandrindiod Wells was a great opportunity for members to network with fellow SLTs and meet RCSLT staff. Delegates could share and learn from best practice, receive updates on RCSLT projects and contribute to initiatives.

RCSLT Connect is holding more free in-person events over 2024. Each event is tailored to suit the interests and needs of our members in the area, and offers sessions and workshops which will equip members with practical tools they can use to further develop their practice.

Join us for a day of learning, development, and networking at an event in your region:

- **RCSLT Connect Scotland**, 17 September 2024 at Perth Theatre and Concert Hall
- **RCSLT Connect England**, 17 October 2024 at the Midland Hotel, Manchester
- **RCSLT Connect Northern Ireland**, 21 November 2024 at Lisburn Civic Centre.

Save the dates and keep an eye out on our website for more information in the coming months.

🔗 Find out more
rcslt.info/connect-events

CENS relaunch

Clinical Excellence Networks (CENs) are an integral part of continuing professional development (CPD) for SLTs.

RCSLT has listened to what members said they want and need to shape the update of the CEN section of the website. We are launching an exciting new CEN Directory search tool which contains clear details about the CENs, helping members to find the group that is right for them quickly and easily.

The CEN information on the website has been refreshed, including the addition of a public page that gives an overview of what CENs do, how they are run, and their relationship to the RCSLT. Comprehensive new guidance has been developed for CEN committees to support their work, reflect the changing way that we work in a digital era, and answer the most common questions we have from members about how to run a CEN effectively.

🔗 Look out for the updated CEN resources **rcslt.info/CENs** and contact
✉ **cen@rcslt.org**

Want your photo to be featured in the next issue of *Bulletin*? Post your pic on X tagging **@rcslt** and using the hashtag **#GetMeInBulletin** or drop us an email **bulletin@rcslt.org** and we'll publish a selection of the best

Got something you want to share?

This issue showcases SLTs getting support from furry co-workers, making waves with awareness campaigns and fundraising 'Where's Wally' walks

To / Sarah

THANK YOU so much!

Thank you for your continuous support
+ guidance throughout my time
on placement xx
From / Zaina

IN PICTURES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8


9


⑩

① Thank you card from **Safah Raza**'s student SLT after she had completed her final year placement.

② Puppies make prepping for a neurodivergent affirming communication CPD so much better. **@AJHSLT**

③ Team of independent SLTs hosted a 'Where's Wally' themed fundraising walk for the National Literacy Trust. **Ellie Pass**

④ **@BCHC_SLT**'s children's team went out and about to spread the message on supporting children's eating and drinking.

⑤ Hull's Hospitals voice team raising awareness and fundraising for wellbeing packs on World Voice Day. **@HUTH_SLT**

⑥ SLTs travel the world! 1996 University of Sheffield graduates of speech science end an epic Costa Rica trip with an unexpected encounter with Kamini Gadhok. **@PoofyC**

⑦ Student SLT Ana-Marie and the special schools team at Cardiff and Vale University Health Board (CAVUHB) informed staff and visitors about swallowing difficulties for Swallowing Awareness day. **Ana-Marie Ipate**

⑧ **RCSLT Wales** team at their Senedd event raising awareness of eating, drinking and swallowing difficulties for Swallowing Awareness day.

⑨ **Lauren Flannery**, SLT at UEA, working with ITV Anglia as a member of their inclusion and diversity panel.

⑩ **@SophieTS_SLT** and team started filming for the first in a series of videos about supporting stroke survivors.

DR SEAN PERT

Call time on non-evidence based practice

Dr Sean Pert asks how we can keep striving to achieve best practice

> Taking time to question your practice offers big rewards for you and your clients

SLTs are required to 'engage in evidence-based practice' so that we can work more efficiently and effectively for our service users (HCPC, 2023). We know that this means we need to be continually challenging our practice and identifying aspects that are no longer appropriate. No one would really argue with this, until we start thinking about terminology, approaches and clinical practice that we ourselves rely on.

An example of a model which is still widely used, despite being highlighted in *Bulletin* as problematic, is the 'communication pyramid'. Morgan and Dipper highlighted that "... the pyramid appears to suggest that each layer represents a stage of development that is completed before the next layer, which is clearly untrue. It could mislead people to think that the development of all receptive language skills must be completed before expressive language skills can emerge" (2018). A quick internet search shows that it is still widely used despite its misleading nature.

Similarly, the concept of 'information carrying words' (ICWs) from the Derbyshire Language Scheme (DLS) (Knowles and Masidlover, 1979) has been shown to be problematic, especially for speakers of languages other than English (LOTE). The clinical guidance on bilingualism states: "Although the concept of ICWs may work for English, which, at sentence level has a very 'bare' morphological structure, the concept of ICWs breaks down for most other languages" (RCSLT, 2024).

Since children who speak LOTE must be assessed and treated in their home language (HCPC, 2023), the use of ICWs cannot be applied to home language clinical practice. The emergence of language packages based on the Constructivist language acquisition model challenge the ICW. Ambridge and Lievan highlight that "...children's language acquisition is emergent from their use of language as a social tool. Children are not "trying" to learn syntax... they are using language, to cajole, to control and to communicate" (2015).

The LIVELY randomised control trial compared DLS with the 'Building Early Sentences Therapy' (BEST) which uses a play-based usage-based approach. This found that BEST was more effective, with carry-over to language structures that were not targeted (McKean et al, 2023). Comprehension does not always precede expression.

It's only human to want to stick to the tools you are familiar with, but taking time to question your practice offers big rewards for you and your clients. Which frequently used concept, model or idea in your practice, or your team's care pathways needs to be re-evaluated in the light of recent research? B

DR SEAN PERT, RCSLT Chair of Trustees
✉ sean.pert@rcslt.org
𝕏 @SeanPert

STEVE JAMIESON

Creating a new generation of SLT leaders

Steve Jamieson looks forward to our new leadership programme and nationwide Connect events coming soon

> My vison is that alumni who become leaders will help shape and direct the future of our profession

My first year at RCSLT has flown by and I feel I have learned so much! I wanted to start my column by saying a big thank you to each and every member I have met across all four nations. Your warm welcome, commitment to the profession and drive to improve services has been so palpable.

In talking to many of you, I have identified that the profession needs more support with leadership skills so that we can nurture the talent in the profession and ensure SLTs reach their full potential. I'm therefore delighted to be launching the first RCSLT leadership programme. This is a one-year programme, and the first cohort will begin in October. The programme aims are to demystify leadership and help SLTs transfer theory into practice.

Our theme will be 'Inspire' and will focus on the development of self, team and profession. My vison is that alumni who become speech and language therapy leaders in the coming years will help shape and direct the future of our profession. More details are available on our website. I hope you will consider applying or encouraging a member of your team to do so.

I'm delighted to have launched our RCSLT Connect events, providing an opportunity for us to get together as a profession in person, share best practice and to look at the key issues facing speech and language therapy. These events are taking place in Wales, Scotland, England and Northern Ireland and are tailored to suit the interests and needs of members in each area. The first event took place in Wales in June and we have more events planned across the country into the autumn. You can find out more on our website, and I hope to see lots of you at these events.

As we move forward into the second half of the year, I am excited about the progress we are making as a profession and the positive changes that lie ahead. I look forward to continuing to work together with all of you to inspire and empower SLTs across the UK.

Thank you for your dedication and commitment to our profession, and I can't wait to see what we can achieve together in the months to come.

STEVE JAMIESON MSC, BSC (HONS), RN
RCSLT Chief Executive Officer
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𝕏 @SteveJamieson12

WILTSHIRE
EST. FARM 1991
FOODS

Wiltshire Farm Foods Receives Fourth Royal Honour

Ready meal provider Wiltshire Farm Foods has been awarded a King's Awards for Enterprise in Sustainable Development 2024.

Regarded as the UK's highest business accolade, it is the fourth time the company has received the Royal honour, having previously won three Queen's Awards for Enterprise. This year, it is one of 252 organisations nationally to be awarded a prestigious King's Awards for Enterprise, with just 29 businesses being recognised for their work in Sustainable Development.

The company's ambitious closed-loop recycling scheme - which involves customers returning food trays back to drivers where 100% of them are subsequently recycled into new trays – is a world-first initiative on an industrial scale.

This groundbreaking project has seen 25 million trays be recycled to date; an achievement which gained considerable recognition from the award body and helped to secure this prestigious win.

The award also recognises parent company apetito's commitment to doing business in a way that positively impacts on the environment. Its ambition to reach Net Zero by 2040 and its dedication to meet challenging short-term targets for carbon reduction, demonstrates how the company is committed to supporting climate change.


Celebrating the win with the team at the Wiltshire Farm Foods Birmingham branch

Speaking on behalf of Wiltshire Farm Foods, CEO Paul Freeston, is delighted with the award win, saying:

"We are proud and honoured to have been recognised in the King's Awards for Enterprise: Sustainable Development 2024. It epitomises the hard work, dedication and vision of our entire team.

"All of us at apetito and Wiltshire Farm Foods are passionate about 'making a real difference' to people's lives and we believe our commitment to sustainable development reflects this. Sustainability informs not just the way we work, but how we treat people, the impact on the environment and our contribution to the economy. Put simply, we believe it's the right way to do business."

The company's Softer Foods range, featuring over 88 dishes, has previously been awarded a Queen's Award for Innovation, having been developed specifically for those living with swallowing difficulties.

Read more about the King's Awards here:
wiltshirefarmfoods.com/blog/kings-award

> **We are proud and honoured to have been recognised**


A Wiltshire Farm Foods customer returning their washed tray to a delivery driver

Finding my place as a leader

Rebecca Rose reflects on how she used her experience and expertise in key leadership roles in the NHS and voluntary sector

REBECCA ROSE

> **There are opportunities to promote our profession and increase our influence in the wider healthcare system**

I have been an SLT for over 10 years, most recently working with adults in the community. I was proud of being an SLT and allied health professional (AHP), but felt that I wanted to branch out from the standard career path to explore other avenues for becoming a leader in the world of healthcare.

In my experience, SLTs are only a small proportion of the AHPs in diverse roles in the NHS. It may be that SLTs have less awareness of and engagement with non-clinical and leadership roles. I feel that it is important for SLTs to understand and consider these alternative career paths as a way of contributing to the wider work of the NHS. We have such a wealth of knowledge and skills to bring to these roles, including a focus on person-centred care and effective and inclusive communication skills. There are opportunities to promote our profession and increase our influence in the wider healthcare system.

When I was considering how to move on my career, I was drawn to learning more about the wider NHS system, exploring ways I could use my knowledge and experience to contribute to improving patient care in a different type of role. I took a year out to study full-time for a Master's in Healthcare Leadership and Commissioning with Brighton and Sussex Medical School, graduating in 2021. It was a great experience, with modules in public health, leadership, quality improvement, commissioning, and teaching. My dissertation was a service evaluation looking at SLT perspectives and experiences with reference to the change management literature.

I started a role as a Practice Development Facilitator working for the Sussex Training Hub in February 2022, and became Primary Care Workforce Lead in February 2023. I was involved in supporting clinical staff and students in general practice including primary care AHPs, going on to develop my knowledge and skills in strategic planning, leadership, and project management.

My leadership role allowed me to take on new knowledge and challenges whilst being an advocate for AHP perspectives. It's been wonderful to work with and learn from colleagues from a variety of backgrounds, and I feel welcomed and valued for my AHP viewpoint. More recently I moved to the health professional's engagement role at the Stroke Association. I am also a co-organiser of the AHPs Everywhere network which exists to support AHPs already in or considering diverse roles.

I am no longer working clinically but I remain on the HCPC register and carry out CPD related to my role.

I hope that SLTs will more readily consider these alternative paths and look out for opportunities to learn more. Perhaps we will start to see a shift in culture and begin to view alternate career routes and portfolio working as increasingly acceptable and desirable for those in the speech and language therapy profession. B

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Find out more about AHPs Everywhere **rcslt.info/future-NHS**

ILLUSTRATION: TIM BOUCKLEY

Early Talk For York

Eve Ibbotson and **Hannah Thomas** on a universal approach designed for the children of York

York has a significant and longstanding gap in outcomes between disadvantaged children and their non-disadvantaged peers. In 2017, the gap at age five was the largest of any local authority area in England (Department for Education, 2017). In response to this identified need, the Early Talk for York (ETFY) approach was developed. This is a co-commissioned approach between York and Scarborough Teaching Hospital NHS Foundation Trust (YSTHFT) and the City of York Council, with the aim of reducing the gap in language and communication outcomes of disadvantaged five-year-olds and their peers.

We started our journey as SLTs within ETFY in September 2021 as the UK was emerging from the COVID-19 pandemic. Due to the well documented impact of the pandemic on children's speaking and understanding ability (I CAN, 2021), the demand for services to work together to enhance the universal and targeted offer is now greater than ever.

Shaping Early Talk for York

The key elements of the ETFY approach involve:

- Annual universal screening in the early years using the WellComm Toolkit (GL Assessment, 2010)
- Consistent training across the early years workforce using The Elklan Communication Friendly Setting accreditation.

EVE IBBOTSON

HANNAH THOMAS

- Working in partnership with other professionals and parents and carers.
- Working with the NSPCC to promote their 'Look Say Sing Play' campaign across the city.

The overall aim of our involvement is to promote sustainability by building practitioners' knowledge, skills and confidence. This empowers them to respond to identified needs, reducing reliance on specialist services over time. We have been involved in supporting all areas of the approach including planning, delivering and evaluating bespoke training packages. We support early years practitioners to identify and respond to children's speech, language and communication needs (SLCN). We also act as a link between the local authority and YSTHFT to evaluate and adapt the support offered across the city.

Having an impact

Results from the statutory assessment of children's development at age five using the Early Years Foundation Stage Profile (EYFSP) show that the gap between non-disadvantaged children nationally and disadvantaged children in the ETFY area has reduced from 34.5% in 2018 to 4.5% in 2023. Early Talk for York is meeting its goal of benefiting disadvantaged children in the city (York City Council, 2023) and the programme is being scaled up for rollout in other areas of York, with the approach is being incorporated in the city's speech, language and communication pathway.

Managing the challenges

The current difficulties surrounding recruitment and retention of staff in the early years sector has resulted in qualified members of staff involved in ETFY leaving, which affects a setting's ability to complete the key elements of the approach. Staff are reporting an increase in numbers of children with complex SLCN which is putting additional demands on capacity. As SLTs we need to be aware of these challenges and work with other professionals in the early years sector to continue to prioritise speech, language and communication in a sustainable way.

The ETFY approach ended 2023 on a high receiving a 'Children and Young People Now' award in the 'Learning Award' category, recognising the positive impact of ETFY in improving children's language and communication outcomes in the early years.

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Presence of mind

Julia Caird looks back at how her yoga practice has informed her work as an SLT and shares some tips on finding a sense of calm

JULIA CAIRD

Mindfulness, meditation and yoga: it's hard to escape these words nowadays, but what do these ancient practices have to offer to our profession presently? How can they support our work as clinicians?

From completing the challenging training to become a therapist, to working managing a large caseload often across multiple sites, being a therapist requires you to be organised, calm and have strategies for self-regulation. The ability to regulate may be something we talk about clinically, but it is just as important that we can model this skill 'live' with our patients. When we use the 'soft skills' of being present, smiling, active listening, acceptance and compassion, we create solid outcomes, as our patients feel calmer (this is backed up by research into mirror neurones).

Our body's ability to regulate itself arguably underpins our overall functioning, and yoga and meditation are evidence-based ways to support our physiology to work efficiently and effectively. When our bodies are well-regulated, pro-social behaviours and communication abilities are supported. Yoga allows us to work from a 'bottom up' (body-led) approach, processing our sensory experience, starting with the nervous system and our heart rate. SLTs work from a 'top down' approach, using language and cognition. Having a solid understanding of how the body and brain interact, and having the tools to work with both, I have found essential to my work.

> **Until a child is feeling safe and calm, no meaningful work can be done**

Experience working with children with language and behavioural needs has confirmed to me that until a child is feeling safe and calm, no meaningful work can be done. This might sound like common sense, but in reality, we are often asking children with challenges with regulation to concentrate. The practices of mindfulness and yoga are now 'socially prescribed' on the NHS for conditions such as anxiety, which people with a communication difficulty are more at risk of, and we as clinicians know that addressing a patient holistically is best practice and will give us the best outcomes.

At the centre of yogic philosophy is the concept of greater self-knowledge. Through our own self-observation we become better clinicians, more able to keep ourselves centred in difficult situations, able to assert boundaries when needed and give authentic feedback to patients. We are also better equipped to support others to self-reflect, which is, as we know, often the first step to change. This may translate into, for example, parents realising that although they are doing their best, there isn't actually any time in the day when their child gets their undivided attention, and this is something they would like to change.

The great thing about bringing more presence to your clinical work is that it begins with you. You could start by counting your breath for five minutes or bringing all of your awareness to drinking a cup of tea. This quality of presence can then be shared with the people you work with and your patients, cultivating an environment of patience, self-awareness, creativity and lowering the stress response in the body.

