

Bulletin

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

RCSLT



DYSPHAGIA AND COVID-19

What do we know now?

WINTER 2022/23

ISSUE 833

Childhood apraxia of speech | Haematology: an evolving specialism | **Life after P scales** |
Implementing an MDT Stroke TOMs scale | **Accommodating adults with capacity-affecting issues within research practice** | The value of preceptorships | **Person-centred care: it's personal**

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**Royal College of Speech
and Language Therapists**

2 White Hart Yard
London SE1 1NX
Tel: 020 7378 1200
✉ bulletin@rslt.org
✉ rslt.org
ISSN: 1466-173X

President: Nick Hewer
Chair: Dr Sean Pert
Deputy chair: Irma Donaldson
Honorary treasurer: Richard Cryer
CEO: Kamini Gadhok MBE

ADVERTISING

Recruitment sales:
Tel: 020 7324 2777
✉ rsltjobs@redactive.co.uk

Display sales:
Tel: 020 7880 7668
✉ bulletin@redactive.co.uk

EDITORIAL

Editors: Victoria Briggs,
Steven Harulow
Editorial assistant: Keely-Ann Brown
With thanks to: Amit Kulkarni,
Anita Foksa, Cara McDonagh,
Fiona Binns, Katie Chadd, Lauren Hopp,
Nikki Gratton, Ruth Murphy,
Ruth Sedgewick, Sarah Lambert,
Dr Sean Pert, Stephanie Holderness,
Kathryn Moysé, Kelly McCann,
Will Christopher

DESIGN

Art editor: Yvey Bailey
Picture editor: Claire Echavarry

COVER ILLUSTRATION
Sophie Standing

ACCOUNT DIRECTOR
Joanna Marsh

PRODUCTION
Aysha Miah-Edwards

PRINTING
The Manson Group



PUBLISHERS

Redactive Publishing Ltd
9 Dallington Street,
London
EC1V 0LN
✉ redactive.co.uk

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VICTORIA BRIGGS

Front and centre

It was a full three years ago when COVID-19 first entered the lexicon of most people's lives. So little was known back then about the virus and so much has been learned since news first emerged about its existence. The prevalence of dysphagia among post-COVID and long COVID populations, for example, is now established – a fact that, on its own, should be enough to place SLTs front and centre of the patient rehabilitation journey.

In this issue of *Bulletin* we're delighted to welcome Gemma Clunie, Sarah Wallace and Camilla Dawson who share their expert knowledge with us of the growing body of evidence about COVID-19 related dysphagia (p24). For members who want to know more about best practice management of the condition and to share experience, the RCSLT's COVID-19 working group can be contacted via our webpages.

Other contributions this issue are brought to you by Karen Bunning, who shares a study with us about how adults with capacity-affecting conditions and communication difficulties might be better accommodated within research practice in order to make it more inclusive (p36). Elsewhere in the magazine, Leigh Andrews, chair of the SLT homelessness clinical excellence network, presents a powerful example of how SLTs can change lives in the case study on p41. While student SLT Niamh Foy shares her lived experience of selective mutism and talks to us about some of the ways it shaped the person she is today (p46).

With more than two decades of service at the helm of the profession, this issue of the magazine is also the last in which



**Thank you
to all those
I've worked with
and learnt from**

Kamini Gadhok writes a column for us as chief executive officer of the RCSLT (p17). I'm sure I speak for everyone in thanking Kamini for her inspirational leadership over the years, as well as her dedication and commitment to always putting members and service users at the heart of everything the RCSLT does. We wish her every success for the future.

The next issue of *Bulletin* will be back with you in April, when incoming CEO Steve Jamieson (see news story p8) will be opening a new chapter for the profession. *Bulletin* too will be in fresh hands. After a fascinating four and a half years editing the RCSLT's member magazine, new horizons beckon. Thank you to all those I've worked with and learnt from in that time: it's been a pleasure and a privilege! **B**

Victoria Briggs

✉ bulletin@rslt.org
✉ @rslt

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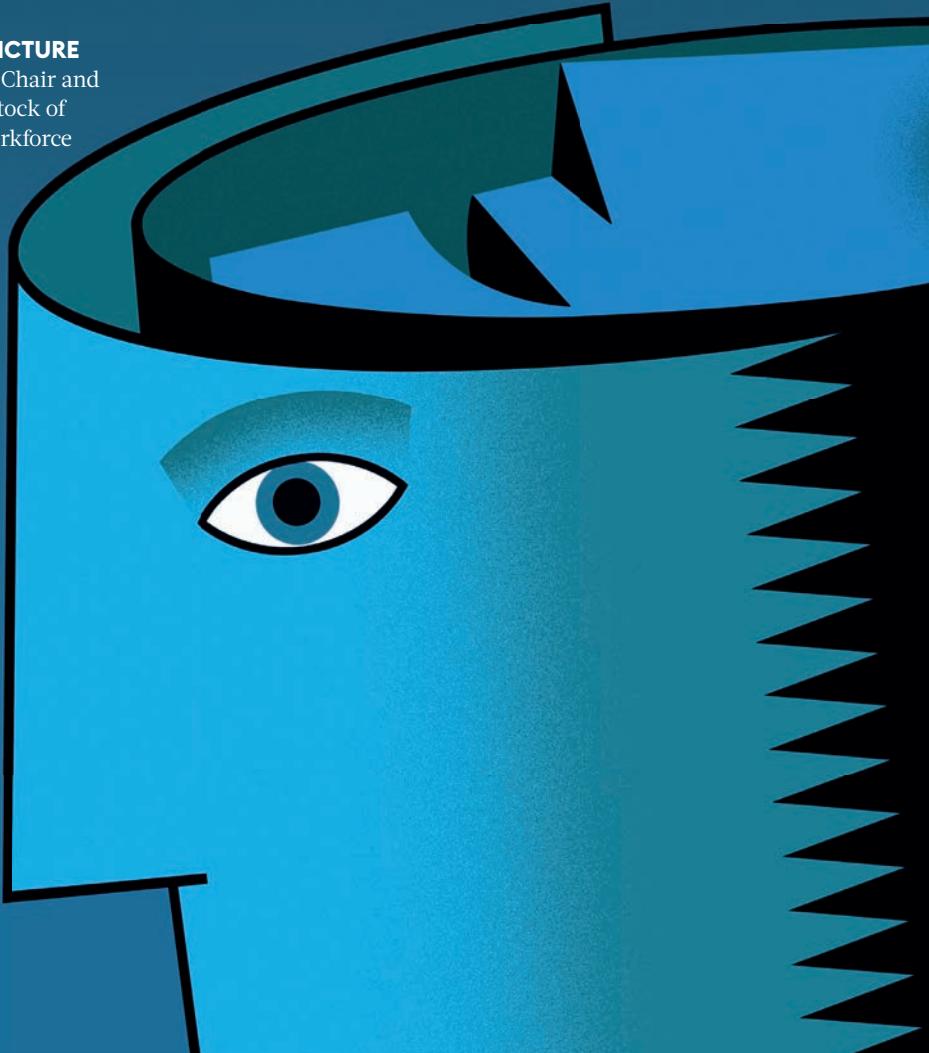
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KAREN BUNNING



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SHARE YOUR THOUGHTS ON TWITTER @RCSLT

#

Taking points

LETTER

Neonatal AHP strategic roles in England

Over the past two decades there has been increasing acknowledgement that infant outcomes following neonatal care need to focus on more than survival and discharge. They must also consider the neurodevelopmental consequences, ensuring care is focused on optimising these outcomes too (Moore, Hennessy, Myles et al, 2012).

While we know that expertise from SLTs in supporting early communication and feeding is beneficial to the neonatal setting, understanding of the role of the SLT and other AHPs in neonatal settings remains limited and the AHP workforce is currently under-represented in neonatal care (Murphy, Harding, Aloysius, Sweeting and Crossley, 2021).

In 2019, the Neonatal Critical Care Review reviewed the evidence for providing high quality neonatal care and outcomes. As a consequence of its recommendations, each of the 10 neonatal operational delivery networks in England were commissioned to establish an AHP team working at a strategic level to contribute to neonatal service development. The aim being to ensure a holistic, equitable and cohesive approach to the delivery of neonatal care through consideration of the neonatal workforce.

There are now 12 SLTs in post within the ODNs across England. These SLTs are working alongside their neonatal ODN strategic leads, other neonatal ODN AHPs

and local neonatal AHPs to scope and support the neonatal workforce. They also serve to highlight the value of SLT involvement in neonatal services.

Much has changed for neonatal speech and language therapy provision in recent years, but it is important that we continue to raise the profile of neonatal speech and language therapy at a national and local strategic level.

Influencing change and demonstrating the skills and expertise that SLTs can bring to the neonatal AHP workforce will help to improve infants and family's outcomes through their neonatal care journey.

If you are an SLT working within a neonatal unit we would encourage you to contact your ODN SLT to access support, education and share best practice within your network.

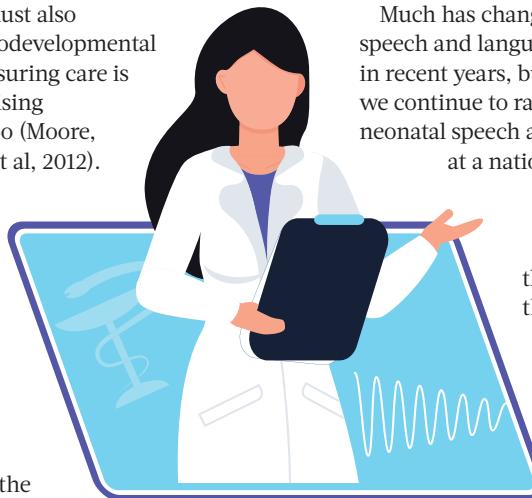
To see this article in full and to get in touch with your local network's SLT contact, visit: bit.ly/3FiZmIU

JO MARKS, North West NODN lead SLT
✉ jo.marks@alderhey.nhs.uk

KATY PARRELL, West Midland NODN
✉ katyparnell@nhs.net

ZOE GORDON, Thames Valley and Wessex NODN
✉ zoe.gordon@nhs.net

ANNIE ALOYSIUS, clinical lead neonatal SLT IBCLC, RCSLT Neonatal CEN chair
✉ annie.aloysius@nhs.net



RCSLT NEWS

Bulletin wins 'best magazine' awards

The RCSLT took home two prestigious industry awards at the 2022 Membership Excellence Awards for its member magazine *Bulletin*.

Beating off stiff competition from across the professional membership sector, *Bulletin* was named 'best magazine' in the awards relaunch category and was highly commended for 'best magazine with a circulation of less than 20,000' in another.

The 'Memcom' awards (see: www.memcom.org.uk) recognise excellence in the membership sector and serve to 'shine a light on the organisations that are increasing value for their profession as well as wider society.'

Last year, the RCSLT picked up four Memcom awards for its Communication Access UK training and awareness raising campaign – an initiative that continues to go from strength to strength (see: communication-access.co.uk).

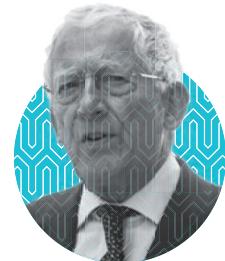
Congratulations to all our members whose submissions and support make the magazine possible, and a big thank you to our publishing partners Redactive.

Find out more about writing for *Bulletin* at: bit.ly/3OWKaEh



QUOTE OF THE QUARTER

As Honorary President of the RCSLT, I am delighted to congratulate @SteveJamieson12 on his appointment as our incoming CEO when, in March, our current CEO @KGadhok retires after an outstanding successful 22 year term.



NICK HEWER, RCSLT honorary president (@Nick_Hewer)

Turn to p8 for the news story.

Trauma service

We are aiming to develop a trauma-informed community-based service at South Tees Hospitals NHS Foundation Trust. Is this something that your teams have already considered and embedded? Would you be happy to share your journey with us? I would be thrilled to hear from you, if so.

On behalf of the South Tees speech and language therapy trauma-informed working group, please contact me at the email address below.



SHARON HODGSON, highly specialist SLT (children's and young people's service)
✉ sharon.hodgson@nhs.net

Corrections

Production errors in the last issue of *Bulletin* meant that two incorrect cells appeared in the table on p50 of Wendy Best et al's article in the Research and Outcomes Forum, while a book review was incorrectly

attributed to Bhaveshi Kumar's Study Skills for Children with SLCN. Our apologies to the authors. The correct book review appears on p65 and the amended table can be found online at reslt.org.

**WHAT'S
NEW ON
rcslt.org**

INCLUSIVE PRACTICE

The third instalment of our new extension to our *Bulletin* 'In the journals' focuses broadly on the LGBTQIA+ community in healthcare. With thanks to RCSLT members Jenny Ray and Alex Wormall for their contributions. We'd like to hear your views on our inclusive practice journals round-ups. Read them online: bit.ly/3iy62ty and email: info@rcslt.org with your thoughts and suggestions.

TELEHEALTH GUIDANCE

RCSLT members can read the revised telehealth guidance on the RCSLT website: bit.ly/3VFsX4o. We are still keen to include real-life examples of telehealth use in our guidance and would like to hear from members wanting to share their case studies.

bit.ly/3umrVyR

TRACHEOSTOMY COMPETENCIES

The updated RCSLT Tracheostomy Competency Framework is now available. The core competencies cover adult and paediatric caseloads and reflect the guiding principles for safe and best tracheostomy practice. Thanks to all who helped with the update, particularly the Tracheostomy Clinical Excellence Network.

bit.ly/3XOvwmO

RCSLT EVENTS

Visit the RCSLT website to keep up to date with our forthcoming online and live events. Missed a webinar? Don't worry, we record all our webinars with subtitles and make these available online:

www.rcslt.org/events

Need to

RCSLT appoints new chief executive

The RCSLT is delighted to announce the appointment of Steve Jamieson as its new chief executive.

Steve joins the RCSLT from the Royal College of Podiatrists, where he was CEO and general secretary, and brings with him a wealth of experience in managing professional bodies in the healthcare sector. A nurse by profession, Steve was deputy director of nursing at the Royal College of Nursing and CEO at the Hospice of St Francis in Berkhamsted. He is also a trustee of Dementia UK and chair of the Dementia UK Admiral Nurses Clinical Committee.

RCSLT Chair Sean Pert said, "I'm delighted to welcome Steve to the RCSLT. During a rigorous recruitment process he demonstrated his wealth of experience in developing membership organisations. A compassionate and insightful leader, Steve's experience in building effective relationships with service users, staff, stakeholders, sponsors and trustees will be invaluable to the long-term success of the RCSLT."

Steve will take up the role of RCSLT chief executive in March 2023 when the current chief executive, Kamini Gadhok MBE, retires after 22 years at the RCSLT helm.



RCSLT AGM 2022

The RCSLT's annual general meeting (AGM) took place online on 6 October 2022. At the meeting, members ratified five new trustees following a new and more equitable recruitment process. The outgoing chair, Mary Heritage, handed over the chain of office to the new chair, Dr Sean Pert. Deputy Chair Irma Donaldson will support Sean's

tenure and together they lead our most diverse board to date. The AGM also provided an opportunity to reflect on the achievements from the past year, summarised in the *RCSLT Impact Report 2021–2022* and available online: bit.ly/3EXG1eK. Find out more about Board of Trustees developments at: rcslt.org/about-us

know



28,000

Twitter followers @RCSLT

Celebrating DLD Awareness Day in style

Developmental Language Disorder (DLD) Awareness Day was the focus of RCSLT NI celebrations on 14 October 2022.

RCSLT members Sinead Marlow and Sarah Wilson took over the RCSLTNI Twitter account and shared helpful hints, advice for parents and teachers, and showcased the amazing work of SLTs. East Belfast mum of four, Sue McBride, arranged a celebration at Thornfield House, where Children's Commissioner Koulla Yiasouma and leaders from the education authority and Department of Education joined Head of RCSLT NI Office Ruth Sedgewick.

Lead SLT Brid Tate kicked the day off

with a presentation about DLD, emphasising this years' theme, 'Growing with DLD'. Members Alicia McTeggart and Ashleigh Kyle also showcased

two group speech and language therapy sessions. Northern Ireland RCSLT members and service users pulled together and achieved great success in raising awareness across the region by wearing purple, throwing class parties and even arranging



CHILDREN'S COMMISSIONER KOULLA YIASOUMA (FAR LEFT) CELEBRATES DLD AWARENESS DAY WITH LEAD SLT BRID TATE (HOLDING SUNFLOWERS) AND RCSLT NI COLLEAGUES

a mayoral visit. The special day came to a close with the lighting of several key buildings across the region, including Enniskillen Castle and Belfast City Hall – the purple lights representing NI united in raising awareness of DLD.

NEWS IN BRIEF

- The RCSLT marked International Stammering Awareness Day on 22 October by joining more than 70 international organisations in calling for the 'Right to Stutter'. Find out more: [@stamly.org/declarationrighttostutter](https://stamly.org/declarationrighttostutter)
- During Black History Month [@SLTsofColour](#) took over the RCSLT's Instagram stories on 27 October, posting a series of engaging and informative graphics. The stories covered everything from who the group is, to the mentoring they offer, including tips for allies, recommended resources and a quiz.

