ROYAL COLLEGE OF SPEECH & LANGUAGE THERAPISTS

August 2005 · Issue 640

bulletin

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

Does speech and language therapy really look after vulnerable children?

Celebrating 60 years 1945-2005

ROYAL COLLEGE OF SPEECH & LANGUAGE THERAPISTS

RCSLT Council vacancies

Two positions:

RCSLT England Country Councillor
RCSLT Wales Country Councillor

There are vacancies for these two key positions on the RCSLT Council

The councillors:

- lead the development of appropriate local structures to reflect members' interests;
- set up communication networks to enable information to be efficiently and rapidly distributed;
- meet with regional representatives, at least annually;
- report and advise the RCSLT council on matters concerning the membership in their countries;
- liaise with the chairs of the boards;
- attend four council meetings a year; and
- as a trustee of RCSLT, contribute to its overall strategic direction.

These positions are available from the date of appointment to the 2007 RCSLT annual general meeting.

For an information pack for either of the above positions, contact Bridget Ramsay, email: bridget.ramsay@rcslt.org or tel: 0207 378 3001. The deadline for receipt of applications for both posts is 1 September 2005.

www.rcslt.org

Picture: Getty Images

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COVER STORY:

Does speech and language therapy really look after vulnerable children?

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A terrible day

The morning of the 7 July started just like any other Thursday: one more day to go to the weekend, the usual news stories to write and the usual deadlines to meet.

However, by 10am, it was clear that this was going to be a very different day.

People started drifting into the office from the far corners of London with tales of transport mayhem and it became clear that something terrible was happening on the London Underground.

We listened intently to the radio, for whatever news there was.

At that time, however, information was scarce and often contradictory.

As people rang in to check up on us, it seemed that everyone outside London knew more than we did.

Thankfully, no one in the RCSLT office was seriously affected, although one person had bruises to show for her close call at King's Cross Station.

Our main problem that Thursday, insignificant, I know, in comparison to the fatalities and injuries that occurred, was how we were going to get members of the RCSLT Management Board back to Scotland, Wales and Northern Ireland with no public transport or taxi services.

I'd like to take this opportunity to pass on the thanks of everyone here at the RCSLT office to all those who rang or emailed to check that we were okay.

Steven Harulow
Bulletin Editor
email: bulletin@rcslt.org

LETTERS

***Bulletin* thrives on your letters and emails**
Write to the editor, RCSLT, 2 White Hart Yard, London SE1 1NX
email: bulletin@rcslt.org
Please include your postal address and telephone number
Letters may be edited for publication (250 words maximum)

Sound cards and Down's syndrome

I have noticed recent increased concern from some parents of children with Down's syndrome that not enough focus is put on their child's speech through the use of 'sound' cards.

Some courses and literature seem to be highlighting the need to introduce directive input on sound discrimination and production as early as nine months.

To provide a differential diagnosis, SLTs need a more extended period of developmental history than nine to 24 months can provide.

I have had to reassure these parents that they have not delayed their child's potential speech development by late introduction of these cards.

Parents can have difficulty adjusting to the concepts of 'communication', when really they hope their child will just 'talk'. Parents of children with learning difficulties can find enough reasons to beat themselves up. I am concerned they may have found another one, in their non-introduction of sound cards.

I assure parents and carers that work on speech processing and production will be introduced when appropriate to the child's stage, and once a functional means of communication is established.

I work on phonology/oro-motor skills and sound discrimination with older children with Down's syndrome (three years and over). These are children who have developed speech, and enough speech range, for me to establish patterns of errors. They also have the language ability and awareness skills to understand the point of sound work.

The children who develop functional speech have the innate ability to do so. Have they developed speech in spite of sound card exposure, rather than because of it?

An important part of my role is to manage parents' and/carers' expectations. This can be a difficult role to sustain. I know working on a child's speech through oro-motor exercises and sound/picture resources would please the majority of parents. We need to use our knowledge and experience to help parents alter their priorities according to their child's stage.

I apply a non-directive approach to facilitating speech, language and communication skills. The 'teaching' involved in sound cards seems to be a more directive approach. I would not apply this approach to any child under two years of age on my caseload - why then just to children with Down's syndrome?

Does exposure to single sound auditory highlighting really lead to functional speech? I believe it is not a functional approach. Teaching children individual notes does not always mean they can play the tune.