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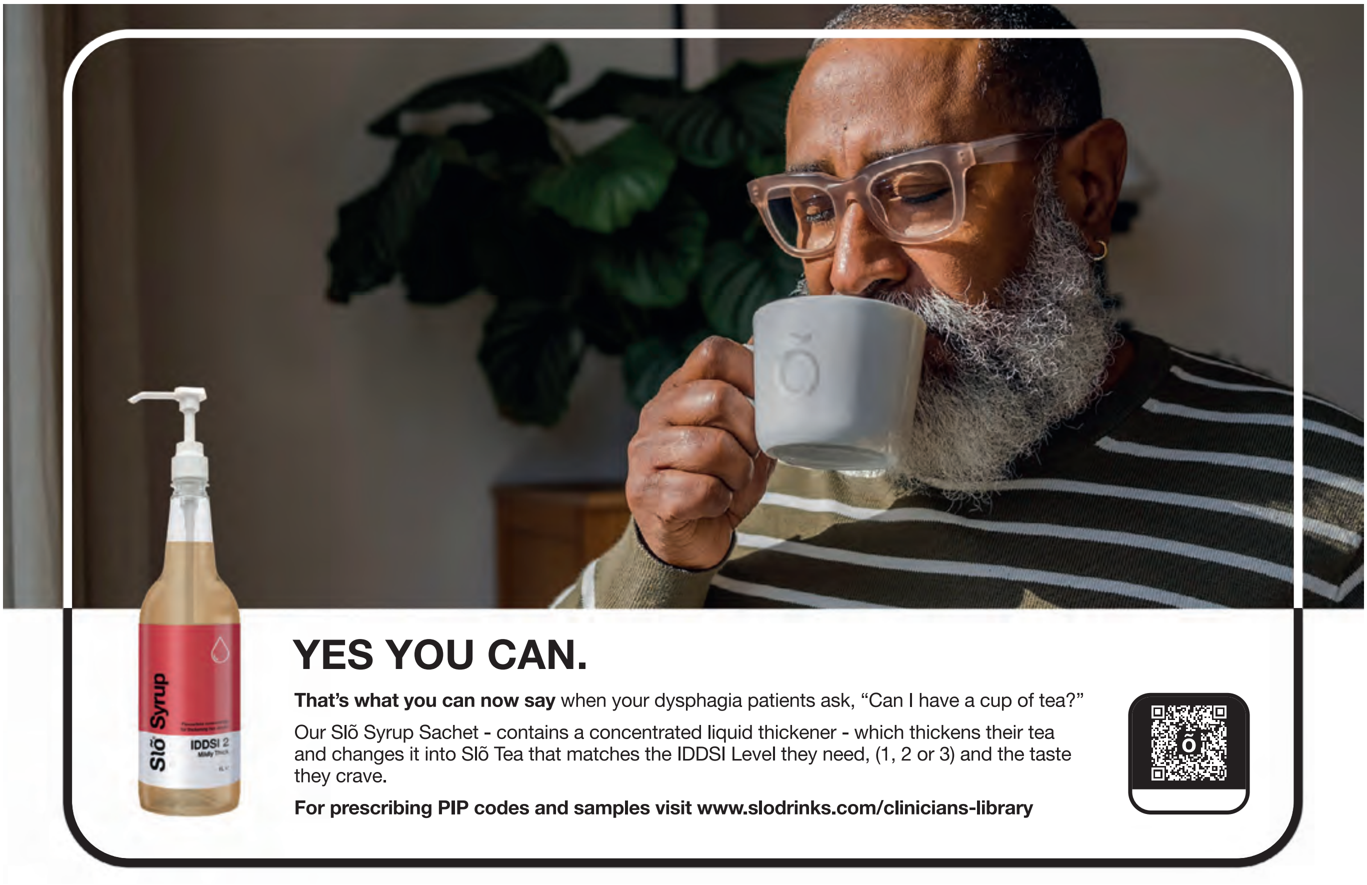
ILLUSTRATIONS: TIM BOUCKLEY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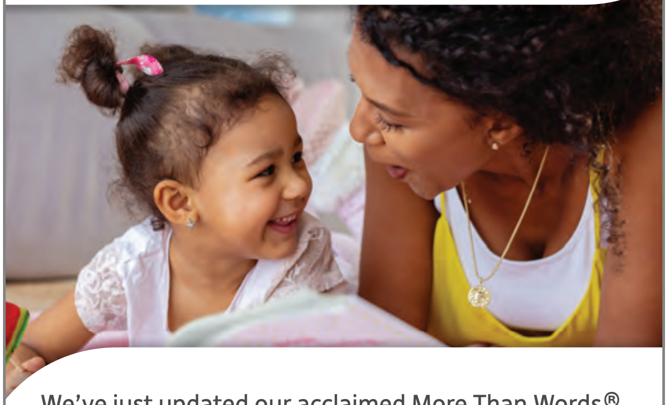

Parkinson's rapid response service

Louise Anderson on a new role that gives people with Parkinson's early access to an SLT

LOUISE ANDERSON

ILLUSTRATION: TIM BOUCKLEY

Parkinson's is the fastest growing neurological condition in the world, and around 153,000 people in the UK are living with it (Parkinsons UK, 2024). While the exact cause of Parkinson's remains unknown, we do know that it can have a significant impact on an individual's quality of life (Al-Khammash et al, 2023).

I have recently started an exciting new role as a Highly Specialist SLT providing a rapid response service to patients with Parkinson's across acute and community settings within the borough of Gateshead. This two-year pilot is a result of a successful bid to the Parkinson's Excellence Network 'Pump Priming bid for specialist allied health professionals'.

Dysphagia is one of the 40 symptoms of Parkinson's, and can be present in every stage of the disease although can become more apparent in the advanced stages (Pfug et al, 2018). It is well-known that dysphagia can complicate medication administration, lead to poor oral intake, weight loss, and result in aspiration with subsequent pneumonia - the most common cause of hospital admission in patients with Parkinson's (Martinez-Ramirez, 2015).

> **My rapid response role enables me to screen swallow on admission as recommended in the 'Hard to Swallow' report**
>
> (NCEPOD, 2021)

Previously, patients with Parkinson's who were admitted to Queen Elizabeth hospital were only seen by an SLT when they were referred for an assessment. However, my rapid response role enables me to screen their swallow on admission as recommended in the 'Hard to Swallow' report (NCEPOD, 2021). In addition to this, the 'Get it On Time' campaign highlights the importance for timely administration of Levodopa medication, which, if delayed, can further impact upon the patient's swallow function and place them at increased risk of aspiration-related chest complications, reduced nutrition and hydration and access to medications.

When a patient with Parkinson's is admitted to hospital I receive an automated email alert. As part of my role, I manage swallowing difficulties, provide education to the patient and their families to aid safe discharge for those on modified diet and fluid textures, and provide timely follow up when returning home.

In the community, my role allows me to see those referrals within a week compared to the average waiting time of six weeks.

By providing this rapid response service across acute and community, the anticipated aims are that it will reduce hospital admissions and readmissions, improve health outcomes, reduce dysphagia related mortality and improve quality of life for those with Parkinson's.

Although the service has only been up and running for three months, the feedback from patients has already been extremely positive. One patient told us: "Brilliant service, rapid response and very informative". Collecting patient/carer feedback alongside high quality data is essential in demonstrating the long-term need for this service. The project has had excellent support from Gateshead Health NHS Foundation Trust Parkinson's consultant and nurses and I feel incredibly proud to be able to offer this responsive service. Having this opportunity for allied health professionals is very promising for patients with Parkinson's, and a step in the right direction for SLTs being a core member of the Parkinson's multidisciplinary team.

LOUISE ANDERSON
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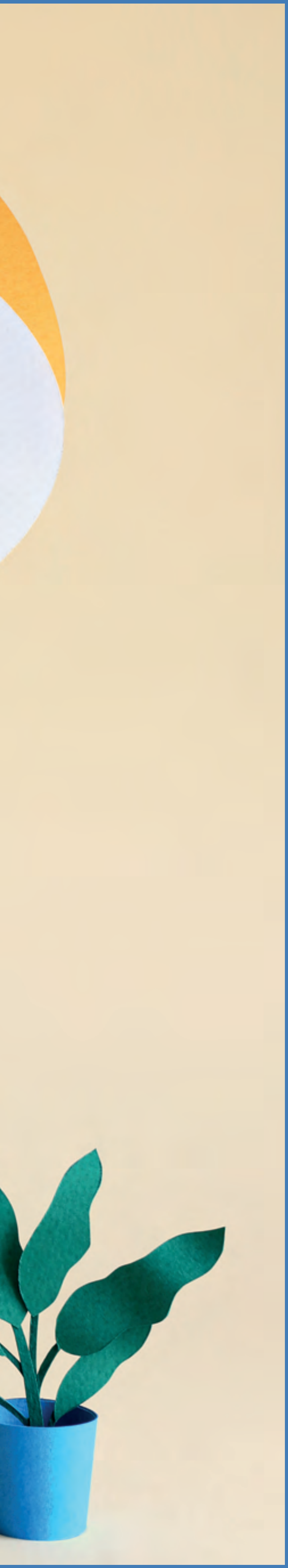

Trust and connection

Leigh Andrews *brings us close to a highly vulnerable group living with the impact of health inequalities*

ILLUSTRATIONS WRK

As SLTs working with people experiencing homelessness, we have a unique caseload. We rarely have a full case history available to us for the people we meet, and we may not be able to find out their first language. Sometimes we are not even sure of a person's identity.

Perhaps the only certainty when we meet someone who is sleeping on the streets is that they didn't start out there. What do we know about the causes of homelessness, and what is the role of SLTs in supporting individuals and addressing the health inequalities contributing to homelessness?

LEIGH ANDREWS

Health inequalities and homelessness

We know that the strongest predictor of adult homelessness is childhood poverty (Bramley and Fitzpatrick, 2018). It is always a surprise to me that the homelessness sector talks so little about class, when being poor and working class is a risk factor for homelessness. Lynn Evans wrote about the experience of working-class people becoming homeless in Birmingham in 2018, making clear the multiple challenges faced by the people she helps (Evans, 2018). This might include teenage experiences such as being in care, school exclusion and serious drug use which Bramley and Fitzpatrick identified as further risk factors for later homelessness. If you are an SLT working with children and young people, homelessness and inequalities are likely to be present in your work.

As in many other health-related areas, we also see a range of intersecting characteristics which, due to discrimination, make things worse for some groups than others (Chikwira, 2023). Being black or of a minoritized ethnic group in the UK leads to a disproportionate risk of homelessness compared to other groups (Bramley et al, 2022). Being female and on the streets has its own risks. Women sleeping rough may choose to hide away to avoid harm from others. This may mean street outreach services miss them and fail to offer vital support as a result (St Mungo's, 2018). Women living and sleeping on the streets have an average age of death of 43 (ONS, 2022).

Inverse care law

When training as an SLT I don't recall the 'inverse care law' being mentioned. Essentially, the inverse care law states that the more you need healthcare the less likely you are to get it (BMJ, 2020). That was shocking to me, but I see the lived reality of this for the people we work with every week. Our clients often tell us about the difficulties they faced at home and school as a child. This can be the start of a trajectory that moves onto school exclusion, being drawn into criminal activity, and drug or alcohol dependency. Relationships can be difficult to build and maintain, life may be itinerant, decent work hard to come by so creating any type of financial stability becomes impossible.

In these circumstances trying to access health services that work in rigid ways and with specific 'single issue' clinical criteria can be impossible. Health services may have very little understanding of the experiences of people who become homeless or the types of health problems they endure, so they fail to offer healthcare that meets those needs.

> **A formal clinical communication diagnosis is often impossible but providing care, understanding and help is not**

Putting speech and language therapy in the picture

Speech and language therapy can be difficult to access due to health inequalities in just the same way as other types of healthcare. I worked in homelessness settings for 15 years before training as an SLT. Not once, in all that time, did I ever meet a SLT working with any of the people I supported. The Change Communication charity was created to try to meet that need while simultaneously helping the homelessness sector understand more about communication, and the communication sector understand more about homelessness. Along the way, we also wanted the NHS to recognize that people experiencing homelessness needed speech and language therapy as much as anyone else, and we would support them to develop services to that end.

It was quite ambitious stuff, but we have influenced NICE guidance; speech, language and communication difficulties are now recognised in NG 214 'Integrated health and social care for people experiencing homelessness'. Greater Manchester Mental Health Foundation Trust now employs the wonderful SLT Laura Cole to work alongside homelessness services in their area and provide therapy to their clients and patients. You can read about her work on **page 27**. Other locations are set to follow suit and we will support them on a speech and language therapy and homelessness journey too.

Speech and language therapy in practice

Lots of SLTs interested in my area of practice ask me about my 'average' day, or the kind of communication disorders we deal with, but it's not that straightforward in my world.

However, I can sum up my days and the things we deal with in three words:

- uncertainty
- creativity
- gratitude.

Because we may not know much about the person, their background or their language needs, we must be creative and ask: "What can I do to help end this person's homelessness? What communication difficulties do I, the client, and others experience when we interact, and what might help make those interactions be less stressful and more effective so that their homelessness can be understood, and accommodation and support identified?"

A formal standard clinical communication diagnosis is often impossible but providing care, understanding and help is not.

We work with people who have experienced rough sleeping and of the clients we work with will have sofa surfed or lived in temporary accommodation. We regularly visit clients living in hostels as well as prisons, hostels, day centres, public buildings and cafes.

They have generally had difficult early lives and experienced poverty, but that's not the case for everyone. Some may have worked in the past, and may be proud of their skills from that time.

Our clients are mainly aged over 25, and about 20% are female. About half the people we work with are living with addiction.

Building trust

Our clients have often, perhaps over years, had difficult experiences when they have approached services that are tasked to help

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

them, so we remember and are grateful for any small trust they put in us. We may meet someone on the street and they tell us to eff off. They may trust us enough to meet for a few minutes. They may trust us to answer a question or two. They may trust us to change things a little today, or next week.

Our team is always grateful and overjoyed when people trust us enough to agree to meet us again. They may allow us to ask about their reading and writing, then feel comfortable with us sharing any support strategies with their hostel keyworker. They may agree that contacting their GP to flag concerns about eating and drinking is a good idea after we notice they cough when sipping from their beer can. They may even sit and let us ask the 40 questions on a form during a clinical assessment and be delighted when they get 100% right.

What can you do?

SLTs can support people in all sorts of circumstances with communication and swallowing difficulties in positive, life enhancing ways, but it isn't always easy work. We must support each other to do this when things get tough, so I want to end with some more ideas for positive action you can take to tackle health inequalities.

- **Learn about the role of empathy in healthcare.** Empathy appears to be a protective factor for healthcare practitioners, patients appreciate it, and using it improves health outcomes (Howick et al, 2022).
- **Be curious about the origins of your practice and challenge your own thinking.** An example from my work is changing the words in the acronym 'SOAP' in case notes. Instead of Subjective and Objective to describe the reports from the patient and clinician respectively, we use Self and Observation to remove

the implication that patients describe things in emotional ways while clinicians are unaffected by bias.

- **Read the fantastic case studies and experiences shared in *Bulletin*** to understand more about the challenges people face in using our services and get top tips for improving access to care.
- **Use the RCSLT health inequalities self-audit tool** to help you get started: find out how SLT Rachel Clare used the tool on **page 28**.
- **Arrange a team meeting to discuss some of the key issues** you find interesting in *Bulletin*. Think about what you can do in the short and longer term to address health inequalities in your work.
- **Be creative:** speech and language therapy doesn't have to be just clinical assessment and diagnosis, it can be about care. How do I show this person I care? What do they care about, and can I help with that? I found 'Being Mortal' by Atwul Gawande helped me learn more about caring. How about starting a Caring Book Club to support your CPD?

I hope you find this health inequalities edition of *Bulletin* helpful, that it introduces new ways of thinking and energizes you to act. We are all human and deserve an equal chance to live our best lives. SLTs can contribute to that goal, improve services, and support their wellbeing and the wellbeing of their colleagues as they do so. Good luck!

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Leigh is the author of new book '"You all f…g talk too much": meeting communication needs in homelessness settings'.

GREATER MANCHESTER PROJECT

Laura Cole leads a pilot project to embed speech and language therapy in local homelessness services in Manchester.

I work with different teams that support people experiencing homelessness (PEH) who have a mental health condition and may also have drug and alcohol dependence. I also work closely with neuropsychology services to best understand the nature of people's difficulties.

Our teams aim to improve health as well has help people out of homelessness through improved engagement and harm reduction work. We follow an assertive outreach partnership model which includes advocacy and facilitating access to the appropriate services. Holistic recovery and safety plans are developed by recovery coordinator teams.

We recently worked with Alex*, who had previously been discharged from speech and language therapy support after a history of failing to attend appointments. The assertive outreach and partnership model helped Alex to engage with SLT support and they are now receiving regular SLT input.

The kind of conditions I come across most commonly are often cognitive difficulties that may be secondary to drug dependence, alcohol related brain damage and head injury. I also meet autistic people and those with a possible learning disability. For many people, conditions are sometimes suspected but not formally diagnosed. The majority have also experienced significant levels of trauma that impact on mental health. In terms of swallowing I meet people experiencing globus sensation and motility issues.

Part of my work is to train team members to adjust their communication. One social worker colleague told me: "Speech and language therapy input helped me understand X's comprehension difficulties, and that nods and gestures did not mean he understood. I found I changed my communication a lot when talking to him, I gave him more time, kept it more simple."

Training also helps teams deliver information accessibly such as using easy read and other support materials. A staff member told me: "I never would have thought about this until you started working with us," and was enabled to edit a safety plan to make it more visual to meet his client's literacy needs. Staff might develop easy read visual explanations and support to help people look after their health, such as using inhalers or taking medication and attending appointments.

Part of what we do is to support collaboration between patients and third sector services. For someone like Alex, our work can have an impact on care planning, therapeutic engagement and support planning. The speech and language therapy report on Alex is being used by the social worker as part of an application for accommodation. We hope to help people access support and ultimately, find a way to reduce homelessness.

**Alex is an anonymised name*

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Practical tips

Using the RCSLT health inequalities self-audit tool to take action: **Rachel Clare** shares her tips

Ensuring our services are meeting the needs of our populations is all our responsibility. I found the RCSLT's health inequalities self-audit tool and accompanying anti-racism webinar useful in identifying practical steps for addressing health inequalities. Visit **rcslt.info/health-inequalities-resources**.

Local population

We must understand our population in order to meet their needs. The Office of National Statistics' website allows you to review the 2021 Census data by area. You can explore the breakdown of the local population's first language, ethnicity, sexual orientation and highest level of qualification.

Consider how this information can be shared. Can you make it engaging? I tried turning data into a quiz, with team members guessing the percentage of the local community belonging to each overarching ethnic group. I was concerned that playing a guessing game could appear insensitive, but it helped my colleagues get involved with the data and supported meaningful discussions.

For example my team discussed why we expected our local Asian population to be larger because they represent a larger proportion of our caseloads; this supported broader discussions about health inequalities. I found using a quiz made the data memorable; I still remember that the Pakistani community was our largest South Asian group.

Anti-racism workshop

The RCSLT'S anti-racism workshop is a fantastic resource. It requires no preparation before delivery, links to several powerful videos and has engaging activities. We were able to discuss racism experienced or observed and considered how we could better respond as allies.

Auditing assessments

I used the self-audit tool to devise criteria for an audit of our assessments. This was useful for our students to complete, but it also supported me to question resources used. For example, when completing an assessment with a man from Sri Lanka, he pulled a confused face when I asked "Was Picasso a train driver?". To answer this question, you require exposure to an artist who is famous in Western culture. The interpreter confirmed that Picasso is not widely known in Sri Lanka. Being unable to answer this question reflected a different life experience, not comprehension difficulties.

