All Party Parliamentary Group
on Speech and Language Difficulties

The links between speech, language and communication needs and social disadvantage

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Foreword

The All Party Parliamentary Group (APPG) on Speech and Language Difficulties was formed following the publication in 2008 of the report from the Bercow review of services for children and young people with speech, language and communication needs (SLCN). The group is currently chaired by an independent crossbench member of the House of Lords. The other officers come from the two main political parties in the House of Commons. The secretariat is provided by the Royal College of Speech and Language Therapists. We have worked to highlight the needs of children with SLCN in concert with other all party parliamentary groups with interests in learning difficulties and disabilities and with The Communication Trust, whose membership consists of many voluntary sector organisations working on this issue.

Early in 2012 we decided to conduct an inquiry into the links between SLCN among children and social disadvantage. In doing so we were conscious that - again following the Bercow review - the previous government had commissioned the Better Communication Research Programme (BCRP), the largest ever programme of research into speech, language and communication services in the UK. The research, which was conducted over three years and funded by the Department for Education, involved ten research projects and the analysis of data from around 6,400 children, 560 parents, 600 speech and language therapists and 750 teachers / special educational needs co-ordinators. Although submitted to the Department in June, the final outputs of the programme were not published until 27 December 2012 and were released without any formal government response. The APPG officers were also aware that the government intended to include proposals for the reform of special educational needs (SEN) provision in its Children and Families Bill. The House of Commons Education Committee published a critical report about the draft provisions on SEN in December 2012.

I mention all this in order to explain why, with a view to making the most effective use of the evidence gathered during the inquiry, the APPG officers agreed to delay publication of the report so that it could refer to the government's response to the BCRP findings and recommendations. In the event that intention has been frustrated by the absence of a government response but, instead, the timing of the publication of our report is now being related to the usefulness of the information it contains for MPs and peers who will be taking part in discussions of the Children and Families Bill. The logic of this approach has been confirmed by the formation of an SLCN working group, specifically aimed at influencing the Bill, under the chairmanship of Paul Maynard MP, which is seeking just that information.

The decision to research and publish this report stems from our growing realisation that the inability of children to communicate, either with their peers or with others including their teachers, is a scourge that blights their lives in our communication-focused society. It has a knock-on effect on many aspects of their schooling and on their future opportunities in the workforce. The boredom and frustration of children who cannot engage properly with their education can lead to truancy or exclusion. The reduced emphasis on child development in teacher training must make it more

difficult for teachers to monitor and respond to children's communication needs. We also recognised that many of those affected by the scourge are from socially disadvantaged backgrounds. The links between social disadvantage and SLCN are complex and we are grateful to all those who gave us clues in the evidence that they submitted, either verbally or in writing, as to how these links might be addressed.

If there is one of our conclusions that stands out above all others, it is that, given the government's determination to localise responsibility for the delivery of both education and healthcare - the two most important contributors to identifying and responding to SLCN - and in order to ensure consistency throughout the country, there must be some form of national framework for what needs to be done locally. In other words a national 'what' framework within which there can be local determination of 'how'.

Therefore, two purposes have been added to the one that gave rise to this report. Firstly, the strongest possible support for the excellent BCRP reports, which we hope will be adopted and exploited by successive governments for years to come. They are a priceless treasure trove of information, evaluation and advice and a credit to the work of all those who contributed to their research and production. Secondly, the hope that, in order to ensure not just consideration and implementation of the BCRP findings and recommendations but also that there will be a national framework covering all children with SLCN, the government will appoint one minister to be responsible and accountable for directing, co-ordinating and aggregating the contributions of all ministries involved in ensuring that the scourge is prevented from blighting our nation's future and that of too many of its young people.

Lord Ramsbotham

Chair of the All Party Parliamentary Group on Speech and Language Difficulties

Summary and recommendations

The evidence received by our inquiry and the findings of the BCRP demonstrate the crucial importance for socially disadvantaged children of home and school environments that effectively promote the development of oral language.

In the light of this evidence we recommend that there should be a comprehensive programme of initial and post qualification training for all relevant practitioners in relation to children's communication needs, that systems for monitoring and responding to the development of children's communication skills over time should be improved and that services should be driven by the nature and severity of children's needs rather than by diagnostic categories, differences in parental expectations or variations in practices relating to the identification of SLCN. We also recommend some targeted additional support to improve the communication environments for children living in socially deprived areas.

In the context of the Children and Families Bill we recommend that there should be a national framework for local authorities' local offers which ensures that they cover education, health and social care services for all children with SLCN and reflect the other recommendations in this report.

In relation to recent early years policy developments we welcome the government's ambition to bring the Healthy Child Programme review at the age of two to two–and-a-half together with the written summary at the age of two in the new Early Years Foundation Stage (EYFS) in a single integrated review from 2015. We also welcome the fact that the government has made communication and language one of the three prime areas of learning in the EYFS.

We recommend
- that children from the most disadvantaged backgrounds should receive additional support in the early years to ensure they have a secure foundation for language and literacy development;
- that provision for pupils with SLCN should reflect their likely need for support to develop peer relationships and prosocial skills and their increased risk of emotional problems;
- that monitoring of these pupils should reflect these domains as well as language and attainment;
- that children referred either to child and adolescent mental health services or to speech and language therapy services should have both their language and their behaviour properly assessed;
- that there should be a focus on social communication in the later years of primary school and not just earlier on in order to improve teenage behaviour;
- that all relevant practitioners should be given the professional development and coaching that will enable them to deliver good oral language environments for all children, especially in socially disadvantaged areas;

- that children's responses to good oral language learning environments should be regularly monitored by practitioners so that, when additional support is needed, it can be provided in an appropriate and timely way;
- that interventions for children with SLCN that are adopted at service level should be underpinned by evidence of their effectiveness and should fit together into a coherent evidence-based model of service delivery;
- that there should be joint commissioning by and effective collaboration between education, health and social care services for children with communication difficulties;
- that local authorities should monitor ethnic disproportionality in the identification of SEN and, where it is particularly high, investigate local practices;
- that the government should work with health visitors and other relevant professionals, especially speech and language therapists, to ensure that health visitors are properly trained in relation to SLCN;
- that the integrated mentorship and training programme for health visitors and speech and language therapists in Leicestershire Partnership NHS Trust should, if successful, be copied elsewhere;
- that the Healthy Child Programme e-learning curriculum in the e-Learning for Healthcare (eLfH) programme, which includes a module on speech, language and communication needs, should be made more widely available and that its content should be commissioned as part of training courses;
- that health and wellbeing boards should be given the task of developing a coherent approach to monitoring and responding to the signals of child development so that they can then provide integrated interagency guidance at local level.

We urge all policy makers with responsibility for children's services, both in national and in local government, to act on these recommendations as quickly as possible.

1. Introduction

Communication is a foundational life skill. The development of a child's communication ability has an impact on their literacy, school performance and employment prospects as well as on their emotional wellbeing and behaviour.

Most children acquire speech and language skills with relative ease. Where difficulties arise they may be due to neurodevelopmental problems or other impairments. They may also, however, be due to reduced developmental opportunities limiting the child's learning of language. These reduced developmental opportunities are commonly linked to social disadvantage.

We have therefore conducted an inquiry into the links between speech, language and communication needs (SLCN) and social disadvantage with the following terms of reference:
1) To examine evidence on the influence of social disadvantage on SLCN among children;
2) To examine evidence on the influence of SLCN among children on their chances of poor social and economic outcomes in later life;
3) To examine evidence on the effectiveness of possible strategies to mitigate these influences;
4) In the light of these examinations to make appropriate policy recommendations.

We have held four oral evidence sessions with invited witnesses including a range of practitioners and researchers with expertise in the field of children's communication development (see Annex A). We have also received written response to our call for evidence from a number of individuals and organisations (see Annex B). Our report builds on the findings of the Better Communication Research Programme (BCRP), a three year research programme funded by the Department for Education, which were published on 27 December 2012.

