

## **Speech and Language Therapy in a Child Development Service**

Mine is a community service in London. My Trust throws around the word 'quality' a great deal, but is extremely focused on cutting costs without considering the consequences. My own service probably remains better than comparable services in many other organisations.

I work as a speech and language therapist with pre-school children with complex disabilities. In the last decade, I have seen services beginning to be transformed – and now, going sharply backwards.

### **History**

When I began working in 'special needs', we saw three or more children per session (half a day). We saw them in clinic. We did not make visits to children's homes or nurseries. We had minimal time for liaison with other professionals working with these children. We rarely ran training for nursery teachers, health visitors or even parents, because these initiatives detracted from the drive for face to face contacts. An appointment would be of 45 to 60 minutes duration, and within this we planned and prepared a session, worked with the child, tidied up the room, wrote up notes etc. We relied very heavily on standard therapy approaches and activities because these enabled us to cut down sharply on preparation time and to measure outcomes relatively easily. Therapists were colloquially known as 'the bubble lady', because a pot of bubbles was a good all-purpose tool for grabbing a child's attention.

It was often a sterile approach to therapy. We put children in our 'boxes', and we told parents 'This is what we offer to children with Down Syndrome/autism/cerebral palsy'. We met our targets, because we saw a great many children. We achieved outcomes, which might be that the child would take turns in a pre-determined activity, or sit down for a few seconds, or make eye contact on a set number of occasions. Sometimes these gains would generalise, but very, very frequently they would not. Yes, you can train a child to vocalise to request that you blow bubbles for him as he sits in a distraction-free clinic room once a week. Will this enable him to ask for cornflakes for breakfast? Or tell his Mum his tummy hurts? Or ask another child to play when he goes to nursery? Usually not. The needs of parents were simply glossed over. Not our job.

### **The Beginning of a Transformation**

The changes that began a decade ago were in the first instance philosophical. A series of government policies recognised that children have rights, and that every single child – from any background, and irrespective of their ability or disability – has the right to reach his or her potential. This was not just about 'political speak' and sound bites. The fine words were accompanied by changing expectations of the services offered to children and their families.

For disabled children, the demands put on service providers were far-reaching. It may be worth saying that I am not a Labour Party member, and disagreed with a great deal of what the last government did. On the rights of children with disabilities, however, the last government pretty much got it right. I have no idea if this came from politicians or from a bright civil servant, but a series of official initiatives were very good indeed. 'Every Child Matters' began to set the scene for children in 2003. This was followed with more detailed guidance around the rights of disabled children: 'Together from the Start' (2003), the 'NSF for Disabled Children' (2004), and 'Aiming High for Disabled Children' (2007). ('Aiming High' got a bit side-tracked with nonsense around diverse markets and personal budgets, but a great deal of the content remained valuable).

These policy documents contained at their core a positive view of disabled children. These children were viewed as having intrinsic worth, and as making a positive and valuable contribution to our wider communities. It was spelled out that tolerance and an understanding of diversity are a necessary part of our society. All children with disabilities were seen as having the right to meet their potential. This alone was a huge step forward. Until 1973, many disabled children were

officially 'ineducable'. Progress had been slow. The new policy initiatives were a brave and principled attempt to transform the experiences of disabled children and their families.

Importantly, the philosophical change was backed up by concrete demands.

*So what were we meant to do?*

- There was an expectation that early assessment and intervention would be offered.
- There was a demand for integration: not just joined up care within the NHS, but integration across agencies. Health, education and social services were expected to work together.
- The needs of families were recognised: the risks of family breakdown, of poverty, of a need for emotional support, respite care, short breaks etc.
- Services were to be individualised: designed around the specific needs of that unique combination of the child and his/her parents or carers.
- Services were to be accessible, and offered in naturally occurring environments (e.g. at home or in nurseries or Children's Centres).
- Families were to be offered access to universal services as well as specialist support; inclusion that didn't mean taking away access to high quality specialist inclusion.
- Enough money was put into the NHS to make some of this stuff achievable.

*And what happened?*

For senior clinicians like myself, this was exciting and liberating. In the two Trusts I've worked in over the last decade, we pushed for and won a significant increase in staffing levels.

We were able to re-design services based on need. We could work with parents meaningfully by visiting a child's home, and looking at patterns of social interaction and communication at home, and agreeing with parents the goals that were most relevant to them. We could visit nurseries, and go with the enthusiasm and commitment of the best staff, and chip away at the recalcitrance of the worst. We could achieve real and meaningful change for children because we could begin to change the environments in which they spent their lives.

Our relationships with parents were very different. Our role became one of supporting and guiding parents in accessing the services that met their needs and their child's needs at that point in time. The 'this is what we offer, take it or leave it' style began to be overcome. It became legitimate to recognise that parents had emotional needs, and for clinicians to work together to offer support. If a parent seemed a bit down, it was possible to ask an open question around 'How are you finding things?', instead of obsessing about counting the occurrences of eye contact made by their child.

Our managers did not always recognise the need for change. We were able to show them the documents and spell out new expectations. We could achieve change by saying 'Look, this is government policy. We have to do this'. Comparable pressures were being put on managers in Education and Social Services. Local policies began to shift.