Inclusive resources

Reviewing our therapy resources, I identified they showed only white people and we lacked picture resources about key vocabulary for our populations. The resources provided by local independent provider Total Communication CIC helped begin to address this. For example, their images to support dysphagia discussions show people of different ethnicities, and they have picture cards displaying same sex relationships.

We also identified that our leaflets needed to be more inclusive, as our IDDSI diet leaflets contained only English foods and images of only white older people.

Looking ahead

I have learned so much from this process and look forward to making further changes. I advise you to watch the webinar, download the self-audit tool and choose a couple of areas to focus on.

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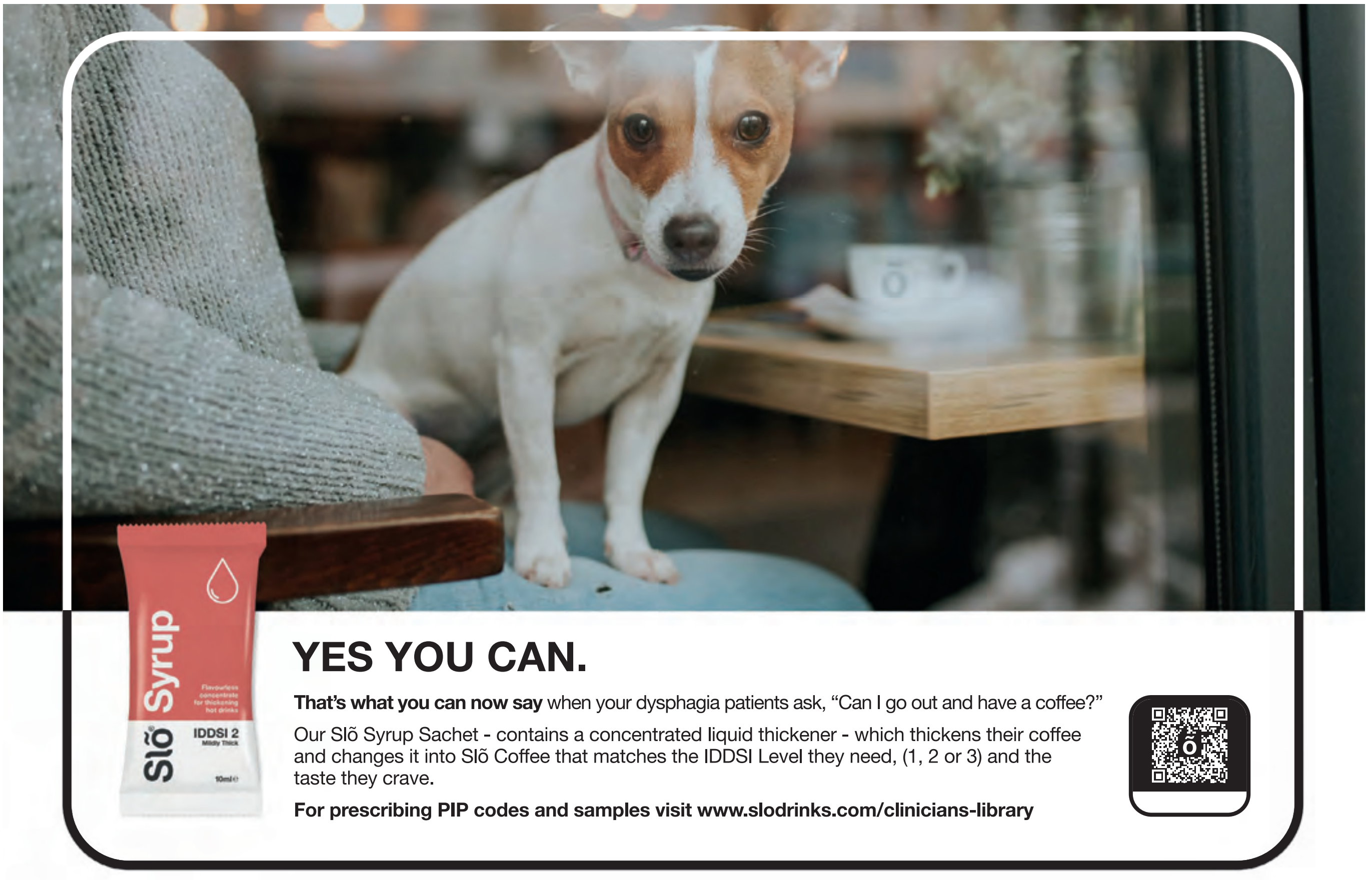
Slõ Syrup
Flavourless concentrate for thickening hot drinks
IDDSI 2
Mildly Thick
10ml

Health inequalities and you

SLTs have a key role to play in addressing health inequalities. **Berenice Napier** *looks at some of the things you can do, and resources to help you get started*

In 2010 Michael Marmot said "Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health."

What is the SLT role across such a broad spectrum of inequalities? The key is to think about services in the context of your wider community. What does your locality look like in terms of diversity, the local economy, social issues and geography? SLTs will know that your caseload may not reflect the full range of needs in the local population. There may be people who are disadvantaged because service models do not meet their needs, much of which is likely to be a result of health inequalities.

Ask yourself if the people you see on your caseload reflect what you know about health inequalities in your community. If they do not then there may be unmet need in your community that is being influenced by health inequalities.

The RCSLT resources on health inequalities offer practical ways to help explore the impact of health inequalities in your own services. These resources are for any SLT, assistant, student or apprentice to use in a way that is useful for you.

These tools will give you a place to start working out the degree of health inequalities in your areas, pointers about what to think about and adjustments you could make. The RCSLT downloadable audit tool takes you through a set of questions to guide you in thinking about this and we encourage you to adapt it for your own needs – you could use it to guide discussion in team meetings, add a rating system, or use as an activity for students on placement with you.

You can also use the RCSLT indicator tool as a quick way to compare and record local population data with data from your service. This might help identify potential discrepancies between who your service is supposed to serve and who it is actually serving, and guide further investigation.

To help you find the information you need about your local population the RCSLT pages include links to lots of external datasets. For example, if you are based in England or Wales you can build a custom dataset for your locality from the Office for National Statistics using Census 2021 data. We have also been working with members on improvements to the RCSLT Online Outcome Tool (ROOT) to help services analyse their own caseload data, so look out for more on this in the next issue of *Bulletin*.

> **Your caseload may not reflect the full range of needs in the local population**

Core20PLUS5 visual resources

RCSLT has produced two new downloadable infographics showing how SLTs can contribute to reducing health inequalities. This resource is based on the NHS England health inequalities improvement programme, Core20PLUS5. This refers to the most deprived 20% of the population plus key groups most at risk of poor health outcomes, alongside five clinical areas which require accelerated improvement.

You might want to use the resources in your workplace, to improve recognition of the role of SLTs in the multidisciplinary team, in training and to stimulate team discussion.

What is the Core20?

The Core20 is the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). This compares deprivation levels between local and national regions, based on things like income, employment, health, crime and living environment.

What are the PLUS populations?

PLUS population groups are identified at a local level, but may include groups who share protected characteristics such as ethnicity, disability and gender. It can also mean inclusion health groups: an umbrella term for people experiencing multiple overlapping risk factors for poor health such as poverty, violence and alcohol dependence.

The five clinical areas

The programme focuses on five clinical areas needing the most improvement to help the affected populations, with separate areas for adults and children.

Using the new resources

There are resources for both adults and children and young people. They explain the five clinical areas and the professional involvement of SLTs, alongside visual symbols to make it more memorable. The resource also gives specific details about the SLT role in local population groups, like care-experienced children. It explains how SLTs can make a difference in many ways by improving outcomes and helping to reduce health inequalities. For example, by advising on oral health, SLTs can reduce the risk of infections and longer hospital stays. And as part of a multidisciplinary team, SLTs can identify and support autistic children and young people, and train others in their care and education.

For more information and ideas about how to use the resources with your team and commissioners, please get in touch: we would welcome your feedback.

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Find out more

Download the infographics from **rcslt.org/health-inequalities**. Watch out for updates on health inequalities and what you can do in e-news and on the website.

FIVE CLINICAL AREAS

Children and young people

- Asthma
- Diabetes (not a routine SLT area)
- Epilepsy
- Oral health
- Mental health

Adults

- Maternity care
- Severe mental illness
- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension case-finding

Find out more about SLT involvement with the clinical areas at **rcslt.info/health-inequalities-resources.**

Open to all

Emma Povey *shares how the Newcastle Autism Team reduced health inequalities by changing their service offer to enable parents to engage with support*

EMMA POVEY

SALLY ELFORD / IKON IMAGES

The Speech and Language Therapy Autism Team at Newcastle upon Tyne Hospitals NHS Foundation Trust supports autistic children and young people. Newcastle is a city with an ethnically diverse population, and 44% of autistic children known to our service are from families with English as an additional language. 49% are from the most deprived decile.

When a child receives an autism diagnosis from our team, parents are offered three follow-up sessions including one by a specialist SLT and two by colleagues from the North East Autism Society. We diagnose between 85 and 110 children every year, and around 35-40% of our families were not accessing our post-diagnosis offer.

It is widely recognised that early intervention is recommended to support the development of speech, language and communication skills in autistic children (NHS England, 2022; Whitehouse et al., 2021).

However, we were concerned that the intervention our team offered was not accessible to all the families on our caseload due to various barriers caused by health inequalities.

To help us get started in addressing health inequalities, we decided to start delivering Paediatric Autism Communication Therapy (PACT).

We wanted to know if PACT was accessible to families experiencing multiple barriers in accessing healthcare.

Bringing PACT to our families

Funding

Newcastle and Gateshead Clinical Commissioning Group received some funding from NHS England which enabled three SLTs to receive training and accreditation to deliver PACT.

Working with families

We recruited 16 families from our caseload who had been unable to access our usual offer due to barriers caused by health inequalities. Each family was offered up to thirteen PACT sessions over six months.

What did the parents tell us about barriers they were experiencing?

Parents reported difficulties related to their child's needs, and difficulties accessing support related to factors such as childcare, travel costs and language.

These included:

- 58% reported that childcare limitations made accessing health appointments difficult. Many parents felt that they could not leave their other children with someone else to allow them to attend appointments.
- 46% reported that transport and travel costs made attending appointments difficult. Parents reported difficulties using public transport with their children, and alternatives were expensive.
- Some families reported reluctance in requesting an interpreter in case they were allocated someone from within their community.

About PACT

Paediatric Autism Communication Therapy (PACT is an autism-specific intervention which has been shown to be effective in the development of communication skills in the short and long term (Mozolic-Staunton et al., 2020; Alred, Green and Adams, 2004; Green et al., 2010). It uses video feedback techniques to help parents recognise their child's communicative signals and create supportive communication environments. Parents identify ways they can change their own interaction to support their child's strengths and abilities.

We chose PACT to trial as an alternative to our standard offer because the intensive nature of the approach over a six month period allows the development of a strong therapeutic relationship, promoting trust and open discussion between parent and therapist. The use of video feedback, rather than the therapist working directly with the child, allows flexible modes of delivery. This helps avoid some of the barriers to attending, with no need to travel to appointments and no need for childcare.

How we reached our families

To ensure attendance we tailored our service in the following ways:

- Flexible offer of session locations.
- Regular and repeated use of the same interpreter.
- Some families were supported to borrow toys from the local toy library. Initially the SLT would support the family to manage the loans, gradually encouraging them to access the service themselves.
- Although parents were given an appointment letter for the sessions, they would often forget. Therapists found that a text reminder message sent to parents ahead of the session was essential to avoid missed appointments.

> **Around 35-40% of our families were not accessing our post-diagnosis offer**

What was the response to PACT?

13 out of the 16 families who took part in the project completed the PACT intervention. The average attendance for the 16 families was 77%.

Parents were asked to evaluate any changes in their ability to support their child's communication development following PACT. They told us that PACT worked for them because they enjoyed setting their own targets and practising agreed strategies. They liked watching and discussing the play session videos with the therapist, and were able to spend more time playing with their child.

- 100% of parents noticed a change in their skills.
- 100% of parents reported feeling more confident in playing and communicating with their child following PACT.
- 100% of parents reported that they allow their child to choose the toys they want to play with and they now follow their child's lead in play.

One parent told us: "Before I started this programme he pushed me away when I tried to play with him …. It's now the other way round, he wants me around and we are playing together. Now I have stopped all my social media because I want to be with my children and I am happier now". Another parent said: "I really wasn't sure about PACT at first but it's made a massive difference".

REFERENCES

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

We found that some families' expectations of the therapy were based on more traditional approaches where the child is seen for 1:1 therapy with a therapist. Families also sometimes expected therapists to demonstrate or 'teach' them how to play with their child. As PACT is a different way of working, at times it was difficult shift this expectation towards parent-mediated therapy.

Thinking about the future

This project showed us that PACT can be an effective treatment option which can be made accessible for families experiencing multiple barriers. We faced some practical challenges, such as finding suitable interpreters. Currently, there is a level of inequality as the waiting time for PACT is longer than our other treatment pathways due to the intensity of the approach, but we hope to secure additional funding to support delivery in future.

We have applied learning from the project to our other pathways, such as sending text reminders for appointments and aiming for the same interpreter for all appointments. We are also implementing coaching techniques with parents and school support staff.

We now offer PACT as pathway when it is clinically indicated for families requiring an interpreter. We also offer it to those not requiring an interpreter but who are unable for other reasons to access our alternative therapy offers such as the Hanen More than Words Parent Program. All SLTs in the Autism Team have now been trained to deliver PACT. With this support in place, we hope it might be possible to see a reduced need for longer-term input from services.

EMMA POVEY, **LUCY BROOKS** and **JENETTE MILNER**, SLTs, Newcastle upon Tyne Hospitals NHS Foundation Trust

Starting from scratch

Emily Davies-Veric *and* **Hannah Roberts** *tell the story of a new critical care and tracheostomy speech and language therapy service*

Although SLTs have a multifaceted role in the management of patients requiring critical care and altered airways, only 23% of critical care services had access to funded SLT services in 2020/2021 (Twose et al, 2023). The SLT role can include the assessment and management of communication difficulties, swallowing impairment and tracheostomy weaning (McRae et al, 2020).

Prior to August 2021, the combined acute and community Royal Wolverhampton NHS Trust (RWT) did not have a funded SLT service for critical care or for patients with a tracheostomy. Input to critical care and those with a tracheostomy was provided by the acute or head and neck cancer service, including occasional assessment in the community. This led to an under-resourced service with SLTs only completing dysphagia assessments. Knowledge of the SLT role in tracheostomy and critical care by the multidisciplinary team (MDT) was therefore understandably lacking.

EMILY DAVIES-VERIC

HANNAH ROBERTS

In its 2020 review of our acute services, the Care Quality Commission recommended that the trust should work to “meet the key standards for critical care workforce in relation to allied health professionals’’ (CQC, 2020). After a successful business case process, a new service providing speech and language therapy specifically for critical care and tracheostomy was started in August 2021.

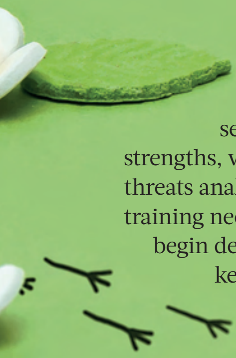
Where we began

Our service incorporates 1.6 full time equivalent (FTE) Band 8a SLTs that cover the integrated critical care unit (ICCU), ward-based and community non-head and neck cancer patients with a tracheostomy. Additionally, it includes a 1.0 FTE Band 7 SLT who covers ICCU and critical care step-down patients. Our ICCU is a 28 bed integrated unit including general and cardiothoracic beds, which are cared for by a skilled nursing workforce. Our community service includes a monthly MDT tracheostomy clinic and

COMPARISON OF REFERRAL NUMBERS AND CASELOAD SIZE

	4 months before new service	4 months after service began	% change
ICCU referrals	22	57	159% (increase)
Ward-based tracheostomy referrals	5	0	100% (decrease)
Community tracheostomy referrals	1	4	300% (increase)

SLT input for patients within their own home or nursing home setting as needed. The service is Monday to Friday only.



Starting a new service

We met as a team to discuss our ambitions for the service. We completed a strengths, weakness, opportunities and threats analysis and identified our own training needs. Our priorities were to begin developing relationships with key stakeholders, establish joint working with the MDT and local care home, and establish referral pathways.

Our aims were to provide early intervention for communication and swallowing on critical care, attend monthly tracheostomy clinic, and to see all patients with a new tracheostomy at the point of sedation hold (when sedation is reduced or removed). We also planned to audit referral numbers to quantify the impact of a new, funded SLT service.

Baseline audit

We reviewed referral numbers of ICCU, ward tracheostomy and community tracheostomy patients for the four months prior to and after the service began. We recognised that use of retrospective audit, and the impact of the COVID-19 pandemic, might influence our findings but felt this was the most practical approach to gain data to demonstrate the changes our service would make.

Referrals

The table shows a large increase in referrals numbers for the ICCU caseload after our service commenced and an increase in community tracheostomy referrals. It also shows a large decrease in ward-based tracheostomy referrals. We reviewed patient notes to learn the reason for the decrease which was due to a variation in transfer numbers from our local neurosurgical hospital as well as an increased numbers of patients being decannulated on ICCU prior to step down.

Compliance

We also reviewed compliance and created a RAG report based on the guideline for the provision of intensive care services (GPICS) (2019), National Confidential Enquiry into Patient Outcome and Death (2014) and Guidance for Tracheostomy Care (2020) before the service started, at four months and at the end of our first year.

RAG report (red, amber, green)

At the starting point of the service, there were 20 items rated red (not meeting the points in the guidance) and none amber or green. After four months, only three items were red including fibreoptic endoscopic evaluation of swallow (FEES) recommendations from guidance for tracheostomy care and GPICS awaiting further wider departmental investment. At the end of the first year, only one item was still red: the NCEPOD recommendation "dysphagia reported in tracheostomy patients warrants ongoing and further study in terms of risk factors, identification and natural history", as our team has yet to actively participate in clinical research. Five items were still amber (in progress) but the remaining 14 were green (achieved).

> Engaging with our key stakeholders was crucial

Stakeholders

Engaging with our key stakeholders was crucial, including meeting with the clinical director, matron, nurse practice development and the leads of the relevant allied health professional services. This was helpful in determining previous views of speech and language therapy and allowing us to do some myth-busting and explain what a fully funded SLT service could provide. We used the audit data to show what we had achieved so far to our key stakeholders.