Our concern in this report is with all those children whose communication difficulties are linked to social disadvantage rather than just with those who are identified as having SLCN in the special educational needs (SEN) system[1]. We therefore use the term SLCN to refer to the broad range of children with developmental speech and language difficulties in line with the following definition from the Bercow report.

> The term speech, language and communication needs (SLCN) encompasses a wide range of difficulties related to all aspects of communication in children and young people. These can include difficulties with fluency, forming sounds

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[1] Children at School Action Plus or with statements in the SEN system are identified as having a primary type of need and sometimes also as having a secondary type of need.   SLCN is one of the twelve categories used for these types of need. Since often no secondary type of need is recorded, references in this report to the identification of SLCN normally relate only to the primary type of need.

and words, formulating sentences, understanding what others say, and using language socially.[2]

Epidemiological data on children aged about 5 years indicate that around 7% have SLCN.[3] There is strong evidence, however, that the prevalence of SLCN is much higher in socially disadvantaged areas. Small scale studies in very socially disadvantaged areas have suggested that around half of the children in these areas may have significant language delays.[4]

The BCRP has demonstrated that socially disadvantaged children are much more likely than other children to be identified as having SLCN, i.e. that there is a strong 'social gradient'. Pupils entitled to free school meals, i.e. children whose parents are receiving any of a number of state benefits, are 1.8 times more likely than other pupils to be identified as having SLCN. Pupils living in a more deprived neighbourhood are 1.3 times more likely than other pupils to be identified as having SLCN. This means that pupils entitled to free school meals *and* living in a more deprived neighbourhood are 2.3 times more likely to be identified as having SLCN than those not so socially disadvantaged.[5] Moreover, even after these two characteristics of individual pupils have been adjusted for, pupils in primary schools are more likely to be identified as having SLCN in schools where a higher proportion of the pupils are entitled to free school meals.[6]

One of the BCRP studies suggests that *among children with similar characteristics and prior attainment* those in schools with a higher proportion of pupils entitled to free school meals are *less* likely to be identified as having SLCN.[7] This implies that, if it were not for variations in practice between schools, the social gradient might be even steeper.

The research literature provides considerable evidence for the view that the way parents talk to children and the way they give children opportunities to talk influences children's early language development - the richer the opportunities provided the faster language develops - and that the levels of stimulation tend to be lower in more disadvantaged families.[8] As Jean Gross, former Communication Champion, makes clear in her written evidence to the inquiry, it is not poverty *per se* which matters most but what parents do to promote their children's communication skills. The child's communication environment (including the number of books available, trips to the library, parents teaching a range of activities and the number of toys available) is the most important predictor of language development at age two.[9]

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[2] Bercow, J. (2008), p. 13.
[3] Tomblin, J. B., Records, N. L., Buckwalter, P., Zhang X., Smith, E. and O'Brien, M. (1997).
[4] See Locke, A., Ginsborg, J. and Peers, I. (2002) and Law, J., McBean, K. and Rush, R. (2011).
[5] Strand, S. and Lindsay, G. (2012), p. 28. A more deprived neighbourhood here means an area at least one standard deviation above the mean on the Income Deprivation Affecting Children Index (IDACI).
[6] Strand, S. and Lindsay, G. (2012), p. 38 and p. 39. This seems likely to be due at last in part to different levels of need as opposed to different levels of awareness of SLCN.
[7] Meschi, E., Vignoles, A. and Lindsay, G. (2010), pp. 37-8.
[8] Hart, B. and Risley, T. R. (1995), Hoff, E. (2006) and Law, J., Todd, L., Clark, J., Mroz, M. and Carr, J. (forthcoming).
[9] Roulstone, S., Law, J., Rush, R., Clegg, J. and Peters T. (2011), p. 3 and pp. 33-4.

There are also indications, as far as child development is concerned, that the neighbourhood in which the child grows up can be influential. Neighbourhood factors (safety, cohesion and crowding) may influence family practices, for example children may not be allowed to play in the neighbourhood park if the area is not deemed to be safe by the parents, which then reduces the number of experiences to which the child is exposed.[10] Neighbourhood effects, though generally overshadowed by family effects in the early years, seem to become more direct as the child moves into school and forms relationships outside the home.[11]

We recognise that the links between social disadvantage and SLCN are complex. It can be difficult in practice to distinguish between SLCN caused by environmental factors and SLCN caused by neurodevelopmental problems – there is overlap between the two.[12] Moreover, our attention has been drawn to evidence from twin studies that the links between social disadvantage and SLCN do not operate only through the environment – there is a heritability component as well.[13] Nevertheless, there is plenty of evidence that a variety of environmental factors, mainly factors linked to social advantage, limit the development of children's communication skills.[14]

We believe the links between social disadvantage and SLCN are highly relevant to the government's commitment following the Marmot review of health inequalities to reducing such inequalities through action on the social determinants of health.[15] Marmot points out that reducing social and health inequalities requires a focus on improving educational outcomes.[16] He also identifies communication skills as being necessary for 'school readiness'.[17] Improving the communication development of socially disadvantaged children would therefore have an important wider benefit in terms of promoting social equity.

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[10] Maggi, S., Irwin, L. J., Siddiqi, A. and Hertzman, C. (2010).

[11] McCulloch, A. and Joshi, H. E. (2001).

[12] James Law, Professor of Speech and Language Sciences, Newcastle University, oral evidence to the inquiry.

[13] Dorothy Bishop, Professor of Developmental Neuropsychology, Department of Experimental Psychology, Oxford University, written evidence to the inquiry.

[14] Roulstone, S., Law, J., Rush, R., Clegg, J. and Peters T. (2011). See also Clegg, J. and Ginsborg, J. (2006), pp. 11-7.

[15] Department of Health (2011).

[16] Marmot, M. (2010), p. 104.

[17] Marmot, M. (2010), p. 106.

2. The long term impact of SLCN

The links between social disadvantage and SLCN run in both directions. We have examined evidence not only on the influence of social disadvantage on SLCN among children but also on the influence of SLCN among children on their chances of poor social and economic outcomes in later life. SLCN has a knock-on effect on school readiness, literacy and school performance generally. It also puts children at risk of a wide range of long term consequences in terms of literacy, mental health and employment.

There is important new evidence about these risks from large studies using population-based data. A study using data from a UK birth cohort of 17,196 children, following them from school entry to adulthood, found that, even after adjustment for a range of other factors, vocabulary difficulties at age 5 are significantly associated with poor literacy, mental health and employment outcomes at age 34.[18] Smaller studies also provide useful evidence but can be biased by the severity of the needs in a clinical sample or undermined by not having a control group of children whose non-language characteristics match those of the sample (for example in relation to social disadvantage). The population-based studies avoid these problems.

The BCRP refers to the substantial research evidence about the effect of language on literacy and school performance. The BCRP itself explored this relationship in a study of children in York. The study looked at whether language development at around 5 as assessed by teachers in the Early Years Foundation Stage Profile (EYFSP) predicts current and future educational attainments.