- The Independent Review of Gender Identity Services for Children and Young People (CYP) (The Cass Review) has published an interim report and recommendations for a new regional service model for gender identity services for CYP. Visit: bit.ly/3H4FMBf. The National Trans and Gender Diverse Clinical Excellence Network is available to support any SLTs who need further information or advice. transvoicecenmembers@gmail.com
- The Advancing Healthcare Awards recognise the work of allied health professionals (AHPs) and healthcare scientists leading innovative healthcare

practice across the UK. Open to AHPs, healthcare scientists and those who work alongside them in support roles, entries close on 24 January 2023.

[@ahwards.co.uk/uk](https://ahwards.co.uk/uk)

- The RCSLT has responded to the Department of Health and Social Care's call for evidence on the Down Syndrome Act statutory guidance. We're pleased the call for evidence recognises the role of speech and language therapy and the challenges some people with Down syndrome and their families can have accessing these services. Find out more: [@bit.ly/3OSA3k7](https://bit.ly/3OSA3k7)

RCSLT joins Inequalities in Health Alliance

The RCSLT has joined the Inequalities in Health Alliance (IHA), the coalition of more than 200 organisations who have come together to campaign for a cross-government strategy to reduce health inequalities.

The RCSLT vision has at its core a commitment to working to reduce health inequalities and the impact of socioeconomic disadvantage on service users, and to provide culturally and linguistically inclusive, co-produced services. Joining the Alliance further strengthens our commitment to addressing social disadvantage and the profession's role in working to counter these.

The IHA is asking government to develop a cross-government strategy to reduce health inequalities; commence the socio-economic duty, section 1 of the Equality Act 2010; and adopt a 'child health in all policies' approach.

The RCSLTs IHA membership came ahead of a webinar on 3 November 2022, which looked at practical steps in addressing health inequalities in service provision.

Find out more about the IHA at: bit.ly/3UG2vqN and the RCSLT health inequalities webinar at: bit.ly/3H1dt6J

Long COVID survey findings available

You may recall that in October 2021 the RCSLT surveyed members working with individuals with long COVID. We are pleased to say the survey findings have now been published in the *Journal of Integrated Care* in the article, 'An evaluation of speech and language therapy services for people with long COVID in the UK: A call for integrated care'.

Thanks to all the RCSLT members who participated in the survey and to those helping with the work behind the scenes: Gemma Clunie, Sophie Chalmers and Kate Harrall. We hope this publication will support SLTs to make the case for additional support for teams supporting individuals with long COVID and for fully integrated and multidisciplinary care for service users.

View the article online and get free access through the RCSLT journals library. Article DOI: 10.1108/JICA-07-2022-0038: bit.ly/3F7vCNS.

Speech and language therapy in the media

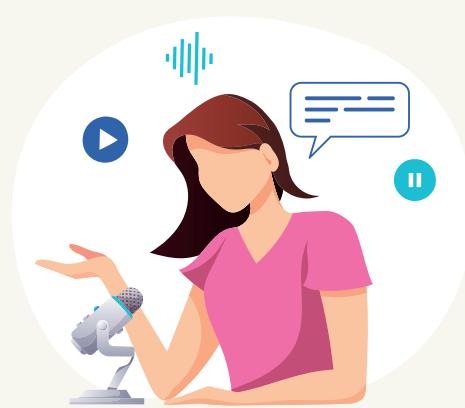
The effects of the pandemic on children's development continue to gain news coverage, creating opportunities for the RCSLT to highlight the work of the profession and the huge difference SLTs make to people with communication and eating, drinking and swallowing needs.

Pippa Cotterill, RCSLT's head of Wales Office, spoke to *BBC News* in summer 2022 about the increase in referrals to SLTs across the UK and how some children who had speech and language difficulties prior to the pandemic are now experiencing more complex issues. BBC TV, radio and online channels

covered the story, and this resulted in further interviews with S4C and Voice of Islam Radio. Read the BBC article: bit.ly/3UrraPm

In September 2022, BBC Radio 5 Live presenter Naga Munchetty interviewed RCSLT Chief Executive Kamini Gadhok about the impact the COVID pandemic has had on children's speech and language development. Meanwhile, *The Sunday Post* interviewed RCSLT Head of Scotland Office Glenn Carter about the need for speech and language therapy for young people in the justice system: bit.ly/3EZzAI8

The RCSLT's media and PR team is busy organising a range of new media



briefings and interviews to raise awareness of the essential work of SLTs. We'll update you on these in the next issue of *Bulletin*.

UP COMING

JANUARY

National Mentoring month
16 Samaritans Brew Monday

FEBRUARY

3 Time to Talk Day
16 RCSLT Minor Grants Deadline

MARCH

13-19 Nutrition and Hydration Week
21 World Down Syndrome Day

AAC guidance update

It's an exciting time for augmentative and alternative communication (AAC) with plans to co-create guidance for the first time. Led by Manchester Metropolitan University's Professor Janice Murray, the author group will consist of local specialist and specialised SLTs, AAC service users and family members. Wider member consultation will take place in Spring 2023, followed by the stakeholder consultation later in the summer.

Support worker framework

Health Education England has developed an allied health professional-wide framework to align support workers across the professions. Using this as a basis, the RCSLT has co-created an SLT-specific framework, promoting the role of the support worker and creating a clear, defined pathway with opportunities to develop skills and progress within the profession. Due for publication online in January 2023, a toolkit and a community of practice will accompany the framework:

www.rcslt.org

RCSLT Horizon project

Look out for the findings of our Horizon member profile project; our ambitious venture to gain a clearer picture of speech and language therapy across the UK. Horizon will help us learn more about your career journey and where you work so we can better support the profession. Members completed an online profile in Autumn 2022 and we will report back our findings early in 2023. NB: At the time of writing more than 1,000 RCSLT members had already completed their member profile. This is an iterative and ongoing process so do log on regularly to keep your professional information up to date and relevant.

[Find out more: bit.ly/3GWnvGp](http://bit.ly/3GWnvGp)

Workforce reform programme: Professional development framework



Work is nearing completion on the three-phase project to develop a profession-specific framework to support learning and development. Phase one involved the RCSLT hosting five discussion events, involving more than 120 members, to inform the initial structure of the resource.

In phase two, we worked with a development group (comprising 82 members) to co-create a full draft. Group members chose to replace the previous working title, 'Career and Capabilities Framework', to focus the context and purpose of the new

resource. The new title is the RCSLT 'Professional Development Framework'. It comprises four domains of practice, based on the multi-professional 'Four Pillars of Practice', with five core components threaded throughout.

At the time of writing, phase three was due to begin; a full consultation on the draft framework to all members. Once completed, we will incorporate feedback to produce the final first edition. The new framework is due for publication early in Spring 2023, along with resources to support its use in practice.

[Find out about projects within the wider workforce reform programme: bit.ly/3UTb8hz](http://bit.ly/3UTb8hz)

RCSLT membership renewal period starts soon

The 2023-2024 RCSLT membership renewal period is about to begin, so look out for membership renewal information arriving in your inbox in February. Remember that you need to renew your membership before the new financial year begins on 1 April 2023. If you pay your fees by direct debit, your

membership will renew automatically. If you would like to set up a direct debit or if you have any questions about renewing your membership, email membership@rcslt.org or phone 020 7378 3010/3011. See p14 for more information on membership renewal.



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

Got something to tweet about?

This issue celebrates the achievements of the 2022 RCSLT's Honours Awards winners: individuals who have made outstanding contributions for the benefit of service users and speech and language therapy





RCSLT Awards

Since 1945, the RCSLT's Honour's Awards have recognised leaders at all levels within and outside the profession who have made outstanding contributions for the benefit of service users and the profession itself.

On 1 September 2022, the RCSLT Honours Awards ceremony took place and once again many members of the RCSLT came together to recognise and celebrate the achievements of the profession. It was the first in-person celebration in two years!

Thank you to all who were able to join in on the celebrations and a special thanks goes out to all staff and sponsors who helped to make this ceremony run smoothly.

To learn more about events at RCSLT, visit www.rcslt.org/events/

1 Dr Barry JM Jones

2 Catherine Harris (left) and Dr Yvonne Wren

3 Alice Benson, Jennifer Benson, Adam White and Richie Cottingham

4 Ellie Pearce, Laura Coupe, Eve Gooday, Karen Duffin and Erum Jamil

5 Linda Lascelles (left) greets Dr Hazel Roddam

6 Becky Clark

7 Julia Johnson and Stephen Frost

8 Lee Bolton

9 Parul Vansadia (left) and Meriem Amer-EI-Khedoud

10 Members of the Include Choir

11 RCSLT President Nick Hewer

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Twitter: [@MRJONGOLDBERG](https://twitter.com/MRJONGOLDBERG)

RCSLT membership renewal

It's almost time for membership renewals for 2023/2024. Look out for the renewal information arriving in your inbox in February, with more details on membership fees for your member category and an overview of the RCSLT's essential services, resources and networks.

Please make sure all your contact information is up to date by logging on to the member area of the website www.rcslt.org/forms/your-data

If you pay your fees by direct debit, your membership will renew automatically. More than 17,000 members now pay by direct debit and benefit from a £14 discount on their

fees. If you have a UK bank account and don't pay by direct debit, consider switching to save time and money.

Deadline and insurance

The RCSLT provides professional indemnity insurance for certified, newly qualified – practising, overseas qualified practitioner – UK practising, student and assistant members based in the UK, as well as non-practising, returners and retired members in respect of past practice. Find an overview of your insurance on the RCSLT website (bit.ly/2YTftAL). You may also be interested in listening to the RCSLT webinar on insurance (bit.ly/2L7av5M).

It is a legal requirement of Health and Care Professions Council (HCPC) registration to hold professional indemnity insurance. Please ensure you are in the correct category when renewing your membership, because your insurance cover cannot be backdated. The RCSLT also provides legal fees insurance for UK-based members in respect of HCPC referrals.

Our insurance covers fully paid-up members only. Members paying by credit card or debit card will only be covered from 1 April 2023 if we have received your payment before this date – if you pay after 1 April 2023 your cover will resume from the date you make your payment.

SLTs who are resident in the Republic of Ireland and are HCPC registered are eligible to join the certified members category. However, you should note that our medical malpractice policy does not provide cover for you to practice in the Republic of Ireland, other than incidental work. Please contact the enquiries team if you have any questions about your insurance cover.

Late renewals and fees

If you renew your membership outside the usual renewals period you will still be liable for your fees on the full-year basis.

If you have not heard from us about renewing your membership by 1 March 2023, please get in touch by emailing membership@rcslt.org or visiting www.rcslt.org.

Statutory notifications

Occasionally, the RCSLT has to formally notify members of corporate business, most notably the annual general meeting. We would like to take this opportunity to remind you that to save money, as well as doing our bit to protect the environment, formal notices will by default appear in *Bulletin*, which is received by all members, with links to the RCSLT website, on which will be posted formal documents. Any member has the right to request hard copy formal notices. Requests should be sent to the company secretary at the RCSLT offices.

Membership category	Designatory letters	Direct debit ¹	Card payment
UK resident			
Certified ²	CertMRCSLT	£280.00	£294.00
Non-practising	MRCSLT	£174.00	£188.00
Newly Qualified – Practising	MRCSLT	£174.00	£188.00
Newly Qualified – Non-practising	MRCSLT	£47.00	£61.00
Returner	MRCSLT	£174.00	£188.00
Retired	MRCSLT	£70.00	£84.00
Student	MRCSLT	Free	Free
Apprentice	MRCSLT	Free	Free
Assistant	-	£101.00	£115.00
Overseas Qualified Practitioner – UK Practising	MRCSLT	£280.00	£294.00
Overseas Qualified Practitioner – UK Non-practising	MRCSLT	£174.00	£188.00
Overseas resident			
International Affiliate ²	MRCSLT	£227.00	£241.00

1. Reflects £14.00 discount for payment by direct debit.

2. HCPC-registered SLTs resident in the Republic of Ireland may wish to join the certified members category.



➊ Celebrations are in order for @chisoSLT as she graduates with a degree in Speech and Language Therapy. Well done, you did it!

➋ Take a look at the SLT Pumpkin – carved and ready to be found in St Andrew's Care's pumpkin hunt. @standrewsSLT

➌ Abi Alsop looking happy as ever taking a short break away before embarking on a new role – congratulations @abialsopSLT

➍ The Spooky Little Tricksters (SLTs) from @LandDHospital enjoying the hospital's charity Halloween quiz. @chrissieSLT

➎ A bit of a surreal day for SLT Ines Jobin, as it was both her first day in the office meeting her team, and results day. Congratulations go out to her for completing her masters and becoming a newly qualified SLT! @ines_slt

➏ SLT Lauren and her team say their farewells to @SamanthaMcL6. Good luck on your next rotation, you're going to smash it @SLTLauren1.

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



DR SEAN PERT

The long view

Dr Sean Pert writes on the challenge of balancing case load demands



Short-sighted approaches store up problems for the future

Throughout my career as an SLT, I've been haunted by the six-week block. A form of arbitrary rationing to manage waiting lists, this approach has been difficult to assign to the dustbin of history. Despite overwhelming evidence of the harm it causes to clients, their families and our profession, it is often resurrected as a remedy for long waiting lists.

In recent times, research into treatment intensity or dosage has progressed. We now know that it is not simply 'more therapy is better', but that the distribution of intervention sessions and the number of attempts at therapy targets within a particular session are also important to achieving good outcomes. And while it is clear that more research is needed to identify the best treatment intensity for each clinical presentation and care pathway, no researcher has suggested that extremely low interventions are effective.

The pandemic has led to a huge increase in waiting lists. Predictably, inappropriate management methods, such as discharging all clients or limiting episodes of assessment and intervention to just three appointments, have been implemented in some areas. These short-sighted approaches store up costly problems for the future. Children and young people who do not receive timely input are likely to experience literacy and educational failure, with many becoming vulnerable to youth offending and

long-term unemployment.

How can individual SLTs and services respond, especially when the NHS is under severe strain financially and staff are exhausted? Many team leads feel powerless in the face of huge numbers and demands from managers and commissioners to 'do more with less'. Can we deliver evidence-based practice and address waiting lists?

Recent research has confirmed that an evidence-based approach is possible within the constraints of real service delivery. The RSLT, as your professional body, engages with and contributes to discussions around service delivery, challenging short-sighted rationing, such as the six-week block. This includes the development of clinical guidelines and position statements, working to influence commissioners and the government to ensure policy decisions improve outcomes and address health inequalities, and providing listening events and an online network for NHS team leads and managers.

If you lead a team, then I urge you to contact the RSLT and engage with the process of making evidence-based treatment intensity a core pillar of your team's practice. In this way we can address waiting lists and ensure children and young people access adequate support to achieve their potential in life. **B**

Dr SEAN PERT, RSLT chair of trustees
✉ sean.pert@rslt.org
☛ @SeanPert

KAMINI GADHOK

Moving forward

Kamini Gadhok looks to the future in her final column as RCSLT CEO

As I enter the last few months as CEO, I want to reflect not just on the past but also on the future.

I have met and worked with so many wonderful and inspiring SLTs, staff, trustees, committee members and external stakeholders that I do not have the space to list them all. It certainly has been a great honour and privilege to work with you all, so I do hope colleagues can forgive me for not giving any personal thanks – you all know who you are!

I can however name and thank our president Nick Hewer and the 10 chairs of the Board of Trustees that I have worked with: Flis Parsons, who appointed me in 2001 and has since sadly passed away, Caroline Sykes, Sue Roulstone, Rosalind Gray Rogers, Mary Turnbull, Hazel Roddam, Bryony Simpson, Morag Dorward, Della Money, Mary Heritage, and now I have the pleasure of working with Sean Pert as he starts his term of office.

In the Spring issue of *Bulletin*, I looked back on my career journey and the developments that have taken place over the years. While change is never easy, it is now a time to look to the future as I hand over the reins to my successor, Steve Jamieson (see news p8).

Challenges undoubtedly remain with the ongoing impact of COVID-19, as well as economic pressures. The RCSLT is alive to these issues and continues to work to influence government and stakeholders to support the profession to meet increased demand and grow the

workforce. As we move forward, it is important to also grab opportunities during what will continue to be a period of significant change.

Opportunities come in many forms, and I hope colleagues are able to influence whenever they arise. Leadership can be exercised with respect to small changes to service provision, innovating new approaches, data collection to show progress and outcomes, embedding work on equality, diversity and inclusion, or research and sharing practice through the RCSLT and other professional networks.

Investing in our current and future leaders is critical: we need to build strong leadership within the profession, across a range of areas and at all levels. I know the importance of this investment. Without mentoring, encouragement and support in my career, I would not be where I am today.

But we know from members that it is not always possible to access formal leadership development. As a member of the Allied Health Professions Federation, I have asked if we can work together to scope leadership courses and opportunities to identify what more we can do to support the future of our professions.

I am excited to see how we continue to build on our collective strengths. I wish the profession and the RCSLT all the success it deserves as we continue to move forward and look to the future. **B**



Investing in our current and future leaders is critical

KAMINI GADHOK MBE

RCSLT chief executive officer

✉ kamini.gadhok@rcslt.org

☛ @KGadhok

Wiltshire Farm Foods at the RCSLT's Awards

The Wiltshire Farm Foods team served up desserts to over 170 Speech and Language Therapists and showcased its Softer Foods range.