Key achievements

Over the year we continually reviewed our progress. Some of our key achievements included consistently offering communication assessment, therapy and advice as well as input for dysphagia. We introduced consistent assessment and use of one-way valves for non-ventilated patients and established an MDT tracheostomy ward round. We joined MDT meetings (both clinical and operational) and increased our influence regarding tracheostomy weaning plans on ICCU and wards as well as joining ICCU nurse training.

Our compliance with key standards and recommendations has improved. We also contributed to a joint ENT/SLT FEES service for tracheostomy patients and made a successful bid for FEES equipment for whole SLT service.

Bumps in the road

We recognised that there were likely to be bumps in the road, but due to the time spent planning few of these bumps were entirely unexpected. Key issues that arose were misconceptions about speech and language therapy, and differing opinions on clinical approaches. There were some differing priorities or complex historical issues that meant that certain projects were more difficult to move forward with. See our top tips on navigating the challenges of setting up a new service.

Goals moving forward

After a year there are still several areas of our service that require further development. We have identified our key goals for improving the service, including:

- further training on augmentative and assistive communication for unit staff
- collection of service user feedback
- slt involvement in follow up clinics
- engagement in research
- seven day service and bank holiday cover.

We also have some specific aims to improve treatment including:

- regular use of Passy-Muir valves in line with ventilators
- review of current evidence base for subglottic suction tracheostomies to aid weaning and allow for above cuff vocalisation and engage with relevant stakeholders about potential change in standard trachestomy usage
- development of our slt-led fees service
- set up of biozoon for suitable nil by mouth patients.

We are proud of what we have achieved as a team in the first year of our service. We know that many services are in a similar situation where they may have just received funding or are currently going through the process of submitting a business case for an ICU and/or tracheostomy SLT service. We hope that our reflections have helped you, and would love to hear from other SLTs in similar positions.

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Top tips

- **Plan, plan, plan:** consider your vision, know your strengths and weaknesses, plan for what barriers you might come up against.
- **Engage your stakeholders:** know who your stakeholders are and make time to get to know them and demonstrate what your service can offer.
- **Understand others' perspectives:** there will be a history to views held and decisions made in the past. Be curious, why does a person think what they are thinking? How can you use this information to help develop your service?
- **Gather baseline data and measure your outcomes:** gather data early, it is so useful to demonstrate the changes you have made.
- **Be realistic:** "Rome wasn't built in a day". This is a new service; it will take time to get to where you want to be.
- **Celebrate your wins:** it can be easy to get down about the things you have yet to achieve. Take time to acknowledge all the changes you have made so far!

KERRY'S STORY

Kerry was diagnosed with Guillain-Barré syndrome. She required a prolonged ICCU stay of 76 days, including the placement of a tracheostomy. We became involved when Kerry was switched to lighter sedation whilst still having an endotracheal tube in place. Kerry had significant global weakness, she was unable to move her arms or hands to point or write. Initially eye movements were her only method of communicating. We used partner-assisted scanning with an alphabet chart, an e-tran frame and head switch for attention calling. Mouthing was difficult due to bilateral facial weakness.

Kerry told us: "Not being able to talk or communicate was terrifying. For me being able to communicate was the biggest priority. I was in a lot of pain and using the alphabet chart I signalled this to the doctor. He then was able to do some tests and the discomfort was due to cholecystitis. Without this chart I wouldn't have been able to tell them I was in pain and where that pain was."

We used a one-way valve with her tracheostomy as her respiratory wean progressed to facilitate her voice. Kerry's tracheostomy was decannulated and she is now continuing her rehabilitation.

Trauma-informed care

How can we shape therapy to the needs of children affected by trauma? **Norma O'Leary** *shares a formative experience from a student placement in children's mental health services*

Trauma-informed care (TIC) is a strengths-based framework to promote resilience and wellbeing, underpinned by an understanding and responsiveness to the widespread pervasiveness and impact of trauma (SAMHSA, 2014). Trauma occurs when extreme stress overwhelms a person's capacity to cope (Cook et al, 2003). Research on the application of TIC within speech and language therapy is still a new field, but it is well established that there is an inverse relationship between trauma and communication development (RCSLT, 2021).

In 2020 I was on placement as a SLT student at a specialist mental health setting. My supervisor explained that the consultant psychiatrist had referred a teenager for a language assessment to establish whether communication difficulties could be affecting her mental health. Sarah* presented with diagnosed depression, anxiety and emotional dysregulation, and a history of parental unplanned teenage pregnancy, parental mental health problems, risk taking, substance abuse, self-harm, and suicidal ideation.

When preparing to meet Sarah, my supervisor shared with me that based on Sarah's history it was important to understand the entwined relationship between trauma and mental health and the importance of being "trauma informed". In retrospect, I didn't appreciate the impact her experiences would have on Sarah, how they could be related to her communication abilities and my involvement with her. As I went on to work with Sarah, I realised how important this information was. Now as an SLT I realise the far-reaching importance of being trauma-informed, beyond working in specialised mental healthcare.

The overall goal of TIC is to facilitate opportunities to foster restoration of a sense of control and empowerment through focus on physical, psychological, and emotional safety (SAMSHA, 2014; Hopper et al, 2009). After completing a postgraduate certificate in TIC at University College Cork, I have undergone a change in mindset in understanding Sarah's lived experience of trauma. I now want to understand "what happened to her?" instead of "what's wrong with her?". I can see how much that changes my understanding of Sarah, my ability to have compassion for her, approach her non-judgementally, and build our relationship.

I was intrigued by the landmark Adverse Childhood Experiences study (Fellitti et al, 1998) in the United States and subsequent replications, consistently highlighting that exposure to early adversity can confer significant risk for adverse physical and mental health outcomes across the lifespan (Bellis et al, 2016; Berliner and Kolko, 2016).

As I went on to study TIC, it was important to understand different areas of research from the fields of neurobiology, trauma, resilience, and attachment which collectively underpin TIC. Here I gained in-depth insight into the correlation between childhood trauma exposure and physical health problems, high risk behaviours, cognitive difficulties, socioemotional difficulties and poor academic performance which all relate to communication skills and development (Bartlett and Steber, 2019; Haritopoulos, 2022). This helped me not only to understand the fact that Sarah's adversity and trauma history could be related to her presentation later in life, but understand why and how those experiences might still be impacting her.

IMAGE: ISTOCK

So, what happened to Sarah? She experienced trauma at multiple points through her young life, mainly related to emotional neglect. Sarah's father reported that he struggled with mental health difficulties throughout his life, and parental mood and anxiety disorders are known to be associated with emotional, social, and behavioural difficulties in offspring (Conti-Ramsden et al, 2019).

When rupture occurred in the father-daughter relationship, Sarah did not benefit from a caregiver who could provide the responsiveness, reliability, co-regulation, and emotional closeness that all infants require to be buffered from stress and build resilience (Centre on the Developing Child Harvard University, 2022). In Sarah's case, this led to feelings of a lack of safety, which is critical in the process of healing from trauma and finding new ways of coping and learning how to regulate.

Sarah met criteria for developmental language disorder (DLD). Yew and Kearney (2015) state that children with DLD are above the 70th percentile on severity of emotional regulation difficulties. Sarah's exposure to trauma and concomitant DLD exacerbated her susceptibility to emotional regulation problems. While SLTs regularly work with children with regulation difficulty, in Sarah's case, knowing her history helped me understand Sarah needed to be acknowledged, validated and to feel safe to get back to a regulated state.

> **I now want to understand "what happened to her?" instead of "what's wrong with her?**

In collaboration with Sarah's mental health providers, I gained insight into what made Sarah feel safe which allowed her to benefit from SLT intervention. And sharing the impact of her DLD diagnosis with her psychologist may have improved the effectiveness of mental health intervention as well.

As Hollo et al (2014) have found, the majority of children with social, emotional, and behavioural difficulty may have unidentified language impairments. We also know that around 30% of children and young people report trauma exposure by the age of 18, and that many SLTs will have children and adults who have experienced trauma on their caseload (RCSLT, 2021).

I now realise that understanding the theoretical underpinnings and application of TIC is an invaluable asset in the toolbox of any SLT that can vastly improve one's understanding of our clients, our relationship with our clients and the care and support we provide. My own interest in trauma was sparked by a supervisor with years of experience in specialised mental health services. Later I was able to join a local course on the subject, in order to allow me to make sure that my clients' 'felt' sense of safety was a priority in my work.

I wrote this article because as Rupert and Bartlett (2021) found, many SLTs report working with clients with trauma history but have little to no training on the matter.

How can SLTs gain the knowledge they need to identify the unique support needs of people affected by trauma? I hope this has got you thinking about trauma and how its impact can be highly interwoven with communication and our work with our clients. B

**Sarah is an anonymised name.*

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Find out more

You can look for the research and resources listed on the RCSLT factsheet 'Supporting children and young people who have experienced adversity and trauma' and you can also access all the leading research journals free as part of your membership
rcslt.info/research-journals

Teaching children to listen

Jacqui Woodcock *and* **Liz Spooner** *on building children's ability to focus and listen*

JACQUI WOODCOCK

LIZ SPOONER

It is over 40 years since Cooper, Moodley and Reynell published the Developmental stages of Attention and Listening (1978) that have influenced the practice of clinicians for many years. However, the decline in children's listening skills has been a recent subject for discussion for both SLTs and teachers. Both professions recognise the impact that poor listening can have on children's learning and language development.

Cooper, Moodley and Reynell described a typically developing Reception age child as having integrated attention. Evidence from education colleagues, suggests that this is no longer typical of current Reception cohorts. This was first identified by the groundbreaking ICAN report of 2006 'The cost to the nation of children's poor communication'. This report stated that head teachers felt that 50% of four and-five year olds entering school showed difficulties with speaking and listening.

Why do children find it hard to listen now?

Learning to listen and successfully focus on others requires children to use several different skills. It is likely that one factor is not solely responsible for so many children finding it challenging to listen when they start school. This may be the result of a complex interaction of cultural changes which make the lives of children today different from past generation.

Screen time

Despite the benefits of technology, every hour spent facing a screen is an hour less for children to spend in interaction face-to-face with another person, experiencing the subtle nuances of turn taking within a conversation. A 2019 paper by the Royal College of Paediatrics and Child Health reiterates this point: "Screen time displaces positive activities. Analysis of what leads to positive wellbeing has consistently supported socialising, good sleep, diet and exercise as positive influences. All of these can be displaced by screen-based activities."

Robust listening skills only develop if children have many opportunities to practise them in real life.

Changes in play

McQuade et al (2019) found that "current child play is often seen as more structured and technology driven" rather than engagement in imaginative play

IMAGE: ISTOCK

> **Robust listening skills only develop if children have many opportunities to practise them in real life**

which helps to develop the skills of listening, negotiation and compromise through interaction.

Background noise

Typical early life experiences of children now include high levels of background noise. All children find it harder than adults to screen out background noise to focus on voices. Conversations during background noise mean that children get used to speaking over others which may affect their ability to stay quiet and wait in order to take turns.

Testing a whole-class approach

Our experience as therapists shows us that most children are able to listen when given opportunities to explicitly learn these skills. Traditional listening intervention has been at a targeted level working with small groups in schools. However, we felt that providing whole class intervention, rather than withdrawing children for group work, would maximise impact. This allows children to learn listening skills in the same environment in which they need to use them.

Our aim was to:

- teach children listening rules and motivate them to carry them out independently
- train teachers to support listening.

Putting our plan into practice

Our intervention began with staff listening training. Six, weekly whole-class interventions were delivered by two therapists with the teacher participating. Each 45 minute session included a game to teach each rule and identification of times when it would be helpful to practise that listening behaviour. These were set as class targets. Working with teachers gave opportunities to model strategies to use while teaching.

The teacher reminded pupils of their targets during the week and we reviewed their success the following week. Teaching staff rated each child's listening using the rating scale before and after intervention, giving a score between 4 to 16. To maximise objectivity, when teaching staff re-evaluated the children's listening, they did not see their original ratings.

Listening scores rating scale

- 12 and above: adequate listening
- 8 – 11: moderate difficulties
- below 8: severe difficulties

Finding the active ingredients

We wanted to find out whether our intervention with the children made a difference, or if staff training and exposure to the learning environment were the key ingredients. To test our approach, we carried out a repeated measures study with the Reception cohort of a large primary school.

We worked with two groups of children over the course of a term. Working within one school ensured that children were from the same population and experiencing a similar learning environment. All children received the same intervention at two different stages within the term. Children were rated by teachers at three points in the term. This enabled us to measure whether intervention at a whole class level resulted in accelerated progress compared to whole school training followed by learning in the classroom environment alone.

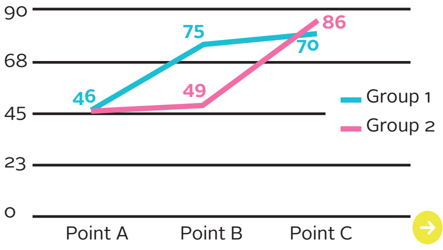
About the children

90 children attending the same school within a semi-rural area of Worcestershire participated. 18% were eligible for pupil premium funding. The district was the lowest in Worcestershire for pupils achieving 'Good Level of Development' at the end of Reception and had an overall ranking of 310 out of 324 in the Social Mobility Index nationally, indicating that low numbers of children escaped the poverty they had been born into.

FIGURE 1: Study process

Whole school training
Point A – Teacher ratings
Group 1 – listening intervention
Group 2 – no intervention
Point B – Teacher re-ratings
Group 1 – no further intervention
Group 2 – listening intervention
Point C – Teacher re-ratings

FIGURE 2: percentage rated as adequate listeners



Results showed both groups made progress in each six-week period, but progress was significantly accelerated when children participated in intervention. Following intervention, the first group sustained this progress, and continued to make small improvements, despite no further intervention.

Making a difference

Anecdotal evidence from teachers suggests that children make some progress with listening skills after starting school. This research provides evidence to support this, as both groups made some progress during the 'no intervention stage'. However it also showed that children made significantly greater progress when they participated in universal intervention to explicitly teach listening. Progress was then maintained following intervention, with no further input.

Were there any limitations to our study?

This design limited other variables that may have impacted on progress by comparing groups of children from the same cohort who were experiencing the same learning environment. However, we recognise that the functional nature of this study led to some limitations in design. For example, working with whole classes meant random assignment was not possible for individual pupils.

Standardised assessments of listening were not available and so informal measures (teacher rating scales) were used. The intervention to all groups was delivered by the same therapists, however each class was taught by a different teacher who was responsible for reinforcing the listening rules during the week. Although each teacher received the same training, how they implemented the approach would have been influenced by their prior learning and experiences.

Reflections

Children's experiences of listening in class over the last few years have been significantly affected by periods of home schooling, virtual learning and different classroom management as a result of the Covid 19 pandemic. The long term impact of this on children's ability to listen and share adult attention in a classroom is not yet known.

The repeated measures design was an ethical way to ensure all the children were able to access intervention whilst still objectively measuring impact. It would be useful to capture information from children themselves about their learning from the intervention.

Whole class listening intervention is not commissioned as part of the core NHS service in Worcestershire. However, many schools choose to commission this intervention directly, often as part of an additional services package to support the school's universal approach to supporting speech, language and communication needs.

Local implementation and impact

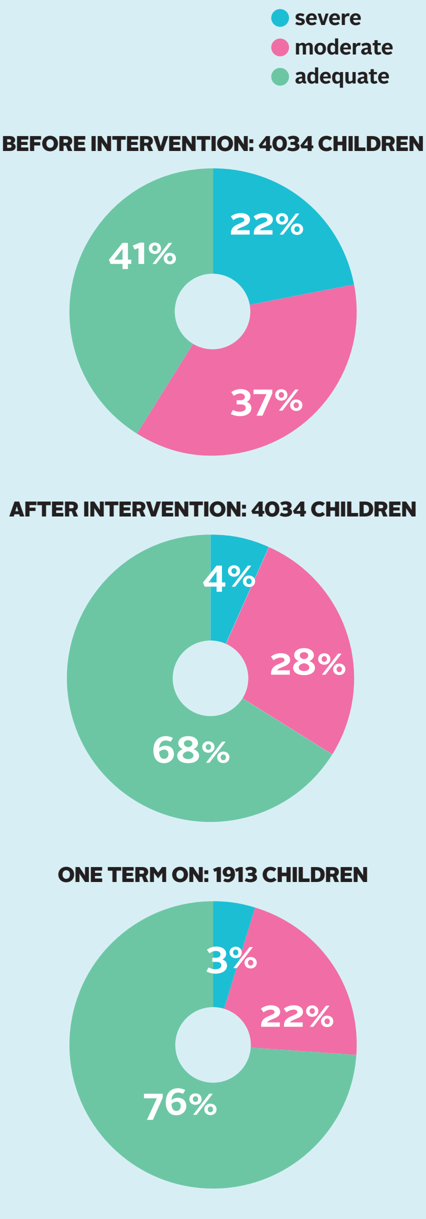
The 'Teaching children to Listen' approach outlined in this research has now been delivered to more than 4,000 children in classes in Worcestershire mainstream schools. Classes from Reception to Year 4 have participated, with teachers rating listening skills before and after intervention and, where possible, again one term on. This enabled us to measure the sustainability of progress.

Results show children in this study made meaningful and sustained progress in listening. Once children have learned what good listening means, and have explicit and consistent expectations placed on them, they are motivated and able to change their own behaviour to listen effectively.

How do we see the future?

Our experience shows that listening intervention can be successfully delivered at a universal level for school-age children. This helps them to generalise skills learned. Partnering teachers with therapists enables teachers to develop skills in supporting children's listening. The Foundation stage curriculum makes clear the importance of speaking and listening skills, but there is less clarity on how this can be achieved. We would love to see universal intervention to teach listening skills as a key part of the curriculum for Reception children.

