Appendix 2: Speech and language therapy retention and waiting times examples

How services are tackling waiting times in children and young people services

As part of the retention and waiting times project we asked speech and language therapists to submit examples of how they are working to reduce waiting within children and young people services and/or minimising the impact of waiting times on children, young people and families. The examples presented here have been submitted directly by each service and represent a range of approaches.

Contents

Introducing a risk matrix to identify highest needs - Blackpool Teaching Hospitals NHS Foundation Trust

Service context

Sector: NHS

Blackpool Teaching Hospital Paediatric Speech and Language Therapy Service is a community team that covers Blackpool, Wyre and Fylde. This is a mixed area with high levels of deprivation in Blackpool and Fleetwood, but also pockets of more affluent areas. Some families can find it difficult to engage with the service, meaning some children may not be brought to appointments and some parents can struggle to implement advice and strategies which are recommended.

Description of the initiative

The speech and language therapy team has introduced the North Staffordshire Risk Matrix as a prioritisation tool to help identify those children with the highest need of support. This risk matrix is used to provide an outcome and an impact score, which together provide an overall risk matrix (RM) score. This score can be used to prioritise those patients with the highest need for intervention.

The team's phonology pathway has evolved recently and those children with an RM score of 12 or 16 and presenting with a significant speech disorder are able to access the newly-established schools' speech service as an alternative to our usual clinic phonology provision. This new pathway has been established out of current clinical staffing levels and without any additional funding being available.

School visits are provided across three days a week to children with the most significant speech disorders, often, but not exclusively, childhood apraxia of speech. Each child gets a visit once per half term and the school also commits to completing daily practice activities as recommended by the SLT. Parents are kept informed of the recommendations and visits via written session summaries, which are shared after school visits.

Impact and feedback

The risk matrix has helped the speech and language therapy team to review the phonology caseload and ensure that those children with the highest need receive a service in school on an ongoing basis. In turn this has helped reduce the wait time for initial assessment and therapy within community clinics, because those with the highest level of need are seen on a specialist pathway via school visits rather than in clinic. This helps to free up appointments for those children with more targeted needs and also

ensures that children with a high need who are at risk of being discharged for non-attendance at a clinic appointment are able to access the service, because it is provided via a school visit instead.

Outcomes for the children with speech difficulties seen in school are good as demonstrated by a reduction in the RM score for those children accessing the specialist pathway. Access to support for speech needs has improved for those children who were at risk of discharge, because they were not being brought to clinic appointments or their family found it difficult to implement therapy recommendations at home. The new pathway means school staff have been upskilled, so in addition to the specialist children the service is provided for they can support other children with less significant speech needs in the classroom.

Top tips

- Risk matrix helps with prioritising need.
- School-based service reaches those who struggle to attend appointments.
- Changing the pathway, so we have a more specialist provision, has helped reduce wait times.

For more information about this work, please contact: Claire Watson, Clinical Lead SLT: claire.watson54@nhs.net

Changing the delivery of speech and language therapy services across the geographical footprint - Cambridgeshire Community Services (CCS) NHS Trust

Service context

Sector: NHS

East Anglia has the lowest quintile of percentage of children achieving a 'good' level of development by age five in England. Families live in a mix of urban and rural areas. Reduction of long waiting lists for NHS services, particularly post pandemic, and easy access to care are key NHS priorities. In the past 12 months, CCS has used the model proven in Cambridgeshire over the past 10 years to start to change the delivery of speech and language therapy services across the geographical footprint (Bedfordshire and Luton, Norfolk and Waveney) as part of a trust-wide transformation programme. We know of no other NHS speech and language therapy service provider in the UK with similar effective and responsive delivery of services. We have been approached by a number of other NHS providers to find out how we deliver our service, showing an appetite to adopt this way of working in other areas.

Description of the initiative

For all ages and needs the CCS speech and language therapy services use:

1. A graduated (universal, targeted and specialist) offer of support.
2. Working in a systemwide way, involving the key people in a child's life.
3. Individualised packages of support; ensuring a throughput so children get what they need, when they need it.

For preschool-aged children we have an open referral process where a parent can request support. The parent and child are offered a short videocall appointment with a therapist. This appointment is used to hear the parental concerns, assess communication, give advice/signposting, confirm further assessment is needed or decide the intervention required. There are defined but flexible evidence-based pathways of intervention offered.

This entry route is successful for several reasons: from the request for support form being accessible and relevant; to the booking and allocation process; to the therapists receiving in-house training in how to clinically deliver the sessions; and to the alternatives offered for families where this is not an accessible route. Settings for preschool-aged children can access confidential advice by calling our 'professionals' drop in, which runs regularly.

For school-aged children there is a named therapist allocated to each school. They meet with a designated lead in a termly planning meeting to discuss meeting the speech, language and communication needs of the children in the school. This may result in a referral to the service, training/support to the school staff or advice. They access defined but flexible evidence-based pathways of assessment and intervention offered as needed.

We have devised the most effective way for these planning meetings to work, the administrative and consent processes involved and the method for allocation of schools/caseload to therapists. We have a robust training and digital resource offer that underpins the specialist support offer. The service is organised in geographical localities with clinical locality leadership and clinical specialists, and a skill mix of registered therapists and non-registered assistants, ensuring the right skills are available for the right needs.

Impact and feedback

Our model of delivery is proven in meeting the variety of needs across our population in Cambridgeshire, resulting in no waiting lists and high service user satisfaction. Families/schools have advice from the first session (preschool-aged children) or termly planning meeting (school-aged children) that they can implement immediately.

There is increased accessibility for families to specialist support and timely accessibility to individualised care. There are reduced waiting times. Preschool-aged children can access support usually within four weeks of completing a form on our website. School staff know who to ask about support in their school and children receive specialist assessment and intervention following the termly planning meeting, with no waiting.

There is an increased positive patient experience. We have support from the CCS patient experience team, who support the analysis of feedback, identify trends and support changes. We send a feedback request to families after every consultation. Where developmentally appropriate, we ask the children and young people to give feedback on the service. We also seek feedback from our system partners.

Caseloads have high throughput due to flexible, evidence-based pathways of intervention and easy access. This means children and young people get what they need, when they need it, so therapy is as effective as possible. There are improved clinical outcomes due to early intervention, directed to appropriate support for the child's needs, and joined up working with all involved in the child's care. Therapists from other services have described it as 'amazingly quick' in terms of seeing children, and 'the ideal SLT service.'