As industry leaders in specialist nutrition with an award-winning Softer Foods range, Wiltshire Farm Foods has always been passionate about engaging with Speech and Language Therapists (SLTs) on how its nutritious, appropriately textured meals and good old fashioned delivery service can support those with swallowing difficulties to live independently.

As proud sponsors of the RCSLT's Awards back in September, SLTs had the opportunity to learn more about Wiltshire Farm Foods' range of more than 85 IDDSI meals and how they ensure the needs of nutritionally vulnerable service users are met.

Its wide range of mains, snacks and desserts have been produced in line with IDDSI guidance and are developed with dietetic input, so you can rest assured that the dishes are nutritious as well as safe to eat for your patients.

Category Development Manager for Specialist Nutrition at Wiltshire Farm Foods Declan Henderson and the team served a selection of texture modified foods, including a Level 4 Purée Summer Fruit Sponge & Purée Hot Chocolate Cake; Level 5 Minced Sticky Toffee Pudding; and Level 6 Soft & Bite-sized Sticky Toffee Pudding & Custard, along with a Summer Fruits Crumble and a Sticky Toffee Pudding from its core range. Declan says:

"We know that not only is blending food time consuming, but that there are lots of challenges in creating IDDSI compliant meals. It was great to have the opportunity to attend these awards and ideal to have so many SLTs not only learn more about our food but also get to try some of our Softer Meals range. These dishes give service users with swallowing difficulties the chance to eat not only safe but nutritious and enjoyable dishes."

Wiltshire Farm Foods will be launching its new Autumn &



① The Wiltshire Farm Foods team at the RCSLT's Awards

The Softer Food desserts served at the awards included:

- ② Level 4 Purée Summer Fruit Sponge
- ③ Level 4 Purée Hot Chocolate Cake
- ④ Level 5 Minced Sticky Toffee Pudding

Spring brochure on 23rd January 2023, which includes new dishes from a Luxury Cottage Pie to a Level 4 Puréed Eve's Pudding & Custard – all perfect antidotes to beating those January blues.

 To listen to the company's latest podcast episode, with Registered Dietitian Maia Fergus-O'Grady in conversation with Clinical Specialist SLT Gemma Clunie, search for 'Dietitian Diaries' on either Apple Podcasts or Spotify.

Person-centred care: It's personal

Emma Hyde reflects on her personal experiences of person-centred care and says there is still work to be done



I am a diagnostic radiographer by background and developed an interest in person-centred approaches to care while carrying out research for my Masters in Education. This led to me undertaking a large-scale national research project to define informed measures of patient-centred care in diagnostic radiography as part of my PhD. In autumn 2021 I was appointed as the clinical director of the Personalised Care Institute, based on my PhD research and subsequent post-doctoral work on person-centred care and personalised care.



Dr EMMA HYDE

The PCI provides free, quality-assured education, training and resources

Personal experience

On a personal level, I have had a valuable experience of personalised care with my family. When my eldest child was approaching their third birthday, I became concerned that their vocabulary

was limited in comparison to their nursery peers. It had become noticeable that they would point at toys or food to indicate what they would like, rather than speaking.

After contacting our health visitor and a hearing test, which showed no issues, we were referred to the speech and language therapy team. The team carried out an assessment, after which we were provided with a series of activities and flash cards to use to encourage my child to speak. The service we received from the team was outstanding and my child made excellent progress as a result – to the point where we now have trouble keeping them quiet. The experience felt person-centred, decision-making was shared and the care plan was personalised to my child. An excellent example of personalised care.

Free education and resources

In my role as clinical director of the Personalised Care Institute I have realised how far ahead many allied health professionals, such as SLTs, are in terms of knowledge and application of

personalised care approaches. However, there is still work to do in some areas to raise awareness of personalised care, as well as to increase the numbers of health and care professionals trained in personalised care, to meet the targets set out in The NHS Long Term Plan (2019).

The Personalised Care Institute supports the health and care workforce to deliver personalised care by providing free, quality-assured education, training and resources. We offer several elearning courses in areas such as shared decision making, personalised care and support planning and remote consultations. We also run regular live webinars on a range of topics including long-term mental conditions and social prescribing, and have a podcast series about topics, such as long COVID. All of which is excellent continuing professional development. **B**



REFERENCE

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

**FOCUS ON DIVERSITY**

A parallel path

Chloe Nkomo reflects on her diversity, equity and inclusion journey in speech and language therapy

**CHLOE NKOMO**

As a working-class woman of multiple ethnic backgrounds, much of my adult identity is shaped by the racialised experiences of my childhood, adolescence and every new day. This impacts the way I perceive and interact with the world. When these experiences intersect with my path to becoming an SLT, I am more acutely reminded of my ‘otherness’ in a profession of majority white, middle-class women. Perhaps inevitably, my SLT journey has set me on a parallel path of diversity, equity and inclusion (DEI) and re-asserting my identity as a woman of colour in a racist society.

Like many, the COVID-19 pandemic inflicted a sustained period of reflection against the backdrop of the murder of George Floyd. My views and frustrations, previously reserved for quiet conversations with friends, bubbled over and I found myself sharing, posting and engaging in public conversations about racism.

A friend asked me, “What has changed? You’ve become so... vocal” (with the slightest hint of disdain). I replied, “I’m sick of this conversation



Everyone needs to be talking about it



At university, I suggested a DEI representative be created as a committee role and unwittingly became that person. I attended the 2021 RCSLT anti-racism workshop and was pleased to see a space reserved for the conversation. Little did I know I would be revisiting this workshop through the University of Reading Undergraduate Research Opportunities

Programme (UROP), an annual scheme providing paid research opportunities to UR undergraduate students.

In summer 2022, I took part in UROP and worked on a research project with the RCSLT and School of Psychology and Clinical Language Sciences – ‘Analysing diversity, equity and inclusion in speech and language therapy’. I was tasked with organising and analysing data collected from a survey distributed to RCSLT members who attended the anti-racism workshop. I organised the survey responses into themes and analysed responses in three groups: all respondents; white ethnic group respondents; and black, asian and minority ethnic respondents. The respondents also ranked 10 research areas by priority and provided additional ideas for research priority setting.

It perhaps comes as no surprise that confidence in DEI in the profession presents a mixed picture. Interestingly, a potential difference emerged in confidence ratings between white and minoritised respondents, particularly in responses to questions around ‘Support for/experience of underrepresented students and clinicians’. The report’s findings suggest some clear next steps for multiple stakeholders to improve the state of DEI in the profession, and identify future research areas to prioritise. At the time of writing, the report is due to be published in early 2023 and will be disseminated through multiple channels.

As I navigate my final year of university and approach the beginning of my career as an SLT, I still have hope for a truly anti-racist profession. I hope this report provides a springboard for future, much-needed research on race and racism in speech and language therapy in the UK. Our profession is a brilliant one; moving forward, we need to work together to ensure it is brilliant and equitable for all.

CHLOE NKOMO, 4MSci Speech and Language Therapy, University of Reading
✉ c.a.nkomo@student.reading.ac.uk



Lost in translation

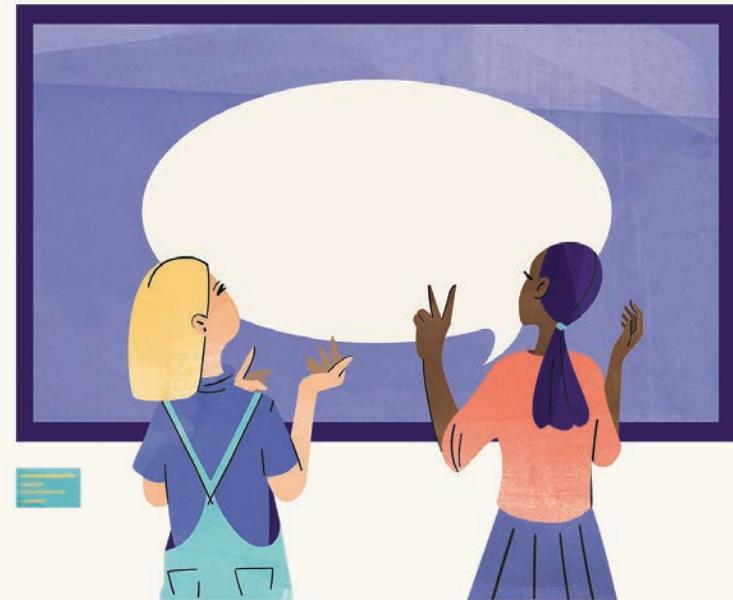
The language used to assess and treat social communication and interaction is ripe for reassessment, says **Susan Thomson**

In Terry Pratchett's novel *Thief of Time* the Auditors try to understand art by deconstructing each painting into its constituent parts. With piles of paint colours in front of them, they remain puzzled about art, and have lost the beauty of the work. Sometimes I wonder if assessment of social interaction and communication is a bit like this. The current diagnostic criteria for autism (DSM-5 and ICD-11) describe it as a disorder. The Autism Diagnostic Observation Schedule (ADOS) uses what it calls 'social presses' to elicit particular behaviours and then scores them in terms of constituent parts such as eye contact and gesture. Many people within the autistic community advocate that autistic communication and interaction is different from - not lesser than - neurotypical communication and interaction. Damian Milton describes this as the



SUSAN THOMSON

SLTs are ideally placed to identify solutions



'double-empathy' problem. There is a growing body of research in this area, but not sufficient to draw firm conclusions. This leaves us with difficult decisions to make in terms of our assessment and intervention.

Let's take eye contact as an example. What is normal variation? What about cultural differences? What are the implications of asking autistic people to conform to using eye contact? People whose eye contact is noticeably different to the social norm face misunderstanding and prejudice. How do we offer intervention that encourages

acceptance but also provides knowledge and skills that may be helpful? As SLTs we hold a position of power, which can have a profound effect on how someone sees and values themselves.

Now is a good time to review the language we use to assess and treat social communication and interaction. As SLTs, we have a duty to use robust tools for assessment and to follow best practice in

terms of intervention. We must also use professional judgement to ensure we incorporate new evidence and meet individual need.

There is a real danger that this debate will become increasingly emotive and polarised. I would argue that SLTs are ideally placed to identify sensitive and effective solutions.

Perhaps we should see individuals' communication as art work. Some may need some careful restoration work (rehabilitation) to bring out their original beauty. Others may be of a style that appeals to a small number of people, or that has gone out of fashion. Our job is to look closely and describe accurately what we see, to step back and see the whole picture so as not to make the mistake of the Auditors, reducing beauty and meaning to nothing, and damaging the original irreparably. **B**



REFERENCES

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



What's in a name?

The Child Speech Disorder Research Network make their case for adopting the term 'childhood apraxia of speech'



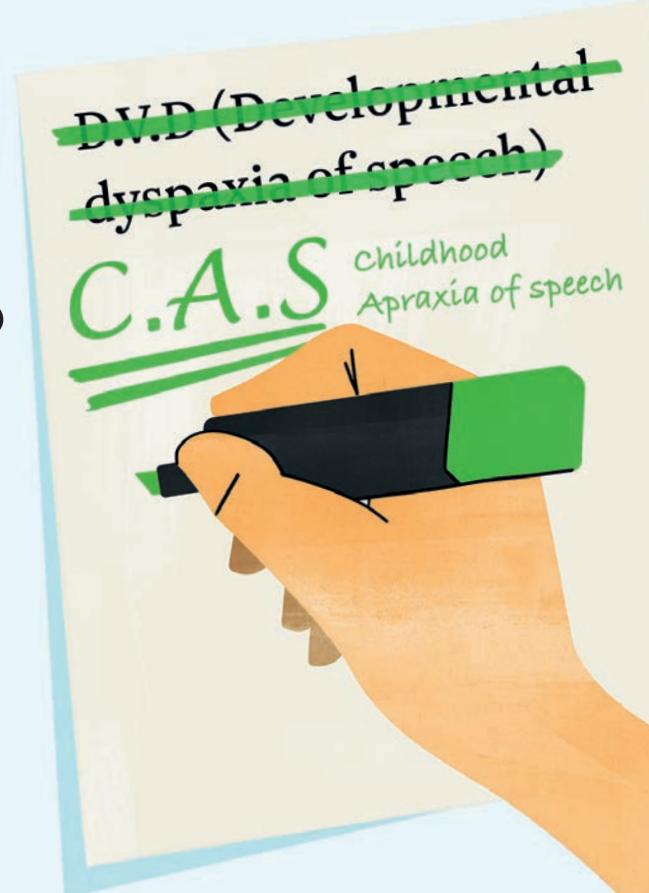
**Dr JAN
BROOMFIELD**



**Dr JOANNE
CLELAND**



**Dr PAM
WILLIAMS**



Professional bodies representing SLTs and speech pathologists across the UK and USA have produced documentation confirming the existence of developmental verbal dyspraxia (DVD) / childhood apraxia of speech (CAS) as a rare but distinct condition, reversing previous opinion about it being a controversial diagnosis. Additionally, DVD/CAS is acknowledged as a long-term condition with life-long consequences, particularly if appropriate and/or sufficient intervention is not received during formative years and into adolescence (McCabe et al, 2020).

Terminology changes over time to reflect national and international views. For example, developmental language disorder (DLD) has now replaced specific language impairment (SLI) (Bishop et al, 2017). Speech sound disorders (SSD) has replaced previous terms such as speech disorder(s),

speech impairment and speech difficulties, and is “an umbrella term for the full range of speech sound difficulties; it is theoretically neutral and accessible to an international audience” (McLeod and Baker, 2017 p.9). Historically, CAS was known as developmental articulatory apraxia/dyspraxia (Morley, 1957) in the UK before the term DVD was adopted in the late 1980s.

In this article, the Child Speech Disorder Research Network (CSDRN) argue that the profession should now adopt the term ‘childhood apraxia of speech’ rather than ‘developmental verbal dyspraxia’, so we can join the rest of the international, English-speaking speech and language pathology / therapy community.

Now is the time for us to join the international community

Background

In 2007, the American Speech-Language-Hearing Association (ASHA) published a technical report and position statement on the subject of CAS. One key recommendation concerned terminology, proposing that CAS should be adopted as a “unifying cover term for the study, assessment and treatment of all presentations of apraxia of speech in childhood... CAS is preferred over alternative terms including developmental apraxia of speech and developmental verbal dyspraxia” (ASHA, 2007a p.2).

Four years later, the RCSLT published a policy statement on developmental verbal dyspraxia (2011). It was acknowledged that varying terminology existed across the world, but that the

preferred term in UK was DVD, in keeping with other RCSLT documents. At that time, UK experts were producing research literature and keeping terminology constant made sense. However, the landscape has now changed.

Current

CAS has become the dominant term in journal articles, books and book chapters. In addition, “suspected CAS” (sCAS) is used when there is some uncertainty over a definitive diagnosis, similar to the way in which “features of DVD” has been used in UK.

A recent literature search of journal abstracts containing the term DVD or CAS found 299 articles from pre-2000 to 2022. Figure 1 illustrates the declining use of DVD and the dominance of the term CAS over time, particularly from 2010. In part, this has been driven by the significant rise in intervention studies for CAS, which have mainly been carried out in the USA, Australia, Canada and New Zealand, all of whom use the term CAS.

CAS is a low-prevalence, high-impact condition. There is estimated to be 1–2 cases per 1,000 for isolated CAS with unknown cause (Shriberg et al, 1997; Shriberg et al, 2019). However, there are greater numbers when CAS occurs in children with a known neurodevelopmental condition: 4.3% for CAS alone and 4.9% for concurrent CAS and childhood dysarthria (Shriberg et al, 2019). The needs of all children affected by CAS are high and often require significant input from speech and language therapy services and other agencies over many years. In their evidence summary on CAS, McCabe et al (2022) refer to “emerging evidence that a significant burden of psychosocial, educational, economic and communication deficits remains across the lifespan with resultant restrictions on participation and daily life” (p.1). A recent article by Cassar et al (2022), describes the findings of a small-scale mixed methods

study of adults who were reported to have had CAS in childhood; they concluded that psychosocial effects and speech characteristics associated with CAS appear to persist into adulthood.