FIGURE 3: Change in teacher rating of children's listening skills



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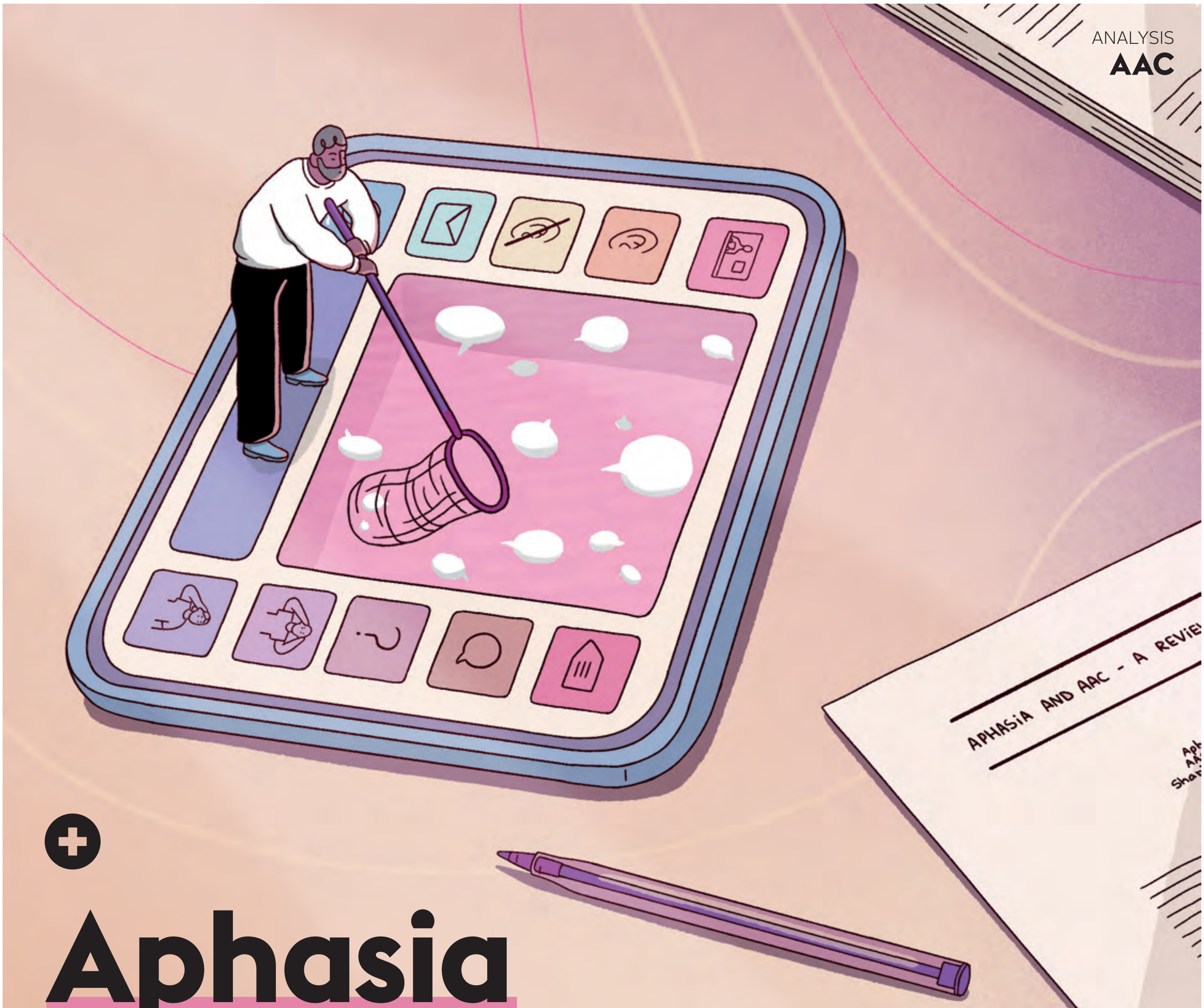


Aphasia and AAC

Shani Ackford *carried out a detailed review of her specialist service to learn more about providing powered AAC to people with aphasia*

People with aphasia (PWA) have communication difficulties that can affect their quality of life and emotional wellbeing, and there are higher rates of post-stroke depression in PWA than those without aphasia (Lincoln et al, 2012). Augmentative and alternative communication (AAC) can provide access to language for PWA. However, providing AAC for PWA can be challenging, as the difficulties they have with spoken and written language can also make accessing powered (high tech) AAC difficult.

ILLUSTRATION: ROWENA SHEEHAN

As an SLT in a specialised AAC service in the West of England, I wondered what outcomes we were achieving with this group and how we could improve the service we provide for PWA who require specialist AAC assessment. To help answer this question, I carried out a project to evaluate the service we provide for PWA. We aimed to explore the AAC recommendations made to individuals, review the outcomes of our input and identify ways to improve the service offered.

Currently, in order to meet the threshold for NHS England specialised AAC service criteria (2016), people who can use a touch screen must be able to use a complex multi-page vocabulary to combine multiple words, phrases or symbols to compile a sentence. This is more challenging for PWA than for someone with a motor speech impairment.

What are the AAC options for people with aphasia?

In choosing and designing an AAC system for PWA, the literature points to two ways to present vocabulary:

1. grid displays with minimal complexity (Petroi and Corwin, 2014)
2. visual scene displays (VSD) (Blackstone, 2004; Dietz, 2006) where a contextual image is presented with related phrases (see image). These are different from VSDs with hotspots, which are more commonly used with children, where a message is spoken when the AAC user selects an area of the image, (eg selecting the fridge in a photo of a kitchen creates the spoken message “I’m hungry!”). (Light et al., 2019).

Evaluating our service

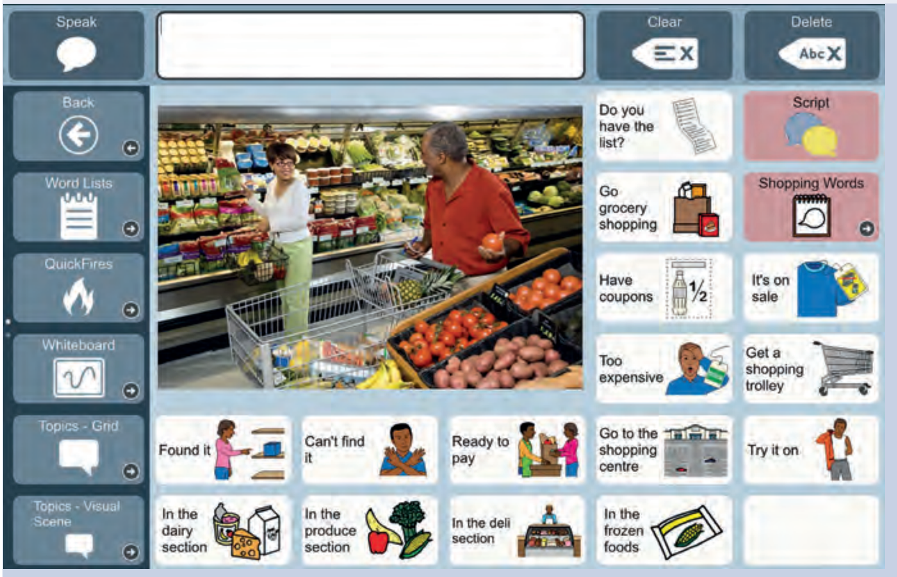
The service evaluation was completed through a retrospective case note review. From our patient database we identified that, between 2013 and 2020, 98 people had been referred to the service who had aphasia, or an acquired neurological condition that can result in aphasia.

I manually reviewed these notes against the following inclusion criteria: adults with aphasia as their main communication impairment, seen for a full assessment process (assessment, AAC loan, review). I found 21 people who met our criteria, including 13 men and 8 women, with an age range of 27-82.

This included:

- 15 people with aphasia following a stroke
- two with diagnoses of traumatic brain injury (TBI)
- two with primary progressive aphasia (PPA)
- two with brain tumour.

EXAMPLE: Visual scene display (VSD) from TD Snap Aphasia Pageset



Our objectives were to gather data on AAC display designs that were recommended and provided for loan, and review outcomes. Retrospective data was gathered from appointment notes, reports, and goal sheets, and pre- and post-intervention Therapy Outcome Measures (TOMs) (Enderby and John, 2019) were recorded for activity, participation, wellbeing and support. TOMs ratings were available dating back to 2017, but not all recorded the optional wellbeing and support. The support score reflects the level of support available and considers the knowledge and skills of communication partners and AAC opportunities provided.

What we learned from our evaluation

21 PWA had been seen for a full AAC assessment process (average of three per year. Of these:

- 20 PWA were provided with grid displays
- one was provided with a VSD.

Vocabulary

- three PWA were provided with a standard AAC vocabulary package
- three were provided with a standard vocabulary with significant changes
- 15 were provided with a highly bespoke vocabulary.

Therapy Outcome Measures

11 PWA had activity and participation TOMs scores, and 100% of these had a significant increase in their activity and/or participation. Nine PWA had patient wellbeing scores and 33% of these showed a significant increase. Eight PWA had support scores and 75% had a significant increase.

The mode average change from pre- and post-intervention TOMs for each of the domains were:

- Activity +1.0
- Participation +1.0
- Patient wellbeing +0.0
- Support +0.5

An increase of 0.5 points is statistically significant (Enderby and John, 2019).

Goal progress, AAC use and linguistic complexity

Goal sheets, reports and case notes were used to allocate each PWA to a group.

- Group 1: goals all/mostly achieved and AAC used in at least one situation (16 PWA / 76%)
- Group 2: goals not achieved, very limited AAC use and device returned (5 PWA / 24%)

At the end of their equipment loans 10 PWA were predominantly 'whole phrase AAC users' (least linguistically complex), 9 PWA were 'sentence starter AAC users' (combining a partial phrase with a word or another phrase), and two PWA were 'mixed AAC users' (most linguistically complex; using a combination of phrases, single words and the keyboard). The chart shows the goal progress for each of these types of AAC users.

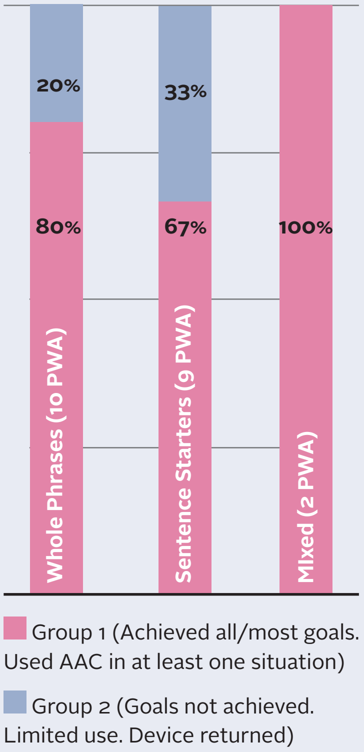
What we learned

The results identified that as a service, we have recommended mostly grid displays and these were largely highly bespoke (vs off the shelf solutions). This indicates that the standard AAC vocabularies available at the time may not have met the needs of PWA, and VSDs were also not regularly recommended. AAC input had a positive impact on functional communication, as demonstrated by an increase in the activity and participation scores. TOMs data was limited so it is not possible to say if this was true of all 21 PWA. The same increase was not seen in wellbeing scores, and whilst there was an increase in support scores, post-intervention support scores were still relatively low (average score of 3/5 indicating a basic or bare minimum level of support). This suggests there may be a need for more communication partner training.

Regarding linguistic complexity, the group who were using the most complex vocabularies had the best outcomes with regards to goal achievement and AAC use; these two PWA had particularly intact reading comprehension and cognitive abilities. Those who were using the least linguistically complex vocabularies (mainly using whole phrases) also had good outcomes; 80% were achieving their goals and using their AAC functionally in at least one situation. However, those who were using a medium complexity vocabulary (sentence starters) had mixed outcomes, with 67% achieving all or most of their goals. This suggests that these AAC systems may not have been best matched to the PWA skills, though more information is needed about the language and cognitive profiles of these individuals.

24% of the PWA did not keep their powered AAC; this indicates that for some PWA complex powered AAC is not appropriate. These PWA were recommended paper based AAC, some basic AAC phone apps, alongside other total communication strategies. Notably 60% (3/5) of these PWA had goals around combining words and phrases. It may be that the linguistic demands of the complex powered AAC for these PWA was unrealistic.

GOAL PROGRESS BY AAC USER TYPE
(grouped by linguistic complexity)



Looking ahead

Although the literature recommends VSDs for PWA, in practice these were not commonly recommended by our service. There are more apps available now that use VSDs, and some designed for PWA that incorporate total communication strategies like whiteboards, photo albums and rating scales. More work is needed to explore how VSDs may impact outcomes for PWA, if they support functional communication for PWA, and how useful PWA find them.

AAC can be beneficial for supporting PWA's communication, but it is important to design an AAC system which is appropriate for the person's language and cognitive skills. Specialised AAC services are funded to meet the needs of the 10% most complex AAC users, but does the national criteria's focus on sentence building negatively affect outcomes for PWA in this client group?

Further questions arise such as: which PWA should be seen for specialised AAC assessment? Does the assessment and design of less linguistically complex AAC systems for PWA require specialised service input? Is there a gap in AAC vocabularies for PWA, leading us to design bespoke ones? What AAC input would have a positive impact on patient wellbeing? And which outcome domains are important to PWA? Given the relatively low numbers of PWA seen by our specialised service, we may need to explore whether there is an unmet need.

Since completing this project, I have been trialling more VSDs with PWA and plan to re-evaluate the service. Next steps for our service are to develop a training video for communication partners of PWA, and to organise an involvement group with PWA to set priorities for future work and research in this area.

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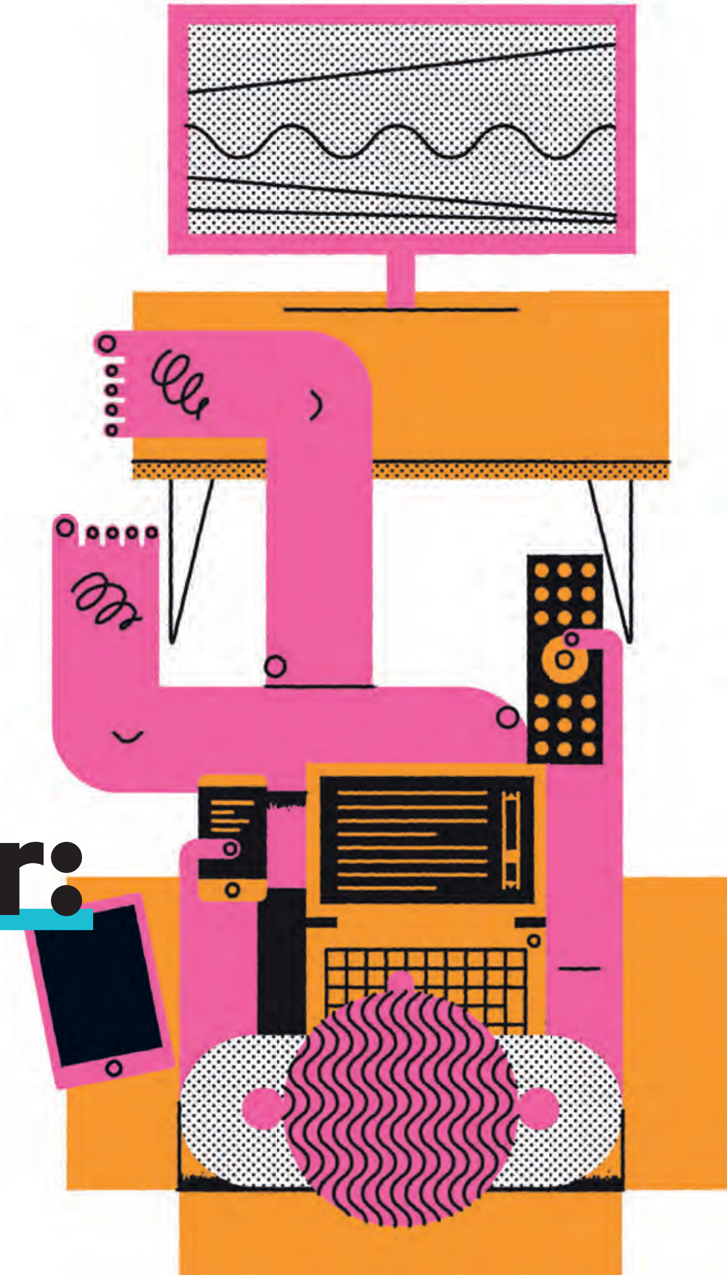
AAC guidance available now
The latest RCSLT guidance on AAC coproduced with service users and professionals is available at **rcslt.info/aac-guidance-2024**.



Head and neck cancer: growing services

Ceri Robertson *and* **Rhiannon Haag** *ask how we can learn from each other when we are trying to improve and develop our service for head and neck cancer patients*

CERI ROBERTSON

RHIANNON HAAG

The National Cancer Experience Survey (2022) highlighted that only 51% of patients felt they received enough support at home from community services, a figure unchanged from the previous year. Individuals living further from their cancer centre are less likely to continue with follow-up and report significant psychosocial burden associated with travelling (Pallin et al., 2024). The challenges of meeting the many unmet needs of cancer survivors have led to a system-wide call to redesign models of care (Jefford et al., 2022). As rehabilitation professionals with a central role in supporting people with head and neck cancer, SLTs are in a unique position to progress personalised, local care for this population.

The RCSLT head and neck guidance reflects the ambition of developing services to meet service user needs. Finding out what others are doing in the field can inspire change, and can provide reassurance about novel approaches that have been tried and tested elsewhere.

New service templates

To help you share your experiences we created a new resource which collects real examples of service developments and innovations in this field. These templates outline the background, approach, challenges, outcomes and impact of the development or innovation. The resource aims to inspire and facilitate future SLT service developments and to celebrate and learn from success.

How you can use the templates

The templates give clear summaries of the approach taken to setting up a new service or development within a service. They provide methods of evaluation, and top tips for other SLTs wanting to develop similar models of practice.

Some of our latest templates

The templates are available now for you to read and try out ideas. Some of the topics already shared include:

- Community and multi-aetiology head and neck fibreoptic endoscopic evaluation of swallowing (FEES) services.
- Improving access to FEES (including for those with mobility challenges) and reducing patient travel time.
- Provision of biofeedback and targeted dysphagia rehabilitation, improved patient experience and engagement with swallowing rehabilitation.
- Two examples of community surgical voice restoration services including access to rehabilitation, long-term support and voice prosthesis changes in people's homes.
- Collaborative multidisciplinary home visits for laryngectomy rehabilitation, swallowing assessments and palliative or end of life input for communication and swallowing.