For more information about this work, please contact: Katie Thompson, Area and Clinical Lead for Cambridge, Paediatric Speech and Language Therapy: katie.thompson1@nhs.net

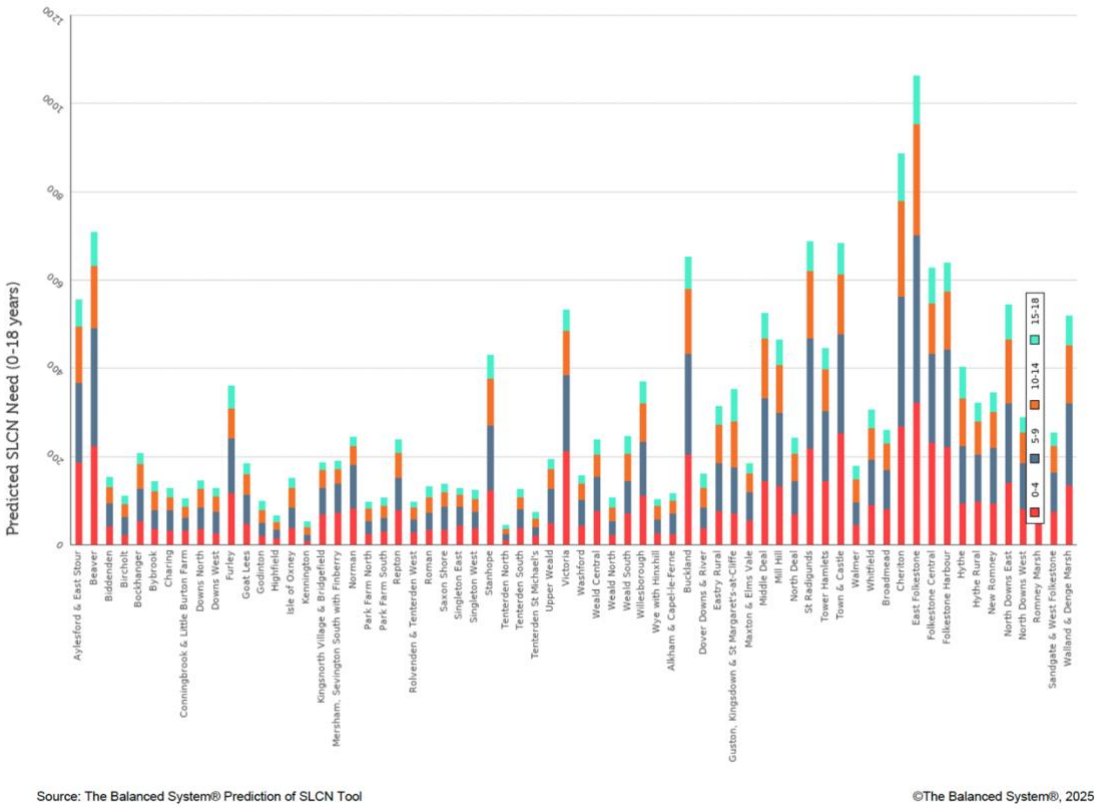
Becoming outcome-focused using a whole system approach - East Kent Hospitals University Foundation Trust

Service context

Sector: NHS

We are based in South Kent, which has a mixture of rural and urban areas, with pockets of deprivation. The Balanced System prediction of SLCN tool provides data to inform which wards within our overall area were predicted to have the greatest number of potential children with SLCN. The tool predicts the full range of possible SLCN, including those children who should not necessarily need to be seen by an SLT. Figure 1 below shows the pattern of need across the wards by age range within our service footprint (exported from the Kent Balanced System account).

Figure 1: Pattern of need across South Kent wards



Description of the initiative

- Introduction of The Balanced System across our service and within the wider Kent County. This has been a whole system approach, including education, ICB and health providers working towards The Balanced System high level outcomes and core delivery principles. Support jointly commissioned from Better Communication CIC by ICB and local authority as part of a strategic five-year plan.
- Move to easy access ('Talking Walk-ins' (TWIs)/school link therapy model) coupled with supporting and enabling the wider workforce and parents to meet the needs of all children with SLCN. Develop a universal and targeted offer and the SLT contribution to this offer.
- Moving from input to outcome/impact focused for our specialist service – underpinned by agreeing Canadian Outcome Performance Measures and embedding these within our service.
- Dedicated senior investment in form of a lead SLT and teacher to support the change has been critical (1.4 WTE) across Kent.
- Consultancy support from Better Communication CIC to understand and implement the model.
- Joint ICB/local authority investment in communication officer (linked to wider SEND) to ensure consistent messages in line with The Balanced System.
- No further investment in staff to deliver within provider speech and language therapy department.
- Whole system engagement including parents, schools and SLTs took place over at least 12 months in order to change hearts and minds.
- Enabling of systems/processes (infrastructure) to support new ways of working and a commitment from the ICB to support cessation of old ways of working to enable change.

Impact and feedback

Access times for advice, support/intervention have reduced significantly. Decrease in the number of children waiting more than 12 weeks from more than 400 in May 2023 to almost none in September 2024. This is despite higher numbers of children accessing the service.

Active caseloads have also reduced (and are therefore more manageable) as the wider workforce is supporting children and only open to speech and language therapy when specific needs require. This has decreased the number of routine reviews (which previously had no measurable outcomes). 'Was not brought' rates have reduced and there is less waste in system. For example, in the old system children had a planned

review whether it was needed or not. Now children are seen when there is a need. This is allowing the speech and language therapy workforce to be responsive to need in a timely manner.

Parent feedback:

- "I'm so glad I went to that walk-in centre. I've seen a massive improvement with A, not only am I understanding her better, so are her school peers, teachers, family and friends!"
- "Really pleased how the sessions are going and how the walk-in process worked."

Nursery feedback:

- The SENCo reported that now their parents have gotten over an initial fear of TWIs and spreading how helpful they are to other parents they are finding that it is having a positive impact on the nursery children and this year's cohort into reception seem to have benefitted and arriving with less need. They feel that it is helping nursery and reception to be joined up.