Jo Clarke
SLT, Cheshire West PCT
email: jo.clarke@cahc-tr.nwest.nhs.uk

LETTERS continued

Blue dye or no blue dye?

The article on blue dye testing made interesting reading in June's *Bulletin* ('The perils of the blue dye test', pp18-19).

At the Manor Hospital, Walsall, we have stopped using the blue dye when assessing a tracheostomy patient's swallow. This decision was made following a seven-month research project involving 12 tracheostomy patients.

Each patient had a clinical swallowing assessment, with blue dye added. A dysphagia-trained SLT with at least one year's experience carried out the assessment and then made a prediction in her case notes as to whether there would be a positive or negative result from suctioning. This was carried out by the nursing team after the therapist had left the ward and once more before the next assessment.

The results from this study identified that, using their clinical judgement and without the evidence from suctioning, SLTs were 100% sensitive (the number of true positives) in identifying those patients who later had blue dye suctioned from their trache tube.

The project also confirmed that SLTs do not solely rely on the information from suctioning as there are cases where we recommend a patient remains non-oral even when the result from suctioning is negative.

As a team, we have agreed that the use of blue dye does not contribute to our management decisions and we are now able to take patients with minimal/no dysphagia from non-oral to oral diet and fluids in one swallowing assessment.

Margaret Young
Head SLT - Adult Service
Walsall Teaching PCT

Cleft-related speech evaluation

We read with interest Sue Jones and Paul Carding's description of the efforts being made to undertake training in perceptual evaluation of the voice nationally ('Auditory perceptual evaluation of the voice: making progress', *Bulletin*, March 2005 p10).

We thought it might be appropriate to inform readers about the approach specialist SLTs within the cleft lip and palate field are taking to address the thorny and difficult issue of inter-rater reliability in perceptual ratings of various cleft-related speech characteristics, so central to this field.

Speech and language therapists specialising in cleft palate/velopharyngeal dysfunction have developed a validated cleft speech audit tool (John *et al*, in press). This was developed with 14 specialist SLTs, over the course of two listening reliability studies. Validity and applicability were also evaluated.

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LETTERS continued

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Following the reorganisation of cleft lip and palate services in the UK into designated regional units, there is now a mandatory requirement to undertake regular audit so that outcomes can be monitored.

In order to do this, and in particular to ensure the highest level of scientific rigour in reporting outcomes, our aim has been not only to produce and validate a reliable tool for measurement, but also to establish the process whereby external, 'trained' specialist SLT listeners make the evaluation.

The model we are advocating is for different groups of therapists who have been trained on the tool to come together to rate digitally recorded standard speech samples, initially independently, and then to negotiate a consensus judgement for each of the speech parameters. These ratings are made under controlled conditions using a high quality amplification system.

This approach provides a unique and valuable opportunity to maintain listening skills, and monitor intra- and inter-rater reliability in perceptual judgements.

Furthermore, working with colleagues with whom the therapists do not usually "listen" is also a benefit.

Through this process a dataset of outcomes for audit is provided eliminating some of the possible sources of bias, and at the same time therapists have an invaluable opportunity for continuing professional development in perceptual judgements.

Dr Debbie Sell
Lead SLT, North Thames Regional Cleft Lip and Palate Service. Head of Speech and Language Therapy Department Honorary Senior Lecturer - Institute of Child Health
Drs Anne Harding Bell, Alex John, Triona Sweeney

Reference:

John, A. *et al*. CAPS-A - A validated and reliable measure for auditing cleft speech. *Cleft Palate-Craniofacial Journal* (in press).

Become a NICE representative

The RCSLT is seeking nominations from SLTs to be a National Institute of Health and Clinical Excellence (NICE) Partners' Council representative, to replace Jane Giles, who is coming to the end of her three-year term.

The Partners' Council has between 25-50 members who represent health care workers from professional and patient-focused organisations, NHS management, quality assurance organisations, trade unions, and relevant healthcare industries. All health care allied health professionals (AHP) groups, are represented.

The Council meets annually in London to review NICE's annual report and a further two or three times each year to discuss, issues, such as evaluating proposals and critically appraising NICEs future work programme.

According to Jane, the role for AHPs has been less central than for some of the medical professions and those representing whole trusts or patient groups, because there are no technical or interventional appraisals covering AHP activities. However, speech and language therapy is included in some of the clinical guidelines.