> **Learning through the experiences of others may help to develop head and neck SLT services nationally**

Understanding the challenges

Our template authors are SLTs working to tackle challenges such as training requirements, skill maintenance and service pressures. The templates outline their approach to setting up a new service or development, while managing challenges such as clinical commitments and capacity, and availability of equipment or other team members. Some of the resourceful and creative responses to these challenges included taking patient-centred, flexible approaches to optimise swallowing and communication rehabilitation. Other solutions included improving patient choice of service delivery location and designing safer discharge processes. Their goals included avoiding potential hospital readmissions and increased collaborative working across the multidisciplinary team and community services.

Thinking about your own service development?

Top tips from the templates include ensuring data collection throughout implementation of the development and beyond within a cycle of continuous improvement. There are also outcome measurement case studies available on the RCSLT website, and head and neck-specific outcome measures listed in the RCSLT head and neck guidance.

When evaluating your service and considering service developments, you may want to use the health inequalities self-audit tool on the RCSLT website to prompt evaluation and reflection about the barriers to healthcare that may affect your local population.

Making an impact

Service users tell us about the difference a well-thought-through service makes to their health and wellbeing. A family member of one service user told us:

"Having an appointment at home… after such a long time in hospital, really meant my Mum got the care she needed at the right time in the right place. Being at home meant her appointment was about promoting independence which was her no. 1 issue at that time… it helped seeing her in her own environment too. The flexibility was, and is, still so appreciated for us both, as patient and family member".

Share your experience and ideas

Do you have a head and neck cancer service development to celebrate? Would you like to inspire others by sharing how you overcame challenges to bring about change or innovation? Add your examples of embedding evidence-based practice, service developments and improvements to our resource by filling in a template.

Learning through the experiences of others and sharing resources may help to develop head and neck SLT services nationally. We will continue to improve outcomes for head and neck patients, offer more personalised care, and provide opportunities for cross-skilling with SLT colleagues.

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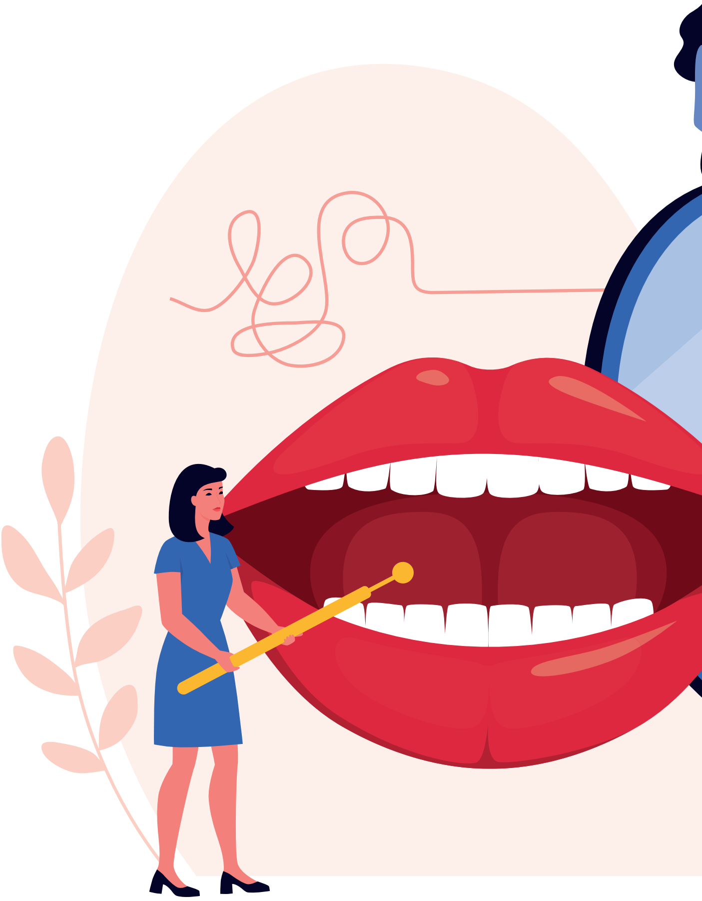
Find out more

Visit the RCSLT guidance on head and neck cancer **rcslt.info/head-and-neck** Look for the new templates in the resources section.

JOHN DEVOLLE / IKON IMAGES

Research arena



Gillian Rudd *and* **Kirsten Howells** *report on STAMMA's new forum for connecting researchers with people who stammer*

The research committee at STAMMA considers around 20 requests a year from researchers inviting our members to take part in research studies. Although we require researchers to explain how they have involved people who stammer in the design and delivery of their study, the stated involvement is often minimal. How could we improve the connections between researchers and people who stammer? And how should we support people who stammer to be active partners in research, as well as participants and observers?

STAMMA is the national UK charity for people who stammer and their allies. Although research is not a primary activity for us, we are conscious that research underpins all of our work, including the aims to support more people who stammer in the UK and to educate the public.

Our research committee provides direction on matters relating to research, including considering how external research should influence STAMMA's activities and the extent to which the organisation should be directly involved in research.

GILLIAN RUDD

KIRSTEN HOWELLS

The research requests we receive range from small-scale student studies to PhD projects to large international projects, which we review in terms of relevance, quality and expected benefit.

There is a growing recognition of the importance of public involvement in research, meaning research that is done 'with' or 'by' the public, not 'to', 'about' or 'for' them (NHS Health Research Authority, 2021). This is in line with anecdotal concerns from the stammering community that research is often done 'to' not 'with' them and that research does not always focus on what is most important to people who stammer.

As a committee we felt strongly that public involvement was important and, noting that it so rarely seemed to happen, we felt we had a role in encouraging this. We also recognised the challenges; while some researchers had established networks of people who stammer, many had not and were unsure how to develop these. We had a mechanism for supporting researchers to make contact with prospective participants once their project had received ethical approval but how could we support people to make connections earlier?

IMAGE: ISTOCK

> **Everyone gets a chance to contribute if they want to and it's a pleasure to attend**

Research Arena

We launched the Research Arena on a Saturday morning in June 2021 and have held events approximately every two months since. We aim to create and curate a space for dialogue, aligning with STAMMA's values of collaboration, community and openness.

Researchers are invited to give short presentations on their areas of interest and current projects, sharing questions with the audience that they would particularly value input on. These questions differ from the questions the researchers are trying to answer in the study itself; instead they are about the aims or design of the study or the dissemination of findings. We encourage researchers to seek, with curiosity and interest, the input, experience and insights of the participating audience through meaningful dialogue.

A written summary of the information is shared with attendees in advance, giving them additional time to consider the topic and the questions. Aiming to model the behaviours we expect from other organisations, we have a keen focus on accessibility and inclusivity and ensure that we implement the following as standard:

- We have a clear and consistent structure and expectations for civil and constructive engagement which we share at the start of every session.
- Timings are indicative, not rigid, pushing back against 'chronopolitics' – or how time pressure is used as a basis to exclude disabled people in research and academic life (Isaacs, 2020).
- Two facilitators are present at each session, enabling rapid problem-solving and resolution of any issues arising.
- There is no expectation that attendees will have any prior knowledge of research or related terminology and we ask researchers to bear this in mind while presenting.
- We invite immediate feedback through polling at the end of each session and more detailed feedback via chat comments and email.

When we asked participants for feedback about why they attend, we were told:

"As well as learning more about stammering research, I've discovered that my own experience and expertise as a person who stammers means I can contribute to the discussions."

Christine Simpson, another regular attendee, shared the following with us: "I am very interested in research about stammering. It has been a very misunderstood condition and I want to do all I can to promote more research particularly of stammering in women. I think it is so that we can have an input into how they research. Research Arena is the best way to do this. Also I keep returning as it is really well managed. Everyone gets a chance to contribute if they want to and it's a pleasure to attend."

Reflective prompts for coproducing research

- How do you promote research through your work?
- How can you support people who access speech and language therapy services to learn more about research and become involved in projects that might interest them?
- Who might be your partners in this sort of work? (eg people with related personal experience, SLTs working in different sectors, other professionals, public and private organisations etc).
- How can we share power in the design and delivery of services and move closer to co-production in practice?

Researchers value having a space in which they can share their developing ideas and participants welcome the opportunity to learn more about how research works and to contribute towards projects as equals. Feedback from researchers participating in the events includes comments such as: "It was a really great experience on Saturday – we are really grateful for the help and input. Amazing opportunity."

There is no expectation that attendees will be involved in projects beyond the Research Arena sessions but many have gone on to volunteer their time in this way. Perhaps this is unsurprising in light of Crocker et al's 2018 findings that public and patient involvement can improve the enrolment of participants with lived experience in clinical trials.

For us as facilitators, the Research Arena has been a wonderful way to connect with others interested in stammering and to be part of meaningful conversations that support positive change. It has enabled us to practise in a way that is closer to our personal and professional values and we look forward to seeing how it continues to grow and change over time. B

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ASK THE EXPERTS

Assessing multilingual children for DLD

Ludovica Serratrice *and* **Emma Pagnamenta** *explore evidence-based tools for language assessment in bi- and multilingual children*

LUDOVICA SERRATRICE

EMMA PAGNAMENTA

According to the latest school census in England from January 2023 over 1.7 million schoolchildren are exposed at home to a language other than English. The percentage of children in state-funded primary school who have English as an additional language (EAL) is 18.1% in secondary schools, 22% in primary schools, and 30.4% in nursery schools. Given that the prevalence of developmental language disorder (DLD) is around 7-8% (Norbury et al, 2016), SLTs in children's services can expect to work with children who have more than one language and who may have DLD. However, SLTs report lacking knowledge of multilingualism and best practice in assessment and management.

IMAGE: ISTOCK

What do we mean by multilingualism?

The EAL category encompasses a range of multilingual backgrounds and experiences, from children who are completely new to English to those who are being raised with two or more languages from birth. Children's experiences of multilingualism vary according to societal context and family environment. Educational opportunities, and the extent to which the languages they speak differ from each other are also important (Dixon et al 2012).

The most common societal context for multilingual children in the UK is exposure to a language at home that is not the dominant language of the wider society (ie the 'heritage' language) for which there is no formal support in mainstream education.

Unsurprisingly, there is a close relationship between the amount of exposure and the diversity of language opportunities, and children's language skills in each of their languages. Therefore, the expectations that caregivers, teachers, and SLTs can have about children's linguistic development in each of their languages must be informed by what they know about the children's language environment and by their language history.

Multilingualism is a spectrum rather than a binary category (Surrain and Luk, 2019) and it is key that the complexity of the children's language background is considered in any type of assessment.

The SLT's goal is to determine whether a multilingual child's language and communication needs are a result of reduced language exposure and use in one or more of their languages, or whether they are pervasive across all of their languages, which would be a red flag for DLD.

The RCSLT is committed to supporting bilingual individuals and their families, recognising bilingualism as an advantage in a person of any age, regardless of the presence of a speech, language, or communication disorder, or feeding and swallowing difficulties.

Which tools are available to support assessment of bi-multilingual children?

Identifying DLD is a complex task that in monolingual children is supported by observation, informal and dynamic assessment, and by the judicious use of standardised assessments. For multilingual children there are very few equivalent assessments that have been standardised on a multilingual population. There is however a set of freely available tools that have been specifically developed by researchers to improve the language assessment of multilingual children, which we have brought together in this article. You can contact the resource developers with any questions you may have about the individual assessment tools.

Multilingual language assessment tools

The Q-BEx questionnaire: quantifying the bilingual experience

q-bex.org

In addition to receptive and expressive elicitation tasks – ideally in all of the child's languages – a clinician will need a detailed picture of the current language environment and of language history. Detailed information gathering on children's language background can be supported by the use of caregiver questionnaires. While most SLTs already collect this information as part of their assessment practice, the Q-BEx questionnaire has been developed with the aim of harmonising this type of data collection and to facilitate data sharing with teachers, other professionals, and parents.

The modular structure of the questionnaire allows SLTs to include up to seven modules including the three obligatory ones (background information, risk factors, language exposure and use). The tool asks the caregivers – or children themselves if 12 or older and with sufficient literacy skills – about topics including perceived language proficiency in all languages, richness of the linguistic experience, attitudes and satisfaction with the child's language skills and most importantly, language exposure and use in all their languages. The questionnaire is available in English and 22 other languages and must be completed online. A summary report is automatically generated which includes a red flag index for children that may be at risk of DLD (currently available in English and Dutch only).

LITMUS tools

bi-sli.org

Over the last 10 years researchers in the LITMUS network have been working collaboratively on a range of tasks that tap into language constructs that are useful to identify children with DLD: non-word repetition, sentence repetition, receptive and expressive vocabulary, and narrative skills.

The tasks are not normed and have not yet been validated as diagnostic tools in clinical practice, but they provide SLTs with useful elicitation tools that have been developed by linguists and SLTs as screeners for DLD in multilingual contexts. A growing body of research is showing that these tasks are effective at distinguishing multilingual children with and without DLD in research studies.

The LITMUS tools include:

1 Quasi-universal non-word repetition task

bi-sli.org/qu-nonword-repetition

Phonological working memory – as measured by non-word repetition – is an area of vulnerability in children with DLD, and phonological working memory task performance remains one of the best predictors of language impairment (see Ortiz, 2021; Schwob et al, 2021). The quasi-universal non-word repetition task in the LITMUS project (QU-NWR) includes both language independent non-words and language dependent non-words and it is suitable for children between the ages of four and nine.

The idea behind the language independent items is that they are built on segments and syllable structures that are available in most languages of the world, thus reducing the burden of language-specific knowledge for multilingual children. The language dependent items include elements of phonological complexity that are part of the language being tested. There are several versions of the QU-NWR available, and a British English version is currently under development.

2 Sentence repetition task (SRT)

bi-sli.org/sentence-repetition

While working memory is necessary in sentence repetition, it is clearly not sufficient. To be able to recall a sentence verbatim children need to parse the sentence into its constituents (eg noun phrases and verb phrases), interpret the underlying syntactic representation, assign syntactic roles (eg subjects, objects, indirect objects) and thematic roles (eg agents, patients, themes, recipients), and elaborate an articulation plan. All these steps tap into lexical, morphological, and syntactic knowledge and therefore performance on a sentence repetition task provides valuable information on children's language skills.

The LITMUS SRT has been developed in parallel for 28 languages. The task includes a core set of sentence structures that are known to be challenging for children with DLD regardless of the language they speak (eg relative clauses), and a set of items that tap into language-specific markers of DLD (eg tense in English and clitics in Romance languages like Romanian and Italian).

The LITMUS SRT is suitable for children between four and nine.

> **Lack of [multilingual] resources is a significant barrier to best practice**

3 Multilingual Assessment Instrument for Narratives (MAIN)

bi-sli.org/litmus-main

Narratives are a relatively ecologically valid method of data collection. They work well with children of different ages from three years onwards and they yield rich data that can be analysed at different levels of language (phonology, morpho-syntax, lexicon, pragmatics) and connected speech, and at the level of story grammar. Studies comparing bilingual and monolingual children with DLD (Boerma et al, 2016; Tsimpli et al, 2016) have found an effect of language disorder but no effect of bilingualism suggesting that narratives can be a useful diagnostic tool that does not penalise bilingual children.

The MAIN (Gagarina et al, 2012;2019) includes four stories with six colour pictures. Each story includes three episodes with an attempt, a goal, and an outcome and two internal state terms. The story can be administered in a 'tell' or 'retell' modality. Following the narrative, children can be asked 10 comprehension questions that tap into their inferential understanding. A template is available for the scoring of the narratives' macrostructure, ie story grammar, and SLTs can use the children's production to include additional information on microstructure (eg syntactic complexity, mean length of utterance, lexical diversity, and story length). The MAIN can be used with children between three and 10 and is currently available in 93 languages.

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Find out more

Online course: Centre for Literacy and Multilingualism FutureLearn online course 'Understanding multilingual children's language development' aimed at pre-registration and practicing SLTs and teachers: **rcslt.info/futurelearn-course**.

Book: '*Working with children experiencing speech and language disorders in a bilingual context: a home language approach*'. Sean Pert, Taylor and Francis 2022. This book is an invaluable and informative resource for SLTs working with multilingual children.

Knowledge does "natter"

NHS Fife Speech and Language Therapy Service share their tips for keeping up with the guidance and connecting with each other

In the Speech and Language Therapy team in NHS Fife, we are always looking for innovative ways to embed continuing professional development (CPD) and learning opportunities into everyday practice.

We were inspired to create our new CPD session format by the Health and Care Professions Council Standards for CPD which stated that "there is some developing evidence that suggests that the most effective learning activities are often those that are interactive and which encourage self-reflection."

What is "Knowledge Natters"? Knowledge Natters is a half-hour monthly CPD session where staff meet online to discuss an identified 'hot topic'. It is an opportunity to develop knowledge and skills, reflect and contribute to the development of others. Sessions enable dynamic learning on practical topics that can be easily applied to practice. They are informal, but follow a regular format.

> It's amazing what you can learn in 30 minutes

Sessions begin with a key speaker setting the scene and introducing the topic. This is followed by a small group discussion in breakout rooms to explore key questions and learn from each other. In the final five minutes, facilitators for each group share brief feedback. Finally, everyone is invited to share a key 'nugget' of learning, using the online chat function. Learning from a "Knowledge Natters" session regularly leads to further discussions about topics in other forums so often leads to further learning and development. We also add our reflections on this learning to our CPD portfolio and HCPC audit evidence.

What is a "hot topic"?

Topics for discussion are around current research and topical issues, both clinical and non-clinical. These are related to service drivers and staff issues. As we are a lifespan service, we discuss topics that are of interest and relevance to staff across all care groups. The inclusion of all staff groups generates a rich breadth of discussion and learning. So far, topics have varied from subjects such as supporting students, good conversations, GDPR and lone working, to topics from the RCSLT *Bulletin* like 'cultural competence'. The topic that generated the most 'nuggets' of learning was 'Wellbeing Natters', where ideas and resources to support our own and each other's wellbeing were discussed.

Evolving Knowledge Natters

So far, the average number of staff at a session is 24 across Adult, CYP Therapists and Support Practitioners (this is approximately 30% of clinical staff). The majority of people attending Knowledge Natters have attended multiple sessions and the feedback has been very positive. Staff have said: "Great session and brilliant format" and "It's amazing what you can learn in 30 minutes".

We plan to continue with our monthly online sessions with current topics, and we recently included our occupational therapy colleagues in a session. We are looking at how our sessions can evolve to keep meeting the CPD needs of the Speech and Language Therapy Service within NHS Fife.