In conclusion

We are not proposing a membership debate or international consensus exercise over the most appropriate label, because it is too late – the rest of the world has moved on without us! Now is the time for us to join the international community and for UK SLTs to adopt the term CAS. This will enable us and those professionals and families we work with, to access the wealth of emerging evidence about the nature, assessment, diagnosis and intervention for children and young people presenting with this complex, pervasive condition. Additionally, it will enable us to continue to strive to implement best current evidence, minimising impact and maximising outcomes for this population. ☺

Dr JAN BROOMFIELD, independent SLT, member of CSDRN, and project lead for

RCSLT's 2011 Policy Statement on DVD
✉ drjanslt@gmail.com

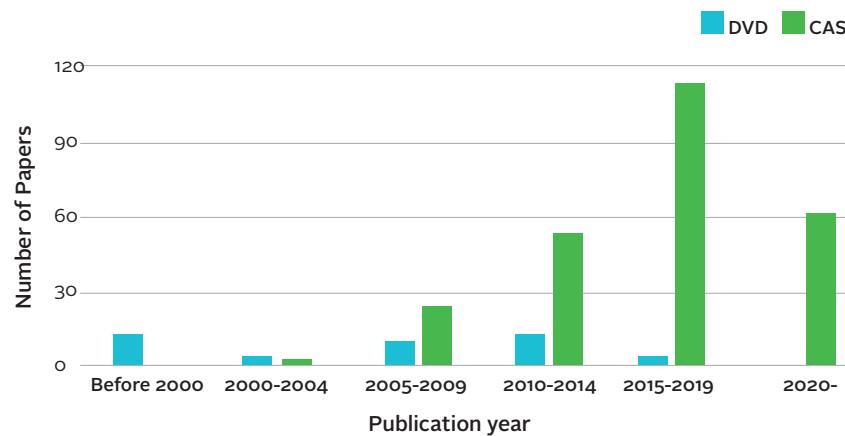
Dr JOANNE CLELAND, reader in speech and language therapy at the University of Strathclyde, member of CSDRN
✉ joanne.cleland@strath.ac.uk

Dr PAM WILLIAMS, honorary lecturer in speech and language therapy at University College London Hospitals NHS Foundation Trust, member of CSDRN, and main co-author of RCSLT's policy statement on DVD
✉ pamela.williams@ntlworld.com

Get in touch!

What's your view on the subject?
Email us at bulletin@rctl.org. Or for more information, drop a line to the enquiries team at info@rctl.org.

Figure 1:
Number of papers with the term DVD or CAS in the abstract







Dysphagia and COVID-19 in adults

What do we know now?

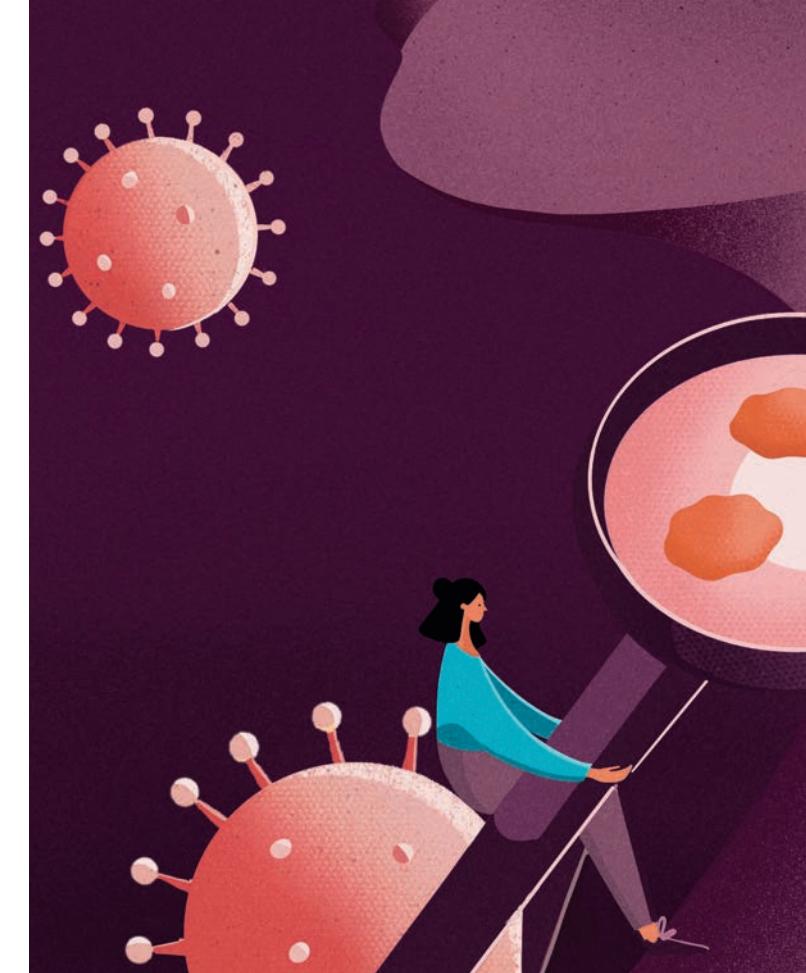
Gemma Clunie, Sarah Wallace and Camilla Dawson assess the current evidence about the link between COVID-19 and dysphagia ➔

ILLUSTRATIONS SOPHIE STANDING

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ince the beginning of the COVID-19 pandemic in 2020, nearly 24,000,000 cases of the virus have been recorded in the United Kingdom (WHO Coronavirus Dashboard, 7 October 2022), with approximately 960,000 UK hospitalisations (www.statista.com). Of that number, 14–26% (up to 249,000) require intensive care (Wang et al, 2019; Richardson et al, 2020).

Initially, respiratory symptoms gained the most attention but as the pandemic progressed it became clear that SARS-CoV-2 causes multisystemic illness. Neurological, cardiac, gastro-intestinal, renal, autonomic and coagulation symptoms feature in addition to respiratory complications, with a much longer impact on bodily systems than first imagined. This includes dysphagia as a frequently reported



Dr GEMMA CLUNIE



SARAH WALLACE OBE



Dr CAMILLA DAWSON

symptom across the whole spectrum of COVID-19 disease severity (Wallace, 2022; Miles et al, 2021; Miles, 2022). COVID-19 presents ongoing challenges in terms of caseload numbers of post-COVID and long COVID sufferers, and a lack of evidence for the most effective treatments (Chadd et al, 2022, *in press*).



REFERENCES

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

Swallowing difficulties

For people requiring admission to an intensive care unit (ICU), endotracheal intubation or tracheostomy are necessary when a person cannot breathe for themselves. The presence of a tube, as well as proning, combined with the impact of the virus, has led to high numbers of people with laryngeal compromise and swallowing difficulties (Dawson, 2022; Wallace and



McGrath, 2021). We are seeing frequent and more severe laryngeal complications such as swelling, stridor (noisy breathing), large granulomas (inflammatory lesions), diffuse cyst-like lesions, erythema (redness), hypersensitivity, glottic injury, airway stenosis (narrowing) and vocal fold immobility. The detrimental impact of these is wider than swallowing and may lead to increased need for prolonged tracheostomy placement, difficulty with tracheostomy decannulation and dysphonia (Naunheim et al, 2021; McGrath et al, 2020; Boggiano et al, 2021; Rouhani et al, 2020). These complications do not always present acutely but may develop once the person has been discharged (Piazza et al, 2020; Naunheim et al, 2021; Rouhani et al, 2020), requiring outpatient or community management.

Dysphagia is a known risk factor in patients who experience muscle weakness and wasting from critical

illness myopathy, delirium and acute respiratory distress syndrome (ARDS) (Härdemark Cedborg et al, 2015; Ponfick et al, 2015; Welch et al, 2014). Patients with severe COVID-19 are at high risk for these conditions and associated dysphagia due to prolonged length of stay on ICU. For clinicians in the critical care setting, it is vital to understand that post COVID-19 dysphagia is multifactorial with ventilation requirements and breathlessness disrupting breath/swallow coordination; neurological complications; sedation, post-viral and ICU-acquired weakness (Aoyagi et al, 2021; Regan et al, 2022; Lindh et al, 2022) leading to swallowing impairments. Rates of dysphagia following ICU admission are high with reports ranging from 23–90% (Sassi et al, 2022; Lindh et al, 2022; Mui et al, 2021; Regan et al, 2021; Miles et al, 2021). This is much higher than a non-COVID ICU population (Brodsky et al, 2018; Skoretz et al, 2011) but likely related to longer intubation times, frequent proning and reintubation, all recognised risk factors for post-extubation dysphagia (Frajkova et al, 2020). However, a positive research finding is that many patients report their dysphagia symptoms have resolved by hospital discharge. This is largely due to healed

intubation trauma, improved strength and reduced respiratory support (Miles et al, 2022; Clunie et al, 2022; Regan et al, 2022).

Dysphagia symptoms are also reported by people who have been admitted to hospital but not ICU (Martin-Martinez, 2021). This is likely due to respiratory-swallow coordination difficulties, COVID-19 neurological symptoms and pre-existing comorbidities (Grilli et al, 2022). Hospitalised patients may require non-invasive ventilation via continuous positive airway pressure (CPAP) or high-flow nasal cannulae (HFNC). HFNC support can prolong laryngeal closure and inhibit swallow coordination (Oomagari et al, 2015; Allen et al, 2020), potentially leading to dysphagia symptoms. There is evidence that swallowing difficulties in this population persisted for longer than those with ICU-related dysphagia (Miles et al, 2021), judged by the need for dietary modification at the time of discharge.

If speech and language therapy intervention is missed on ICU, dysphagia as an ongoing symptom of post intensive care syndrome needs to be identified. The PICUPS tool can help in doing so and can signpost to speech and language therapy (Turner-Stokes et al, 2021; Puthecheary et al, 2021).



Dysphagia is a frequently reported symptom across the whole spectrum of COVID-19 disease severity



Dysphagia is also experienced by people who managed their COVID-19 illness at home and developed long COVID (symptoms persisting beyond 12 weeks: www.nhs.uk/conditions/coronavirus-covid-19/long-term-effects-of-coronavirus-long-covid/). A survey-based study of people living with long COVID indicated approximately 30% had difficulty swallowing or globus sensation (a lump in the throat) (Davis et al, 2021). Eating and drinking are also impacted in long COVID by fatigue, muscle weakness, coughing, laryngeal hypersensitivity, shortness of breath, anxiety, depression and cognitive disturbance (Miles, 2022).

SLTs are key to the optimal assessment and management of patients with dysphagia in the context of COVID-19 infection, throughout the patient's journey from acute admission to outpatients and in the community. The absence of speech and language therapy from the NICE guidance for the management of COVID-19 and long COVID has had significant implications for staffing and service provision. As more evidence emerges about the link between COVID-19 and dysphagia, we are hopeful this will change.

Start with the basics: Clinical swallowing evaluation and a thorough history

This is particularly important with COVID-19 associated dysphagia, no matter which setting. Patients may have coexisting comorbidities (Dawson et al, 2021) that impact their swallowing presentation and management, or an unknown pre-existing dysphagia (Adkins et al, 2020). Knowledge of reduced interest in eating and drinking, gastro-intestinal symptoms and ongoing altered sense of taste and smell are important to understanding dysphagia presentation, since they affect management. In some cases, reintroduction of flavours and textures as re-education or desensitisation will be necessary. Appreciating that swallowing disorders need to be managed in the context of physical, cognitive and psychological aspects of COVID-19, post intensive care syndrome (PICS), or long COVID is vital.

A focused clinical swallowing evaluation with a clear rationale has a positive impact on patient outcomes (Pillay and Pillay, 2021), including for COVID-19 patients. This provides a solid foundation for dysphagia management. Early intervention and MDT involvement will lead to better outcomes and reduced need for prolonged SLT intervention (McGrath and Wallace, 2014; McGrath et al, 2020).

Instrumental assessment is of huge value

Flexible endoscopic evaluation of swallowing (FEES) is advantageous in the ICU setting to identify laryngeal complications, secretion management and expedite tracheostomy weaning as part of swallowing management (Boggiano et al, 2021). As silent aspiration is known in the hospitalised COVID-19 population (Lagier et al, 2021; Sassi et al 2022), access to FEES is invaluable for efficient and effective management of any patient, and indispensable for those requiring CPAP or HFNO instrumental assessment (Flores et al, 2019). Even in non-ICU hospitalised or ENT/ SLT outpatient settings, FEES is immensely helpful in visualising laryngeal issues related to the virus.

Gastro-oesophageal reflux disease is closely linked with COVID-19, with a recent study identifying a potential genetic relationship, particularly in the context of obesity (Ong et al, 2022). Videofluoroscopy (VFS) is useful if reflux or oesophageal stage difficulties are suspected since these often present as a referred laryngeal sensation. Using VFS images as biofeedback often excludes oropharyngeal dysphagia issues and reassures patients as well as guiding onward referral, eg ENT review. Additionally, FEES can determine if laryngopharyngeal reflux signs are present and if they are exacerbating sensory swallowing impairments.

For people living with long COVID, FEES can provide vital biofeedback to identify muscle tension patterns leading to symptoms of globus and perceived dysphagia, both to reassure patients and to demonstrate therapeutic techniques to release tension.

Use your existing toolbox

Dysphagia management in the context of COVID-19 has been largely reliant on compensatory and rehabilitation strategies, such as diet modification and therapy exercises (Dawson et al, 2020; Clunie et al, 2022). Pharyngeal electrical stimulation may benefit patients with a severe post-viral neurogenic dysphagia and sensory impairment (Blakemore et al, 2021). For patients with laryngeal hypersensitivity or globus, it may be appropriate to use voice therapy strategies and education. In cases where fatigue, breathing pattern or upper airway dysfunction have been identified as factors impacting on the swallow function, it is critical that we seek support and work collaboratively with occupational therapists, physiotherapists and



REFERENCES

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



Clinical Top Tips for SLTs

Key signs and symptoms of dysphagia post COVID-19



Aspiration



Choking



Recurrent chest infections



Respiratory/swallow incoordination



Excess or thick secretions



Coughing when eating and drinking in the absence of aspiration



Fatigue



Taking longer to finish a meal or eating less than normal



Anxiety and fear during eating and drinking



Breathlessness during eating and drinking



Avoiding harder textures



Laryngeal hypersensitivity and globus



Laryngeal muscle tension



Persistent throat clearing



New dissatisfaction/unenjoyment for eating/drinking



Impact on psychosocial wellbeing



specialists in upper airways. We are yet to develop specific therapy strategies for COVID-19 induced dysphagia; however, as skilled clinicians we can confidently apply our existing knowledge and tailor our rehabilitation strategies appropriately for this patient group.

Being able to eat “normal diet and fluids” does not mean you don’t have a swallowing difficulty

Many people post COVID-19 report changes to their swallowing despite presenting with a safe swallow function on assessment. One study (Rouhani et al, 2021) reviewed patients post-tracheostomy in an outpatient ENT clinic one month post hospital discharge. All had been discharged from SLT services on IDDSI 0 and 7, with no ongoing input; however, 30% still reported difficulties swallowing according to the Eating Assessment Tool-10 (EAT-10). Symptoms were subtle including reduced pleasure in eating; effortful swallowing; and finding eating and drinking stressful. Such problems may only become obvious or a priority following hospital discharge, on returning to social eating and trying to maintain full oral nutrition. This highlights that SLT re-referral pathways should be clear and accessible, with SLT input fully resourced.

Telehealth

The implementation of telehealth services has a huge benefit to the management of COVID-19 patients in community settings. It enables patients to be remotely managed, including dysphagia symptoms. Telehealth or

a hybrid approach can be preferable for outpatient services and service-users as well as hospital outreach programmes.

Considerations for dysphagia management using telehealth include taking a systematic approach, training, technology availability and an evidence-based model of care. This must include safety measures and patient support (Ward and Cameron, 2022). Telehealth both offers a flexible service delivery option for direct dysphagia management, and facilitates virtual mentoring and supervision for staff, especially for the management of complex patients.

You are not alone

Even if you are not working in a long COVID service, or a well-supported acute hospital setting, patients benefit from multidisciplinary management. It is important to liaise with other team members involved in COVID-19 patient care and know how to refer on:

- ENT/ Neurology/ Respiratory/ Gastroenterology/ Cardiac/Critical care follow-up
- Physiotherapy
- Occupational therapy
- Dietetics
- Psychology
- Patient support groups

Actively seek support from colleagues locally or from the RCSLT clinical advisor network and COVID-19 working group. There is an RCSLT long COVID community of practice and online forum ([via www.rcslt.org](http://www.rcslt.org)), where SLTs are sharing experiences and therapeutic techniques as they develop a better understanding of this condition. Finally, there is a growing body of evidence for COVID-19 related dysphagia which guides clinical practice and decision making. Knowledge of this literature base is vital for best practice management.

Dr GEMMA CLUNIE, clinical specialist SLT (complex laryngology and airways), Imperial College Healthcare NHS Trust; honorary research fellow.

✉ gemmaclunie@nhs.net

SARAH WALLACE OBE, consultant SLT (critical care and dysphagia), Manchester University NHS Foundation Trust
✉ sarah.wallace@mft.nhs.uk

Dr CAMILLA DAWSON, consultant SLT (dysphagia and altered airways), University Hospitals Birmingham NHS Foundation Trust; honorary research fellow
✉ camilla.dawson@nhs.net

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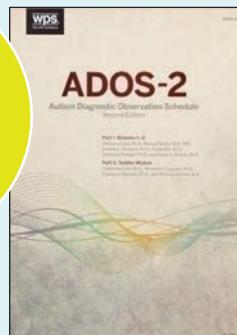
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An evolving specialism

The evidence base for swallowing and communication impairments in the haematology population is limited. Orna Doris and colleagues share their insights



U

niversity College Hospital London (UCLH) is home to Europe's largest treatment centre for patients with haematological conditions. To our knowledge, it is the only hospital that funds a dedicated

SLT for this patient cohort.

After placing an ad in *Bulletin* for SLTs working in haematological conditions to get in contact, Orna Doris of UCLH met online with SLTs from around the country to share their practices and learn from each other about this caseload. Here we present our joint learning and experience to date with this fascinating adult patient group.

Haematological conditions

Haematological conditions are disorders of the blood and bone marrow including malignancies such as leukaemia, lymphoma and myeloma, and benign conditions such as anaemia or clotting disorders (Smith et al, 2011).