The BCRP study validated teachers' EYFSP judgements of children's language development by giving children a language screening test at school entry.[19] It also showed that the language scale used in the EYFSP correlated very strongly with all the other scales, "suggesting that language is a fundamental ability associated with progress in all other domains of development".[20] Moderate to strong correlations were found between EYSFP scores and Key Stage 1 (KS1) attainments and the highest correlations were found to be between Communication, Language and Literacy (CLL) scores and reading and writing attainments.[21] Moreover, about 50% of the differences between children's KS1 attainments could be accounted for by their CLL scores.[22] Children who obtained below the nationally expected level in reading were typically characterised by poor CLL scores.[23] Other results from the

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[18] Law, J., Rush, R., Schoon, I. and Parsons, S. (2009).
[19] Snowling, M. J., Hulme, C., Bailey, A. M., Stothard, S. E. and Lindsay, G. (2011), pp. 12-4.
[20] Snowling, M. J., Hulme, C., Bailey, A. M., Stothard, S. E. and Lindsay, G. (2011), pp. 15-8.
[21] Snowling, M. J., Hulme, C., Bailey, A. M., Stothard, S. E. and Lindsay, G. (2011), pp. 19-22. The CLL category has been split up in the 2012 statutory framework for the Early Years Foundation Stage. Communication and language is now one of the three prime areas of learning and development and literacy is one of the four specific areas of learning and development.
[22] Snowling, M. J., Hulme, C., Bailey, A. M., Stothard, S. E. and Lindsay, G. (2011), pp. 23-5.
[23] Snowling, M. J., Hulme, C., Bailey, A. M., Stothard, S. E. and Lindsay, G. (2011), pp. 33-6

study suggested that CLL scores were generally better at predicting literacy in Year 3 than concurrent measures of vocabulary and listening comprehension.[24]

The BCRP concludes that teachers' assessments of children's development at age 5, which are based on ongoing observation rather than formal tests, can be used to identify children at risk of later educational difficulties.[25] It also points out, however, that, since the EYFSP can be expected to account for only around 50% of differences between children, a substantial number of children could 'fall through the net' if the EYFSP was used as a one-off screening instrument. Additional checks should therefore be made at regular intervals.[26]

The same BCRP study highlights the association between social disadvantage and the likelihood of a child falling below national expectations in the EYFSP or at the end of KS1. 17% of children from the 10% most deprived homes in terms of the multiple index of deprivation failed to show expected progress in reading at KS1. 25% failed to show expected progress in writing.[27]

The BCRP suggests that children from the most disadvantaged backgrounds may need additional support in the early years to ensure they have a secure foundation for language and literacy development. This recommendation is all the more important in the light of other recent research showing a very strong association between children's early language development and their performance at school entry.[28]

The BCRP also refers to the substantial research evidence that children with SLCN are more likely than other children to develop behavioural, emotional and social difficulties (BESD). It points out, however, that the relationship between SLCN and BESD is complex. It emphasises the need to distinguish between different kinds of SLCN and between different kinds of BESD and to consider other factors that influence both language and behaviour including social disadvantage.[29]

The BCRP conducted three studies examining the prevalence of BESD in different samples of children and young people with language difficulties. The results support earlier research indicating that children and young people with SLCN are at risk of BESD but suggest that conduct problems are not common - the most significant types of difficulty are peer problems, emotional difficulties and impaired prosocial behaviour.[30]

One of the BCRP studies provided data from the KIDSCREEN children and young person self-report quality of life measure that is used across a number of European countries. KIDSCREEN asked questions such as 'Have you ever felt so bad that you didn't want to do anything?', 'Have other girls and boys made fun of you?' and

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[24] Snowling, M. J., Hulme, C., Bailey, A. M., Stothard, S. E. and Lindsay, G. (2011), pp. 26-30.
[25] Snowling, M. J., Hulme, C., Bailey, A. M., Stothard, S. E. and Lindsay, G. (2011), p. 40.
[26] Snowling, M. J., Hulme, C., Bailey, A. M., Stothard, S. E. and Lindsay, G. (2011), p. 43.
[27] Snowling, M. J., Hulme, C., Bailey, A. M., Stothard, S. E. and Lindsay, G. (2011), pp. 37-9.
[28] Roulstone, S., Law, J., Rush, R., Clegg, J. and Peters T. (2011), p. 3 and pp. 31-3.
[29] Lindsay, G. and Dockrell, J. (2012), p. 9.
[30] Lindsay, G. and Dockrell, J. (2012), p. 22.

'Have you felt lonely?'. The results indicate that children with language difficulties have an impoverished quality of life in terms of moods and emotions and in terms of social acceptance and bullying.[31]

The BCRP recommends that provision for pupils with SLCN should reflect their likely need for support to develop peer relationships and prosocial skills and their increased risk of emotional problems. Monitoring of these pupils should reflect these domains as well as language and attainment.[32]

One problem here is that the extensive overlap between communication difficulties and behavioural problems may not be reflected in professional practice. In his oral evidence James Law, Professor of Speech and Language Sciences, Newcastle University, suggested that speech and language therapists often do not assess behaviour and child psychologists often do not assess language. In particular, it seems there are too few speech and language therapists working in mental health teams. Professor Law suggested that all children referred either to child and adolescent mental health services or to speech and language therapy services should have both their language and their behaviour properly assessed.

Professor Karen Bryan, Head of the School of Health and Social Care, University of Surrey[33], told us in her oral evidence about the relationship between SLCN and youth offending. She suggested that children with SLCN face what she calls a compounding risk: their communication difficulties put them at risk of literacy difficulties and this in turn puts them at risk of further educational problems; then as they come to adolescence they have problems coping with peers, with school and with family relationships and their communication difficulties become labelled as behavioural problems. She reported that 60% of young offenders have speech, language and communication problems. She also referred to studies showing that four out of five young people not in education, employment or training and a large proportion of young people excluded from school have speech, language and communication problems. She drew attention to the effectiveness of speech and language therapy in helping young offenders to improve their language skills and contrasted the cost of providing it with the much larger cost of keeping a young person in the criminal justice system.

A key question then in relation to possible interventions is whether early language difficulties can predict later behavioural problems. The BCRP says that earlier evidence on this question is inconsistent.[34]   In his oral evidence Professor Law suggested that the relationship does not emerge very clearly from population-based studies. The results of a BCRP longitudinal study that looked at reclassification of pupils with SLCN after the transition to secondary school suggest that these children are not particularly likely to be reclassified as BESD. The most common destinations for those who move into another SEN category during secondary school are

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[31] Lindsay, G. and Dockrell, J. (2012), p. 17, and Dockrell, J., Ricketts, J., Palikara, O., Charman, T. and Lindsay, G. (2012), pp. 81-5.
[32] Lindsay, G. and Dockrell, J. (2012), p. 7.
[33] Professor Bryan has left this post since the oral evidence session and is now Pro Vice-Chancellor, Faculty of Health and Wellbeing, Sheffield Hallam University.
[34] Lindsay, G. and Dockrell, J. (2012), p. 11.

moderate learning difficulties (MLD) or specific learning difficulties (SpLD). Many other children move from the category of SLCN to a lower level of need or out of the SEN system altogether. [35]

Professor Law nevertheless drew our attention to new evidence from a population-based study that social communication or 'pragmatics' (i.e. 'higher order' language skills that involve understanding the meaning and nuances of language) mediates (i.e. reduces) the effect of social disadvantage on adolescent behaviour. This new evidence supports the earlier evidence to which the BCRP refers that problems with social cognition or social communication - as opposed to problems with structural language (for example grammar or vocabulary) – do predict later social problems.[36] The new evidence was obtained by using data from the Avon Longitudinal Study of Parents and Children (ALSPAC), a representative population-based cohort first identified in 1990-91 and followed through to adolescence and beyond, to look at the effect of pragmatic skills at age 9 on the relationship between social disadvantage in the first year of life and behaviour at age 13.[37] Pragmatic skills were found to mediate the effect of social disadvantage on several different aspects of behaviour: emotional difficulties, conduct difficulties, hyperactivity and peer problems.

This finding is significant because it strengthens the evidence that there may be a causal relationship between social communication and behaviour and that targeting social communication could reduce teenage behavioural problems. In particular, it suggests that a focus on social communication in the later years of primary school and not just earlier on could improve teenage behaviour. Professor Law referred to an intervention recently trialled by the Nuffield Foundation that has targeted children with pragmatic language problems and has had a positive impact on parent-reported measures of social communication.[38] Most of the children also had behavioural problems and, if social communication affects later behaviour, the intervention should improve their behaviour too.