"One of the pressing issues the Partners' Council has been asked to consider over the last three years has been how NICE can influence health care professionals to implement its guidance," Jane said.

"It has been important to make sure NICE is aware of how speech and language therapy undergraduate training and postgraduate continuing professional development (CPD) systems are organised and to ensure that we are included in any roll out programme focusing on implementation of guidance in a way that has meaning to our clinicians. This is an on-going agenda."

Jane feels she has gained a lot in terms of CPD from the role, learning about how NICE operates, understanding the issues relevant to other AHPs and gaining valuable contacts from networking.

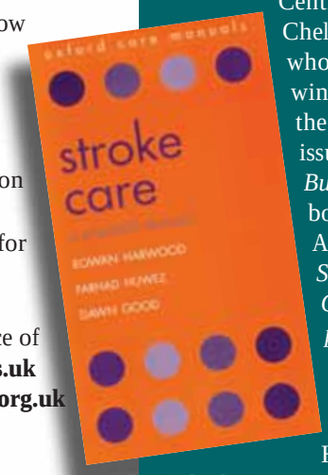
To apply, email a letter of application with your CV and referee contacts to **jo.offen@rcslt.org**. The closing date for applications is 31 August.

To talk to Jane about her experience of the role, email: **jane.giles@nmht.nhs.uk** or tel 0191 2563463. Visit **www.nice.org.uk**

NB The RCSLT is also seeking nominations for an alternate Partners' Council member, someone who will attend meetings if the first representative is unable.

Bulletin book draw winners

Congratulations to Joanne Fillingham from the Rakehead Rehabilitation Centre at Burnley General Hospital and Catherine Epps, from the Prestbury Centre in Cheltenham, who are the winners of the July issue of *Bulletin's* book draw. A copy of *Stroke Care: a practical manual* by Rowan Harwood, Farhad Huwez and Dawn Good is on its way to both of them.



RCSLT president receives knighthood

RCSLT President George Cox received a knighthood in the Queen's Birthday Honours list announced on 11 June.

Sir George told the Bulletin, "I felt very honoured indeed to be awarded my knighthood. Although it was cited as being for services to business, I like to think that it reflects my wider range of interests.

"Like an increasing number of business people nowadays, I am very keen to put my experience to wider use, and I feel very privileged to be involved with the College."

Sir George has been RCSLT President since October 2004. He has also been Chairman of the Design Council since 2004, and previously held the post of Director General of the Institute of Directors. He has spent most of his business career in IT, as UK Chairman of Unisys and heading its European service-based businesses.

Meanwhile, RCSLT Senior Life Vice President Sir Sigmund Sternberg has been appointed a member of the King's Fund General Council for 2005-2006.

The King's Fund is an independent charity working to tackle health inequalities, particularly in London. The Fund carries out research and policy analysis and runs leadership and education courses for those working in health.

Design Council

College President George Cox says he is very honoured to receive his knighthood

It also offers grants to London-based community organisations that work towards improving health and health care. In 2003-2004 it invested around £2.2 million in grants.

Visit: **www.kingsfund.org.uk**

Kay Fegan takes up Scotland country councillor post

Kay (pictured), manager of SLT services in Ayrshire and Arran General Hospitals, took up her post in June having stepped down from a two-year stint as the Scottish representative on the RCSLT's management board.

"I'm delighted and honoured to represent the RCSLT's 1,000 members in Scotland both within RCSLT and in the world beyond," Kay said.

"More than ever there are opportunities for SLTs in Scotland to influence change for the better and I am determined to support them to make those changes.

"While the present political agenda presents many challenges, there are also great opportunities for SLTs in Scotland, such as extended scope practitioners and consultant practitioners."

Kay added that there is already a clear action plan set out by members in Scotland at the last annual meeting in 2004, and this includes continued improvements to RCSLT communications systems and supporting members with the continuing professional development log (CPD) and the Health Professions Council (HPC).

Lead link days are being arranged for north, east and west Scotland, and these meetings are open to all members in the geographical area. These half days will give members an opportunity to meet Kay, and will provide information and practical help on HPC and CPD logs.

The RCSLT Scotland annual meeting will take place on 31 October, at Murray Royal Hospital, Perth. Contact your lead link for more information.