AURA BISHOPS, **CHARLIE MALLOY** and **RUTH WALLACE**, SLTs in the Speech and Language Therapy Service, NHS Fife

Inclusion and diversity: core to professional practice

RCSLT's **Naila Noori-Khan** and **Victoria Harris** pick up some of the questions you may have about equality, diversity and inclusion

Equality, diversity and inclusion (EDI) is a golden thread that runs through all areas of professional practice.

We all aim to ensure we are providing equitable, respectful, and effective care to all individuals, regardless of their background or identity. It's a critical aspect of professional practice, promoting better outcomes for service users and fostering a more diverse and empathetic field.

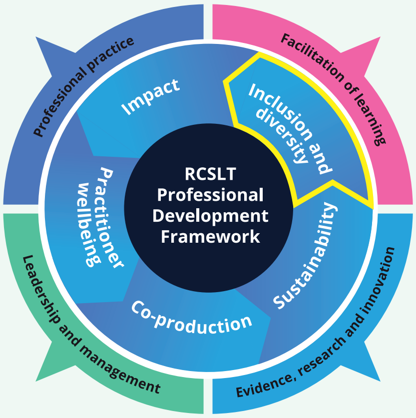
The HCPC updated its standards of proficiency in 2023 and strengthened and extended the section on EDI. These are the standards SLTs are required to uphold, under the broad heading: "Recognise the impact of culture, equality and diversity on practice and practise in a non-discriminatory and inclusive manner."

The RCSLT Learning Team has been out and about and in online events for the past year, meeting members to share the Professional Development Framework. We've been asked by members how they should approach the inclusion and diversity aspect of the framework, so here is an overview and some practical tips to help you find a way in.

What do we mean by 'inclusion and diversity'?

"Inclusion and diversity involves valuing differences and engaging in continuous learning and development to promote greater equality, diversity and inclusion for all, and embed anti-racism within the profession and in service provision" (ACAS, 2022).

'Inclusion and diversity' is one of the five core components of the RCSLT Professional Development Framework. It sits alongside impact, practitioner wellbeing, sustainability and coproduction as a key value for speech and language therapists. The framework recognises the central importance of inclusion and diversity, which has been woven through the four domains of practice, sub-themes and detailed topics to embed the values across all areas of learning and development.



> **Inclusion and diversity is one of the five core components of the RCSLT Professional Development Framework**

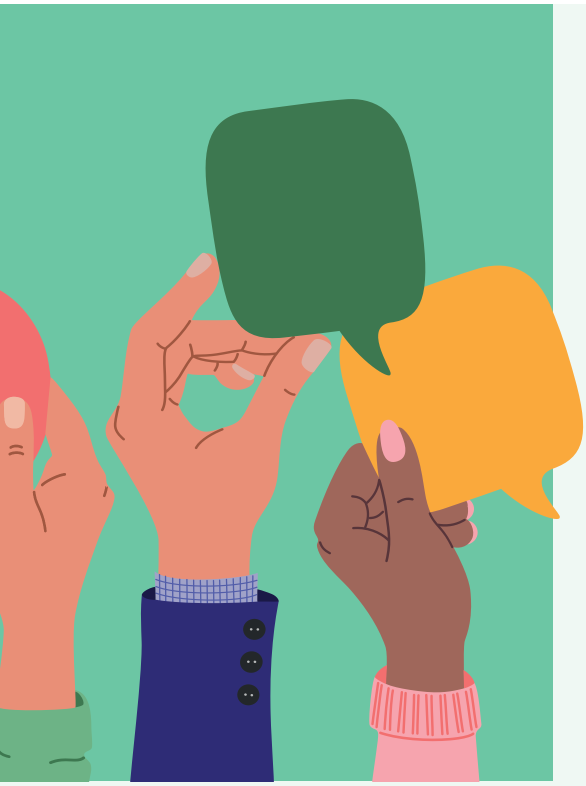


IMAGE: ISTOCK

As individuals and as a profession, our aspirations include:

- A more diverse student population and workforce, across all protected characteristics, at all levels of seniority, who are valued and can bring their whole selves to work.
- Everyone, including those from underrepresented groups such as members from a black, Asian or minority ethnic background, who are LGBTQIA+ or who are disabled, are fully included in the profession.
- Culturally and linguistically inclusive, coproduced services, made accessible to all.
- A profession empowered to tackle racism and discrimination in our services and society.
- A profession that works proactively to reduce health inequalities and the impact of socioeconomic disadvantage on service users (RCSLT, 2022).

How to think about your Inclusion and diversity as a practitioner

The RCSLT Professional Development Framework offers a set of reflective questions around inclusion and diversity (p14). These are offered as a starting point for conversations about inclusion and diversity in relation to your practice, learning and professional development.

Reflective questions

Think about the definition of inclusion and diversity in relation to your own current knowledge and experience.

- What does inclusion and diversity at work look like for you?
- What is within your control to keep doing?
- What is within your control to improve or start doing?
- What is within your control to stop doing?

This framework gives you permission and time to reflect on your Inclusion and diversity in your practice. You can consider these questions individually, in a team, or with someone you trust.

Finding the support materials you need

Aligning with and supporting the framework to promote good clinical and professional practice in line with HCPC standards, the RCSLT have published an array of guidance and resources supporting diversity and inclusion within the profession and to improve outcomes for service users. The information below is not exhaustive but highlights some resources we hope will be beneficial.

Workplace guidance

The RCSLT offers a hub of resources to support good practice around diversity, equality and inclusion at **rcslt.info/resources**.

We have recently added the following sections to it:

Supporting SLTs with disabilities in the workplace

A guide on supporting qualified SLTs, speech and language therapy assistants (SLTAs), and SLT students with disabilities in the workplace, written in consultation with the RCSLT disability working group. It is designed for everyone, including disabled SLTs/SLTAs and students, managers, colleagues, and placement coordinators.

Supporting LGBTQIA+ colleagues in the workplace

A guide with the aim of helping to raise awareness and promote understanding of supporting LGBTQIA+ colleagues in the workplace, written in consultation with UK SLT Pride Network LGBTQIA+ working group. It is for all SLTs, support workers and students, irrespective of whether they identify as LGBTQIA+. It is hoped material will help increase understanding of some of the issues affecting LGBTQIA+ people accessing speech and language therapy services. You and your team can also try the audit tool to get a picture of your inclusivity for SLTs, support workers, and students who identify as LGBTQIA+.

Supporting neurodivergent colleagues in the workplace

Our new resource is designed to help you fully include and welcome neurodivergent people in your teams and services.

Guidance when working with diverse or underrepresented populations.

The RCSLT's guidance on bilingualism supports SLTs to improve their cultural competence and provide equitable services to all: **rcslt.info/bilingualism**.

The RCSLT's guidance on health inequalities aims to develop understanding across the profession of health inequalities and the role of SLTs in addressing these. You can also use our health inequalities self-audit tool for prompts and questions to help you to mitigate inequalities in your service: **rcslt.info/health-inequalities-resources.**

We are continually working with members to identify gaps in the guidance and resources currently available, as well as barriers to implementation. We would love to hear from you with your success stories, ideas and questions about equality, diversity and inclusion.

NAILA NOORI-KHAN, RCSLT External Affairs Officer – Wales
✉ naila.noori@rcslt.org

VICTORIA HARRIS, RCSLT Head of Learning
✉ victoria.harris@rcslt.org

Embracing failure

Felicity Smith shares her reflections as a student SLT on her first paediatric placement

Being a university student, the prosect of failure can at times feel all-consuming and inevitable. During my second-year paediatric placement, after a really exciting week full of new experiences, I found out I had failed a university assignment. If I failed the second attempt, I would need to re-take the year.

> I have reduced the size of the overbearing podium I put 'failure' on

The placement experience and the support from the exceptional therapists I was allocated to helped me identify, accept, and develop who I am as both an academic and a person. Feedback from my midway meeting has already helped me to begin developing my self-confidence and my ability to rationalise failure. I have reduced the size of the overbearing podium I put 'failure' on.

During placement I was able to acknowledge how tremendously harsh and self-critical I am. I have realised how much time I devote to making comparisons of myself to those around me and holding up the ideals I had created, especially surrounding potential failure. The fear of failure for me is connected to how I view myself and how I've always felt so afraid of people knowing I failed.

However, my feelings about failing this assignment were met with immense kindness from my placement therapists. They shared their own experiences about failings, and all declared how we are all better for it.

This failure and the acceptance I received has enabled me to develop academically, personally, and professionally. SLT life and clinical practice isn't just about getting the top grades but how you support others. The valuable experiences I had throughout placement have truly felt life changing and will always stay with me.

What I have found from facing my biggest fear, is that failure is not so scary or terrifying as I imagined it to be. I can break it down into smaller, more understandable parts. I know that my future will not only be filled with positives, but there will setbacks and difficulties too. I may not succeed in everything, but that is okay. I now know that I will be able to deal with each challenge as it comes. I will no longer allow myself to be consumed by fear of failure. I will allow myself the space to interact with my failings, be gentler with myself and more forgiving.

Truly, I feel my first failure of an assignment has come just when I am ready to handle it and this whole experience has helped me become stronger in myself. I don't feel that overwhelming shame or embarrassment I thought I would: really, fear made the wolf look bigger.

University and placement don't just present opportunities for us to learn academic material and study the literature but offer space for us to learn our own intrinsic values about who we are and who we want to be.

FELICITY AMBER SMITH, Student SLT, Birmingham City University
✉ Felicity.Smith2@mail.bcu.ac.uk

COURSE LISTINGS

You can now find course listings online! Visit **rcslt.org/course-listings** to see the latest training and CPD opportunities

The current evidence base for school-aged children with DLD with Dr Susan Ebbels
24 and 25 September, online via Zoom
Day 1: Appraising the reliability of research. Evidence for different methods of delivery of intervention including tiers 1, 2 and 3, the role of SLTs and evidence-based pathways to intervention.
Day 2: Interventions at sentence, narrative and word levels
Book at least 10 days before course
01883 712271
✉ **training@moorhouseinstitute.co.uk**
🔗 **moorhouseinstitute.com/the-current-evidence-base-for-school-aged-children-with-dld**

The SHAPE CODINGTM system
Part 1: Self-paced *online course available anytime.*
Part 2: 2-part workshop, *7 and 14 November, 1-5pm, online via Zoom*
Practical Applications: 2-part workshop, *5 and 12 December, 1-4.30pm, online via Zoom*
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.
Book at least 5 days before course
01883 712271
✉ **training@moorhouseinstitute.co.uk**
🔗 **moorhouseinstitute.com/shape-coding-courses**

British Aphasiology Society International Conference 2024
16-18 September, online or in-person, De Montfort University
This year the BAS conference will take place at De Montfort University in Leicester. It will be a hybrid conference, with options for in-person and online attendance. The conference programme spans three full days and explores three strands: aphasia theory, clinical practice and future directions.

Keynote speakers across the three days are: Dr Aura Kagan, Professor Argye Hillis, Dr Swathi Kiran, Professor David Howard, Professor Chris Code, Professor Cathy Price, Professor Matt Lambon Ralph.

Early bird tickets are available until 28 June 2024. Currently accepting abstracts from all areas of aphasia clinical practice and research.
✉ **morag.bixley@dmu.ac.uk**
🔗 **rcslt.info/british-aphasiology-society-conference**

smiLE Therapy Training Day 1 and 2
10-11 and 14-15 October, 9am-12pm, online
Innovative 10-step therapy teaching functional communication and social skills in real settings for students who are deaf, have DLD, learning difficulties, Down Syndrome, and physical disability. Also teaching functional communication for some autistic students, where criteria apply, where therapy is delivered in a neurodiverse-affirming way.
For ages 7 to 25.

Clear visible outcome measures, empowering parents and generalisation integral. For SLTs and teachers. Loved by students, parents, practitioners, managers, SENCOs, OFSTED. Now named on EHCPs. Email us to book a place or to enquire about bespoke training for your Team.

FREE 1-hour taster session online for you, your NHS Trust, CEN, university, special school or college, local authority, or independent practice. Email us.
✉ **info@smiletherapytraining.com**
🔗 **smiletherapytraining.com**

Gestalt Language Processors Conference
24, 25, 26 September and 1-2 October, online
The Speech Den is hosting an online conference over 5 days to include Dr Barry Prizant, Marge Blanc, Alex Zachos, Corinne Smoos, Cathy Shilling, and many more to delve deeper into Gestalt Language Processors. Topics being covered include how to identify recap of NLA stages, working in schools, sensory supports, AAC, literacy, parent perspectives, practical supports, the nervous system, case studies, music and GLPs. This is a one-off event, with leading global experts
07876 537213
✉ **enquiries@thespeechden.com**
🔗 **rcslt.info/glp-conference-register**

NHS

Our Hampshire Children and Family services team are recruiting now.

Join us and help transform lives as a **Specialist Speech and Language Therapist**

Work across our inpatient CAMHS and local authority services

Bespoke training and support • Continuous professional development

Competitive salary • 23.7% Employer contribution pension • Generous annual leave • NHS discounts

Apply online at **tiny.cc/camhsSLT** or scan the QR code

NHS Southern Health NHS Foundation Trust

NHS Solent NHS Trust

Working in partnership to become

Hampshire and Isle of Wight Healthcare

NHS Grampian

Speech and Language Therapy Service Aberdeen Royal Infirmary

Full Time Band 6 Speech and Language Therapist in Acute Frailty and Respiratory Services - Permanent

Full Time Band 6 Speech and Language Therapist in Acute Stroke - Fixed term (11 months)

We are recruiting two SLTs to join our established, friendly and supportive Acute Adult Team within Aberdeen Royal Infirmary, a large teaching hospital covering a wide range of acute hospital patient care.

The permanent post is a new and exciting role, developed through bed expansion within Respiratory and Frailty services.

The fixed term post is to cover for maternity leave within our Acute Stroke Team. For both roles, we are seeking SLTs with a depth and breadth of clinical knowledge, skills and experience of working with adults in an acute care setting. Our team provides excellent opportunities for collaborative working, quality improvement initiatives, supervision, and a commitment to providing CPD opportunities.

We are open to considering full and part time applicants with experience in adult dysphagia. For the permanent post, an attractive relocation allowance of up to £8,000 is available in certain circumstances.

Informal enquiries, meetings and visits are encouraged. For more information, please contact: Clare Emerson (Lead Speech and Language Therapist) on 01224 553566 or email clare.emerson@nhs.scot.

Scan QR codes above to apply

Want to know more about Aberdeen? Take a look: https://youtu.be/moaWooD-ayk

Natalie
STRONG

Specialist SLT in a content and training role

I trained to become an SLT five years ago when I was 46, following a pre-motherhood career as a TV researcher and director on shows including 'Grand Designs'. My career change came after my experience of receiving little professional help with supporting my son with selective mutism. I'd had to go into his school myself, put strategies in place and 'slide-in' alongside his teacher. I enjoyed using my creativity to help him move forward, and after a year volunteering at local schools, applied for my master's in speech and language therapy.

After qualifying, I worked at specialist provisions and mainstream secondaries with autistic students and those with language disorders. Witnessing the disparity between children with diagnoses who had access to weekly therapy, versus those with mild to moderate needs with no support made me keen to work with the latter.

When Speech & Language Link advertised on the RCSLT jobs page for an SLT to provide content and training for their language screening and support service, the role jumped out at me. Not only did it combine my two careers but, importantly, it would give me the opportunity to help thousands of children at the mild-to-moderate end of the speech, language and communication needs (SLCN) spectrum. What was exciting was the chance to be involved in the universal screening of students and provision of interventions for all those with difficulties. I was also training school staff on how to identify and support SLCN in the classroom.

As SLT jobs go, this role is truly unique. I'm predominantly home based, with one day in the office to collaborate with the other SLTs (including a monthly journal club!). Although I'm not working clinically every week, I get the chance to work directly with children during our research projects. Currently I'm enjoying visits to nurseries to assess preschoolers with our new language screener.

> Another big part of my role is writing articles for our magazines

I get the opportunity to support school staff each week when I work on the help desk, answering questions on how to help individual pupils with SLCN. I'm also a tutor on our CPD courses where I meet my adult students online before guiding them through the modules, marking their assignments and offering practical advice and strategies.

Another big part of my role is writing articles for our schools magazines, giving me the chance to share my experiences of supporting children with different SLCN. This, along with meeting SENCOs and headteachers at education shows and running online training workshops, goes a long way towards raising awareness among school staff.

When I want to get even more creative, producing resources for our packages more than ticks this box. Plus, one day a week, I have different focus altogether, working for Confident Children, coaching parents to support their children with selective mutism. So, while I don't have as much direct contact with school students these days, I feel that the rewards of being part of a passionate team making a difference to thousands of children with mild and moderate SLCN nationwide more than makes up for it.

✉ nataliestrong24@gmail.com

RCSLT

Make the most of your RCSLT membership

Whether you're a long-time member or are new to the RCSLT community, here's how you can make the most of your membership beyond *Bulletin*

Find us online

rcslt.org
twitter.com/RCSLT
instagram.com/RCSLT

Your online CPD diary

Log and organise evidence of your CPD activity in this specially designed online diary.

rcslt.info/cpd-diary

Access to journals

Members can access more than 1,700 journal titles for free in the RCSLT journals collection, including the International Journal of Language and Communication Disorders.

rcslt.info/accessthejournals

Clinical Excellence Networks

CENs are essential and accessible networks for CPD, covering a wide range of clinical areas.

rcslt.info/join-cens

Your local RCSLT Hub

RCSLT Hubs are a great way to connect with peers in your local area for regional updates and professional support.

rcslt.info/rcslthubs

Get involved in research

Find out more about RCSLT research champions and how to join the network.

rcslt.info/research-champions

Chat with peers in professional networks

Get involved in up-to-date discussions on key topics like COVID-19, anti-racism, redeployment and telehealth on the RCSLT's online forum, professional networks.

rcslt.info/professional-networks

Insurance and legal support

Find out more about the professional indemnity insurance and medical malpractice cover included as a benefit of your membership.

rcslt.info/legal-support

Professional enquiries service

The RCSLT enquiries team is here to respond to all your professional enquiries. They can put you in touch with expert clinical advisers or provide the most up-to-date guidance to address your query.

Get in touch with them by emailing **info@rcslt.org** or phoning **020 7378 3012.**

Questions about your membership?