The prevalence of dysphagia and communication impairments in the haematology population is not well documented and the literature is largely made up of single case studies (Frowen, 2019). However, as clinicians working with a haematological caseload, we've observed a range of swallowing and communication impairments.

Our experience is that the majority of haematology patients referred to speech and language therapy have malignant diagnoses; haematological cancers account for around 9% of new cancer diagnoses each year (Haematological Malignancies Research Network, 2017). While the median age at diagnosis is 70.6 (Smith et al, 2011), our speech and language therapy caseloads are characterised by a broad age range, with high numbers of patients in early-mid adulthood.

We have reflected on how our care is shaped by these patients' often complex and arduous treatment pathways, which range from active monitoring, to stem cell or bone marrow transplants, chemotherapy and radiotherapy. Advances in these treatments are resulting in more patients being cured, or living longer with their disease, making this an evolving caseload.

Patients may undergo multiple treatments, with their medical status and therapy needs fluctuating throughout their pathway. This is reflected in the differing composition of our working group's posts but may also mean other speech and language teams are involved along the way, such as critical care SLTs.

Swallowing and communication

By collating data from all inpatients referred to our services over a six-month period, we identified three of the most frequently occurring speech and language therapy referral indicators:

1. Diffuse Large B Cell Lymphoma (DLBCL)

DLBCL is an aggressive lymphoma with rapidly growing lesions that can present in the oropharynx and nasopharynx. Dysphagia can be severe and can occur alongside odynophagia, dysphonia and airway complications, see table 1. Urgent treatment is advised for this population; management with steroids can reduce the severity of symptoms and function can

TABLE 1:

	Possible difficulties	Interventions implemented
DLBCL	<ul style="list-style-type: none"> ● Oropharyngeal dysphagia secondary to presence of mass; impaired sensation and function ● Odynophagia ● Dysphonia (vocal cord palsies are common) ● Airway obstruction ● Compromised nutritional status 	<ul style="list-style-type: none"> ● Regular re-assessment to monitor for changes ● Instrumental assessment to look at position, size and impact of mass ● Compensatory manoeuvres and postural changes (eg: head tilt away from mass) ● Advice on management of odynophagia ● Highlight need for ENT assessment ● Airway/tracheostomy management ● Communication support ● Short-term enteral feeding
CNS disease	<ul style="list-style-type: none"> ● Cranial nerve dysfunction ● Dysphagia ● Dysarthria ● Aphasia ● Cognitive impairment ● Seizure activity ● Appetite changes ● Fatigue 	<ul style="list-style-type: none"> ● Regular re-assessment to monitor for changes ● Instrumental assessment to aid MDT/SLT management ● Compensatory approaches for patient, family and MDT ● Facilitating participation in decision making ● Greater focus on patient comfort and preferences

improve within a number of weeks of chemotherapy and/or radiotherapy (Cancer Research UK; Silva et al, 2016; Kwak et al, 2017; Frowen, 2019).

2. Central Nervous System (CNS) involvement

Lymphoma can occur within the CNS; the brain, spinal cord, meninges and cerebrospinal fluid (Cancer Research UK). CNS disease can directly or indirectly impact on swallowing and communication (see table 1). Neurological symptom onset is often sudden with significant changes to function, and presentation may mimic symptoms of other neurological diagnoses (Simmons and Bursaw, 2015; Lymphoma Action). There are often improvements in

symptoms during or following treatment, though these can be temporary if CNS disease relapses, which occurs in over half of cases (Green and Hogg, 2021).

3. Treatment related effects

Patients with haematological conditions are vulnerable to infection, due to the disease itself and immunocompromising treatments such as chemotherapy (Frowen, 2019). By their nature, treatments can be harsh, causing unpleasant symptoms or more serious complications, such as neutropenic sepsis, type one respiratory failure, graft versus host disease and tumour lysis syndrome; which often requires critical care admission.

Assessment and intervention

Through case discussions and sharing clinical experience, we have found much consensus within our group on appropriate management for this patient cohort.

Speech and language therapy assessment is required throughout the treatment pathway. Taking a thorough case history is vital in differentiating between CNS involvement or another form of neurological involvement. Continuous reassessment is recommended as patients' needs change rapidly due to disease or intense and new experimental treatments, such as CAR-T therapy.

TABLE 2:

Treatment side effects

- Systemic treatments can lead to general deterioration impacting on swallow function
- Radiotherapy to the oropharynx or nasopharynx can cause acute oedema, impacting on swallow, airway and voice
- Xerostomia and mucositis
- Taste and appetite changes
- Immunotherapy can cause neurotoxicity with cognitive and neurological impairments

Clinical swallowing evaluations (CSE) can help inform whether a patient requires further instrumental assessment. Videofluoroscopy (VFS) and fibreoptic endoscopic evaluation of swallowing (FEES) can guide therapeutic interventions for this caseload depending on their presentation. Patients with nasopharyngeal lymphomas benefit from VFS to visualise the impact of the tumour on the surrounding soft tissue; whereas a FEES is more favourable for patients with tracheostomies/airway concerns.

Patients with CNS involvement may

Speech and language therapy assessment is required throughout the treatment pathway

need support with their communication: from basic augmentative and alternative communication to involvement in mental capacity assessments and supporting decisions around future treatment planning and ceilings of care.

We have found that interventions required for this patient group are often complex and patient specific, due to the need to consider treatment induced complications (see tables 1 and 2). At times, patients require SLTs to adopt a 'watch and wait' approach for the outcomes of chemotherapy on specific impairments. Conversely, we have also found that once patients have emerged from acute illness, they have responded well to intense dysphagia rehabilitation.

Patients suffering with serious treatment related effects benefit from a cautious approach, due to their susceptibility to infection. Close multidisciplinary team (MDT) working is required, and due to the treatment cycle involving regular re-admission and discharge, patients are generally well known by all members of the MDT.

Future research

The evidence base for the assessment and management of patients with swallowing and communication impairments in the haematology population is limited. As a group we are collecting data on referral numbers, demographics, therapeutic

interventions and outcomes to expand the current literature.

Conclusion

Through our clinical experience we have gained expert insight into this patient group. The variety of clinical presentation of patients with haematological conditions is vast and varies from mild to severe. These patients are now being treated with both life-prolonging and curative treatments, which require intense and consistent SLT input. Longer-term side effects on communication and swallowing may also not yet be fully known.

As SLTs, we must be considerate of service delivery pathways for this patient group because of their weakened immunity and vulnerability. Given their complexity we have found that they are best managed by specialist SLTs who are integrated into the haematology MDT, which supports the need for further dedicated haematology posts. 

ORNA DORIS, highly specialist SLT in haematology, University College Hospital London

✉ orna.doris@nhs.net

⌚ @ornadoris

ABIGAIL CAMPS, highly specialist SLT in general oncology, Guy's & St Thomas' Trust

✉ abigail.camps@gstt.nhs.uk

⌚ @campsabbie

KATIE FAHY, specialist SLT in oncology and haematology, University Hospitals Bristol and Weston

✉ katie.fahy@uhbw.nhs.uk

⌚ @katie_fahy

CAROLINE MCGILL, highly specialist SLT in oncology and haematology, University Hospitals Bristol and Weston

✉ caroline.mcgill@uhbw.nhs.uk

CORINNE AVERY, highly specialist SLT in specialist medicine, King's College Hospital

✉ corinneavery@nhs.net



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Lost Voices

How can adults with capacity-affecting conditions and communication difficulties be accommodated within research practice? Karen Bunning and the ASSENT team share their study

Research involving human beings is essential for developing new knowledge. Gaining informed consent is one of the prerequisites of such research (Declaration of Helsinki, 2000). Founded on the principle of respect for autonomy, it formally recognises people's interest in making decisions and acting voluntarily, as well as understanding and processing information relating to these decisions. However, our society also includes people who lack mental capacity and who may have associated communication difficulties (eg adults with intellectual disabilities, autism, dementia, acquired brain injury).

In England and Wales, the legal, ethical and regulatory frameworks governing capacity and consent are provided for under the research provisions of the Mental Capacity Act (MCA: 2005). The proportion of people who require some kind of support in decision making is increasing; as people live longer, so the number of people



REFERENCES

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

who have dementia rises, and there are more survivors of acquired brain injury. Improved neonatal care means that premature babies are also surviving in greater numbers, with an associated risk of developmental disability. There are ethical questions about whether it is appropriate to include such people in research. However, some researchers and research ethics committees may find it easier to err on the side of caution, with the result that people who seem unable to give informed consent are excluded. This leads to an under-representation of these groups in research, which negatively impacts the development of medical, educational and social interventions.

Methods

Project ASSENT was conducted over a three-year period (2018–2021). The aim was to define a way through the complexities of including adults with capacity-affecting



conditions and associated communication difficulties in ethically-sound research. We adopted mixed methods over two stages to:

1. review the ethico-legal landscape of research in England and Wales; and
2. explore current practice around the inclusion of adults with capacity-affecting conditions and/or associated communication difficulties in ethically-sound research.

Stage 1. Ethico-legal landscape

Our composite research question was: How are adults with capacity-affecting conditions and associated communication difficulties recognised, represented and accommodated in research governance in England and Wales? We addressed this through three activities (*Table 1*).

TABLE 1: Summary studies: stage 1

Objective	Activity and Sample	Number
1.1 Review of MCA (2005)	We carried out textual analysis of legal documents: <ul style="list-style-type: none"> ● Primary sources included legislative provisions of the MCA and some relevant legal cases. ● Secondary sources included Hansard Reports in the build-up to the implementation of the MCA and accompanying policy documents, such as the MCA Code of Practice (MCA CoP, 2007; Chapter 11). 	31 54
1.2 Review of policy guidance	We conducted summative content analysis of policy guidance documents provided by the Health Research Authority (HRA).	14
1.3 Systematic review of the literature with narrative synthesis	The review focused on published research involving adults with capacity-affecting conditions and associated communication difficulties in the post-implementation period of the MCA (2005), i.e. from 2007 to 2018. <ul style="list-style-type: none"> ● Full text review ● Final sample 	134 29

Stage 2. Current practice

Our composite research question was: How is research practice characterised around the inclusion of adults with capacity-affecting conditions and associated communication difficulties in England and Wales? We addressed this through four activities (*Table 2*).

Results

Based on our comprehensive review of the ethico-legal landscape for research in England and Wales, we concluded that the MCA (2005) is largely focused on treatment, welfare and financial decisions. The separate provisions for research seem to be poorly drafted and lack an appropriate balance between protection and empowerment (Heywood et al, 2019). The MCA Code of Practice (2007) provides some elucidation of the technical aspects of the MCA, including formal governance procedures related to protection and risk management (Heywood et al, 2019; Ryan et al, 2020). However, the ethical approval process appears to place contrasting obligations and expectations on different parties (eg MCA REC members, researchers, consultees), which may

blur the allocated responsibilities and the formation of ethical opinions (Heywood et al, 2019). We found relatively few studies featuring adults with capacity-affecting conditions and/or associated communication difficulties. Sporadic use of consultees and the stated exclusion of adults with capacity and communication difficulties indicates that this group continue to be under-represented in research (Jimoh et al, 2021).

Our review of current practice revealed that exclusions continue to be made on the basis of a lack of capacity (Bunning et al, 2022). Where participants with capacity and communication difficulties are included, researchers use a range of materials, resources and procedures to support their understanding of the planned research. However, the majority of recruitment procedures seem to involve the use of some form of documentation to convey project information. Furthermore, the accessibility value of such resources in terms of the language content and presentational features to augment meaning is inconsistent. The use of consultees is variable across our populations of interest, eg adults with learning disabilities, autism, dementia, acquired brain injury, aphasia after stroke and mental health disorders, and a source of some confusion to researchers regarding the responsibilities and obligations of the role. Where a consultee is involved in giving advice on the individual's likely wishes and feelings about participation, there appears to be minimal recognition and report of the active involvement of participants who are deemed to lack capacity in decision making as far as their abilities allow.

Conclusions

If, as members of a research community, we are to maintain the balance between protection and

TABLE 2: Summary of studies: stage 2

Objective	Activity and Sample	Number
2.1 Survey of research applications made to MCA-approved Research Ethics Committees (RECs)	We carried out: ● a retrospective survey (2007-18) of REC-approved studies using the publicly available HRA database (www.hra.nhs.uk/news/research-summaries/) ● a prospective survey (2018-9) of research applications to MCA-flagged RECs in England and Wales over a 12-month period.	1617 83
2.2 Review of adapted resources for participant recruitment	We surveyed the design and linguistic features of participant information sheets devised and used by researchers for people with capacity-affecting conditions and associated communication difficulties.	25
2.3 Survey of researcher reasoning about research under the MCA (2005)	We asked researchers in England and Wales to complete a bespoke e-questionnaire about the MCA (2005) and their views around the inclusion of adults with capacity-affecting conditions and associated communication difficulties.	128
2.4 Values and opinions of stakeholder groups	We carried out structured interviews with REC members; researchers; practitioners, supporters, and carers; adults with capacity-affecting conditions and associated communication difficulties. The last group included adults with learning disabilities; autism; acquired language disorder after stroke; acquired brain injury; dementia; and mental health disorder.	60

empowerment of people with capacity and/or communication difficulties, we need to view decision making as a continuum. The crisp dividing line between having capacity and not having capacity for informed consent does not exclude individuals from expressing their own views about research participation and having these views recognised. Nor

does it diminish the need for research to be explained in ways that can be appreciated by people with capacity-affecting conditions and associated communication difficulties. This points to the need for a more nuanced approach to participant recruitment, where an individual's capacity and communication abilities are recognised and

accommodated in ways that move beyond participant-facing documentation, towards the construction of meanings in the real-world context. Thus, information about a research project might be conveyed through opportunities for the person to engage with and try out the study materials and to view video simulations of what research participation is about.

There is a possible tension between meeting the ethico-legal requirements necessary for a 'favourable opinion' from an REC and accommodating the processing capacities of potential participants effectively. Furthermore, the accessibility value of such resources in terms of the language content and presentational features to augment meaning is inconsistent. The implication of such a narrow view of accommodation is that critical strategies that support inclusion are neglected.

Fundamentally, the research provisions of the MCA (2005) and its accompanying CoP, which is currently under review, need to change in favour of a clearer, more functional framework that would help to define a way through the complexities of working with adults with capacity-affecting conditions and associated communication difficulties. This would be achieved by recognising personal autonomy in all its gradations as a continuum that ranges from informed consent/refusal (the decision made by a person deemed to have legal capacity); through degrees of engaged assent or dissent (the person's active dis/agreement to a proposition through a process of supported interaction); to passive dissent (lack of observable response or extreme passivity). Through use of practical strategies and adapted resources, the potential participant's greater agency can be endorsed.

Three key recommendations came out of project ASSENT:

Promotion of researcher-participant cooperation: The system for developing, reviewing and conducting ethically-sound research that includes adults with capacity and communication difficulties would benefit from redefining. This requires promotion of cooperation between a researcher and a participant such that empowerment is recognised within a system that protects. A renewed emphasis on seeking positive assent from a participant may be a more desirable method of guaranteeing greater emphasis on supported decision making.



Exclusions continue to be made on the basis of a lack of capacity

2 Support for participant autonomy: There is a strong and enduring need for guidance that focuses on the researcher's efforts to promote the autonomy of the participant as far as possible, regardless of their assessed capacity, and even where a consultee is involved, with specific attention to strategic adaptations and accommodations that enable people with capacity and communication difficulties to have a voice in research.

3 Use of a full range of adaptations and accommodations: Researchers and ethics committee members need to be better informed about the full range of methods to support people to make autonomous decisions so they can advise applicants seeking ethical approval for their research. The researcher needs to make sure that the conditions are right for a person to use their available skills as far as possible, to understand information, to retain and weight it up, and finally, to communicate their decision. Traditional ways of obtaining informed consent are not appropriate for all and there is a need to consider alternative processes.

Ultimately, there is a critical role for SLTs in the research process, whether using their expertise in communication at the cutting edge of inclusive research, or drawing on their knowledge and skills as active members of research ethics committees. The MCA Code of Practice was redrafted and entered a public review/consultation period earlier this year. However, the original research provisions remain relatively unchanged. Project ASSENT is currently in an extended 15 months focused on the development of web-based guidance to support researchers and REC members in the shared endeavour to establish research practices that are truly inclusive.

Acknowledgements

Project ASSENT was funded by the Nuffield Foundation. The ASSENT team is: Karen Bunning, Rob Heywood, Anne Killett, Peter E. Langdon Ciara Shiggins, with Florence Jimoh and Hayley Ryan. Our gratitude to the advisory and working groups who supported project ASSENT. Further information about project ASSENT can be found at: www.uea.ac.uk/groups-and-centres/assent.

Dr KAREN BUNNING, associate professor in learning and developmental disabilities, University of East Anglia
 k.bunning@uea.ac.uk
 [@AssentProject](https://twitter.com/AssentProject)



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Improving interactions

Speech and language therapy in homelessness settings is all about flexibility, practicality and partnership. **Leigh Andrews** writes

Sam was in his mid-50s and had a reputation of challenging behaviour and a long history of street homelessness. He had just been evicted from a hostel for making repeated threats to harm staff.