The impact of SLCN feeds through into adulthood. The study using a birth cohort of 17,196 children mentioned at the beginning of this section provides strong evidence of this impact in relation to literacy, mental health and employment. The long term impact on employment may well reflect the effect on school performance and on behaviour. Moreover, since communication skills are now highly prized in a wide variety of work places, communication difficulties that persist into adulthood will themselves have a direct effect on employability.

In his oral evidence Leon Feinstein, Associate Professor, Centre for the Analysis of Social Exclusion, LSE, used data on children's cognitive test scores from the British cohort studies to highlight that children's development is characterised by

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[35] Meschi, E., Mickelwright, J., Vignoles, A. and Lindsay, G. (2012), pp. 45-7. Interestingly, the likelihood of pupils with SLCN moving into another category of SEN rather than remaining in the SLCN category is higher in schools where a higher proportion of the pupils are entitled to free school meals – see pages 56-7 of the same study.

[36] Lindsay, G. and Dockrell, J. (2012), pp. 11-2.

[37] Law, J., Rush, R., Clegg, J., Peters, T. J. and Roulstone, S. (under review).

[38] Adams, C., Lockton, E., Freed, J., Gaile, J., Earl, G., McBean, K., Nash, M., Green, J., Vail, A. and Law, J. (2012).

discontinuities as well as continuities. This makes it difficult for a group of children who are at risk of poor outcomes and at whom resources should be targeted to be identified at a very early age.

Professor Feinstein provided a striking illustration using data from the 1970 cohort study: children from working class families who are in the top 25% in terms of cognitive test scores at age 22 months are overtaken by children from upper middle class families who are in the bottom 25% at age 22 months by the age of 10. He also used data from the 1958 cohort study to show that something similar happens between the ages of 7 and 11. 65.0% of the children from upper middle class families who are in the bottom 25% at age 7 escape from it by age 11 as opposed to only 22.6% of the children from working class families. Similarly, 74.3% of the children from working class families who are in the top 25% at age 7 fall out of it by age 11 as opposed to only 20.4% of the children from upper middle class families. We should note, however, that the methodology behind these findings has been contested.[39]

In so far as socially disadvantaged children do fall behind relative to their peers during their primary school years their difficulties might well be prevented or mitigated by the kind of effective oral language learning environments that are advocated by the BCRP and discussed in the next section. Regular monitoring of their needs over time could help to ensure that, when additional support is needed, it is provided in an appropriate and timely way.

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[39] Jerrim, J. and Vignoles, A. (2012).

3. The emerging evidence base for interventions

The support provided for children's speech, language and communication is normally understood in terms of three levels: universal provision (for all children), targeted provision (for children in mainstream settings who need additional support guided by specialists) and specialist provision. This framework reflects the concept in the SEN Code of Practice of a 'graduated approach' to meeting the needs of children and young people with SEN.

The framework can also be understood as a 'response to intervention' model in which practitioners assess the level of a child's need partly by delivering relatively low level support and monitoring the child's response. Children from socially disadvantaged backgrounds often have relatively low level communication needs that can be effectively addressed through relatively low level support (e.g. play opportunities or small group work). The children who do not respond to such support may well be those with more severe problems that require higher level intervention.

The BCRP stresses the importance of universal provision. It focuses, in particular, on the importance in educational contexts of providing oral language environments that foster good communication skills. It describes this kind of universal provision as "the first phase in a systematic approach to reduce the impact of lower language competence on attainments in schools". It also suggests that such provision may be cost effective: "Only when children have been provided with appropriate language learning environments to develop their language and communication skills at school and at home, can financial and professional resources be allocated in cost effective and efficient ways.".[40]

One BCRP study involved observing in 101 reception and Key Stage 1 classrooms three aspects of support for children's communication: the language learning environment (i.e. the physical environment and learning context), the language learning opportunities (i.e. the structured opportunities to support children's language development) and the language learning interactions (i.e. the way adults in the setting talk with children). The study found a consistent pattern in which scores on the second and third aspects were lower than scores on the first aspect.[41] The BCRP stresses that all school staff should be able to make good use of the interaction techniques that have been shown to develop oral language.[42]

The BCRP argues for effective oral language learning environments to be combined with appropriate monitoring of children's progress.[43] Regular monitoring of children's language development is regarded as preferable to one-off screenings.

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[40] Dockrell, J., Ricketts, J. and Lindsay, G. (2012), p. 18.
[41] Dockrell, J., Ricketts, J. and Lindsay, G. (2012), pp. 20-1, and Dockrell, J., Bakopoulou, I., Law, J., Spencer, S. and Lindsay, G. (2012).
[42] Dockrell, J., Ricketts, J. and Lindsay, G. (2012), p. 23.
[43] Dockrell, J., Ricketts, J. and Lindsay, G. (2012), p. 22.

This is because children's patterns of development vary and one-off screenings have limited power to predict later performance.[44] Monitoring over time is seen as necessary both for the targeting of additional support and for reducing variation in patterns of identification.[45]

The BCRP wants the interventions for children with SLCN that are adopted at service level to be underpinned by evidence of their effectiveness.[46] It reports that the evidence base for such interventions is expanding relatively rapidly and illustrates this expansion by pointing out that there were 33 randomised controlled studies in the first version of the Cochrane Review of speech and language therapy interventions in 2003 and 64 in the 2012 version.[47]

The BCRP 'What Works' report, which draws the evidence together, finds that there is "a sound emerging evidence base".[48] It sets out ten criteria that commissioners and practitioners can use to help them make evidence-based decisions about interventions.[49] It does also suggest, however, that interventions for which the evidence is not yet especially strong may still be effective.[50]

One of the main recommendations of the BCRP is that services and schools should systematically collect evidence of children and young people's outcomes in relation to SLCN including the perspectives of children and young people and their parents.[51] Another is that there should be a comprehensive programme of initial and post qualification training for all relevant practitioners in relation to children's communication needs that would develop the joint planning and implementation of evidence based provision.[52]

We were given two impressive examples of systematic evaluation of interventions in our oral evidence session on the evidence base. One was the evaluation of a universal level intervention in a study of pre-school children. The other was the evaluation of three targeted level interventions in a study of primary school children.

Julie Dockrell, Professor of Psychology and Special Needs, Institute of Education, University of London, told us in her oral evidence about the systematic evaluation of a universal level intervention called 'Talking Time' in a study of pre-school children in Tower Hamlets. The area had been chosen because of its very high proportions of socially disadvantaged children and children with English as an additional language (EAL) – groups of children that are at higher risk of SLCN. In initial testing the monolingual children scored poorly and the EAL children scored very poorly in terms of the number of words they could put together in a sentence. Some adult-led activities were producing good language input but many of the children were opting out of these activities to play in the playground.

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[44] Dockrell, J., Ricketts, J. and Lindsay, G. (2012), p. 20.
[45] Dockrell, J., Ricketts, J. and Lindsay, G. (2012), p. 42.
[46] Law, J., Beecham, J. and Lindsay, G. (2012), p. 37.
[47] Law, J., Beecham, J. and Lindsay, G. (2012), p. 4.
[48] Law, J., Lee, W., Roulstone, S., Wren, Y., Zeng, B. and Lindsay, G. (2012), p. 4.
[49] Law, J., Lee, W., Roulstone, S., Wren, Y., Zeng, B. and Lindsay, G. (2012), pp. 17-9.
[50] Law, J., Lee, W., Roulstone, S., Wren, Y., Zeng, B. and Lindsay, G. (2012), p. 26.
[51] Lindsay, G., Dockrell, J., Law, J. and Roulstone, S. (2012), p. 22.
[52] Lindsay, G., Dockrell, J., Law, J. and Roulstone, S. (2012), p. 24-5.