Feedback from schools:

- Seeing the link therapist more regularly has been a huge benefit, because this has enabled more opportunities to work in partnership to identify areas of need within the whole school not just for individual pupils.
- Staff are more skilled. They really feel more involved, whereas fewer staff had met and spoken to a therapist before we made the changes.

Top tips

- Work as a system and have dedicated professional to support the change.
- Identify outcome measures – become outcome-focused not input-focused.
- Change hearts and minds before anything else or real change will not happen.

For more information about this work, please contact: Acting Head of Community Child Health/CYP Therapy louisa.waters@nhs.net.

Delivering community-based services to reach children and families where they are - HCRG Care Group

Service context

Sector: NHS

We deliver a community service based in North Essex providing speech and language therapy assessment and support to children 0-19 and their families and educators. We are working with Better Communication CIC to develop a service that is in line with The Balanced System. We serve a coastal community with severe deprivation and high SLCN (Tendring – 36/317 LSOA ranking). This ranking is an indicator of deprivation grouped together in England using the England indices of deprivation. There are 71,500 0-18 year olds (27.5% are predicted to have SLCN using The Balanced System prediction tools), 148 primary schools and approximately 17 secondary schools.

Description of the initiative

The preschool population has access to weekly drop-in sessions across the locality, delivered in different geographical areas and family hubs. The sessions are delivered alongside already established stay and play sessions. This is normal practice for our service and is being delivered in line with The Balanced System principle (place-based, easy-access services) and framework (with wider system partners). Health visitors refer children to the drop-in session. Parents who can't bring their children (e.g. those have mental health challenges) can still access speech and language assessment and support via an initial telephone call initiated by the service. An assistant and SLT deliver the session.

Benefits:

- Currently no children are waiting for input.
- Parents are signposted to local universal and target resources/support delivered by the service and other partners, and can access specialist assessment as required.
- Liaison is established with wider system partners so that families can be signposted easily to their support.
- Supports development of the knowledge and skills of the local workforce, because they are able to observe SLT/As in practice.
- Supports early identification.
- No costs to service as local community venues are used, including space, toys and information technology.
- No additional funding has been required.

Service users were involved in the development process, which has supported decision making about places and frequency of delivery.

Impact and feedback

- Reduces the amount of time that children wait for initial assessment – no children currently wait in the early years. Before this way of working was introduced, children had to wait up to 43 weeks.
- The child receives immediate advice and signposting to further information. Targeted support is then delivered within 6-8 weeks.
- This approach reduces the amount of time that children require from speech and language therapy – they don't stay on a caseload and are able to re-access any drop in when needed.
- Parents are more knowledgeable and confident to understand their child's needs and provide support; children access the right support at the right time; the workforce increases knowledge, skill and confidence in supporting the children in their communities; children's needs are identified and supported early.
- Feedback from SLTs – they feel this is a good use of their time and have high job satisfaction, because they are not managing waiting lists and are able to provide an impactful service quickly.
- Feedback from parents – positive feedback as they access services in a community family hub, like the non-medical approach and understand what other services are available to them.
- Feedback from partners – health visitors and early years practitioners find that they are empowered to be able to confidently provide support.

Top tips

- Find out where families go and are accessing services – put your services where the children and families go. You may need to think outside of the box to do this.
- Just do it. Start small and build over time using support staff.
- Work with system partners to share information about where and when.

For more information about this work, please contact: Monette Dormant, Paediatric Service Lead: monette.dormant@hcrgcaregroup.com

Opening the door to ensure children are supported at the right time in the right place - Herefordshire and Worcestershire Health and Care NHS Trust

Service context

Sector: NHS

We are the main NHS provider in Worcestershire, serving a population of 125,000 children and young people aged 0-18 years. Worcestershire is a large rural county divided into six council districts: Worcester City, Malvern, Wyre Forest, Bromsgrove, Redditch and Wychavon. We have a mixed demography with areas of social disadvantage and poor social mobility outcomes. For example, Wychavon, a district in Worcestershire, is the third worst performing local authority in the UK for social mobility outcomes (Social Mobility Index). Bromsgrove is our most affluent area and Redditch the most disadvantaged.

Description of the initiative

Since 2010, we have adopted The Balanced System framework, working with Marie Gascoigne and utilising a range of The Balanced System online tools to help us to redesign and support the ongoing development of our service. This whole system approach involves working in partnership with families, education and health colleagues. The core principles of The Balanced System in action have led to our ongoing successful management of waiting lists both prior to the pandemic and in most recent years, i.e. easy access to the service and support, being place based (working in settings and schools) and offering a rich targeted offer. This has been normal practice across the service for more than 10 years now. It means:

- Families can access advice at any time either by calling us or dropping in to a drop-in session (offered weekly across the county).
- We provide advice without requiring a referral, via a drop in or during the regular meetings we hold in schools.
- We are accessible online – advice is provided on our website and across social media platforms.
- Anyone can refer in and we provide advice both pre and post referral so children can be supported straightaway.
- Children are seen for their first assessment within 18 weeks – on average children are seen by 13 weeks, with some children being seen much sooner. Following the original lockdown during the pandemic our waiting times had recovered by October 2020.

- We are very easy to access, being available out in schools and settings to give advice and offer support as needed – we aim to make it very easy to speak to an SLT for advice.
- Children are referred into us earlier – 80% of referrals received now are for children aged four years and under, compared to 60% in 2010-2011.
- We are now seeing a shift in the age of children on the caseload, with children making good progress earlier during their early years and primary years – 85% of the caseload are children nine years of age or under.

Parents and families were involved in the service redesign in 2010-2011, they were part of our consultation and development group.

We were a lean service in 2010-2011 and we did not receive any additional resource or funding, working with the existing resource but deploying our staff in a different way. We have since grown as a service, because we have developed our additional services to schools, so schools can enhance their core NHS offer with 'more of the same'.

Impact and feedback

- We see children quickly and offer advice sooner.
- Children are often included in interventions before they see a therapist. For example, they may already attend a targeted intervention group in school. The waiting time for targeted intervention in early years is a number of weeks, rather than months.
- We provide advice to families as it is needed, including pre-referral – we may meet families at school for example, giving initial advice before the referral process begins.
- We are monitoring the number of children discharged at the end of reception and into key stage 1, because we know we are discharging increasingly younger children as they make good progress following intervention.
- We are piloting the new Prove It! platform from The Balanced System to track outcomes across levels (universal, targeted and specialist) and strands (families, environment, workforce, identification, intervention). For example, confidence and competence of the wider workforce supporting children with SLCN; quality changes to the environment to support children; individual case studies demonstrating progress and functional outcomes.
- Feedback from the wider system is overwhelmingly positive.

