Ipswich and East Suffolk
Clinical Commissioning Group

GOVERNING BODY

Agenda Item No.	**10**
Reference No.	**IESCCG 19-04**
Date.	**22 January 2019**

Title	**Speech, Language and Communication**
Lead Chief Officer	Richard Watson, Deputy Accountable Officer and Chief Transformation Officer
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Purpose	For decision

Applicable CCG Clinical Priorities:		
1.	To promote self care	**Y**
2.	To ensure high quality local services where possible	**Y**
3.	To improve the health of those most in need	**Y**
4.	To improve health & educational attainment for children & young people	**Y**
5.	To improve access to mental health services	**Y**
6.	To improve outcomes for patients with diabetes to above national averages	
7.	To improve care for frail elderly individuals	
8.	To allow patients to die with dignity & compassion & to choose their place of death	
9.	To ensure that the CCG operates within agreed budgets	**Y**

Action required by Governing Body:

1. Endorse the proposed integrated model
2. Agree additional funding as part of the uplift within the Suffolk Community Health contract for financial years 2019/20 and 2020/21

1. Introduction

1.1 The ability to establish effective language and communication skills is fundamental to the development of all children and young people. These skills impact on a child or young person's ability to reach their full potential in education and the contribution they can make throughout their childhood and later in adulthood.

1.2 Language and communication skills have a profound effect on the ability to develop social and emotional connections with others which are important factors in emotional and physical health throughout life.

1.3 In a context of increasing mental ill health in children, young people and adults the need to effectively support speech, language and communication skills at an early age cannot be underestimated. Speech, language and communication need to form a key part of the local strategy when creating the conditions for a population of physically and emotionally well people in Suffolk.

1.4 The Suffolk system has recognised the need to develop its approach to supporting the speech, language and communication needs of children and young people and has asked representatives from a broad range of services and parents and carers to develop the response to this challenge.

1.5 This Business Case sets out the current position in Suffolk, introduces evidence drawn from both local and national intelligence and recommends a way forward that seeks an active role for those who support children across education, social care and health.

2. Background

2.1 National research suggests that 10%[1] of all children and young people will have some kind of speech, language or communication need. Of this cohort, 70% are likely to have a low to moderate need that could be effectively supported by universal services, with 30% needing specialist therapy support[2].

2.2 The level of need is understood to be influenced by the demographic of the local area. Suffolk has a patchwork of communities, some of which are high on the index of multiple deprivation with pockets of affluence and high levels of social mobility in other parts of the county.

2.3 Applying a needs-led approach strengthened with well evidenced research to the Suffolk population has enabled the development of a well-informed group of assumptions. These provide an indication to the level of need of children and young people within our population.

2.4 Based on our demographic, the applied assumption in this Business Case is the likely need in Suffolk for speech, language and communication support is 10%. This prevalence assumption has been tested with the demand experienced by our specialist speech, language and communication services.

2.5 Specialist services, parents and carers have raised concerns that there is insufficient capacity in the specialist provision to meet the current need, and for those who are not having their needs met. The negative impact can be significant and enduring. The most vulnerable children and young people that require specialist speech, language

[1] http://www.bercow10yearson.com/

[2] SLCN Activity and Finance Model, v5 2018

and communication support as part of their package of care or support are not always able to access this in a timely way or with sufficient levels of support.

2.6 A relatively small number of children who have the highest level of need can be referred to a specialist provision to address their needs, there are three Speech and Language Units across Suffolk that provide this. However, the units only cater for an average of 45 children per two school years. Whilst the units are able to effectively meet the needs of these children, hundreds of children with a high level of need in mainstream settings do not receive the benefit of specialist education outreach support alongside therapy. The children in the units are only registered for two years (from Year 1) meaning that every child in the unit has two additional schools' transitions. For some children journeys to school from home are considerable.

2.7 The ambition is to be able to use the resources available to effectively support all children with high speech and language needs with a new outreach service which provides support alongside traditional therapy within mainstream education. The schools and the children will receive the expertise and support needed to achieve high levels of attainment.

2.8 Experience and evidence nationally show early identification and intervention is key. The longer children and young people wait for support, the greater the impact and the risk of delayed development is, resulting in lasting impact. There are some compelling examples from elsewhere in the country of where universal services have played an effective role in providing early speech and language support, particularly where there are low to moderate needs, preventing the need for specialist services and reducing the risk of delayed development.

2.9 Despite the context of reducing public resources and competing demands, partners across health and social care have given their commitment to prioritise the support for speech, language and communication. Stakeholders have recognised that it will require a concentrated and whole system effort by many of those services who support children and young people in order to meet the challenge.