To contact Kay, email: **kay.fegan@aaaht.scot.nhs.uk**

NEWS IN BRIEF

CQ3: have your say

The draft content of *Communicating Quality 3 (CQ3)* will be available on the RCSLT website in September. We will consult with all members and a range of external stakeholders on *CQ3*, so let us have your comments on what we have achieved so far. Feedback will help to further shape the content prior to the online and print launch of *CQ3* early next year.

Shelia take a bow

Congratulations to Sheila Wirz the new Professor of Disability and International Development at the Institute of Child Health, University of London. Sheila, an SLT by background, previously worked as senior lecturer in human communication studies at University College London.

NHS gender bias

The NHS suffers from a gender bias that favours the progression of men over women, according to new University of Liverpool research. The study found men occupy the most authoritative and influential positions in the NHS. Study participants felt that 'old boy networks' were still evident in selection processes for senior positions.

New Generations coordinator

Rachel Wright has taken up her post as the New Generations project coordinator. The project promotes allied health professions careers and is a joint initiative between the AHP professional bodies and the NHS. Rachel will be supporting regional coordinators and promoting the ambassador scheme. Email: rachelw@sor.org, or visit: www.newgenerations.org.uk for details.

Getting boys reading

The National Reading Campaign has launched a new school-based framework to encourage boys to read. Reading Champions for Schools aims to promote effective practice to stimulate boys' interest in reading and encourage participation in reading schemes. Resources are available to help schools get involved. Visit: www.readon.org.uk

New stroke service takes off

SLT Sarah Easton is leading a team of health professionals to offer a new stroke service in Portsmouth, giving support and care to stroke patients at home and cutting down on hospital stays.

With a service looking after patients from the Portsmouth city area and the south of East Hampshire, Sarah is the team leader of seven nurses, five healthcare support workers, three physiotherapists and three occupational therapists, a part-time SLT, an SLT assistant and a newly created stroke rehabilitation technician post.

The service works towards ensuring patients receive joined-up care and places an emphasis on functional communication. Not being consultant led, the service allows care to be tailored to individuals' needs, which are assessed directly by the team.

The focus on working with patients in their own homes means they can be discharged from hospital sooner. Local and national studies have shown that many patients feel happier and make much better progress when they are at home.

"The response from patients is amazing," said Sarah. She cited the example of a stroke patient who made speedy progress under the service, graduating to being able to climb the stairs at home.

The team is currently forging links between the professions and getting nurses used to the idea of working in patients' homes rather than on the ward. Although still in its infancy, Sarah has big ambitions for the stroke service's future. She hopes that it will be offered in other geographical areas and that the age limit, currently set at 65 years, will be lowered.

Portsmouth Stroke Service

The Portsmouth multidisciplinary team is helping to care for stroke patients in their own homes

Are you involved in autism research?

Kate Evans, an SLT in Gloucestershire, is working with the Department for Education and Skills (DfES) on a project to map autism research and wants to find out what other SLTs are doing in this field.

The project is looking at a diverse range of agencies' experiences of autism, including the RCSLT, education authorities, the National Autistic Society, parents and research organisations, to find out what research is currently being done and to identify gaps in the knowledge which could be addressed.

Kate is particularly keen to hear from SLTs doing research in this area, so she can report back to the DfES working group.

Kate says, "We need to know who's involved with what, what they are doing and what their results are, in order to inform this high level working group".

If you are working in autism research, share you findings with Kate, email **Kate.Evans@glos.nhs.uk**

Michelle Morris joins national leadership network

Michelle Morris, Professional speech and language therapy adviser for Salford PCT, (pictured) took up a key role in May as one of three allied health professionals (AHPs) who will actively influence government health and social policy.

Michelle, along with fellow AHPs consultant radiographer Dorothy Keane and consultant physiotherapist Jill Gamlin, joined the National Leadership Network (NLN) after an overhaul of the one-year-old network.

The trio are the only regularly practising clinicians on the 150-strong NLN, which comprises leading figures in health and social care, strategic health authorities, primary health care trusts, charities and trades unions.

The network will work with ministers over the next five years to influence the next wave of health and social care reforms, as part of the government's 10-year NHS plan.

Michelle is delighted with the chance to influence policy at such a high level.

"I was astonished to be nominated by the Department of Health, but absolutely thrilled and honoured," she said.

"It is a huge opportunity to influence the development and roll out of health policy, and to ensure that the AHP and speech therapy voice is heard at an opinion forming and highly strategic level.