Top tips

Employ the core principles from The Balanced System, become place based and easily accessible, working out in the community alongside families and colleagues in schools

and settings. With increasing demands there is a tendency to change referral criteria, raising the threshold and making it more difficult for families to access a service. This is about doing the opposite – open the door instead and ensure children are supported at the right time in the right place.

For more information about this work, please contact: Emma Jordan, Service Lead, Children's Speech and Language Therapy Service: emma.jordan@nhs.net

Providing a one-stop-shop of preventative care for education settings - Homerton Healthcare NHS Foundation Trust

Service context

Sector: NHS

According to I CAN, 1.9 million children have communication difficulties that impact life outcomes (I CAN, n.d.). Nationally, we are experiencing an SLT recruitment crisis (Speech and Language UK, 2023) with a supply versus demand imbalance and long waits (for 76,000+ children) (NHS England, 2023) and disparity in the availability of local services. These children experience health inequalities. In socioeconomically deprived areas, half start school with inadequate language (I CAN and RCSLT, 2018).

- Aged 11: 6x more likely to fail English; 11x more likely to fail maths (Speech and Language UK, 2003).
- 90% of care leavers have below average language skills. (Clegg *et al*., 2021).
- 70% in youth justice have communication needs (Bryan *et al*., 2007).
- Mental health difficulties and unemployment twice as likely (Speech and Language UK, 2003).

Description of the initiative

Verbo offers a one-stop-shop of preventative care for education settings to deliver the Department for Education's graduated response. An online platform provides instant access screeners from age two through post-16, automatically-generated targets, resources, video-modelling and built-in impact measures. Verbo aims to upskill education professionals and complement existing speech and language therapy services.

Currently used within our Hackney service and 1,000+ settings nationally, Verbo enables educators to provide early identification and intervention, focusing on universal and targeted evidence-based support. These principles reflect service delivery in Hackney, itself informed by The Balanced System (Gascoigne, 2008-2025), a theoretically driven, practically-tested model. The approaches on Verbo are all things we recommend when working face to face.

Verbo supports plan-do-review cycle implementation, leading to better quality referrals (one local authority recorded 10% fewer rejected referrals), improved education health and care plan applications (another local authority recorded 66% fewer requests) and associated cost savings.

We are adding occupational therapy support and welcome other professional collaborations. Verbo's development and everyday use has involved partnership working with education and our NHS trust in Homerton, plus support from NHS England's Clinical Entrepreneur Programme.

Verbo was co-designed by education staff and therapists: pilot schools provide ongoing feedback and user groups support feature development.

Purchasing models vary for settings, local authorities, integrated care boards (ICBs), speech and language therapy teams or other commissioners.

Impact and feedback

One key impact of Verbo is that pupils waiting for speech and language therapy support are 'waiting well'. During the past academic year, nearly 4,500 children benefited from screening for early identification of needs prior to referral. More than 5,000 education staff had access to content to upskill them to support the pupils waiting. Schools can also share targets with parents, who can access the resources related to their child.

Verbo has helped reduce inappropriate referrals, which will contribute to waiting time reduction. In a small sample of 16 early adopter schools, we found that in the first school term alone, 30 children were recommended to Verbo rather than being referred for therapy. Some of these children may go on to need a referral, but the support received through Verbo is a vital part of their plan-do-review cycle and contributes to a more informative referral. Regarding the time a child is on a speech and language therapy caseload, SLTs can confidently discharge pupils onto Verbo, knowing settings have the tools to continue support at this level. Of the 16 early adopter schools, 18 children were discharged onto Verbo support in the first term. Over time, this positive data will be built on further.

Last academic year, 96% of pupils' targets were met – these are pupils who, without Verbo, may have accessed very little or nothing at all while waiting for SLT support. 94% of education staff said Verbo content will change their practice and 82% reported increased confidence in setting up interventions. 89% of parents said the intervention videos were helpful. 90% of SLTs report their time is being used more efficiently since having access to Verbo. One SLT service lead gave feedback that "Verbo addresses the recruitment crisis that we are all facing nationally, as well as locally". For more feedback and testimonials: https://verboapp.co.uk/feedback/

Top tips

1. Verbo can be rolled out by local authorities, speech and language therapy teams or other commissioners, e.g. ICBs. It is most successful when the local speech and language therapy and other multidisciplinary teams that work closely with

settings are a key part of this process, and support settings to get started and engage with Verbo.
2. Speech and language therapy services can integrate Verbo into their local processes and systems. For example, they can support settings to use Verbo as part of their plan-do-review cycle, whereby they use Verbo to complete a screener, set targets and carry out interventions before making an SLT referral.
3. SLTs can share Verbo videos and resources when making recommendations to parents and education staff, this enables their time to be used efficiently. When discharging pupils, SLTs can signpost to Verbo for ongoing setting-based support.

For more information about this work, please contact: Caroline McCallum, Clinical Lead SLT: caroline.mccallum@nhs.net

References

Bryan, K., Freer, J. and Furlong, C. (2007). Language and communication difficulties in juvenile offenders. *International Journal of Language and Communication Disorders*, 42: 505-520. https://doi.org/10.1080/13682820601053977

Clegg, J., Crawford, E., Spencer, S. and Matthews, D. (2021). Developmental language disorder (DLD) in young people leaving care in England: A study profiling the language, literacy and communication abilities of young people transitioning from care to independence. *International Journal of Environmental Research and Public Health* 18, 4107. https://doi.org/10.3390/ijerph18084107

Gascoigne, M.T. (*2008 – 2025). The Balanced System.* Available, at: www.thebalancedystem.org

I CAN (no date). *The prevalence of speech, language and communication needs.* Available, at: https://ican.org.uk/i-cans-talking-point/professionals/information-for-inspectors/scale-of-the-issue/ (Accessed: 6th June 2022)

I CAN and the RCSLT (2018). Bercow: Ten Years On – An independent review of provision for children and young people with speech, language and communication needs in England. Online: www.bercow10yearson.com/wp-content/uploads/2018/03/337644-ICAN-BercowReport-WEB.pdf

NHS England (2023). *Community health services waiting lists*. Online: https://www.england.nhs.uk/statistics/statistical-work-areas/community-health-services-waiting-lists

Speech and Language UK (2023). *Listening to unheard children report* Listening-to-unheard-children-report-FINAL.pdf (speechandlanguage.org.uk)

Putting the voice of children and young people at the centre of services - NHS Forth Valley

Service context

Sector: NHS

NHS Forth Valley is located in the central belt of Scotland and covers three local authority areas; Clackmannanshire, Falkirk and Stirling. There are estimated to be 62,500 children and young people living in Forth Valley and data from 2019 suggested that 16,450 of these children are predicted to have speech, language and communication needs (SLCN). This figure is likely to have risen following the COVID 19 pandemic.