Over the next two years he was evicted from a further four hostels.

When Sam came on my radar, I was at the end of my speech and language therapy training, and he was on the cusp of being evicted again. Sam's current keyworker, Maria, had attended a short communication awareness session that I'd run, and she asked if I could help her to support Sam to avoid another eviction.

We considered whether Sam exhibited autistic traits. He seemed overwhelmed by interaction with others, conversations could quickly escalate into arguments, and

he had specific detailed interests. I explained that his 'aggressive' behaviour may be sensory overload and an attempt to communicate distress.

My suggestions included:

- Being direct and literal
- Providing Sam with conversational picture support
- Splitting tasks into smaller chunks to avoid overwhelm
- Tackling cleaning tasks together to model planning and organisation
- Noticing and praising Sam for his efforts, eg when a fire started in his room Sam alerted other residents and staff thanked him for taking action to help people
- Providing a key contact in the hostel (Maria) and meeting one-to-one in quiet spaces where possible
- Keeping all staff informed so that Sam had consistent interaction even when Maria was not present
- Reframing 'angry' behaviour as sensory overload and responding



CASE STUDIES

WANTED

We're looking for case study contributions for this new section of *Bulletin*. Email: bulletin@rcslt.org with your submissions. More information at: [bit.ly/Bulletin CaseStudy](https://bit.ly/BulletinCaseStudy)

accordingly, eg if Sam shouted, "Don't speak to me" and slammed the front door, staff understood this as a request rather than aggression.

This altered interaction led to Sam remaining in the hostel without further serious incidents. Maria and I discussed supporting Sam to access a formal autism assessment, but the waiting list was long and Sam put his difficulties down to another medical issue. In Sam's case the benefits of a formal autism assessment did not outweigh the risks, but implementing practical strategies had a positive and lasting effect that helped Sam to remain accommodated, safe, and engaged with his interests.

Sam had been known to homelessness services for nearly two decades, but support had never been obtained from a speech and language therapy service. This reflects a lack of awareness of speech and language therapy across professions, something the Homelessness Clinical Excellence Network and Change Communication are trying to address through training and networking (see: bit.ly/3CQjSz8).

Individuals like Sam who are multiply disadvantaged encounter many different services, which can be unsettling as well as resource intensive. Finding a way to communicate more effectively with Sam enabled him to understand what was required and to adapt his behaviour. In turn, staff at the hostel recognised that they were making a difference and helping a vulnerable man remain accommodated. ■

LEIGH ANDREWS, Change Communication and chair, SLT Homelessness CEN
 ✉ leigh.andrews@chgcomm.org
 🐾 [@ChgCommCIC](https://www.twitter.com/ChgCommCIC)



Life after P scales

Kate Hopcraft
presents a clinical idea designed to support the lateral progress of pupils with SEN

It's quite daunting being one of the only SLTs in a sea of teachers and education professionals, but hearing Diane Rochford talking at the Equals Conference in November 2018 really changed my thinking about how I work within the education setting. As an inspector herself, she confirmed that the new Education Inspection Framework (May 2019) had a change of priority: rather than focusing on data, the focus – at last – is on the individual.

Having worked in special schools across Berkshire, Buckinghamshire and Oxfordshire for students with a wide range of learning difficulties, the one request from teachers I really had to brace myself for each year was for help reviewing the P scales for our children with special education needs (SEN).



REFERENCES

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

P scales are a set of descriptions for recording the achievement of pupils with SEN who are working below the standard of the national curriculum tests and assessment.

While I knew the children had made great progress, this progress just wasn't captured in the jumps on the P scales. Used for benchmarking, the P scales always felt as though the students were being pushed to learn skills on a checklist, rather than facilitating overall development. I was not surprised by the Rochford Report (2016) findings that P scales were not fit for purpose for pupils with SEN.

Pupil journey

After attending the conference, it was the idea of the 'pupil journey' that resonated most. At the time, the services I worked in were keen to see evidence of outcomes. Presuming outcomes meant data, I created a spreadsheet that would collate all the progress scores given to each student for each target and I made graphs to show all manner of variances and outcome data. However, on presenting these, the headteacher simply asked 'so what?'



This approach allows the team to review learning intentions much more widely

It was a pertinent question and it stumped me for a few moments. When I heard Diane Rochford speak about placing the focus on that child's story, and how we needed to show our intervention and impact for an individual, rather than presenting a sweeping set of data, this made perfect sense.

If I needed to show my part of a student's journey, I asked myself where what I did would fit in with what school staff were doing? What impact my targets had? And how could I reflect on all the other indirect 'stuff' we do in speech and language therapy?

To answer these questions, a new style of clinical notes was created, split into three sections:

- Key information on the young person and their various targets
- Dated clinical notes kept in accordance with local policy
- Summary/review

Instead of the 1-5 scale against a target on a separate target sheet, the various targets

were collated on a single sheet for each individual student, alongside the service input written in the clinical notes (eg calls home, liaison with teachers, direct therapy intervention, training given) for the school term. The last section was a brief summary of the impact of the interventions and the next steps planned.

This document became the record of the student's journey, comprising the intent, implementation and impact of the therapy that the young person has received. Ultimately, it's the basis of what Ofsted would see under the new Inspection Framework – when they 'deep dive' to review the progress of a given individual student.

Tracking progress

Shortly after attending the conference, I started working in Endeavour Academy, a Macintyre Academies Trust provision within the local authority for 32 secondary age pupils with significant learning disability and autism, as part of Oxford NHS Foundation Trust and Symbol UK.

The senior team at Endeavour were beginning to use Mapping and Assessing Personal Progress (MAPP-2, Sissons, 2017) as a way of tracking termly progress against learning intentions.

Endeavour has been successful in encouraging students to attend the termly meetings, and – thanks to the sudden increase in video conferencing – an average of 75% of the meetings involved parents in the latest year of reviews. For this to be a truly holistic approach, the therapy team is keenly involved in the process, and these intentions take prime position at the top of the new clinical notes format. There is also space for additional specific speech and language therapy targets that have been highlighted at annual review, and – to keep them in mind – the relevant education, health and care plan (EHCP) outcomes are included.

At a glance, all of the various interventions the team are involved in for that individual can now be seen in one place and the impact of these is considered on an ongoing basis. In services where there is less



SPECIAL EDUCATIONAL NEEDS

need for intervention, or less capacity, the same form could easily be adapted to work for a whole academic, calendar or review year.

Data has not left us entirely, and there is definitely a place for both. Endeavour tracks progress against the learning intentions; however, they do this using the Continuum of Skill Development from MAPP-2. This approach allows the team to review learning intentions much more widely than simply marking 'achieved', 'partially achieved', 'not achieved', or using a single 1-5 scale. Instead progress is reviewed on four parameters:

- The level of prompting required
- The fluency (or accuracy) with which the pupil can do the target skill
- The maintenance of the skill use over time
- The generalisation of each skill

Lateral progress

This review of lateral progress rather than linear progress has enabled the staff team in Endeavour to see progress beyond ticking off a target that has been achieved, as was the case typically when using the P scales. Instead, each learning intention is considered in its widest form – one which supports the student to take a development leap, and where possible this leap can happen with the young person taking some responsibility for the progress.

Sisson's (2017) writes: "Linear progression presupposes a fixed hierarchy of skills... thought of as a ladder whose rungs are the skills... progress is measured in terms of the number of rungs climbed. Lateral progression, by contrast, is concerned with the refinement and strengthening of skills over time and not simply with enumerating the number of skills gained".

This focus on strengthening skills over time is exactly what I want to support, and what I want the students in my care to achieve. As legislation moves forward, it is very pleasing to see that a focus on lateral progress is one of the main principles in the recent Standards and Testing Agency publication outlining the statutory requirements for schools, which progresses the work of Diane Rochford (The Engagement Model, March 2020).

The discussions that take place in the learning intention meetings lend themselves to looking more thoroughly at the evidence collected. In addition, the teaching staff have become more aware of the impact of prompting and the need to generalise the skills that are being taught, as they are having to reflect on each of these as the outcomes.

In recording lateral progression, I can move forward confidently now that we are laying better foundations for our students. Whether one works in a setting where there is lots of scope for intervention, or one where very little direct therapy is required, using this format for the clinical notes enables the intent to be clearly shown, as well as the intervention and the impact of services for each individual. 

KATE HOPCRAFT, specialist SLT
 Kate.Hopcraft@symbolconnect.co.uk



CASE STUDY



For Jenny, a 16-year-old with autism and a learning disability, this breadth of coverage allowed for a much more positive review experience. Jenny wanted to do well and – as a result of using the parameters above – we could show her much more specifically what she needed to do to achieve the task, rather than simply marking 'partially achieved' and continuing on.

Jenny's learning intention was to maintain her attention in a group activity for at least two tasks. She achieved the first three parameters shown by high scores (7-8/10 on each scale), but her generalisation score remained low at the 3/10 descriptor.

Jenny agreed that the target should continue, and with support she was able to reflect on what worked well in the one specific group in which she had achieved the target. She was helped to plan how she could generalise the skill to other sessions. As the review meeting involved the whole team working with her, a new plan of action to meet this learning intention formed within the meeting discussion.

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A sense of identity

Niamh Foy had selective mutism as a child, now she's studying to be an SLT. *Bulletin* caught up with her...



Niamh, you were diagnosed with selective mutism at three years old. How did it affect you?

Selective mutism was such a defining part of my childhood that I don't think it occurred to me how fundamental it was to my development until later on. You can't speak to people between the crucial developmental ages of two and 10 years and have it not affect you in some way. I was deeply lonely, and I do think that I missed out on a lot of social milestones that would characterise the growth of a typically developing child. I had a lot of imaginary friends and felt that they were the only 'people' I could talk to. I didn't eat in front of others. I didn't even feel human, since to be human was to talk. I felt strongly that society at large did not want me from the moment it occurred to me that society existed, which was at about five years old.



SLTs and child psychologists at Alder Hey Children's Hospital in Liverpool helped you find your voice. What was that experience like?

Wonderful, once I got access to help. My family and school had to fight to be listened to, and waiting lists were long. I can't imagine how it must be now,



REFERENCES

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



and how tough it must be on families post-COVID.

An educational psychologist initially suggested I was autistic, on the incorrect assumption that all nonverbal children are autistic, and vice versa. This example just goes to show how a lack of awareness about selective mutism not only affects selective mutes, but also individuals with other presentations, such as those in the autistic community, who require and deserve different types of care. Once I got the support, my voice came back and so did my confidence and sense of identity. Thank you to everyone who helped me on my journey.



You're studying to be an SLT and did your placement in a specialist school. What was that like?

I adored my placement. The teachers at the school took an active interest in what we SLTs were doing



I didn't even feel human, since to be human was to talk

over in the clinic space, and the resources we made to support communication were always integrated into the classroom. That's the standard that all schools should be at, I think. I was also lucky enough to have a peer with me on placement, and a really wonderful practice educator.

What I learned from the experience is that all children with selective mutism are different: different needs, different anxieties, different backgrounds and contexts. There are commonalities, but you cannot assume anything. Of course, we are trained to treat each case on

a case-by-case basis, and that's crucial to me. However, there were probably one or two moments where I had to pull back and ask myself, 'Is this evidence based or observation based. Am I just guessing something based on my own experiences?'



How important is raising awareness when it comes to disorders like selective mutism?

I've done a lot of raising awareness work in the media. After the BBC ran an interview with me about selective mutism (see: www.bbc.co.uk/news/uk-england-merseyside-57062085), I got so many lovely messages from very brave people. All had either had selective mutism, or known someone with it, but had never seen it mentioned in the media or had seen a bad representation of it. Many of them were parents who were nervous for their child and wanted advice. I was delighted to help as much as I could, but it made me wish that

there was better support for them. One day, I'd love to set up some kind of online forum, or even an in-person centre with resources, to help people affected by selective mutism. These families and their children need and deserve a sense of community.

I've also spoken on the BBC *Sunday Politics* show about the critical need for funding for all SLTs. I think that by standing together as a profession and fighting for more funding we can lift each other up and ensure better speech and language therapy provision for our service users, whatever their condition.

One thing I wish there was more of in selective mutism discourse and research is follow-ups of what happens to so-called 'recovered' mutes. I would hypothesise that there would be high rates of anxiety and possibly loneliness among that population, though research would of course need to confirm this.



As well as being a student SLT, you're also an avid poet. Tell us about that...

I have loved all things creative since childhood, but I started writing seriously - as in entering competitions - at about 16 or so. I began writing short stories - particularly flash fiction, which is generally accepted to be any literature under 2,000 words. I moved into poetry - and particularly sonnets and villanelles - partly because I fell in love with Keats' sonnets at A-Level.

I see my poetry more like music than speech; you will hear a lot of singers say something along the lines of 'what I can't speak aloud, I sing' and dancers say 'what I can't say, I dance', and I feel the same way about my poems. The word 'sonnet' actually comes from the Italian sonnetto which, adorably, means 'little song'. For this reason, I feel like my spoken voice and my poetic voice are two separate entities. My spoken voice uses my larynx and articulators, and my poetic voice uses my soul. But they are both important, and having at one point had neither, I am grateful for both.

What does the future hold for you?

My primary thoughts at the moment revolve around completing my studies, but my creative projects are also important to me. I have social media accounts set up for my small business, Mercury & Morrigan, which you are welcome to follow me on: @MercuryMorrigan on Twitter, Instagram, TikTok, YouTube, and LinkedIn. It's such a privilege to have already connected with some fabulous SLTs and I can't wait to meet some more! **B**

NIAMH FOY, student SLT

A 'stroke' of teamwork

Freyja Bell discusses the process and benefits of adapting and implementing a multidisciplinary Stroke TOMs scale

In our early supported discharge (ESD) team it is imperative that we maximise our limited six weeks of input for patients by identifying areas of need early on in their recovery and measuring our outcomes. After joining the Croydon Stroke Rehabilitation Team (CSRT) in 2015, we needed to establish a multidisciplinary team (MDT) approach to measuring how effective we were as a team and embed this across the stroke care pathway to demonstrate the strengths and needs of our services to patients.

We wanted to take into account a holistic view of our patients' health and wellbeing, as per the International Classification of Functioning, Disability and Health Model (WHO, 2001). Enderby and John (2019) identified Therapy Outcome Measures as the 'best-fit' outcome measure against the criteria agreed by the profession. They found TOMs to be reliable, quick to administer and an effective tool in measuring change (Powell et al, 2015). Therapy Outcome



REFERENCES

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Measures look in particular at changes in levels of independence, social engagement and emotional wellbeing. For these reasons, we chose the TOMs as our MDT outcome measure.

TOMs adaptations

One challenge for our team was time. We did not have time to do multiple TOMs scales, such as the stroke scale and aphasia scale. The Stroke TOMs was very physical in nature, in that a patient who was unable to speak, swallow or was severely cognitively impaired would score potentially very high on the Stroke TOMs. This did not feel holistic enough to me and I was struggling to complete multiple scales for all my patients. I contacted Emeritus Professor Pam Enderby, one of the authors of the TOMs, and asked her about making the scale more holistic, including these areas. She encouraged me to get my writing hat on and develop a new 'adapted' scale for stroke. Never one to shy away from a challenge, I gave it a go, and in 2017 the MDT Stroke TOMs were born. All the TOMs adapted scales have 11 points, and have ordinal best-fit descriptors.





I realised the importance of highlighting TOMs champions early on

To illustrate an example of the difference between the original scale for stroke and the new MDT version, below is a comparison between the descriptors for someone with a moderate level of impairment:

Original Stroke Scale: “**3 Active**

movement against gravity, controlled isolated movement, occasional associated reactions, moderate sensory inattention, movements may not be accurate, or one severe sign/symptom, for example dense hemiplegic arm, or two moderate signs/symptoms, for example moderate arm/leg hemiplegia.” (Enderby and John, 2019:185)

New MDT Stroke Scale: “**3 Moderate degree of signs and symptoms (could be one severe, or multiple mild – moderate signs/symptoms).** For example, active movements against gravity, actively cooperative, reduced dynamic standing balance, controlled isolated movements with occasional associated reactions, moderate sensory inattention, moderate apraxia. Severe signs could be dense hemiplegic arm/swallowing/communication/cognition or a combination of milder signs. Actively contributes to therapy.”

Implementing the scale

Some of the challenges of implementing the scale included getting buy-in from the wider MDT; time to complete the scale all together; resources to document the outcomes; time to train; and, finally, time to collate/audit the information gathered. I realised the importance of highlighting TOMs champions early on: people to push the team to keep up to date with scoring and to act as cheerleaders for the project. This is the number one piece of advice I can give to any team changing clinical procedure – get a champion or two.