Professor Dockrell reported that the Talking Time intervention targeted three aspects of language: vocabulary, oral narratives and comprehension. School staff were trained to deliver the intervention through professional development and coaching. The improvement in terms of language comprehension, naming vocabulary and sentence repetition among children receiving the intervention was considerably greater than the improvement on these measures among a group of children who had received an alternative intervention called 'interactive bookreading' and far greater than the improvement among children in a comparison group from another nursery. After the intervention it was found through observation that staff had found more ways of talking to the children throughout the day in all the other activities. The staff themselves considered that their pupils had language skills which were age appropriate.

In the light of this study Professor Dockrell argued that enhancing oral language skills is achievable and that staff should be helped to develop the ability to provide frequent well-tuned positive interactions. They need to understand both the development of children's language and ways to support that development in an educational context.

In her oral evidence Maggie Snowling, Professor of Psychology, University of York, described three randomised controlled trials of targeted level oral language interventions in a study of children in York. She reported that the interventions had been designed to be delivered by trained teaching assistants in mainstream schools and suggested that they could therefore be very cost effective.

In the first intervention the research group screened five year olds in reception class to identify in each school those with the weakest speech and language development and then allocated them either to a programme to boost their phonic skills or to an oral language programme. The oral language programme was a 20-week programme beginning in reception and going through to Christmas of Year 1. The children received daily input with the programme essentially alternating from day to day between individual sessions and small group sessions.   The components of the programme included speaking, listening, vocabulary, telling stories, listening comprehension and asking questions. The programme was found to be effective in improving the children's expressive language skills, especially vocabulary and grammar.

In the second intervention the research group selected children in nursery school with poor speech and language development and then randomly allocated them either to receive a 30-week oral language programme delivered by trained teaching assistants or to a waiting control group who had no intervention until the end of 30 weeks. The first 10 weeks of the programme were in nursery school where the children received three 15-minute group sessions each week. When the children went into reception class, the group sessions were lengthened to 30 minutes and there were also two 15-minute individual sessions with the child. This format continued in the second term of reception class. In nursery school and in the first 10 weeks of reception class the components were narrative, vocabulary and listening. In the last 10 weeks of the programme the oral language work was supplemented

with work on letters - sound and phonological awareness - to support the children's development of what might be called 'alphabetic skills' or the 'phonic principles'. After 30 weeks the children had made very good progress in language and had achieved significant improvements in their listening comprehension, vocabulary, expressive grammar and spoken narrative. They had also improved in their letter knowledge and some of their phonological awareness.

The third intervention Professor Snowling described to us was an intervention used with children she called 'poor comprehenders'- children who read very well but have difficulty in comprehending what they have read and are found to have had earlier problems with language development. The research team identified these children following a screening of 1,000 children and randomly allocated them to receive one of three interventions: an intervention which directly targeted their reading comprehension, an oral language intervention or a kind of combined programme. The oral language programme was a 20-week programme delivered by teaching assistants in the summer term of year 4 and the autumn term of year 5. The children were given three sessions a week: one individual session and one session with another child. The components were listening comprehension, vocabulary, figurative language and spoken narrative. At the end of 20 weeks all of these poor comprehenders were effectively improving in tests on comprehension compared with those who were on a waiting list control group. The most impressive findings came a year later, however, when the group which had had the oral language intervention had continued to improve and had pulled ahead of the other two groups. Professor Snowling suggested these findings were important because they suggested that for children who have slipped through the net there was still a possibility of intervening to very good effect and with long lasting effects.

Professor Snowling concluded that there was robust evidence that language intervention delivered by trained teaching assistants could work and that such intervention should be delivered within an overall programme of continual monitoring. Another conclusion we might draw from the second intervention she described to us is that interventions that combine oral language and literacy components can be effective early in primary school.

The BCRP 'What Works' study points out that individual programmes for children with SLCN do not function in isolation and should fit together into a coherent evidence-based model of service delivery. It illustrates how this might be achieved with a case study.

Talk of the Town is described as "an integrated, community led approach to supporting speech, language and communication in children from 0-18 years, which focuses on a small community in Wythenshaw, South Manchester".[53] It was piloted as one of the three strategic programmes of 'Hello, the national year of communication'[54], which was delivered by The Communication Trust in partnership with Jean Gross, the government appointed Communication Champion[55], and therefore also illustrates the potential role of the voluntary sector in bringing together

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[53] Law, J., Lee, W., Roulstone, S., Wren, Y., Zeng, B. and Lindsay, G. (2012), p. 20.
[54] The Communication Trust (2013), p. 9.
[55] The Communication Trust (2013), p. 28.

different agencies and professional groups. A range of interventions with a solid evidence base have been implemented including interventions at the universal, targeted and specialist levels.[56]

A crucial element in Talk of the Town is workforce development. This includes supporting school staff to develop knowledge and skills, giving specific training around particular programmes and enhancing the work being done already. It has taken place in whole school training days, staff meetings and coaching and mentoring approaches with specialists. Some staff have been supported to complete a national qualification.[57]

The area has a history of social and economic problems. Initial standardised language assessments of children entering two primary schools in the area at nursery age found that a quarter of the children were at a level that would qualify them for a statement of SEN in many areas and that half of the children were at a level that in other areas would lead to them being deemed in need of extra support.[58]

The outcomes reported from the project include substantial increases in standardised scores on a range of language tests after just one year, improved language levels across both nurseries - with a 15% increase in children not scoring below the expected levels - and improvement of both schools in relation to Ofsted inspections.[59]

One consideration with regard to intervention relates to the issue discussed in the introduction to this report about the role of the neighbourhood in which the child is growing up. In an article submitted to the inquiry Dr Janet Lees, University of Sheffield, drawing on her experience of working in a Sure Start programme in a multiethnic area in Sheffield, maintains that local communities, including faith communities, can play a positive role in supporting and developing the knowledge of parents.[60] The experience of Sure Start has demonstrated that formal evaluation of such projects can be challenging but it is important to acknowledge that language (like many other aspects of cognition) does not develop exclusively within the child's head and the extended family and wider community may have an important role to play. Providing access to that wider community can be a real challenge. The importance of its role is also reflected in the written evidence to the inquiry from Jane Young, speech and language therapy service lead for Nottinghamshire children's centres, about the evaluation of Nottinghamshire's Home Talk service, an intervention to promote language development in the home which has access to "different child and family services" as one of its four types of targets.

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[56] Law, J., Lee, W., Roulstone, S., Wren, Y., Zeng, B. and Lindsay, G. (2012), pp. 24-5. The universal interventions include the "Talking Time" nursery intervention described to us in Professor Dockrell's oral evidence.
[57] Law, J., Lee, W., Roulstone, S., Wren, Y., Zeng, B. and Lindsay, G. (2012), p. 25.
[58] The Communication Trust, written evidence to the inquiry.
[59] The Communication Trust (2013) p. 5.
[60] Lees, J., Stackhouse, J. and Grant, G. (2009).

An implication that might be drawn from the evidence presented in this section is that universal interventions, especially when they form part of a coherent evidence-based model of service delivery, can be both effective and cost effective. More resources need to be directed towards evaluating them – only five of the interventions identified in the BCRP 'What Works' study is at universal level – and to assessing the costs of interventions at different levels. It seems likely, however, that expenditure on providing practitioners with the professional development and coaching that would enable them to deliver improved universal provision, especially in socially disadvantaged areas, would be money very well spent.

4. Developing collaborative working

The professionals involved in meeting the needs of children with communication difficulties linked to social disadvantage include teachers, teaching assistants, early years practitioners, speech and language therapists, health visitors, GPs, paediatricians and social workers. This makes commissioning services for these children a complicated process. Disputes over responsibility can easily arise, for example between education and health services in relation to speech and language therapy. Parents and practitioners are sometimes unclear about who should be providing what. Joint commissioning by and effective collaboration between education, health and social care services is therefore of paramount importance for these children.[61]

There are a number of issues raised in the BCRP that relate to equity of access to services for children with communication needs and are unlikely to be addressed properly without joint commissioning and effective collaboration. These include variations in practices relating to the identification of SLCN and an apparent variation in the levels of support provided for children who are in different SEN categories but have similar needs.