Description of the initiative

In 2019, we reviewed the way that we were delivering services and the impact that we were having. Our population data indicated a significant number of children were likely to have SLCN and at the time were working with a traditional refer-assess-treat model, which meant we were only managing to support a very small number of those with SLCN. As a result, we redesigned the service, focusing on a tiered model of service delivery and intentionally focusing on early intervention and prevention. We also wanted to put the voice of children and young people at the centre of services, while still ensuring there was specialist support available for those who needed it. We worked together with families, the three education authorities and health partners to understand what was important. We also collaborated with the Better Communication team to underpin the new service offer, focused on a range of dimensions:

- Family support, including a helpline, social media presence and parent workshops.
- Environment, e.g. communication-friendly environment accreditation; development of communication champions.
- Workforce: training packages for education and health visiting staff.
- Identification: training for education and health visiting staff about typical development; targeted conversations (early conversations regarding potential concerns).
- Intervention: asset-based approaches including whole class interventions.

Impact and feedback

- Our service currently has the lowest waiting times in Scotland (correct as of December 2024). Nearly two-fifths (38%) of children and young people are seen within one week and more than 90% are seen within 12 weeks.
- In the academic year 2023-2024, we had 458 early intervention conversations with parents; 48% (n=219) of callers were supported through advice, reassurance and signposting and did not need a further appointment. We also had 1,479 early intervention conversations with health visitors and education staff; 75% (n=1,113) were supported without the need for onward referral to the speech and language therapy service.
- There is evidence that demand for support has increased by 43% since 2018-2019, but this isn't translating to an increase in requests for assistance to speech and language therapy – it seems that the early support model is being effective in meeting local needs.

Case study

A recent success story from our service highlights how early and easy access to expertise, positive collaboration and a child-centred approach can transform the lives of children with communication needs.

In August 2022, four-year-old Penny (name changed for privacy) began her transition into primary school. While she had thrived in nursery, speaking freely with teachers and peers, her start in primary school was a different story. Penny became unable to speak to anyone outside her immediate family, including her teacher, classmates, family friends and even grandparents. This silence extended beyond school, with Penny refusing to speak in everyday public settings, like parks and shops, leaving her family deeply concerned.

Recognising that something was amiss, Penny's mother and teacher took immediate action to access the help she needed, initiating a coordinated plan of support that involved both the school and NHS speech and language therapy.

In September 2022, Penny's teacher sought advice from the school's dedicated NHS link therapist, a unique model that allows teachers to access expert advice on early intervention without the need for formal referrals. Upon listening to Penny's symptoms and the impact on her everyday life, Penny came onto the caseload and a series of tailored strategies were recommended to help her overcome her communication barriers. The key approach was the 'sliding in' technique, a gradual and incremental supportive method designed to build Penny's confidence in speaking in the presence of others.

The sliding-in technique began at home, where Penny's teacher joined her for carefully structured play-based sessions. At first, her teacher observed from another room, allowing Penny to acclimatise, before gradually participating in activities with her. This gentle approach helped Penny feel safe and supported as she reintroduced speech into different environments.

By November 2022, Penny was able to speak freely to her teacher at home. As her confidence grew, she began to engage with other family members, such as her grandparents and eventually she started speaking to her peers. Throughout the process, the therapy team provided ongoing, tailored support, addressing speech sound challenges that arose during her journey.

A key element of Penny's success was the partnership fostered between her school, the NHS speech and language therapy team and her family. Her parents were actively involved at every stage, empowering them to play a pivotal role in Penny's progress and ensuring that the strategies used were consistently reinforced at home.

By June 2024, Penny was confidently speaking in class and in the playground, fully expressing her personality and engaging with her peers.

Her mother expressed immense gratitude for the support that had made this life-changing progress possible: "We had concerns when our daughter started school in 2022. Thanks to the strong partnership between our daughter's school and the speech and language team, we were able to access the help we needed very quickly."

A spokesperson from NHS Forth Valley Speech and Language Therapy added: "Our goal is to make it as easy as possible for families to access the support they need, and to do so in a timely manner. We understand the importance of involving everyone in the child's life, from teachers to parents, in supporting their wellbeing. Penny's story is a perfect example of how this collaborative approach leads to meaningful, lasting progress, as was the case for Penny and her family."

Now thriving in school, Penny's journey is a powerful example of how early, accessible and child-centred support can make a transformative difference in a child's life. The NHS Forth Valley Speech and Language Therapy Service remains committed to ensuring that every child has the opportunity to find their voice and reach their full potential.

Top tips

- Focus on developing a healthy culture at work.
- Start with hearts and minds; bring people on the journey with you.
- Gather data. Understand your local demographics and take baseline measures of current offers, caseload and workload data before implementing changes.
- Move from being reactionary to being proactive.

For more information about this work, please contact: Louisa McGuire, AHP Coordinator, Children's Speech and Language Service, NHS Forth Valley Therapy: louisa.mcguire@nhs.scot

Supporting effective and sustainable partnership working - Northumbria Healthcare NHS Foundation Trust (NHCFT)

Service context

Sector: NHS

We are commissioned by North East and North Cumbria ICB to provide services to children and young people up to age 18 (19 if still in full-time education) with SLCN and/or eating and drinking needs across Northumberland and North Tyneside (this stretches from banks of the River Tyne to the Scottish Border and from the North Sea to the Cumbrian Border). Our challenges include having a large geographical area and rural population on a coastal boundary, as well as having the highest levels of poverty in the country, with more than a third of babies, children and young people living in poverty, while also containing some of the most affluent areas of the country.