2.10 The development of an integrated model for Suffolk aims to draw on the strengths and relationships of the universal offer to meet the needs of children and young people with low and moderate needs and enable those with higher levels of need to be identified early and be referred into specialist services.

2.11 In summary, the model recommended in this Business Case seeks to:

- Equip Health Visitors, Family Support Practitioners, Early Years, providers and mainstream primary schools to play an effective role in assessing need and providing early evidence based interventions and support;
- Resource and develop a robust workforce within the specialist speech, language and communication service which are able to meet the needs of those referred into their service to ensure children and young people reach their stated outcomes;
- Maximise the resources within the council for specialist education support, so that the needs of all children with high levels of need in their education setting are better supported;
- Create a pathway which makes it easier for parents and carers and professionals to navigate and ensures that children and young people have their needs met in a timely manner and with the right support and interventions.

3. Preferred Option Summary

3.1 The preferred option is Option Two.

3.2 This option ensures that:

- The new Speech Language and Communication Needs (SLCN) pathway will be clear, visible and well understood by all health, care and education settings. The pathway will be open, transparent, and easy to navigate by professionals and service users.
- The service will be equitable, consistent, sustainable, and realistic, outcomes focused, evidence based and jointly owned.
- The new model aims to ensure the whole system has the skills and knowledge to identify and support Children and Young People (CYP) with SLCN.
- The pathway is to focus on early identification of SLCN, which would result in a timely, impactful intervention – at every stage.
- The project intends to bring clarity to roles, implementing accountability and shared responsibility.
- The new model will be fully co-produced.
- This project will also address the SLCN element of the SEND reforms and implement the changes with the SEND Code of Practice 0 to 25.

3.3 The new integrated health and care SLCN model commences at birth with Midwives and Health Visitors working together to identify SLCN; including cleft palate, tongue tie and feeding difficulties. The model provides clear pathways for professionals to manage and escalate concerns at this point.

3.4 Throughout a child's early years (birth to 5) the core contacts (1 year and 2 year checks) provided by professionals have been highlighted as key points to assess attainment in SLC, these points sit alongside ongoing assessments made by pre-schools, nursery and health visitors. Clear pathways for identification, intervention and management have been documented. For those children requiring specialist input, routes into Speech and Language Therapists (SLTs) have been identified to ensure health and care work together to provide the best outcomes for the CYP.

3.5 The pathways for both special schools and mainstream schools have been reviewed with an emphasis on the 'screen, intervene, screen' methodology and clear routes into SLT specialist services when required.

3.6 The child's journey when requiring SLC intervention by a Speech and Language Therapist is made explicit in the new model. Referrals will continue to be received by the Care Co-ordination Centre (CCC) and triage will continue to be completed by a Senior SLT.

3.7 The new integrated model requires the initial assessment to be completed within 18 weeks of referral.

3.8 At the assessment the decision will be made regarding the best format for the child to receive therapy based on the presenting clinical need rather than the capacity of the service. This means CYP will receive therapy in the most suitable environment to meet their needs, whether this be in a clinic, a group setting or in a school setting.

3.9 The new integrated model requires the therapy intervention to commence within 12 weeks of the assessment

3.10 For those children receiving therapy in a school environment, both the parent and the school will be informed in advance of the therapy schedule to ensure education can provide a suitable therapy partner. This means not only are health and education working together to provide therapy but the families are kept informed.

3.11 The families of children receiving therapy in a group or clinic setting are invited to attend a parent gateway session in which the therapy expectations are set, consent is discussed, information and guidance is provided, the role of the therapy partner is discussed, and information on clinic and group locations are provided, giving families the ability to select a suitable location for their needs.

3.12 There is no standard therapy package. Each child will have a needs led intervention plan developed based on their individual requirement.

3.13 If a child requires a communication aid the SLT will continue to be able to refer into Suffolk Communications Aids Resource Centre (SCARC) for an assessment, aid or equipment loan and training.

3.14 Once a CYP has completed intervention with the SLT the proposal is for handover from health to care into the Specialist Education Outreach Service (SLCN) to ensure the education setting is equipped to continue to meet the CYPs needs.

3.15 In summary the key changes featured in Option Two are:

- Implementation of 'Screen, Intervene, Screen' methodology in all universal services utilising WellComm for Early Years and Early Help and Speech Link and Language Link in Mainstream Primary Schools. *
- More universal staff trained on Makaton (Makaton is a language programme using signs and symbols to help CYP to communicate).
- More Speech, Language and Communication training provided to Early Years and Early Help staff and settings.
- A clear pathway for GPs to utilise when considering a CYP that has attended a GP appointment and is presenting with a SLCN.
- Removal of SLCN drop in clinics in East and West Suffolk.
- Support for a CYP during key transition points, for example; the transition from Early Years into mainstream school
- Suffolk Communications Aids Resource Centre (SCARC) to deliver a communication aids service for adults with an EHCP up until 25 years of age.
- Phased closure of Speech and Language Units (SLU) (x3) and the establishment and implementation of a Specialist Education Outreach Service (SLCN).
- The development of the Assessment Centre sits outside of the scope for the SLCN review, however the SLCN 'To Be' model demonstrates how children will be identified and managed in the new process.