One BCRP study suggests that children in schools with a higher proportion of pupils entitled to free school meals are less likely to be identified as having SLCN than children with similar characteristics and prior attainment in other schools.[62] This variation between schools is likely both to conceal and to exacerbate the impact of social disadvantage.

Another BCRP study highlights the variation between local authorities in the extent of the ethnic disproportionality among pupils identified as having SLCN. There is substantial overrepresentation of Bangladeshi, Black African, Black Caribbean, Black Other and Chinese pupils relative to White British pupils.[63] The overrepresentation of Black Caribbean and Chinese pupils remains even after social deprivation, gender and age have been taken into account.[64] In relation to the disproportional representation of Black pupils there is substantial variation between local authorities. Black pupils are substantially underrepresented in 36 local authorities and substantially overrepresented in 56 local authorities.[65] The BCRP advises local authorities to monitor ethnic disproportionality in the identification of SEN and, where it is particularly high, to investigate local practices.[66]

The BCRP also discusses the possibility that resources are being allocated on the basis of diagnostic categories rather than needs. The issue arises in relation to a BCRP study comparing children with Language Impairment and children with Autism

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[61] Lindsay, G., Dockrell, J., Law, J. and Roulstone, S. (2012), p. 28.
[62] Meschi, E., Vignoles, A. and Lindsay, G. (2010), pp. 37-8.
[63] Strand, S. and Lindsay, G. (2012), pp. 23-4.
[64] Strand, S. and Lindsay, G. (2012), p. 27 and p. 29.
[65] Strand, S. and Lindsay, G. (2012), pp. 41-2.
[66] Strand, S. and Lindsay, G. (2012), p. 43.

Spectrum Disorder (ASD) in which the former appeared to receive lower levels of support and resources despite having higher levels of needs.[67] Any excessive reliance on diagnostic categories in the allocation of resources is likely also to be detrimental to children whose communication difficulties are linked to social disadvantage rather than to a specific condition.

In the light of the need for collaborative working in the delivery of services for children with SLCN we would like to highlight two very encouraging examples of collaboration at local level that we heard about in our oral evidence session on that topic. One relates to early years provision in Stoke-on-Trent. The other relates to provision for children of secondary school age in Walsall. In each case two or three practitioners from different service backgrounds appeared together at the session and reflected their collaboration in the manner in which they contributed to our inquiry.

Janet Cooper, Early Language and Communication Programme Manager, Stoke on Trent City Council, and Team Leader for Community Paediatric Speech and Language Therapy, Staffordshire and Stoke on Trent Partnership NHS Trust, and Gill Latos, Lead for Early Years, Stoke on Trent City Council, told us about the Stoke Speaks Out programme.

Ms Cooper explained that Stoke on Trent is one of the 16 most deprived areas in the country. The extra funding provided through Sure Start provided an opportunity to study the needs of local populations of children. The findings highlighted a huge deficit in speech and language skills – around 64% of children tested exhibited delay in language skills on entry to nursery.

Ms Cooper illustrated how a multi-agency approach to tackling this problem has been adopted. All developments have been through multi-agency discussion and scrutiny so that the problem has been 'owned' by everyone. Training about communication needs has been provided for everyone involved with children. Over five thousand people have been trained in the last eight years including people from the fire service and the police service. Parents are crucial in view of the link between emotional attachments and child development. The aim is for everyone to take responsibility for their part in nurturing children's development. A multi-agency tool called a 'staged pathway' has been produced to help people to identify and to respond to problems in children's development and a standard form for referral to speech and language therapy has been introduced. The figure for delays has fallen from 64% in 2004 to 42% in 2010.[68]

Ms Latos told us about the improvements in the quality of local settings and about the Stoke Speaks Out Level Four award in which settings are accredited as being places of great communication.   She also indicated that, as successes in raising attainment at the end of the early years are not being reflected in children's reading at the end of Key Stage 1, the possibility of developing a model of delivery around reading that fits in with Stoke Speaks Out was being considered.

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[67] Dockrell, J., Ricketts, J. and Lindsay, G. (2012), p. 41.
[68] The two figures differ in that the first one did not include children with English as an additional language. The second one would be 39% without them.

Margaret Wiredu, Advisory Support Team Manager, Walsall Children's Services – Serco, Linda Bromwich, Head of Speech and Language Therapy, Walsall Healthcare NHS Trust, and Pam Boyden, Senior Assistant Speech and Language Therapist, Walsall Healthcare NHS Trust, told us about the Walsall SLCN pathfinder project.

Ms Wiredu provided an outline of the project. It aimed to assess the needs of young people entering secondary school – including those not classified as having SEN, to develop a range of tools to support the identification of SLCN that can be used by all practitioners, to understand workforce needs, to acquire better knowledge of the views of young people and their families and to make a sustainable difference through informed and co-ordinated commissioning of services. Each setting identified a cohort of young people and a process for screening them. A key finding was that 57% of the total sample in mainstream settings had difficulties in the area of language comprehension.

Ms Bromwich explained how in phase two of the project engagement with teachers has increased school awareness of SLCN. A two-tiered training programme has been developed involving a general broad awareness programme and a more specialist programme for SEN departments. Links have been developed with looked-after children and youth offending teams. A resource loan bank has been developed that enables schools to try things out without buying them.

Ms Bromwich reported on progress to date. This has included a reduction in referrals to speech and language therapy for 11-19 year olds from 11% to 8.2%, the engagement of 12 schools in the programme and the training of 189 professionals in supporting children with SLCN. In one cohort 37% of pupils reported improvements in making friends, 33% in joining in classroom activities, 56% in volunteering to help, 41% in using the school canteen and 48% in asking for help.

Our oral evidence session on policy and practice in SLCN provision focused more specifically on the degree of collaboration between professionals in the identification of children with communication difficulties during the pre-school years. Health visitors have a key role here, especially for children from socially disadvantaged backgrounds, in view of their contacts with children and parents. Health visitors need to be effective in making their own judgements about children's language development and in making sure that the right children are referred to other services such as speech and language therapy. Otherwise, there is a danger that the allocation of services could be skewed by the differing expectations of parents from different social backgrounds. The training and support that health visitors receive is therefore of crucial importance.

Mary Rafferty, Service Development and Improvement Nurse, Public Health Agency, Northern Ireland, and Jane McConn, Clinical Co-ordinator for Community Speech and Language Therapy Service, Lisburn Health Centre, County Antrim, Northern Ireland, told us about the speech and language therapy information and referral guidance for health visitors in Northern Ireland that speech and language therapists

have taken the lead in producing.[69] Ms McConn was one of the authors of the guidance.

Ms Rafferty referred to the introduction of the Northern Ireland child health programme, Healthy Child, Healthy Future, in 2010.[70] The programme is a universal service which requires a number of set contacts to be made with each family to identify health need.[71] She indicated that it was now supported by the speech and language therapy information and referral guidance. The guidance was for all health professionals but was specifically targeted towards health visitors. Health visitors use the guidance and, if they are not certain about something, seek advice from their speech and language therapy colleague on whether referral is appropriate. Where referral is not appropriate the document can be used to get appropriate health promotion advice to parents. She said health visitors had been very welcoming of the document.

In response to questioning about the impact of the new system Ms McConn said that the rates of referral into her service had gone up significantly among children in the two to two and a half year age range following the introduction of a new universal contact at that age. She would be looking at whether the referrals were in the service for one or two contacts or whether there were significant needs and onward referrals to other services.

Ms McConn also provided further information on the information and referral guidance. She explained that it contains 13 stages going from 3 months to five years. For each stage the document outlines normal development, causes for concern and management options. The last of the management options each time is speech and language therapy as other options may be more appropriate. The document is a guidance document to enhance the skills of heath visitors rather than a screening tool. Health visitors are trained on the use of it before they enter clinical practice. In her trust early years practitioners have been trained on the use of pre-referral information from the document and on the identification of speech, language and communication problems.