Description of the initiative

Northumbria Healthcare NHS Foundation Trust – Newcastle University Universal Targeted and Specialist Framework (NNUTS) is a resource for speech and language therapy services to share with educational settings as a framework that supports effective and sustainable partnership working. The framework aims to normalise the implementation of urgent treatment service models of service delivery, achieving positive outcomes for children with SLCN. The framework is based on behaviour change theory and models, and the development of social capital to ensure delivery of a flexible service offer to meet the needs of children and young people with SLCN.

This model of working is established and embedded within the NHCFT speech and language therapy service offer and was designed and evaluated in conjunction with Newcastle University. At a strategic level, SLTs are part of partnership discussions around planning to meet children and young people population needs, bringing the focus on communication supportive practices across the local area and the graduated response to needs. At an operational level, this model of working informs the delivery of the speech and language therapy service offer into schools and settings. Initial phases of implementation and evaluation were part of a knowledge transfer partnership which included an academy of schools, the speech and language therapy service and Newcastle University. A number of quality improvement projects related to specific aspects of the model have included service user involvement and feedback.

This initiative has no cost implications, because it is related to service delivery and used existing staffing resource.

Impact and feedback

- Northumbria Healthcare waiting times from referral to treatment are on average six weeks (and have been for the past five years), with subsequent minimum waits for follow up treatment. This model of working allows us to offer a responsive service via an episodes of care model. When a package of care is in place and a child is well supported, parents/carers and setting staff have confidence in allowing us to discharge/or move to action on request packages, in the knowledge that if they need to access the service again they can do so quickly.
- We deliver our service through locality-based teams and work in schools and settings (not outpatient clinic appointments). This means we are integrated into local communities and provisions within that local community.
- Our approach to assessment care and treatment is holistic and based on International Classification of Functioning, Disability, and Health domains, not only focusing on communication impairment, but also on knowledge, skills and confidence of agent of change, impact of impairment on activity and participation and wellbeing and confidence. Our service model is flexible to take into account all of these aspects so packages of care can differ for children with similar difficulties depending on these other factors.
- Because our service framework is flexible, we can (to a degree) be responsive to challenges and changes.
- Quality improvement (QI) is embedded within our service strategy and annual planning cycle, and all staff, through QI, are involved in generating practice-based evidence
- Patient-rated outcome measure results show high satisfaction with the service offer in terms of its impact on individual children's progress, the resulting positive impact on their activity and participation and the increase in school staff (and parents) knowledge and confidence to support their child. Feedback from education staff and parents/carers is routinely collected.

All the Newcastle University Universal Targeted and Specialist Framework theory and resources are available here.

For more information about this work, please contact: Gillian Vince, Professional Lead SLT: gillian.vince@nhct.nhs.uk

Enabling a whole-system approach to support SLCN
- Salford Care Org, Northern Care Alliance

Service context

Sector: NHS

- Salford has 61,372 0-18 year olds and there are 3,902 children and young people in Salford schools.
- Salford is one of most rapidly growing cities and is the 18th most deprived area in England.
- 25.6% of the population are living in poverty (35% of children in schools are eligible for free school meals).
- 5.6% children and young people have an education, health and care plan.
- 17.9% have special educational needs support.
- 37% are ethnically diverse.

Description of the initiative

Joint commission enabling whole-system approach to support SLCN (local authority and NHS) and enhanced offer, which is bought in by local schools and other agencies, such as complex safeguarding. This collaborative approach allows for efficient and co-ordinated service for families and children.

It involves:

- Graduated approach and application of thrive model across the children's workforce.
- Implementation of The Balanced System approach.
- Place-based working.
- Early identification and intervention.
- Skill-mix: the speech and language therapy team in Salford consists of SLTs with a range of skills and experience, communication development workers and SLT apprentices.
- Streamlined administration systems.
- Workforce development.
- Shared outcome framework monitored and reviewed by commissioners.

Impact and feedback

- Up-skilling of the children's workforce enables timely initial advice from practitioners who are confident in their knowledge and skills around SLCN, and

practitioners who are able to access a wide training offer and specialist advice. This also supports children while they are waiting for specialist appointments.

- A systematic approach to identification of need and intervention – for example, use of the WellComm toolkit and whole-class screening using Test of Abstract Language Comprehension and vocabulary assessments – supports the whole system approach and therefore reduces the stress on waits for specialist resource.
- Most children are seen within the referral to treatment target of 18 weeks and the waits are shorter than neighbouring departments.
- Waits for both assessment and intervention are monitored and resources moved accordingly.
- Place-based working and use of administration systems, such as automatic text reminders, has increased access/reduced 'was not brought' rates.
- Positive feedback is regularly received from parents regarding intervention, training and family support in the home.
- Feedback gathered from training and setting input is used to shape future service delivery.

Top tips

1. Build and maintain relationships across the system at all levels.
2. Know your population and use local data to identify themes and develop shared goals.
3. Don't lose sight of the importance of the speech and language therapy workforce development/retention/career progression/leadership/skill mix.

For more information about this work, please contact: Rebecca Shirt, SLT/Early Years Team Lead: rebecca.shirt@nca.nhs.uk or Fiona Taylor, Principal SLT/Service Lead: fiona.taylor@nca.nhs.uk

Putting support in place whilst waiting for a specialist referral - Southern Trust RISE Team

Service context

Sector: NHS

We have a wide geographical area with rural areas and some towns.

Description of the initiative

No extra funding was required as we put The Balanced System in place with lots of training, pre-recorded and live online trainings. We also offer whole class programmes and small group support. School staff can avail of all of this whilst waiting for a specialist referral to be seen. To make a referral, the teacher has to have a telephone conversation with a team member and at this stage some of the universal/targeted supports can be put in place immediately. Also, parent online workshops are in place for access while children are waiting. Often, beginning like this enables teachers and parents to get started and then their journey with the specialist support can be shorter; hence, the impact on the service as a whole.

Impact and feedback

- Supports the child whilst waiting for an appointment (as indirect/generic intervention can be started).
- Reduces the amount of time a child is on our specialist caseload.
- Feedback from schools is positive.

Top tips

You would need time allocated/protected for service development.