*Summary of Early Intervention Case Studies (full case studies can be found in Section 6.5.2.1 and 6.5.2.3):

3.16 Speech Link and Language Link[3]

- Wye Forest area: After implementing Speech Link for one school year 78.4% of all children with an identified SLCN no longer needed support.

[3] Speech Link Impact Report 2018

- Derby City: 76 children had their needs met by implementing Speech Link and Language interventions.

WellComm[4]

- South Staffordshire Children's Centre's: after a term and a half of interventions, there was a 13% drop in those screening red, a 12% drop in those screening amber, and a 25% rise in those screening green. Staff with sufficient skills and knowledge to support these children had risen from 13% to 90%.

4. Demand Profile

4.1 80% of all referrals received into the SLT team require intervention and are transferred onto the caseload. West Suffolk Foundation Trust (WSFT) activity data shows the age range of SLT referrals is getting younger; more referrals are being made by Early Years than previous years.

4.2 The current caseload number for WSFT SLT is 3,565 (as of May 2018). Based on the current population this equals a total population prevalence of 9%, split between 74% low need and 26% high need (requiring intervention). Therefore a 10% population prevalence estimation has been used in the new model to include estimated population growth.

4.3 The whole SLT caseload is split between four caseloads as below;

- Community Clinics (36% of total caseload)
- Mainstream Schools (37% of total caseload)
- Special School (16% of the total caseload).
- Pre-school complex (11% of the total caseload)

4.4 All children in Special Schools have an EHCP; these numbers are forecasted to increase by a further 15% by 2020. 244 of the CYP in mainstream school caseload have an EHCP (25%).

4.5 There are currently 1,116 children that require intervention that are not receiving therapy. These can be broken into the caseload as below;

- Community clinics 30% of waiting list
- Mainstream schools 36% of waiting list
- Special school 24% of waiting list
- Pre-school complex 9% of waiting list

4.6 Wait times are exceeding the national standard of 18 weeks, with some children waiting over 12 months for active intervention.

4.7 At present (November 2018) there is currently limited Speech and Language intervention taking place in Special Schools due to SLT capacity issues.

[4] www.gl-assessment.co.uk/news-hub/case-studies/wellcomm-helping-under-5s-talk-to-learn-at-south-staffordshire-children-s-centres/

4.8 There is 46.27 whole time equivalents (WTE) in the SLT team, including 3.39 WTE administration. The clinical caseloads are split as such;[5]

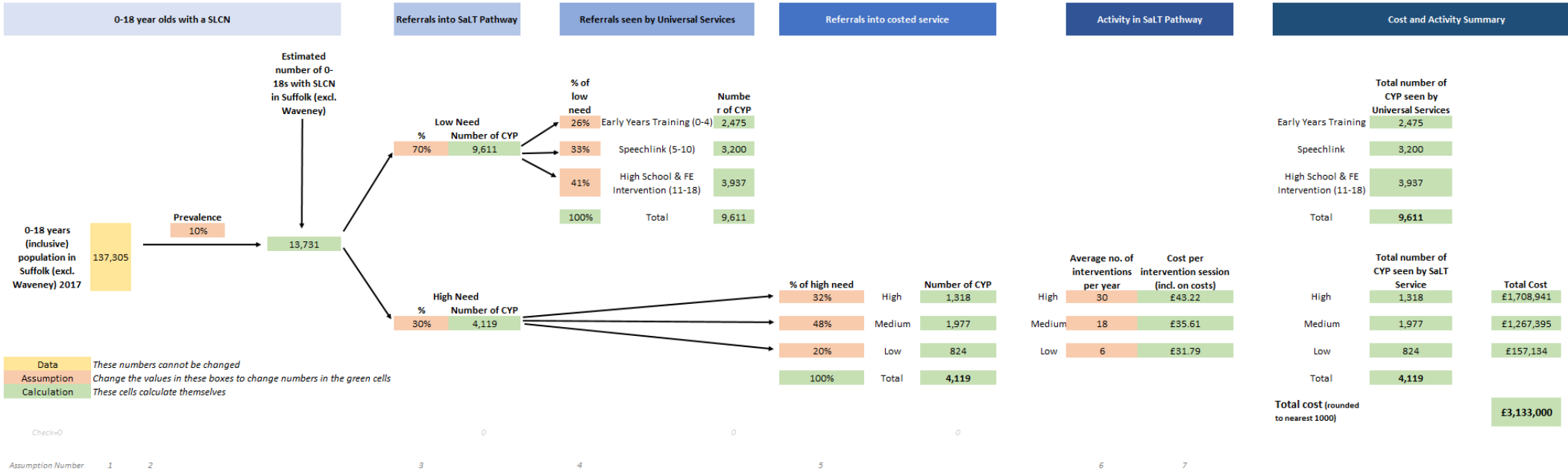
- Community clinics, 38% of workforce (mix of Band 6 and Band 5)
- Mainstream schools, 38% of workforce (majority Band 6)
- Special school, 12% of workforce (majority Band 7)
- Pre-school complex, 11.5% of workforce (majority Band 7)