Professor Viv Bennett, Director of Nursing, Department of Health, and the Government's Principal Advisor on Public Health Nursing, provided us with extensive material on developments in the Healthy Child Programme in England. A key aim of the programme is to identify early SLCN and to provide early help and support to children and their parents.

In the course of her oral evidence Professor Bennett referred to two government policies that are of particular significance for our inquiry. One is the commitment to providing an extra 4,200 health visitors by 2015 – a 50% increase. We note that this commitment makes it all the more important for the government to work with health visitors and other relevant professionals, especially speech and language therapists, to ensure that health visitors are properly trained in relation to SLCN. The other is the ambition to bring the Healthy Child Programme review at the age of two to two–

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[69] Public Health Agency (2011).
[70] Department of Health, Social Services and Public Safety (2010).
[71] Department of Health, Social Services and Public Safety (2010), p. 7.

and-a-half together with the written summary at the age of two in the new Early Years Foundation Stage (EYFS) in a single integrated review from 2015. We note that this ambition reflects a recommendation in Clare Tickell's review of the EYFS.[72] We welcome the fact that the government has already implemented the recommendation in the Tickell review that communication and language should be one of the three prime areas of learning in the EYFS.[73].

In response to questioning Professor Bennett addressed the issue of whether the standardisation of health visitor referral practice described by the witnesses from Northern Ireland was possible in England. She argued that it was not because of the size of the country and the variations in the way services are delivered. For example, in one area a health visitor might specialise in work on early attachment that in another area would require a referral. Similarly, in one area a children's centre might be set up to provide speech and language therapy input that in another area would require a specific referral to speech and language therapy. She thought that the country was "just too big" and that there were "too many possibilities" for referrals to be standardised.

Professor Bennett did draw our attention to a number of new 'pathways' that have been produced as part of the health visiting and school nursing programmes. These pathways essentially constitute guidance for professionals in delivering services. They include guidance for health visitors and midwives on pregnancy and the early weeks, guidance for heath visitors and school nurses on supporting children and families from age 2 until settled into school and guidance for school nurses and youth justice workers on supporting children at risk of entering the criminal justice system. The guidance does not focus specifically on children with SLCN but systematic implementation of it would undoubtedly be beneficial to socially disadvantaged children.

We therefore strongly welcome this new guidance but note that it does not remove the need for guidance that is related more specifically to the children that are the focus of our inquiry and that is applicable to the work of the other professionals who deal with these children on a day to day basis (including teachers, teaching assistants, early years practitioners and speech and language therapists). Such guidance would need to be based on a coherent approach to monitoring and responding to the signals of child development. One possibility is that health and wellbeing boards could be given the task of developing such an approach so that they can then provide integrated interagency guidance at local level.

One particularly welcome initiative is the integrated mentorship and training programme for health visitors and speech and language therapists in Leicestershire Partnership NHS Trust that is being supported by the Department of Health as part of its Health Visitor Implementation Plan. If successful, this programme could be copied elsewhere. The focus of the initial stage of the project is on interagency working between health visiting and speech and language therapy. Health visitors and speech and language therapists are being trained to provide mentoring for one

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[72] Tickell C. (2011), p. 57.
[73] Tickell C. (2011), p. 21.

another. A pilot will be undertaken of joint mentorship with health visiting and speech and language therapy students. There will also be refresher training for health visitor teams on effective language development and the importance of social interaction.

In his written evidence to the inquiry Dr Mitch Blair, Reader in Paediatrics and Child Public Health, Imperial College London, suggested that the Healthy Child Programme e-learning curriculum in the e-Learning for Healthcare (eLfH) programme, which includes a module on speech, language and communication needs developed by speech and language therapy experts and endorsed by the Royal College of Speech and Language Therapists, has the potential to support practitioners with high quality sessions of self-directed e-learning. He thought it should be made more widely available and that its content should be commissioned as part of training courses.

In our oral evidence session on practice and policy in SLCN provision we also heard from Dr Fawzia Rahman, Consultant Paediatrician, Community Child Health, Derbyshire Healthcare NHS Foundation Trust, and Convenor, British Association for Community Child Health. She explained that the role of community paediatricians is to assess children referred by colleagues in primary care, health visitors and school nurses, speech and language therapists and general practitioners for a variety of developmental problems. In relation to the problem that SLCN poses for health professionals she pointed out that, unlike with deafness, there is no reliable screening test for it and that it is associated with other learning problems and with deprivation.

Dr Rahman argued that there is no proper commissioning of child health. She said that paediatricians have become separated from health visitors, school nurses and speech and language therapists by reorganisations and that their input into the Healthy Child Programme has vastly diminished as they concentrate on specialised caseloads. She said that there are very few child health surveillance coordinators left.

Dr Rahman also spoke of other problems. She suggested that new systems are discouraging multiprofessional working. One example she cited is managers preventing their staff from talking to other professionals because their service will not get paid for it. She also referred to the higher risk of non-attendance at appointments for socially deprived children. Methods of bringing the numbers down can exclude people automatically (for example where families without credit on their mobile phones have to ring in to confirm the appointment). She was concerned that an emphasis on shorter appointments makes it difficult to complete assessments and that an emphasis on parent-led contact is problematic because of parents' lack of awareness of the signs of language problems. She also suggested that local authorities do not have enough data on the number of children with SLCN and that the NHS does not have enough data on the number of people who attend outpatient appointments but are not actually admitted.

Professor Bennett did not think the problems with children's commissioning would be solved by structural change but suggested that the way to develop it properly was by

making sure that the needs of children were prominent on the agenda of health and wellbeing boards.

One other point we need to emphasise in this section is the importance of collaboration with parents and families and with the children and young people themselves. Any intervention is much more likely to work if it involves all concerned, whether they are the parents of the child at two and a half years identified as experiencing delayed language development or the teenager in a young offender institution. We did not receive evidence directly from parents or from children and young people but their perspectives were covered to some extent by the BCRP.[74] Children and young people with SLCN reported when interviewed that they had felt vulnerable in terms of social acceptance and emotional well-being.[75] Parents' reports indicated that there was considerable variability as to when SLCN was identified[76] and in terms of the way it was managed[77]. They often stressed the importance of working closely with different professionals to have the needs of their children met.[78] More information is needed about the perspective of the more 'hard to reach' parents who would not necessarily have volunteered for this type of consultation.

In this section we have reported some very promising examples of good collaborative practice. The challenge for policy makers is to make sure that this kind of practice is evidence-based and sustainable and that good collaborative practice becomes common practice. A key vehicle for doing this will be the health and wellbeing boards. We note that the duty of local authorities and clinical commissioning groups to make joint commissioning arrangements that has been included in the Children and Families Bill can be fulfilled by making use of the joint strategic needs assessments and joint health and wellbeing strategies that are to be developed by the health and wellbeing boards.[79] We hope the government will encourage local commissioners to fulfil the duty in this way.

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[74] Lindsay, G., Dockrell, J., Law, J. and Roulstone, S. (2011), pp. 103-6, and Roulstone, S. and Lindsay, G. (2012).
[75] Roulstone, S. and Lindsay, G. (2012), pp. 9-14.
[76] Roulstone, S. and Lindsay, G. (2012), p. 27.
[77] Roulstone, S. and Lindsay, G. (2012), p. 21.
[78] Dockrell, J., Ricketts, J., Palikara, O., Charman, T. and Lindsay, G. (2012), p. 129.
[79] The Stationary Office (2013), p. 36 (explanatory note 172).

5. Conclusions

The evidence received by our inquiry and the findings of the BCRP demonstrate the crucial importance for socially disadvantaged children of home and school environments that effectively promote the development of oral language.