For more information about this work, please contact: Ashleigh Gamble, SLT: ashleigh.gamble@southerntrust.hscni.net

Delivering speech and language therapy while waiting - Speech Club

Service context

Sector: Independent practice (sole provider)

Speech Club was founded in 2022 by independent SLTs Claire Whittaker and Claire Heslop. We were keen to create a flexible, inclusive and affordable solution for families and schools seeking speech and language therapy support that could be implemented immediately. Our digital intervention means the platform is available internationally.

Description of the initiative

Speech Club is a way of delivering immediate speech and language therapy to all children who are currently on a waiting list. It consists of prerecorded speech and language therapy lessons delivered by experienced therapists, direct to the child. It provides not just the lessons themselves, but also all the handouts, activities, stationery and information PDFs that can be used by parents and nursery staff immediately. It was trialled by Essex Local Authority who now use it in more than 42 of their settings. Speech Club is now being used all over the UK and in more than 50 countries worldwide.

Impact and feedback

Speech Club provides immediate help so that preschool children no longer have to wait on long waiting lists before they can see an SLT. It also provides all family members, nursery staff and carers with advice and all the information they need. Our simple 'just press play' approach has already helped thousands of children.

Examples of feedback include:

"Speech Club is the Sesame Street for speech and language! My daughter wants to watch it the whole time and really sees the videos and activities as a treat. You have made this whole thing fun and educational for us both! Thank you, ladies!"

“There really is no better way to learn than from professionals. We are working away at home and your course is giving us, as parents, direction and focus. We are so grateful to you and will continue to tell everybody about the benefits of Speech Club.”

Please see our detailed website for more feedback and testimonials.

For more information about this work, please contact: Claire Whittaker, SLT: claire.w@speechclub.com

Using an evidence-based programme to support parent/child interaction - Stockport NHS Foundation Trust

Service context

Sector: NHS

Stockport is a borough in Greater Manchester. The 2023 SEND Joint Strategic Needs Assessment shows there were 81,003 children and young people aged 0 to 24 years living in Stockport and 6,400 were under two years. Nearly half (45%) of births occur in the two most deprived quintiles. Across primary/secondary in Stockport there are an estimated 1,500 pupils with autism – around 2.9% of all pupils in primary schools and 4.5% of all pupils in secondary schools. This level is higher than the expected prevalence. Around 1,000 pupils have an identified SEND with a primary need of autism, a number similar to the estimated prevalence.

Description of the initiative

The use of the Social Attention and Communication Surveillance-Revised (SACS-R), which identifies children with a high likelihood of autism, has been introduced in Stockport. Children scoring grey or black for communication on the Ages and Stages Questionnaire (ASQ) at 12 months will be followed up with the SACS-R, which screens for social communication differences. If indicated from SACS-R, the child/family are offered iBASIS (an eight to 10-week evidence-based parent child intervention). iBASIS is an evidence-based, parent-mediated programme, which uses video feedback to support parent/child interaction and empower the parent to respond in a more attuned way to their child.

After iBASIS, children are screened again and offered further support at universal, targeted or specialist level, depending on the need. This is provided before two years of age – within the first critical two years of development.

This pathway was developed following an invitation from Manchester University/IMPACT to pilot this in Stockport. The pilot began in a targeted area, but with such positive feedback from the health visitors, the majority of the health team are trained in SACS-R and this is now part of routine practice. The iBASIS intervention and follow up specialist support is provided through GM funding.

Information about the research can be found here.

Parent focus groups have shaped the pathway.

Impact and feedback

The children who are indicated with social communication differences requiring iBASIS are not waiting for an initial assessment. They receive iBASIS intervention a few weeks after the 10-minute SACS-R screen carried out by the health visitor/early years worker. Evidence in Australia has shown long lasting impacts and reductions in longer-term impact/costs in later years.

Parent feedback includes:

- "iBASIS helped me focus on what I could see was happening with my child. It helped me see things from a different angle. It's beautiful. It's a good idea."
- "I have to wait. I've learnt to be in the passenger seat and see what my child does."
- "It's beautiful. It helps the child and adults master tools to actually help the child."
- "I love my child more since doing iBASIS" (because I have changed my interactions and understand them more)."

Health visitors say:

- "Doesn't take long to do – can incorporate into my assessment – really useful focusing on individual observations/ supporting practice."
- "Gives parents a lot of reassurance, you can point out typical behaviours, also relief when you see what they have been worried about."
- "Parents welcomed the SACS-R with open arms."
- "As a screening tool its brilliant – Mum was reassured and very positive."

SLTs/SLTAs say:

- "I have enjoyed iBASIS. The structure and flow of the therapy is great and parents like the clarity of it. Favourite part: when a parent has a light bulb moment and starts to adapt to their child's communication style and asks questions, e.g. 'What is he trying to communicate to me here?' The home plan is very useful, it gives parents the opportunity to be involved with how they want to implement their learning."

Top tips

- This is going to be discussed by NHS England, so firstly speak to your local commissioners about what they know about SACS-R and iBASIS.
- Request information from our service about our experiences and outcomes.
- Read up the info on the Manchester University and Australian study to find out more.

For more information about this work, please contact: Carol Sperring, Children's Therapy Manager: carol.sperring@stockport.nhs.uk

Using research-based content to help parents support their child while they wait - Sussex Community NHS Foundation Trust

Service context

Sector: NHS

The trust covers a large county with a mixture of large towns and widely-distributed small villages. There are areas of wealth and areas with high levels of deprivation.

Description of the initiative

'Let's get Talking' and 'Playing with Sounds' are booklets that can be given to parents/carers at the child's assessment appointment to provide information and strategies to support their child while they are on a therapy waiting list. The books are designed to be personalised by the SLT during the assessment session by writing in information about the child's current communication and next steps, by marking the most relevant information for that family to make it stand out (e.g. a particular tip, or something that was discussed or demonstrated in the session) and by ticking the option(s) for what will happen next in the pathway. A speech and language therapy assistant (SLTA) calls the parents after three weeks to answer any questions they have about the book.

The content was developed following a literature search and a survey of parents who were at the end of their time on the waiting list, asking what information they would have liked while waiting for therapy and in what format. A follow-up survey is underway for more detailed feedback from parents about the new resources.

Benefits: research-based content, ready to personalise and give to parents.