For a number of years, the ESD team in Croydon were the only team using the MDT Stroke TOMs, but I soon trained up our acute stroke team and eventually our community neuro team to collect data from across the entire stroke care pathway. I wanted to see if different domains of the TOMs would show more change, depending on what part of the

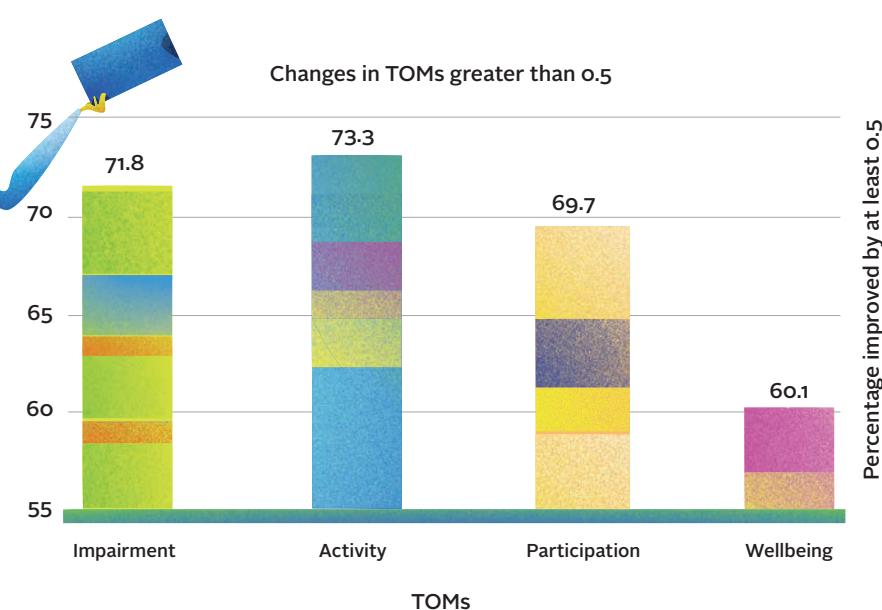
pathway it was (eg the biggest change in impairment but least in participation might have been the acute setting; but the biggest change to participation might have been with the community team). It has been clear that in ESD positive changes appear relatively even in all domains, with wellbeing slightly behind (figure 1).

Croydon sits as part of a South West London network, where we work closely with other boroughs, sharing resources and training, and aim to streamline our stroke and neuro services. I presented the MDT Stroke TOMs to the managers of these teams and they were very interested in using this as an outcome measure across the network of community teams. It helped enormously that I had a very supportive manager, who believed in me and allowed me the time to invest in this venture. With permission, I trained 150 of the South West London MDT members in TOMs and hosted inter-rater reliability sessions online, to enable those using the MDT Stroke TOMs to practise scoring and maintain consistency. Each South West London Team began using the MDT Stroke TOMs for all stroke patients in the community, using a similar data collection style and method.

Virtual feedback on each workshop, sent via Google Forms, collated information on whether the training was accessible and useful and if participants felt the MDT Stroke TOMs was a good development.

Based on a sample of 33 responses:

Figure 1: Changes in more than 0.5 (clinically significant change) across all four domains in six weeks (2021)



- 32 attendees felt the workshop was relevant to their workplace and that the trainer was clear and engaging
- 30 felt the MDT Stroke TOMs was a good development
- 31 would recommend attending to a colleague

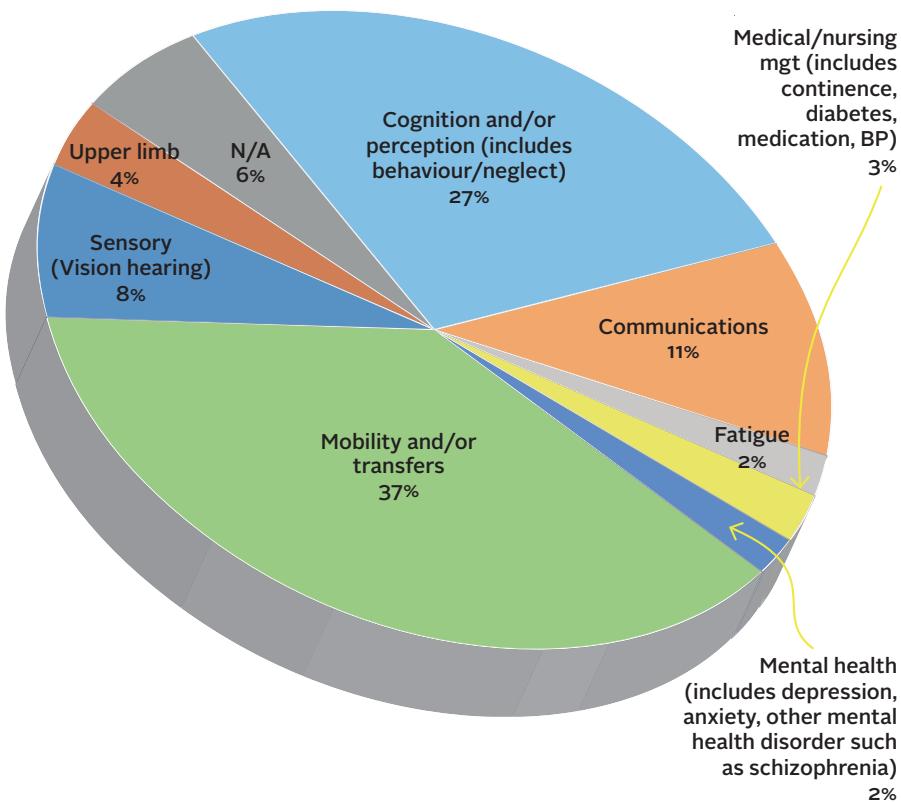
Some qualitative feedback examples include: “*It was very informative and important for my practice*”; “*Good to have the reminder on how data collection can assist your team for funding, equipment, staff etc.*”; “*Really enjoyed the TOMs courses, after the training it gave me the confidence to discuss patients during MDT and determine outcome efficacy*”; “*Really valuable and clear training, found using examples really helped to give an understanding of how we apply TOMs in an MDT team*”.

One year on

We are nearing one full year of comparable data in community stroke services throughout South West London. By having this data it will allow our services across stroke to compare, contrast or combine our findings to make the necessary changes to policy and procedures. It may also demonstrate the variability between our services, aiding us in eventually



Figure 2: The most profound impairment for each patient on entry to the service in CSRT



becoming a more streamlined service. This data can be used to demonstrate our strengths and weaknesses to commissioners and decision makers, in the hope of addressing these issues, such as acquiring more resources.

Speaking for the ESD team in Croydon, it has been a very successful implementation of a new MDT tool. When analysing our data, it was not possible to attribute all changes solely to the rehabilitation we provide; however, we could postulate that our services are associated with a reduction in impairments (71.8%), improved independence (73.3%) and social participation (69.7%) for our patients (respectively) and increased wellbeing in over

60% in 2021 (figure 1). This was an average 10% reduction across each domain from the previous three years of data, which we felt was potentially due to COVID-19 related issues (including more complex patients, less attendance at appointments, reduced staffing, reduced intensity of input, attributed mental health difficulties etc). It also highlights a gap in neuropsychological services, as wellbeing was much lower than other domains.

I anticipate a positive change in that for 2022 there is a now full psychology team and a reduction in COVID-19 restrictions. Participation is also lower than previous years, again potentially highlighting the limits in social participation during the final leg of the COVID-19 pandemic. We have also been collecting information on

what each patient's "most profound impairment" was, to acknowledge what may have been the greatest influence on their score (figure 2). Mobility, cognition and communication appear to be the main areas of profound impairment within ESD in Croydon.

Team feedback

The ESD team have commented that they feel it has been a very helpful tool to encourage early and specific communication around patients' strengths and needs, making goal planning and targeted rehabilitation more appropriate. My physiotherapy colleague stated, "Had we not discussed his TOMs that first week, I would have continued treating this man's physical difficulties, not understanding the extent of his cognitive difficulties. When scoring, I received invaluable feedback from the occupational therapy assessment and changed my approach accordingly".

The use of the MDT Stroke TOMs has been relatively easy to implement and quick to use within a multidisciplinary team and extended interdisciplinary working. It is currently being further tested for inter- and intra-rater reliability with the aim of making it an official outcome measure to be used by different stroke services nationally.

Finally, Emeritus Professor Enderby is always encouraging therapists, experts in our fields, to come forward and experiment with new scales. We can often see the gaps, but also the possibilities. I did.

FREYJA BELL, highly specialist SLT,
Croydon Stroke Rehabilitation Team
 ✉ freyjabell@nhs.net@freyjabell
 🌐 @freyjabell

Structure and support early on

Victoria Harris and **Amanda Weaver** look at the value of preceptorships as a way of supporting NQPs



e hear from newly-qualified practitioners (NQPs) and their managers that the NQP period is very challenging.

First there's the clinical work. Added to that are the challenges around adapting to new processes, people and pressures in the system, and the fact that NQPs need more support post-pandemic. Some NQPs decide it's not the career they thought it was and leave the profession.

This is reflected in the attrition numbers. From Health Education England (HEE) data (England) we know that the first 36 months are particularly precarious. From January 2015 to September 2022 leaver rates in year 1 were 10.6%, 8.0% in year 2 and 9.6% in year 3 – although we do not know if individuals left the NHS or the entire profession. This represents a real problem in professions where there are not enough staff to meet the population needs.

Perhaps there is value in providing more structure in the early days of the SLT career, so that NQPs have better support, more points to check-in and a more uniform experience. That's where preceptorships might come in.

What is a preceptorship?

A preceptorship is a period of structured support and development during periods of transition, during which the allied health professional (AHP) will receive support to help them grow in confidence as an autonomous

and accountable practitioner.

It is not intended to make up a shortfall in pre-registration education, because individuals registered with bodies like the Health and Care Professions Council (HCPC) are considered to be competent and accountable. Neither is it intended to replace profession-specific frameworks, such as the NQP framework that SLT new registrants complete before becoming full RCSLT members. A preceptorship programme would normally be multidisciplinary.

Having a preceptorship period can help improve an employee's confidence and sense of value, and increase their job satisfaction. It can also help to form strong working relationships across the multidisciplinary team and develop a sense of belonging. As we have shown, the newly-qualified period is a time when many AHPs leave their chosen professions. Having a preceptorship in place can therefore improve retention.

Preceptorship challenges

One challenge about bringing in a preceptorship is how to ensure that the NQP and their managers and supervisors are not overwhelmed when done in combination with profession-specific requirements. For example, SLT NQPs complete the RCSLT NQP competency framework in order to become fully-practising members. The solution is careful mapping to avoid duplication of effort. A preceptorship should also be well thought out, with time set aside for

preceptors and preceptees, good awareness of the programme and buy-in at all levels. These and other pointers to good practice come out of recent research (Salt et al, 2022).

Developing principles

The RCSLT is part of a joint project run by HEE and the HCPC to develop preceptorship principles for AHPs – The National AHP Foundation Preceptorship programme of work. This aims to ensure AHPs receive high-quality preceptorship and foundation support as they transition into employment. It will be fundamental in standardising the quality of preceptorship programmes and foundation support available to AHPs across England and will play a key role in ensuring we retain, upskill and maximise the potential of AHPs, especially in the early years of their career.

The programme's aim is for AHPs to have inclusive access to tailored support and development opportunities across a range of transitions into employment to help them grow in confidence as autonomous and accountable practitioners, enhance career development, and improve recruitment and retention while ultimately supporting the development of a diverse workforce fit for the future. It aims to support over



REFERENCES

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



Feeling valued, supported and part of the team should be a given for anyone joining our workforce

three phases of pre-preceptorship, preceptorship and foundation support. For further information, visit: bit.ly/3H97Tzm

According to Helen Marriott, regional head of AHPs Midlands and national lead for the HEE AHP Preceptorship and Foundation Support Programme, ensuring that AHPs who are joining our workforce are well supported, welcomed, valued and have the confidence to carry out their role is fundamental to reducing the high leaver rates, especially within the first two years of their career journey.

"Preceptorship is fundamental to achieving this and we need to work with partners, including professional bodies such as the RCSLT, to ensure there is a consistent, high-quality preceptorship programme available to all AHPs," Helen adds.

"I'm delighted that HEE and the HCPC have worked in partnership to develop the draft AHP preceptorship principles that are currently being consulted." Visit: bit.ly/3FjRp4P

Have your say

We would like to encourage all AHPs to engage with this consultation work to ensure these evidence-based principles will help employers to offer consistently high-quality and effective preceptorship for every newly-registered AHP, those returning to practice or those who have trained internationally.

The RCSLT is also working to promote and raise awareness of preceptorships. A working group, consisting of NQPs, students and managers, will create guidance and case studies around preceptorship, to increase the confidence and capability of new graduates in the workforce and to support managers to do this. All resources and guidance will be online by the end of March 2023. Email: tahiyat.rashid@rcslt.org to receive regular updates.

VICTORIA HARRIS, RCSLT head of learning,

AMANDA WEAVER, HEE AHP preceptorship workforce lead

victoria.harris@rcslt.org

Resources

Nursing and Midwifery Council. *Principles for preceptorship*.

bit.ly/3VxxvdE

RCSLT resources for NQPs and their managers: bit.ly/3iAhpRR

PRECEPTORSHIP ACROSS THE UK

Northern Ireland: There is variation of approach across the five health trusts, including structured one-to-one supervision and group supervision for band 5s and NQPs provided by band 6s; giving each NQP a mentor who is an experienced band 5 or new band 6; or buddying NQPs with more experienced band 5s.

Scotland: The Flying Start programme is the national development programme for all newly-qualified nurses, midwives and AHPs, designed to be used in the first year of practice. It consists of four units, each related to one of the four pillars of practice. In each pillar there are two learning outcomes, which relate to aspects of practice.

Wales: Some services have used the 'Annex 21' for SLTs to start in a band 5 and progress to a band 6 post. For the most part, this has been where dysphagia competencies are required for a post and the SLTs receive intensive training to complete these. The timescales vary for different SLTs. The chief allied health professions adviser for Wales is awaiting HCPC guidance before deciding whether anything additional is required in Wales.



Professional Development

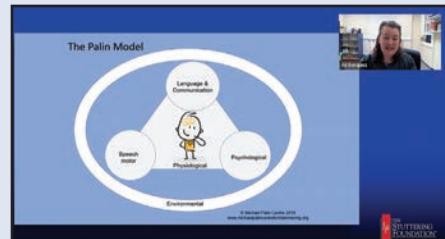
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Speech and Language Therapist

Join our Team

Therapy Links UK (CIC) is a not-for-profit multidisciplinary social enterprise. We provide an innovative “pay what you can afford” service to families, as well as high quality services to schools.

We are looking for NQTs and band 6 equivalent Speech & Language Therapists to join our team in south London.

£31,680-£45,857 pro rata, South London (based on experience and inclusive of London weighting)

Please see our website at www.therapy-links.co.uk/vacancies for more details, job descriptions and the application process.
www.therapy-links.co.uk/vacancies, or phone for an informal discussion 07719 109 656.

Therapy Links UK

RCSLT

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Unique roles available in a clinically-leading national service

We are seeking 2 specialist SLTs to join our established team who are already at band 6 level, or ready for their next career step. Experience of working in mental health is desirable, but we have seen time and again that skills from other settings are highly transferable.

We are looking for someone who is:

- Passionate about supporting mental health conditions
- Skilled and pro-active in advocating for people with SLCN and swallowing difficulties
- Skilled at identifying complex SLCN and swallowing needs and linking these to risk
- Enjoys working closely with a MDT members including psychiatrists, social workers, nursing staff, OTs and host of other professionals
- Works towards reducing health inequalities
- Develops therapeutic goals and interventions that are functional and patient-led
- Enjoys working with SLTAs and guiding therapy plans
- Ready to supervise others
- Self-motivated and a problem-solver
- Develops through self-reflection and effective clinical supervision
- Keen to support service development and projects

Rampton Hospital is a High Secure mental health facility in north Nottinghamshire. Care streams include male mental health and personality disorder, and national high secure services for learning disabilities, d/Deaf services and women's services.

SLTs work to ensure that SLCN and swallowing needs are identified and addressed. We embed good practices in the management of dysphagia, communication accessibility and use of communication skills in professional practice.

See one of our SLT team talking about their career at Rampton: <https://www.youtube.com/watch?v=IltRpNkrd6k>

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Please contact

Sally Wood: SLT Professional Lead

e: Sally.wood3@nottshc.nhs.uk

e: ramptonSLT@nottshc.nhs.uk

t: 01777 248321 x7909



Brand new
content
available

"The website's full of fantastic information and ideas that use research evidence to support SLC development. It's really accessible and easy for parents to put into practice."

Anne, Lead SLT Sure Start,
Belfast

A website to help parents and carers develop their little ones' communication skills.



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- Improves the safety, efficacy and physiology of swallowing¹
- Transparent results and neutral taste
- Amylase resistant features to maintain consistency²
- Simple dosing and mixing directions (IDDSI compliant)



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FIND OUT MORE ABOUT
NUTILIS CLEAR

This information is intended for healthcare professionals only.

Nutilis Clear is a Food for Special Medical Purposes for the dietary management of dysphagia and must be used under medical supervision.

References: 1. Bolivar M et al. Neurogastroenterol Motil. 2019; e13695.

2. Oudhuis L, Vallons K, Sliwinski E. Clinical Nutrition Supplements, 2011; 6(1): 18 (OP043).





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SOFFI® integrated approach to supporting oral feeding in preterm and medically complex infants is relevant for SLT's, doctors, nurses and other therapists working with babies with dysphagia and other feeding challenges, both in the NICU and community settings. SOFFI® provides the practitioner with extensive evidence based information regarding feeding development as well as assessment and intervention strategies. At the end of the course, the participant will be certified as a SOFFI® Professional.