Integration was one of the most important things to achieve – but also one of the hardest. These are children who see the paediatrician and the neurologist and the ophthalmologist and the audiologist and the orthotics specialist and the physio and the OT and the SLT and the visual impairment teacher... For the parents of a child with complex disabilities, it is close to a full time job simply juggling the appointments. Therapists can mess up life by being over-focused on 'their' goals and their homework activities for parents. Advice from different therapists can conflict. Individual therapists can get cross if parents do not 'comply' with the advice they have been given. Parents could find themselves discharged for having the misfortune to be overwhelmed and DNA-ing two appointments in a row.

Again, the clear policy expectations supported us in making change. It was possible to argue for a 'team around the child' approach: for professionals to work very closely together but to drop in and

out as needed, to set joint goals, to spend the time educating one another on how to support one another's goals. We had enough time to liaise with one another, and set up joint training, and run joint groups. A clinical psychologist and an SLT visiting a nursery together is costly – but a great way of looking at how to manage a child's challenging behaviour. An OT and an SLT visiting a child's home and observing a meal time is equally expensive – but that multi-disciplinary assessment and intervention create powerful opportunities for change. We chipped away and chipped away and chipped away. Every little gain made for a better service.

Did we get there? No, but we moved decisively in the right direction. In my team, we had a shared vision of what a gold standard service looked like, and we worked flat out to achieve it. The speech and language therapists in my team were inspired by the work we did. Job satisfaction was through the roof. We were so proud of the difference we made for children and their parents.

### **And now?**

The policy documents are all archived now, when you do an internet search. They've never been formally withdrawn, but no one is bound by them. It is no longer possible to raise the argument 'Well, this is what we're supposed to do' when everyone knows that there are no longer any meaningful standards for the provision of care.

My Trust has been told by commissioners to cut costs by 6% a year, year on year. The transmission belt is via senior management initiatives and our own departmental managers. Frontline clinicians get no say at all.

In my own team, we are back to an expectation of seeing three children per session, six children per day. We are measured by the number of face to face contacts, not by our ability to change people's lives. Liaison doesn't count, because it's not 'face to face'. Policies imposed by our own managers sharply restrict home and nursery visits. The pressure is on to set goals for children that are measurable, rather than meaningful. This means that the needs of parents – a central and essential consideration in working with children with complex needs – get lost. In my team, we tried to quietly subvert the worst changes, but this has become pretty much untenable. We continue to be told regularly that we are too expensive.

Staff cuts in my team have had a significant impact:

	<b>2 years ago</b>	<b>Now</b>
Band 8a SLT Team Lead	1.0 wte (1 staff)	0.5 wte (1 staff)
Band 7 SLT	1.9 wte (3 staff)	1.5 wte (2 staff)
Band 6 SLT	2.6 wte (4 staff)	1.4 wte (2 staff)
Band 5 SLT	0.4 wte (1 staff)	1.4 wte (2 staff)
Band 4 SLT Assistant	1.0 wte (1 staff)	0.2 wte until March
Band 3 Admin Assistant	0.4 wte	Occasional informal

The overall allocation of staff is reduced. The skills and knowledge levels of team members are less. Of our existing allocation, two colleagues will be going on maternity leave within a few months, and cover is unclear. One of the Band 6 therapists is a locum, on a contract renewed monthly. The Band 5 therapists are newly qualified and need a high level of support and structured supervision from more senior staff. Future SLT assistant cover seems unlikely. The lack of admin and assistant support adds substantially to the workload of clinicians. It is a complete myth that support staff can be lost without damaging services. If clinicians are taking phone messages, addressing envelopes and doing

the photocopying, this is time that is unavailable for clinical care. The failure of the Trust to invest in an adequate IT infrastructure adds to the pressure on staff.

Integration is off the agenda. The other agencies we would wish to join up with are facing cuts even more severe than our own. Other services within the NHS are battling with their own cuts, the staff leaving and not being replaced, the drive to achieve targets and so on. Joined up services take time to plan and deliver, and cost money. We don't do that stuff anymore.

Therapists are very stressed now. For a time, staff in my team tried to fill the gaps by working ludicrous amounts of unpaid overtime. It was routine for therapists to be coming into work at 8.00 am and working to 7.00 pm or even later, grabbing a quick sandwich for lunch. We went through a period of therapists being tearful in supervision, or when things went wrong during the day. Relationships in the team have deteriorated from time to time, when therapists have made the mistake of blaming one another for crisis. There is a culture of working through sickness. This has always been there in the NHS, but it's worse than ever. Senior therapists have now tried to set boundaries to protect more junior staff, but have found it very hard to break from the culture of overtime ourselves. Morale is extremely low.

The future will undoubtedly be worse. Other parts of the Trust have been re-organised to get rid of almost all Band 8s and to put in place new teams led by a small number of Band 7s. We know this is coming our way. The future for the Band 8a and Band 7 therapists is an insecure one, and people are very aware of this. For Band 6 staff, their future career prospects are being taken away. Band 5 staff will have nowhere to go. This is London. The message to our Band 5 and 6 staff is that if you want any hope of buying your own home, get out of this job.

We had a few good years. We had a glimpse of what the NHS can accomplish, when you bring together adequate resources and enthusiastic staff who share a vision of what high quality care looks like. That's gone now.

**Gill George, Unite NEC**