4.9 There are 5.93 WTE Speech and Language Therapy Assistants which work under supervision of SLTs.

[5] 'As Is' Speech and Language Therapy Supporting Narrative, May 2018

5. Activity and Financial Summary

Estimating the cost and activity of the To Be SaLT Pathway - 10% prevalence



5.1 The recurrent full year costs for the new model are £3,133,000. This case is requesting additional funding to the amount of £1,096,476. The funding will be allocated as per the below breakdown (details are in section 8.2.6.1 to 8.2.6.3):

Service	Fully Implemented new model annual cost to system		Current cost to system		New additional cost to system (being requested via this Business Case)
West Suffolk Foundation Trust, Speech and Language Therapy	£2,630,116	=	£1,628,058	+	£1,002,058
Suffolk Communications Aids Resource Centre	£291,710	=	£197,292	+	£94,418
Speech and Language Units and Specialist Education Outreach Service (SLCN)	£338,937	=	£355,232	+	£0
Total	**£3,260, 763**	**=**	**£2,180,582**	**+**	**£1,096,476**

5.2 It is being requested that the amount awarded is split over two financial years.

Financial Year 19/20: £644,962, of which:

- £94,418 to Suffolk Communications Aids Resource Centre
- £550,544 to West Suffolk Foundation Trust Speech and Language Therapy

Financial Year 20/21: £500,038 of which:

- £500,038 to West Suffolk Foundation Trust Speech and Language Therapy

5.2 In addition, the case requires £6,500 of non-recurrent costs in year one. This will enable SCARC to deliver a communication aids service for adults with an EHCP up until 25 years of age. This would mean an additional 80 young people would be eligible for SCARC services which would include the following:

- Communication aids assessment.
- Management of local care pathway and referral to Specialised ACC Hub if young person meets the criteria.
- Training as required for adults with communication aid loans from the Hub after the initial assessment and training package.
- Review and technical support for priority communication aid users including those receiving equipment from the Hub.

5.3 The transitions costs in this case total £464,495 and cover the dual running of both the Speech and Language Units and the part running of the Specialist Education Outreach Service (SLCN) until July 2020.

6. Timescale

6.1 A full Project Plan has been developed in Microsoft Project and details all tasks and milestones, owners, dates and interdependencies. The below table demonstrates the 'rolled up' project plan.

Task Name	Duration	Start	Finish	% Complete
Speech, Language and Communication Needs Service Redesign	533 days	Tue 30/01/18	Fri 14/02/20	52%
SLCN Steering Group Key Dates	251 days	Tue 30/01/18	Tue 15/01/19	77%
'As Is' Mapping	73 days	Mon 12/02/18	Thu 24/05/18	100%
'To Be' Mapping	201 days	Thu 24/05/18	Fri 01/03/19	76%
Parent and Carer Engagement	38 days	Tue 11/09/18	Thu 01/11/18	83%
Transformation Funding	44 days	Wed 01/08/18	Mon 01/10/18	100%
Business Case	144 days	Mon 13/08/18	Thu 28/02/19	85%
Public Consultation	22 days	Wed 02/01/19	Fri 01/02/19	0%
Implementation	468 days	Wed 29/08/18	Fri 12/06/20	14%

7. Patient and Public Engagement (if appropriate)

7.1 Suffolk Parent and Carer Network are integral to the Steering Group which has co-produced the new integrated model proposed within the business case. Three workshops were held in September 2018 to test and refine the model with parents and carers.

8. Recommendation

8.1 The Governing Body is recommended to:

1) Approve that Option Two is taken forward into full implementation;
2) Agree additional ring-fenced funding within the Suffolk Community Health contract of £330,326 in financial year 2019/20 and £300,022 in financial year 2020/2021