Registration is £649 - a discounted rate of £599 is available for the first 10 delegates who book via our website.
Go to therapy-links.co.uk/training or email us at training@therapy-links.co.uk



Annual professionals' conference

A society that works for autistic people



2 March 2023, online

Key topics include:

- **supporting people with complex communication difficulties**
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Salary start-point can be negotiated to ensure it is competitive

Where?



Based in Hampshire, and organised in quadrants, we work across the county with:

- Mainstream Schools, Special Schools, Post 16 Settings, and in the home.
- Local authority partner services such as Primary Behaviour, Youth Offending, Educational Inspectors, Educational Psychology, SEN, and the Virtual School for looked after young people.
- Regular opportunities for face-to-face meetings with colleagues for service development projects, CPD opportunities and team meetings.

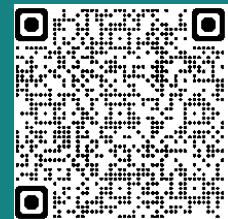
Closing date: 31 March 2023

Interview dates: 30 January, 13 March, 20 April and 24 April 2023

Due to the high priority of these roles, applications will be reviewed upon receipt and successful candidates will be contacted re interview arrangements asap.

Scan the QR Code to look at more details and apply!

Contact lynne.ralston@hants.gov.uk and louisa.gray@hants.gov.uk to talk more or sign up for our free virtual webinar about life in our team.



In the journals



Inconsistent speech

This research analysed over time the speech of children with high levels of token-to-token inconsistency (pronunciation of the same word differently).

Thirty-nine children (aged 4;6-7;11) were assessed every six months for two years. Receptive vocabulary (at outset) was found to be a significant predictor of speech accuracy and inconsistency. The authors, therefore, propose that enhanced word learning could support consistency. Notably, for some children, inconsistency increased as their consonant accuracy grew with age, possibly due to their expanding phonetic repertoire lending to more opportunity for inconsistent production.

The model of therapy support (consultative or direct, with and without breaks) was not found to be a predictor of speech accuracy or inconsistency. The authors suggest this could be because even those in the 'direct' group were not receiving input at a level of intensity (number of sessions and frequency) shown by previous research to be effective. They also point to the importance of targeting the area of the speech processing chain that underlies the difficulty. The authors conclude: "The ongoing nature of the speech difficulty experienced by many participants... suggests that access to appropriate intervention that is implemented at the required fidelity is crucial for this population."

LAURA BALDOCK, SLT, Phuket

 McNeill et al., (2022). Predictors of speech severity and inconsistency over time in children with token-to-token inconsistency. *Journal of Speech, Language, and Hearing Research*, 65, 2459-2473.

Intensive aphasia therapy

The therapeutic benefits of two different intensive aphasia interventions for people with chronic post-stroke aphasia were investigated in this large scale, phase III, randomised-control trial.

A total of 201 adults, who were more than six months post-stroke, completed the study. They were stratified by baseline aphasia severity and randomly assigned to complete either a 30-hour programme of Constraint-Induced Aphasia Therapy Plus (CIAT-plus), Multimodality Aphasia Therapy (M-MAT), or receive their usual non-intensive community care. CIAT-plus concentrated on speech production and verbal cueing, whereas M-MAT included multimodal input and cues. Aphasia severity, changes in word retrieval, functional communication, quality of life and efficiency of connected speech were measured post-intervention and at

12-week follow-up.

Aphasia severity did not significantly change following intervention. However, the study found "significant improvements in word retrieval, functional communication and quality of life immediately following both treatments and maintenance of word retrieval at follow up, with a differential benefit of M-MAT for multimodal communication and communication related quality of life and CIAT-Plus for word retrieval".

VICKI FLOOD, advanced specialist SLT, Communication Aid Service

 Rose, ML et al (2022) Results of the COMPARE trial of constraint-induced or multimodality aphasia therapy compared with usual care in chronic post-stroke aphasia, *Journal of Neurology, Neurosurgery and Psychiatry*, 93, 573-581.

Mobile health resource

A randomised controlled trial (RCT), pre-test post-test research design was used in this study to determine whether a mobile health (mHealth) parental resource influenced 4-to 5-year-old preschool children's language abilities.

Participants (42 in the experimental group and 40 in the control group) were identified from six early childhood development (ECD) centres from a

low-income community in South Africa. Data were collected using the language subtests of a South African standardised protocol, the Emergent Literacy and Language Assessment Protocol (ELLA).

After a 17-week intervention period, the parental mHealth application targeting language stimulation did not significantly improve the experimental group's language outcomes when

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

 The RCSLT Research Team authored a number of papers in 2022. Three articles featured the RCSLT research priorities: dysphagia (doi.org/10.1136/bmjopen-2021-049459), learning disabilities (doi.org/10.1108/TLD-06-2021-0018) and DLD (doi.org/10.1111/jijcd, in press).

jcpp.13592). Plus a paper on speech and language therapy in long COVID (doi.org/10.1108/JICA-07-2022-0038), and the protocol for a review of the value of AHP research engagement on healthcare outcomes and care processes (*IJLCD*, in press).

Universal language screening

This study aimed to compare the screening performance of two commonly used language screening assessment tools, the Ages and Stages Questionnaire (ASQ) and Sure Start Language Measure (SSLM), against a reference test (Preschool Language Scale, 5th edition). A pragmatic diagnostic accuracy study was carried out in a socially diverse sample, in five areas of England, with 357 children aged 23–30 months.

The findings suggest that the ASQ Communication Scale performs poorly as a language screening tool, with the lower predefined threshold for the ASQ communication (ASQ-3) domain missing 35% of children with low language ability. The higher ASQ-3 threshold missed over 50% of such children. The SSLM performed better as a screening tool for children aged 23–30 months, missing 17% of children with

significant language pathology. Neither tool performed well among families in which English was not the only language spoken at home.

The authors propose that “the SSLM yields relatively robust results, and this could potentially be used for selecting participants for intervention in a trial of a comprehensive screening programme in the future”.

Further work to refine the performance of language screening tools is required, particularly with bilingual and non-English-speaking families.

LAUREN FLANNERY, SLT and lecturer at University of East Anglia

 Wilson P et al (2022) Universal language development screening: comparative performance of two questionnaires. *BMJ Paediatrics Open*, 6:e001324

compared with the control group. The authors hypothesise that this was because most of the parents ($n = 27$) used the application for less than 20% of the active days.

The authors conclude, “mHealth appears to improve access to resources to support involvement and language development; however, parents may require additional support to increase their use of mHealth applications”. They suggest future research should

investigate orientation workshops and 1:1 coaching to support application use.

DR SHABNAM ABDOOLA, SLT and lecturer, University of Pretoria, South Africa

 Roux, E.W.L et al (2022) The effect of a parental mHealth resource on language outcomes in 4-to 5-year-old children. *South African Journal of Childhood Education*, 12(1), pp.1-8.

Word learning and maternal education

Numerous studies have documented that prior to school entry, children from lower socioeconomic status (SES) backgrounds often have lower language measure scores than peers from higher SES backgrounds. This study examined whether SES impacted word learning, and whether response patterns could explain differences.

A total of 58 pre-school children were assigned to high- or low-SES groups, as defined by maternal education. Explicit vocabulary teaching of non-words as synonyms for known words included exposure to the non-word and definition, and opportunities to use the non-word and definition. A dynamic word-learning assessment measured learning after one and then two teaching sessions. No SES-related differences were observed during initial administration. However, children from lower-SES backgrounds had significantly lower scores than their higher-SES peers during the second administration.

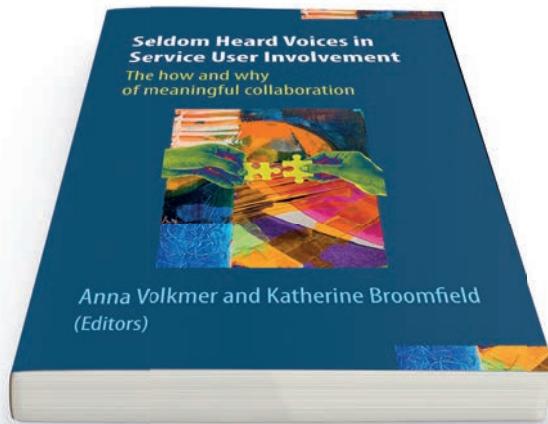
The study concluded that differences in word learning may be SES-related. The authors acknowledge that maternal education does not fully describe SES or early language environment, despite being a frequently-used measure of SES. They suggest “responses to hierarchical prompting may show the types of support that will be useful during intervention or be used to monitor improvement over time”.

JENNIFER HEATH, SLT team leader, Midlands Partnership Foundation Trust

 Kelley, E.S. and Bueno, R. (2022) Explicit word learning in preschoolers from families with high or low maternal education. *Communication Disorders Quarterly*, 43(4), pp.246-260.

BOOK REVIEWS

Books and resources reviewed and rated by *Bulletin* readers



Seldom Heard Voices in Service User Involvement. The how and why of meaningful collaboration

AUTHORS: Anna Volkmer and Katherine Broomfield (Eds.)

PUBLISHER: J&R Press 2022

PRICE: £24.99

This book shares experiences of co-design and co-production. It provides the opportunity to learn about service user involvement from different perspectives, including people with seldom heard voices: people with communication difficulties, children, young people, minority and ethnic groups who have taken a collaborative stance to research, service improvement and service delivery. It provides practical support and expertise on ways to start, continue and improve ways to engage with underserved communities.

This is an excellent guide for all healthcare professionals, with references to the knowledge and skills of SLTs that enable us to be pivotal advocates. A must-read for Giving Voice activists.

CARRIE BIDDLE, SLT and regional head of Allied Health Professions Health Education England, South West Region



Self-care for Allied Health Professionals: From Surviving to Thriving

AUTHOR: Alison Batty

PUBLISHER: Routledge

PRICE: £15.99

This easy-to-read and beautifully illustrated book offers AHPs, and other healthcare professionals, information and practical strategies to help with physical and emotional wellbeing in the workplace and at home. The author is an SLT who draws on a wealth of experience, including a background in yoga and meditation.

In this book self-care covers a range of topics such as sleep, food, resilience and meditation, dealing with stress, conflict and adversity. It offers the reader ways in which to 'tune in' and 'go deeper' into specific self-care strategies, while discussing ways to make self-care a habit by building it into our everyday routines.

Taking small steps to improve your wellbeing and build healthy habits in the workplace is so important, especially with adapting to changes in working practices since the pandemic. I thoroughly enjoyed reading this book. It has provided me with ways to improve my own wellbeing and build good habits for the future.



LOUISE MCATEER, SLT, Southern Health and Social Care Trust, Northern Ireland



Better Conversations with Brain Injury for Kids

AUTHOR: Emma Louise Sinnott (Illustrated by: Lleucu Gwenllian)

PUBLISHER: Better Conversations with Aphasia / Aneurin Bevan University Health Board

PRICE: FREE

This is a beautiful resource and a valuable addition to the Better Conversations resource set. It is a downloadable PDF document, aimed at children who are in contact with peers (or potentially adults) who have communication difficulties resulting from brain injury.

It is simple, accessible and well written with lovely illustrations, and there is space for children to add



comments and drawings.

My only niggle was I felt there could have been more blank spaces/drawing activities to encourage children to share feelings and thoughts - but

otherwise this is a great resource to introduce children to cognitive communication disorders at an early age, helping to reduce fear and stigma and promote a social model of communication disability.

ALIX LEWER, CEO & SLT lead at The Include Project (include.org)



Word Aware 3 – Teaching Vocabulary in Small Groups for Ages 6 to 11

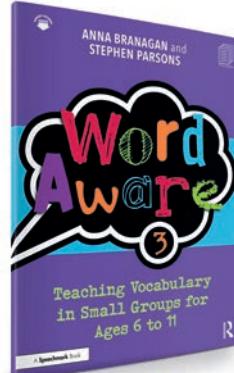
AUTHORS: Stephen Parsons and Anna Branagan

PUBLISHER: Routledge (2022)

PRICE: £32.99

Word Aware 3 focuses on taking the principles of vocabulary learning and applying them to a 6-week small group intervention. The session plans included are well thought out and engaging for this age group, as well as being easy to follow. Advice is included on how to set up a group and how to work as a vocabulary team within the setting, which is key to implementing this approach effectively. I think it's a fantastic resource and an important part of a whole school approach to vocabulary teaching; it has strengthened my SLT toolkit and been well received by schools.

JULIA HENLY, senior SLT, Children's Speech and Language Therapy Service, Coventry and Warwickshire Partnership NHS Trust



Study Skills for Children with SLCN

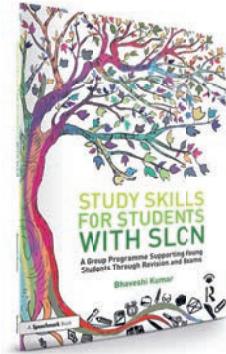
AUTHOR: Bhaveshi Kumar

PUBLISHER: Speechmark Books; Routledge 2020

PRICE: £20.99

This is a resource aimed at supporting students with speech, language and communication needs (SLCN) to learn how to study. Learning how to study is a complex skill and it is very positive to see a resource tackling this. The book is practical and contains background information and 10 well-defined study sessions, complete with resources and worksheets.

The book would be useful for primary school children; however, it could be adopted to cover those in secondary education. While the book contains lovely resources and ideas, imagination and innovation are needed to deliver this in an engaging way and compete with the computerised resources many children are used to.



LAUREN DRAKE, highly specialist SLT

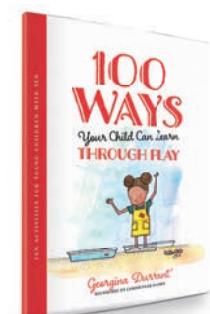


100 Ways Your Child Can Learn Through Play

AUTHOR: Georgina Durrant

PUBLISHER: Jessica Kingsley Publishers

PRICE: £14.99



This book includes 100 different activities that parents can complete with their children. There are six categories (eg sitting still, on a walk) with activities to suit. Each activity includes a description and how-to guide, with information on the equipment needed, as well as alternatives and additional tips. One of the key elements I liked about the guide is the inclusion of a key at the bottom of each page to indicate what skill the game targets. The book is really easy to read and follow. It provides a wide range of activities that will appeal to children. As a parent, I loved getting new ideas.

BECKY MASSEY, SLT



Where next?

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



Get involved

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

- RCSLT Horizon project: complete your online professional profile and help us gain a clearer picture of speech and language therapy across the UK: bit.ly/3GWnvGp
- View all current opportunities to get involved with our work at: rcslt.org/get-involved

DON'T FORGET

Key resources on the RCSLT website

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



Read

SWALLOWING

- Information and resources: bit.ly/3Niezw3

LONG COVID

- Report: bit.ly/3DiZCoP

MENTAL CAPACITY

- Factsheet: bit.ly/3Wa3jGd

SELECTIVE MUTISM

- Information and resources: bit.ly/3zm1Wdy

PRECEPTORSHIPS

- Tips for managers and supervisors of NQPs: bit.ly/3FpGTLg

SPECIAL EDUCATIONAL NEEDS

- SEND Review: bit.ly/3FntiUH

DEVELOPMENTAL VERBAL DYSPRAXIA

- Guidance: bit.ly/3DGk58C



Listen

RCSLT PODCASTS

Stammering: time for a radical rethink? In this episode, a panel of speakers discuss why it's important to reframe how society views stammering: moving from thinking of stammering as a problem to be solved, to one that celebrates and takes pride in difference.

To listen to more episodes, visit soundcloud.com/rbst or search 'RCSLT' on your favourite podcast app.



Watch

RCSLT WEBINAR RECORDINGS

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

- Annual Stephen Hawking MND lecture: bit.ly/3OOlmhX
- Health Inequalities: bit.ly/3H1dt6J
- View upcoming webinars at rcslt.org/events

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

Dysphagia: New Advances



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

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

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

Exploring IQoro

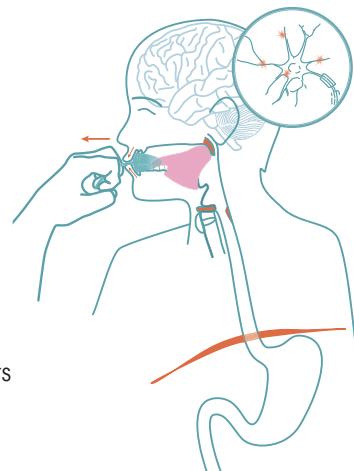
The lack of alternative therapies led me to explore IQoro neuromuscular training, which had shown evidence in previous scientific studies of supporting swallowing, particularly with adults who have post-stroke dysphagia. I embarked on a practice-based evidence project, using a case series design, and this evidenced positive and encouraging outcomes for improving swallowing and saliva control when using a goal attainment scaling approach with a group of individuals with CP. I wanted to share my experience and evidence with others. I was delighted to be offered the opportunity to collaborate with

renowned Swedish associate professor, Mary Hägg, who invented IQoro. Between us we authored a chapter now published in the InTechOpen scientific journal: <https://www.intechopen.com/online-first/79510>.

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

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

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



- Natalie Morris



IQoro is available on
NHS prescription in the UK



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