Costs: printing and telephone calls with the SLTA.

Impact and feedback

The aim is to support parents to wait actively and towards agreed goals.

As the information is all in one place, therapists don't need to spend as much time writing strategies into the report, but do need to allow extra time in the session itself to personalise the book and point things out or demonstrate them.

Feedback from parents is being gathered, but so far has been positive:

- “It has given us so many tools to build her vocabulary. An eye opener – aiming the information towards the adult rather than the child, helping you realise how influential you are as a parent.”
- “It helped me to help him and gave me a better understanding of how to help him with his speech.”
- “If she hadn’t have done that* I would have forgotten what she told me.” (*written in the book to highlight particular information).

Top tips

Research shows that personalising an information leaflet as part of the consultation enhances its use.

For more information about this work, please contact: Jo Sainsbury, SLT, Clinical Lead for Early Years (Chichester Locality): johanna.sainsbury@nhs.net

References

Sustersic, M., Gauchet, A., Foote, A. and Bosson, J-L., (2017). How best to use and evaluate patient information leaflets given during a consultation: A systematic review of literature reviews. *Health Expectation* 20(4), pp 531-542

Linking therapy block duration to successful outcomes - The University of Manchester

Service context

Sector: HEI/NHS

Working within a clinic-based children's service, we addressed three-year waiting list times for children with SLCN (language difficulties and speech sound disorder (SSD)), consistently achieving waiting times of <18 weeks. We won the NHS trust's 'Going for Gold' award as a result. The example is now old, but is still relevant.

Description of the initiative

The service delivery model includes:

- Detailed assessment.
- Setting care/therapy aims.
- Group models for first treatment language (Building Early Sentences Therapy (BEST)) and speech sound disorder (phonological awareness, articulation skills, learning sound-picture-cued articulation links) followed by evidence-based complexity approach – training for SLTs is needed here.
- Linking therapy block duration to successful outcomes to avoid poor outcomes and 'roundabout' service access, lengthening waiting lists.

More detail information about this work can be found in the book chapter by Pert (2010) – see references below.

Assessment: Crucially, more time was allocated to SSD assessment to get the correct diagnosis and identify the correct evidence-based therapy. This saved time misspent on the wrong therapy through ineffective short screening.

Group therapy: 'First treatment groups' (original trials of BEST were implemented. These ran constantly with children entering when there was a space and exiting when they achieved the threshold score (there is no rigid need to start and finish at a set point). 'First treatment speech groups' focused on phonological awareness and articulation skills (Bigmouth and Cued Articulation) prior to one-to-one therapy. There was no grouping together of children by phonological process – groups continued and children left as they achieved their aims.

Dosage/treatment intensity: Treatment packages were one to 18 weeks and dependent on successful outcomes rather than rationed to six-week blocks, which are known to be ineffective (Law and Conti-Ramsden, 2000). This stops the refer-treat-

discharge-re-refer cycle, which keeps waiting lists long. Instead, children recover and do not need further episodes of care, because therapy is more effective. BEST is now evidence based following a randomised control trial last year (McKean *et al*., 2023).

Description of the initiative

- Effective and detailed assessment: Not using Speech Screens (such as the CLEAR, STAP etc.), which miss children with inconsistent phonological disorder and fail to differentiate between articulation disorder and phonological speech errors leading to ineffective treatment. We wouldn't assess and diagnose DLD using a screen, but this is common practice for SSD.
- Group therapy first for the majority of clients with SSD and language difficulties – just as effective as one-to-one and even children with more complex needs benefit from learning foundation skills. Allows for dynamic assessment.
- Evidence-based interventions for language difficulties (BEST) and SSD (complexity approach – more effective and faster, but seldom implemented due to lack of training for SLTs).
- No arbitrary six-week blocks, which in the medium term lengthen waiting lists, due to the ineffective dosage.
- Two to three times per week intensives for SSD.

Impact and feedback

- The whole system moves and children are genuinely discharged as treatment complete, rather than rationed a series of ineffective six-week blocks, lengthening the waiting times and leading to poor outcomes for individual children.
- Groups allow for rapid turn-over with children then accessing one-to-one care, which is more effective because the child has learnt foundation skills, such as articulation skills, phonological awareness or basic sentence production.
- The BEST language programme has simple, child-led home pack packs.
- Evidence-based (see above).
- Award-winning approach with positive feedback from SLTs and parents.

Top tips

- Think medium term and don't be tempted to ration using six-week blocks – there is no evidence that they work, they are more likely to lead to poor outcomes and longer waiting lists.
- Prioritise accurate assessment and diagnosis, especially for SSD, so that the selected therapy is correct, Avoid screens (CLEAR, CROSS, STAP) unless screening

at classroom level. Use a full assessment (DEAP) and reach a conclusive diagnosis. Remember, SSD is not a diagnosis.

- Prioritise training and allow SLTs to learn evidence-based intervention: crucially, constructivist language theory (BEST) and Complexity Approach to SSD. This will lead to more effective therapy and quicker discharge of clients.

For more information about this work, please contact: Sean Pert, Senior Clinical Lecturer: sean.pert@manchester.ac.uk

References

Law, J. and Conti-Ramsden, G. (2000). Treating children with speech and language impairments: Six hours of therapy is not enough. *British Medical Journal* 321, 908-909. https://doi.org/https://doi.org/10.1136/bmj.321.7266.908

McKean, C., Jack, C., Pert, S., Stringer, H., Letts, C., Preston, E., Ashton, E., Conn, K., Sandham, J., Rose, N. (2023). A randomised controlled trial comparing the efficacy of pre-school language interventions – Building early sentences therapy and an adapted Derbyshire Language Scheme. RCSLT Conference. https://doi.org/10.1111/1460-6984.13041

Pert, S. (2010). Supporting staff to balance caseload demands. In H. Roddam and J. Skeat (Eds.), *Embedding evidence-based practice in speech and language therapy: International examples* (pp. 72-78). John Wiley & Sons, Ltd.

Trebacz, A., McKean, C., Stringer, H. and Pert, S. (2023). Piloting building early sentences therapy for pre-school children with low language abilities: An examination of efficacy and the role of sign as an active ingredient. *International Journal of Language and Communication Disorders* 59(3), 1128-1151. https://doi.org/https://doi.org/10.1111/1460-6984.12980