"I am able to bring not only a clinical professional perspective but a reality check from my experience as a front-line practitioner. I work closely with my two other AHP colleagues to make sure that we maximise the opportunities to influence."

Michelle is already tackling her role as a 'leader' with enthusiasm.

"At the last NLN event 'Leveraging Health', which covered the public health agenda, I was able to raise the issue of the tensions between treatment and prevention."

Email: **michelle.morris@salford-pct.nhs.uk**

Roberta's birthday honour

Congratulations to Roberta Lees (pictured), awarded an MBE for her services to education in the Queen's Birthday Honours in June.

With a career spanning nearly 40 years, Roberta began working as an SLT for Dunbartonshire Education Authority in 1966. She then moved on to lecturing in speech and language therapy at undergraduate level, working her way up to the post of reader at Strathclyde University in 2002.

During her academic career Roberta has held a number of management positions, including undergraduate programme coordinator, postgraduate course director and head of department in speech and language therapy.

Roberta said, "I am absolutely delighted about this honour, as is my family. I think that the honour reflects the sterling work of all of my colleagues in the SLT division of Strathclyde University: they're a great team. I would like to thank all of them for their support over the years."

Roberta has taught a large number of SLTs working in both the UK and abroad, and her specialist interest in stammering enabled her to present at a number of international specialist conferences and publish on this subject.

Actively involved in developing links with SLTs overseas, Roberta's work has allowed students at Strathclyde to undertake placements abroad, including the organisation of a three-month placement scheme in Strasbourg, to further students' professional development.

Roberta has also been a valuable adviser to the RCSLT on stammering and is currently an adviser to the British Stammering Association.

ACAMH elects its first SLT

The Association for Child Psychology and Psychiatry has changed its name to the Association of Child and Adolescent Mental Health (ACAMH) to reflect the wide range of professions involved in working with child and adolescent mental health.

The ACAMH aims to advance the scientific study of child and adolescent mental health and provides information by organising meetings and producing publications.

Alison Wintgens, head of speech and language therapy at South West London and St George's Mental Health Trust, is a newly elected member of the London and South East ACAMH branch committee and the first SLT be involved in an official capacity.

Commenting on her appointment, Alison said, "I believe this shows a commitment on ACAMH's part to work with closely with a range of professionals."

The branch plans to hold meetings on developments in children's psychological therapies, managing self-harm and learning disabilities.

Visit: **www.acamh.org.uk**

Coleraine student receives university award

The University of Ulster has named speech and language therapy graduate Kathleen Graham as its Convocation Student of the Year 2005.

Kathleen Graham, 23, from Coleraine, graduated with a first class honours degree in speech and language therapy, and received the award in recognition of her voluntary work and overcoming personal adversity.

Throughout her time as a student at Ulster, Kathleen has been actively involved in a number of charitable causes and fundraising.

In spite of personal illness, Kathleen was a role model to other students through her position as class representative.

She played a full part in staff-student negotiations, organised a number of events and mentored her peers.

In August, she takes up a position as an SLT with a health authority in Lancashire.

The Convocation Executive Committee is the University of Ulster's graduate body and comprises all graduates of the university, all academic members of staff and a number of university officers.

NEWS IN BRIEF

Stroke feeding research

Stroke Association research shows that feeding stroke patients with swallowing problems as soon as possible can help to reduce deaths from the condition. The study found that nasogastric tube feeding of recent stroke patients is better than abdominal feeding because it helps reduce the risk of disability. Visit: www.stroke.org.uk

Cancer referral guidelines

New National Institute of Health and Clinical Excellence guidelines aim to reduce the variation in referral times from primary care to specialist investigation for those with suspected cancer. The guidelines make recommendations on the diagnostic and referral process and set out processes for healthcare professionals to follow in reaching an initial diagnosis. Visit: www.nice.org.uk/CG027quickrefguide

Patient Safety 2006

The National Patient Safety Agency (NPSA) will hold its second major conference, Patient Safety 2006, in Birmingham next February. The NPSA wants proposals for posters and presentations that demonstrate local initiatives for improving patient safety before 30 September. Visit: www.patientsafety2006.nhs.uk