To change your name, address, membership category, or if you have any questions about payments, get in touch with the membership team – call **020 7378 3010 / 3011**.

membership@rcslt.org
rcslt.info/MemberQs

In Memory

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

Lorraine Burroughs

1983-2023

Lorraine graduated from Reading University in 2007 and worked at Powys Teaching Health Board for the remainder of her career. She was a true specialist generalist and highly skilled across various areas of adult acquired work: she could treat anyone that walked through the door. Voice disorders and stroke were of special interest to her. Lorraine will be remembered as a generous and thoughtful friend, and a skilled and empathetic clinician. She had a beautiful beaming smile that lit up a room - always smiling, happy, and easy company. Lorraine tragically lost her fight against cancer in 2023, and her loss is greatly felt by her friends and colleagues. Our heartfelt thoughts are with her husband, Mark, and their two children.

CEINWEN DOUGLAS Powys Teaching Health Board

Joyce Cook

1930-2024

Much can be said about Joyce's lifelong devotion to her profession. We are grateful to Joyce for training generations of ENT surgeons, who went on in their career knowing the value of speech therapy and respecting our input. Joyce's dedication to the Royal College was admirable and she did much to support its authority. Those who knew 'Joyce the Voice' will remember she had no compunction in speaking up. Joyce gained membership, later received Honours, and remained involved with the profession post-retirement by establishing the popular Retirement Network.

She will always be remembered as our loyal, supportive, and generous friend. On behalf of past, present and future SLTs, thank you, Joyce, for being our mentor for nearly 70 years.

CHRIS HURLL, **LYN** and **FRANCESCA BEAVAN**, **STEPHANIE MARTIN** and **LIZ SIMONS**

Jane Whitaker

1951–2023

Jane qualified as an SLT in 1984 from City University. She was a mature student with two young children at a time when this was not the norm. She worked in NHS adult services in Portsmouth, Southampton and Chichester. In 2000, Jane started her own independent practice, Communication Partners, which she continued to run alongside other roles. She was always keen to develop her skills, take on new challenges and never one to retire! Her drive saw Jane picking up a variety of SLT roles in the independent sector. More recently, Jane drew on her many years of clinical experience as an expert witness. She is warmly remembered by her family and those of us who worked with her.

KATHERINE GIBBON, **SARAH EGGLETON** and **CARLA BRYSON**

In the journals

This section highlights recent research articles in the International Journal of Language and Communication Disorders (IJLCD). All members get free access to IJLCD and a wide range of other journals at **rcslt.info/journals**. For tips on critically appraising evidence to inform your practice visit **rcslt.info/EBP**.

Turning up and tuning in

What this paper adds

Current research tells us how important it is for parents to be involved in their child's therapy, but there is very little information on rates of involvement or factors that may help or reduce parental involvement. This paper looks at parents' involvement in speech and language therapy interventions for children under five years old. It aims to spot any parent or child factors linked to non-attendance and non-adherence. This study is one of the first to investigate parents' adherence to SLT recommendations for interventions and adds to previous research on understanding parent's non-attendance.

Why this matters

To make sure children get the best outcomes, SLTs need to consider the views and experiences of parents. What are their perceptions of speech, language, and communication needs, and how can we foster a collaborative environment in interventions? This study is a starting point for deeper research into parental involvement, and how to enhance outcomes for children in interventions.

Williams, P., Slonims, V. and Weinman, J. (2023) 'Turning up and tuning in'. Factors associated with parental non-attendance and non-adherence in intervention for young children with speech, language communication needs, *IJLCD*, 59(2), 762–778.

Optimising cognitive communication interventions

What this paper adds

There is a body of existing research on the problems people can have with cognitive communication disorders (CCD) due to acquired brain injuries (ABI), such as how it affects their daily life and what SLTs can do to help. However, there are still challenges in using this knowledge regularly in speech and language therapy practice.

This research introduces a helpful tool for SLTs, the CCEAS-Map, that combines the best methods for helping people with CCD. The CCEAS-Map tool is a large summary of 129 different studies and guidelines with 148 evidence-based clinical recommendations, which can be used to guide SLT practice and education.

Why this matters

The CCEAS-Map can help SLTs use the latest research in interventions by connecting practice recommendations directly to the research. This paper recognises the difficulty SLTs face when using current methods and how the tool could assist in overcoming these difficulties, ultimately improving practice.

MacDonald, S. and Shumway, E. (2022) Optimizing our evidence map for cognitive–communication interventions: How it can guide us to better outcomes for adults living with acquired Brain Injury, *IJLCD*, 59(2), 623–647.

Gaze speaks louder than words

What this paper adds

Parkinson's disease can affect movement, thinking, social skills and talking. It is also known to affect eye movements, and eye gaze is considered an important cue to turn-taking in conversation. This study looked at whether differences in eye movement patterns in Parkinson's are linked to difficulty with turn-taking in conversation and talking efficiently. In the study, people with Parkinson's showed longer periods of eye fixation during conversations compared to controls. Delays and overlaps between speech turns were also affected.

Why this matters

Understanding how Parkinson's affects eye movements can help doctors and SLTs improve their patients' communication skills and help people with Parkinson's to connect with others in the future.

Hodgson, T.L., Hermens, F. and Ezard, G. (2023) Gaze speech coordination during social interaction in Parkinson's disease, *IJLCD*, 59(2), 715–727. .

RISING STAR

Claire Hoyle *tells the story of how SLTs supported her daughter Amelia's progress with developmental language disorder (DLD)*

It was quite a long journey. At two years old, it was obvious that Amelia had substantial difficulties with language, but we didn't know whether this was part of a more generalised developmental issue or whether her difficulties were purely down to problems with language. Over time, other conditions were ruled out and she was given a working diagnosis of language delay/disorder. As she approached her transition to Junior school, we opted to get a private assessment for a comprehensive picture of her language ability, and she was diagnosed with developmental language disorder. It was such a relief to finally get a diagnosis - being able to tell Amelia she had DLD was really helpful. We watched some YouTube videos about DLD and she asked if she could join the DLD club - and I was able to tell her she was already part of it!

I hadn't been too worried that Amelia wasn't talking yet, as I knew children didn't always meet milestones at the exact time they should, but when we realised she wasn't understanding any language, it was very concerning. It was slightly reassuring at our first appointment when I was told we were doing absolutely everything right! But there was still a lot of anxiety about why she had no language.

> **She was able to be cheeky and mess around: so very important when you're a preschooler**

As Amelia had no real understanding of spoken language, we the initial focus was on giving her an alternative means of communication. First using Picture Exchange Communication System (PECS), and then Pragmatic Organization Dynamic Display (PODD), a symbol-based communication system, proved transformative. Not only was she was able to ask for things she wanted, but she was also able to tell me what to do, play games and express preferences. She was able to be cheeky and mess around: all little things, but all so very important when you're still a preschooler.

Amelia learned her first consistent word, 'bubble' from PECS, but her language really started to develop through PODD.

As her language developed, and she no longer needed to rely on her PODD book, we worked through Colourful Semantics and Shape Coding to help her develop sentence structure. She was also explicitly taught a range of vocabulary.

She still sees an SLT through the Communication and Interaction team, and she knows it's because of her DLD - and she rather enjoys being different.

Amelia needs a lot of support in some areas, but she doesn't let that stop her. She plays the cornet, does pole fitness, dance and musical theatre. She is now 12 and has settled in well to a mainstream secondary school as well as being a Young Ambassador for Afaisic.

Without early intervention, Amelia would have grown increasingly frustrated and, even if she had eventually developed language in her own time, the emotional damage would have been significant. Most children pick up language through exposure, but Amelia needed to be taught each and every stage. Speech and language therapy unlocked Amelia's voice. B

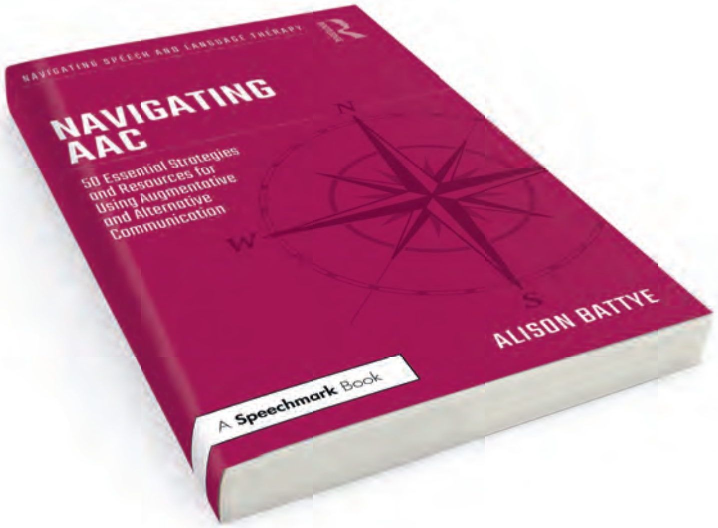
CLAIRE HOYLE, Parent Engagement Officer, Afasic
🔗 @Karmaviolet12
𝕏 @amelia_and_dld

Book reviews

Books and resources reviewed and rated by *Bulletin* readers

★★★★

Navigating AAC: 50 Essential Strategies and Resources for Using Augmentative and Alternative Communication



AUTHOR: Alison Battye
PUBLISHER: Routledge
PRICE: £19.99

Engagingly written book that helps SLTs increase confidence in supporting augmentative and alternative communication (AAC) users of all ages. It covers a wide range of topics, even the usually forgotten areas, such as literacy and advocacy in AAC. Some chapters are intertwined with interesting case studies, which help bring theory to practice.

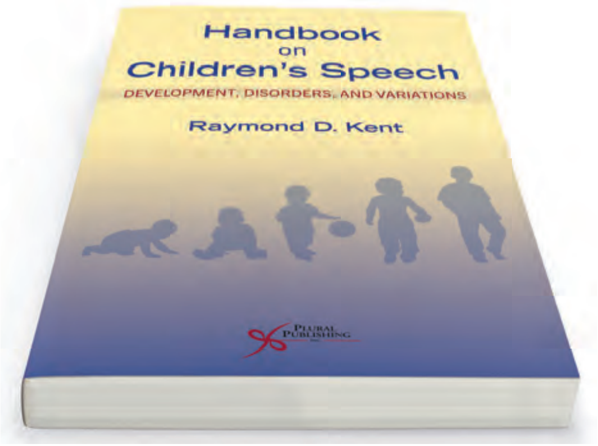
I also found the last chapter on further resources about AAC very useful. As I work in paediatrics, I hoped Alison would cover the differences between analytic language processing (ALP) and gestalt language processing (GLP) and how this affects our selection of vocabulary and modelling. Despite this, I still learnt a lot of new information from this excellent book and would highly recommend it to SLTs who are professionally interested in AAC.

NATALIA CAVAJDOVA, Specialist SLT, Specialist Children and Young People's Services, ELFT NHS

◆

★★★★

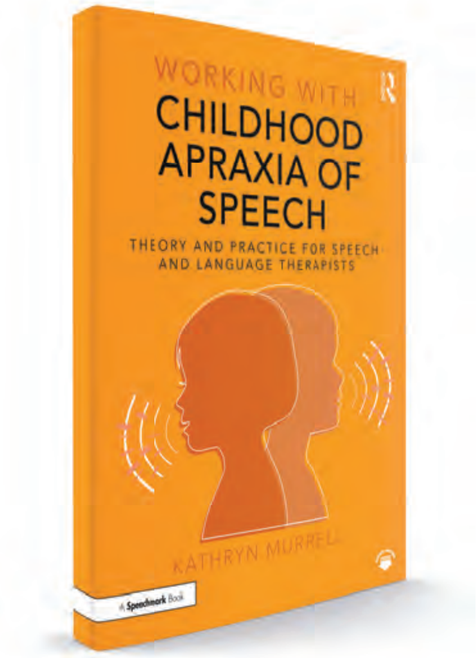
Handbook on Children's Speech: Development, Disorders, and Variations



AUTHOR: Raymond D. Kent
PUBLISHER: Plural Publishing Inc.
PRICE: £110

This book is aimed at clinicians, researchers and students. It gives a detailed insight into children's speech development, speech disorders and differences. I particularly enjoyed the chapter on bilingualism and the chapter on exploring specific clinical populations and conditions, which I found useful to dip in and out of. There are many useful diagrams and references that present a recent review of the current evidence base to support clinical practice. As a clinician, rather than a researcher, the detail felt a little overwhelming at times. The conclusions at the end of each chapter are therefore a welcome addition.

CLARE METAIS, Highly Specialist SLT, East Kent Hospital University Foundation Trust (EKHUFT)



★★★★★

Working with Childhood Apraxia of Speech: Theory and Practice for Speech and Language Therapists

AUTHOR: Kathryn Murrell
PUBLISHER: Speechmark
PRICE: £27.99

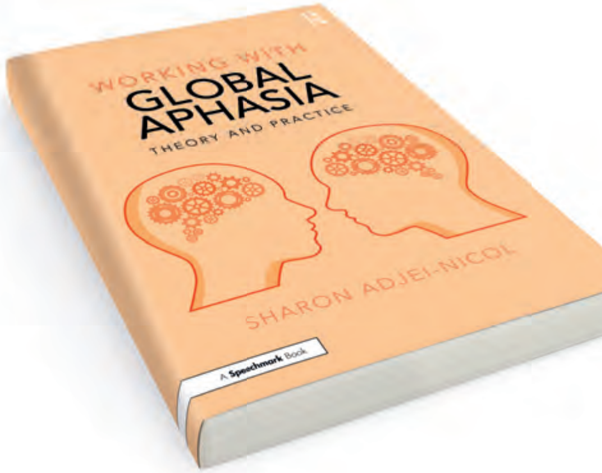
Beginning with a discussion of the current theoretical overview on childhood apraxia of speech (CAS) from a UK perspective, this book provides a comprehensive and easily accessible guide on assessment, differential diagnosis and intervention for children of all ages. It gives advice about working with parents/schools and concludes with eight case studies. There are many useful printable resources such as, parent/teacher handouts, assessment guides and summaries.

The book is clearly laid out and may be read cover to cover or dipped into. This is a hugely valuable resource for SLTs and students, of all levels of experience, working with children with speech sound disorders.

HATTY MORGAN, Highly Specialist SLT, Sussex Community Foundation Trust

★★★★★

Working with Global Aphasia: Theory and Practice



AUTHOR: Sharon Adjei-Nicol
PUBLISHER: Routledge, 2023
PRICE: £34.99

This book is an excellent resource for clinicians working with individuals with global aphasia. As the first book on global aphasia to be published in 40 years, it fills a gap in aphasia literature tackling a condition historically seen as difficult to assess and treat.

It is an innovative and accessible toolkit, underpinned by a detailed understanding of global aphasia and critical analysis of research evidence to date. It particularly explores the role and impact of cognitive difficulties in this population, encouraging clinicians to evaluate current practice, consider novel approaches and think outside the box when treating this complex condition.

CHRISTINE GORMLEY, Advanced Specialist SLT, Royal Hospital for Neuro-disability, Putney

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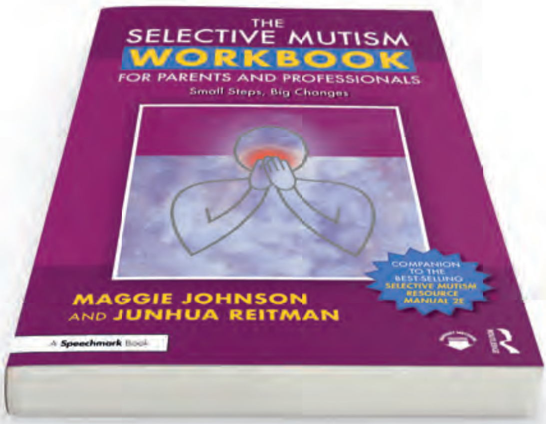
The Selective Mutism Workbook for Parents and Professionals



AUTHORS: Maggie Johnson and Junhua Reitman
PUBLISHER: Routledge
PRICE: £28.99

This workbook, a companion to the Selective Mutism Resource Manual, is for parents, clinicians, and educators, offering clear action plans. It's easy to navigate with practical tables and excellent implementation guidance. I really like the 15 strategies which are fundamental techniques that adults need to employ, complemented by 43 activities, which are focused on daily routines across different contexts. The step-by-step approach is individualised by selecting the most relevant items. Personal experiences and global examples enrich the content, promoting cross-cultural relevance. It aids in prioritising needs and monitoring progress. However, it's not a standalone resource.

RUTH FINE, Highly Specialist SLT and Clinical Tutor

A PROBLEM SHARED...

Having work or career issues? Tom from the RCSLT Professional Enquiries Team is here to help

A relative of a patient I have been treating has raised concerns about the progress being made in therapy and says that they want to make a complaint. I've never had any complaints made about me and am unsure how to handle the situation. Can you help?

When working in a healthcare setting it is not always possible to please everyone. It is important not to take this personally, as the majority of time when a client is unhappy it is about the situation and not about you. Sometimes patients or relatives may feel they are not making enough progress, or they might not understand why therapy has ended. Others may feel they are not being kept fully informed, and this may lead to a complaint.

It is important to discuss this with your manager or supervisor as they will be able to help talk through the situation and support you in addressing any issues raised. This may be in the form of joint sessions and feedback to look at lessons learned from the process.

Often, communication can be at the heart of the solution. Ensuring that you are talking with the patient or relative and keeping them abreast of what is going on can really help. Agreeing regular update points can act to manage expectations and provide a focal point, so they feel more in control.

At the same time it is vital that you document everything agreed or said so that there is a clear timeline that can be looked back at should the issues continue.

It may be they feel they have not had all the information they need or that they don't feel heard. So taking the time to listen to their concerns and provide information in a format they can understand helps to alleviate their concerns.

If issues remain and the patient or relative wants to take things further they should be directed to any local complaints procedures. This may be through NHS patient advice and liaison services (PALS) or through an in-house policy for independent practitioners.

If someone decides to take their complaint to the HCPC, we are here to help. If you are made aware of a referral or receive communication from the HCPC to say a complaint has been made it is vital that you contact the RCSLT straight away. We recommend speaking to us before you respond to the HCPC's communication.

Remember the RCSLT is here to support members, and the insurance policy that you receive through membership provides legal support to help you deal with HCPC complaints.

TOM GRIFFIN,
RCSLT Professional Enquiries Manager
Contact the team
✉ info@rcslt.org
☎ 020 7378 3012

Useful links

- RCSLT insurance information **rcslt.info/insurance**
- HCPC support pages **rcslt.info/hcpc-support**
- Having difficult conversations guidance **rcslt.info/difficult-conversations**

Questions are anonymised or fictitious examples, representing a range of professional issues affecting our members.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