In the light of this evidence we recommend that there should be a comprehensive programme of initial and post qualification training for all relevant practitioners in relation to children's communication needs, that systems for monitoring and responding to the development of children's communication skills over time should be improved and that services should be driven by the nature and severity of children's needs rather than by diagnostic categories, differences in parental expectations or variations in practices relating to the identification of SLCN. We also recommend some targeted additional support to improve the communication environments for children living in socially deprived areas.

In the context of the Children and Families Bill we recommend that there should be a national framework for local authorities' local offers which ensures that they cover education, health and social care services for all children with SLCN and reflect the other recommendations in this report.

We list below some other specific conclusions and recommendations that arise from the evidence that has been set out in previous sections of our report.

The long term impact of SLCN

SLCN has a knock-on effect on school readiness, literacy and school performance generally. It also puts children at risk of a wide range of long term consequences in terms of literacy, mental health and employment.

Teachers' assessments of children's development at age 5 based on ongoing observation rather than formal tests can be used to identify children at risk of later educational difficulties. However, additional checks should be made at regular intervals to make sure children do not fall through the net.

There is an association between social disadvantage and the likelihood of a child falling below national expectations in the EYFSP or at the end of Key Stage 1. There is also a very strong association between children's early language development and their performance at school entry. In the light of these associations we recommend that children from the most disadvantaged backgrounds should receive additional support in the early years to ensure they have a secure foundation for language and literacy development.

Provision for pupils with SLCN should reflect their likely need for support to develop peer relationships and prosocial skills and their increased risk of emotional problems. Monitoring of these pupils should reflect these domains as well as language and attainment. Children referred either to child and adolescent mental health services or to speech and language therapy services should have both their language and

their behaviour properly assessed. We note the need for more speech and language therapists working in mental health teams.

In the light of new evidence from a population-based study that social communication or 'pragmatics' mediates (i.e. reduces) the effect of social disadvantage on adolescent behaviour we conclude that there may be a causal relationship between social communication and behaviour and that targeting social communication could reduce teenage behavioural problems. We recommend a focus on social communication in the later years of primary school and not just earlier on in order to improve teenage behaviour.

The emerging evidence base for interventions

The BCRP focuses on the importance in educational contexts of providing oral language environments that foster good communication skills and stresses that all school staff should be able to make good use of the interaction techniques that have been shown to develop oral language. It also advocates regular monitoring of children's language development over time.

We accept that communication difficulties among socially disadvantaged children can be prevented or mitigated by good oral language learning environments but that children's responses to these environments should be regularly monitored by practitioners so that, when additional support is needed, it can be provided in an appropriate and timely way.

We also agree that interventions for children with SLCN that are adopted at service level should be underpinned by evidence of their effectiveness and that, since individual programmes do not function in isolation, they should fit together into a coherent evidence-based model of service delivery. We note, however, that interventions for which the evidence is not yet especially strong may still be effective.

In the light of the evidence we have received for the effectiveness of universal interventions we strongly recommend that all relevant practitioners should be given the professional development and coaching that will enable them to deliver improved universal provision, especially in socially disadvantaged areas.

Developing collaborative working

Joint commissioning by and effective collaboration between education, health and social care services is of paramount importance for children with communication difficulties linked to social disadvantage.

We are concerned by the issues raised in the BCRP relating to equity of access to services for children with communication needs including variations in practices relating to the identification of SLCN and an apparent variation in the levels of support provided for children who are in different SEN categories but have similar needs. Local authorities should monitor ethnic disproportionality in the identification of SEN and, where it is particularly high, investigate local practices.

The commitment to providing an extra 4,200 health visitors by 2015 makes it all the more important for the government to work with health visitors and other relevant professionals, especially speech and language therapists, to ensure that health visitors are properly trained in relation to SLCN. We recommend that the integrated mentorship and training programme for health visitors and speech and language therapists in Leicestershire Partnership NHS Trust should, if successful, be copied elsewhere. We also recommend that the Healthy Child Programme e-learning curriculum in the e-Learning for Healthcare (eLfH) programme, which includes a module on speech, language and communication needs, should be made more widely available and that its content should be commissioned as part of training courses.

We welcome the government's ambition to bring the Healthy Child Programme review at the age of two to two–and-a-half together with the written summary at the age of two in the new Early Years Foundation Stage (EYFS) in a single integrated review from 2015. We also welcome the fact that the government has made communication and language one of the three prime areas of learning in the EYFS.

We recommend that health and wellbeing boards should be given the task of developing a coherent approach to monitoring and responding to the signals of child development so that they can then provide integrated interagency guidance at local level. We hope that the government will encourage local authorities and clinical commissioning groups to fulfil the duty to make joint commissioning arrangements that has been included in the Children and Families Bill by making use of the joint strategic needs assessments and joint health and wellbeing strategies that are to be developed by the health and wellbeing boards.

Annex A: Oral evidence sessions

Session 1: Practice and policy in SLCN provision

Tuesday 26 June 2012, 3-5pm, Committee Room 7, House of Commons

<u>Witnesses</u>

- Mary Rafferty, Service Development and Improvement Nurse, Public Health Agency, Northern Ireland, and Jane McConn, Clinical Co-ordinator for Community Speech and Language Therapy Service, Lisburn Health Centre, County Antrim, Northern Ireland

- Professor Viv Bennett, Director of Nursing, Department of Health, and the Government's Principal Advisor on Public Health Nursing

- Dr Fawzia Rahman, Consultant Paediatrician, Community Child Health, Derbyshire Healthcare NHS Foundation Trust, and Convenor, British Association for Community Child Health

Session 2: Demonstrating collaborative working in SLCN provision

Wednesday 27 June 2012, 3-5pm, Committee Room 4A, House of Lords

<u>Witnesses</u>

- From Stoke on Trent: Janet Cooper, Early Language and Communication Programme Manager, Stoke on Trent City Council, and Team Leader for Community Paediatric Speech and Language Therapy, Staffordshire and Stoke on Trent Partnership NHS Trust; Gill Latos, Lead for Early Years, Stoke on Trent City Council

- From Walsall: Linda Bromwich, Head of Speech and Language Therapy, Walsall Healthcare NHS Trust; Margaret Wiredu, Advisory Support Team Manager, Walsall Children's Services – Serco; Pam Boyden, Senior Assistant Speech and Language Therapist, Walsall Healthcare NHS Trust

Session 3: The emerging evidence base for interventions

Tuesday 3 July 2012, 3-5pm, Committee Room 7, House of Commons

<u>Witnesses</u>

- Professor Maggie Snowling, Professor of Psychology, University of York

- Julie Dockrell, Professor of Psychology and Special Needs, Institute of Education, University of London

- Jon Brown, Head of Strategy & Development (sexual abuse), NSPCC

Session 4: The long term impact of SLCN

Tuesday 10 July 2012, 3-5pm, Committee Room 13, House of Commons

<u>Witnesses</u>

- James Law, Professor of Speech and Language Sciences, University of Newcastle

- Leon Feinstein, Associate Professor, Centre for the Analysis of Social Exclusion, LSE

- Professor Karen Bryan, Head of the School of Health and Social Care, University of Surrey[80]

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[80] Professor Bryan has left this post since the oral evidence session and is now Pro Vice-Chancellor, Faculty of Health and Wellbeing, Sheffield Hallam University.

Annex B: Written evidence

Written evidence was received from the following organisations.

- The Better Communication Research Programme

- The Communication Trust

Written evidence was received from the following individuals.

- Professor Dorothy Bishop, Professor of Developmental Neuropsychology, University of Oxford

- Dr Mitch Blair, Reader in Paediatrics and Child Public Health, Imperial College London

- Dr Claudine Bowyer-Crane, Sheffield Hallam University, and Dr Silke Fricke, University of Sheffield

- Dr Judy Clegg, Senior Lecturer, Human Communication Sciences, University of Sheffield

- Jean Gross, former Communication Champion

- Dr Janet Lees, University of Sheffield

- Jane Young, speech and language therapy service lead for Nottinghamshire children's centres

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