Leadership scheme applications

The Health Foundation is seeking applications from AHPs for its Leadership Fellows scheme. This offers personal and professional development opportunities to individuals who have the potential to significantly improve the quality of NHS healthcare services. Fellows will benefit from one-to-one coaching, seminars and workshops. The deadline for applications is 15 September. Visit: www.health.org.uk

SLTs in palliative care

More education and research are needed to support SLT service development in palliative care, according to SLTs Samantha Eckman and Justin Roe. The pair highlighted the issue in the *International Journal of Palliative Nursing*. For details, email: justin.roe@st-mary.nhs.uk

Get yourself known – become an adviser

The RCSLT held an induction day for advisers in London on 16 June. **Sarah Gentleman** reports on the day's events

Around 20 new adviser recruits attended the day and listened to a number of speakers explain more about the role.

In her adviser role, Alison Peasgood has dealt with over 40 enquiries over three years, ranging from talking to the media through to working with other organisations, such as the National Deaf Children's Society. Alison told the group how she found the role to be "fascinating and challenging".

"Every request I've received has been valid and interesting", she said.

Speaking about her experience dealing with enquiries, Alison said that although the idea of being an adviser can be "scary at first", SLTs find they actually have a lot more knowledge and a bigger network of contacts than they realise.

RCSLT advisers support members by responding to enquiries and acting as a respected voice for the profession. They also help College contribute to government consultations, influence key policies and help to develop research and development in their field.

As the then RCSLT Deputy CEO Anne Whateley said, advisers are "the lynchpin in our structure. College needs advisers to help us link to clinical expertise and build up a network of contacts and to enable specific interest groups to get more involved in the RCSLT's work."

Alison emphasised the enabling function of advisers, considering the role to be less about problem solving and more about helping others to find the right information.

The benefits of becoming an adviser are multiple. Alison feels it has helped her be motivated to stay up to date with clinical practice, kept her on her toes and provided opportunities for both professional and personal development.

The role has also allowed her to build networks with SLTs, College and other professionals.

"Being an adviser is fascinating and widens your scope," Alison added. She was also keen to highlight the advantages for employers, as advisers are acknowledged specialists in their field and this benefits their department.

Alison felt a key challenge for new advisers was the concern about the amount of time the role may take up. However, she was keen to point out that advisers do not actually have to answer every query thrown their way.

"It's ok to say no," she said. "Every adviser's experience and response will be different dependent on their personal circumstances."

Alison also highlighted the need for employers to encourage staff who want to undertake the role, as it is important to have support from colleagues and managers. In her experience, Alison noted that people tend not to come forward themselves to sign up and need to be encouraged to have faith in their own skills and ability.

Summing up, Alison said, "The role of the adviser is clearly of benefit to the RCSLT, the profession and the public. Have courage!"

If you know someone who you think would make a good adviser, encourage them to take on the role. If you would like to apply yourself contact the RCSLT membership and information team for an application pack, email: info@rcslt.org, tel: 020 7378 3012. For specific questions about the role contact RCSLT Policy Lead Linda Nixon, email: Linda.Nixon@rcslt.org or tel: 0207 328 3013

Claire Wells – voice, Northwick Park Hospital, London

"I became an adviser due to peer pressure from my manager and colleagues. They told me that I ought to do it, because I do have a body of knowledge and people were already ringing me with questions, so it made sense to become an adviser and get support. It helps keep me on my toes, encourages me to keep reading and to be more in touch with College."

Elaine Hurst – language impairment, Linden House, Nottingham

"I had been encouraged to apply before, but as I'd just returned from maternity leave, I didn't feel I had the time to spare. However, as time went by and I took on a clinical leadership role, I thought this would be a good way of getting my voice across. Being an adviser has given me a bigger support network. I don't think I would have done it if I hadn't been encouraged by others."

Ann Hurren – head and neck, Sunderland Royal Hospital, Sunderland

"I was unhappy with some of the guidelines and I thought I should do something about it. I thought the guidelines were essential and that we need more of them and that I should and could contribute towards their development. I would definitely encourage others, and would say just remember that you don't have to do all of it, you can just do some of it - so it's manageable."

Julie Mullis – autism spectrum disorders, Hollies School, Cardiff

"I was asked if I would become an adviser and at first I was reluctant because I thought it would take up a lot of time. I've been an adviser for about a year and dealt with six enquiries so far. The interesting thing is that they have come from Luxembourg, Malta and Ireland, and not just from Wales where I'm based."

HPC wants your views on consultation documents

The Health Professions Council (HPC) launched two consultations on 1 July: *Returning to Practice;* and *Managing Fitness to Practise;* a guide for registrants and employers.

During these consultations, the HPC will present ideas on how health professionals wanting to return to practice can update their skills and knowledge, and how registrants and employers can manage fitness to practise.

Returning to Practice contains proposals about how registrants who have ceased practising can update their skills and knowledge before they apply for registration, readmission, or before they renew their registration.

Managing Fitness to Practise deals with issues regarding changing fitness to practise and changing scope of practice. It gives examples of how registrants can make adjustments in their practice so that they can continue to meet the HPC's standards, remain registered, and continue to practise.

HPC Policy Manager Rachel Tripp said, "We are looking forward to listening to registrant and stakeholder views on the two consultations, and developing systems that are flexible and that meet the different needs of health professionals.

"Anyone who wishes to take part in the consultations and have their views heard, can write to us with their comments by post or email. We look forward to hearing a variety of views and ideas over the coming months."

The consultations run until 9 September 2005. The full documents are available online. Visit:
www.hpc-uk.org/aboutus/consultations/

Speech and Language Therapy Week

10-14 October 2005

'Breaking down barriers to communication'

To obtain your promotion pack, write to Sandra Burke, 2 White Hart Yard, London SE1 1NX or email: sltweek@rcslt.org

Travelling towards independence

Abbey Anderson describes how she helped develop independent travelling skills for her special needs students

I am a therapy assistant working with both occupational therapists and SLTs at St Dominic's School in Surrey, a special school for children with complex learning difficulties.

Part of my role is working with Key Stage 4 students (ages 14 to 16) who need to learn life and social skills, such as travelling independently, road safety rules, and behaving in a socially acceptable manner when out in public.

In school, students may appear quite able. However, when out in public and in strange surroundings they can react very differently and their difficulties become very apparent.

The students need lots of encouragement to achieve independence skills, especially when travelling. They lack confidence in their own ability to accomplish what their mainstream peers would achieve easily.

Examples of these difficulties include:

- problems reading and following information from information boards and road signs;
- sensory modulation difficulties causing problems in crowded and/or noisy environments;
- problems with spatial perception, so they find it difficult to judge distance and speed, for example when crossing roads;
- problems with spatial awareness, so there may be difficulties judging steps and gaps between platform and train;
- lack of awareness of the needs of others;
- inappropriate mannerisms which draw unwelcome attention to themselves;
- lack of self awareness in social situations; and
- no sense of fear.

During my journeys I have seen some interesting incidents, some unexpected surprises and received some strange looks from the public. For example:

- I was stopped by the police for having a pupil out of school during school hours;
- A student with a severe allergic reaction to nuts had hand cream containing almond oil put on to his hand. This needed immediate attention;
- We were stranded for an hour when a train stopped mid-journey due to an unforeseen incident (this caused great anxiety to both of us);
- Some students make strange noises and use odd mannerisms that have sometimes attracted unwelcome attention; and
- On one occasion a student emptied the entire contents of his piggy bank on to the floor at the entrance of a large stationery store and proceeded to count his pennies.

Independent travel programme

St Dominic's therapists cover the theory of travelling, including vocabulary, types of tickets and problems that may arise, as part of their social communication skills programme.

We draw up a list of the students in years 10 and 11 (aged mainly 15) who would most benefit from developing independence skills, and request permission from their parents.

We give priority to those who are most likely to achieve independence. Therefore, we devote a greater amount of time to those who will be travelling independently to college after they leave St Dominic's.

I briefly introduce the travel plan and explain our aims. We (the students and I) jointly set realistic and achievable goals to enable them to focus on their particular difficulties. Personal targets are assigned to each student. It is vitally important to praise the students in order to build up trust. They can then communicate their fears and work effectively with me.

For our first trip I try to choose a venue that is well known to the students and therefore less stressful. This enables me to observe and assess their personal needs. If they seem very nervous about travelling I invite a friend of theirs along for support and companionship. A confident friend is a good role model.

A successful outcome

The following is an example of how I applied the above tasks to Daniel (not his real name), a 15-year-old student – and a very talented musician – with an autistic spectrum disorder, who was really frightened to travel alone.

Daniel's main fear was that he would be mugged or attacked and that he would not be able to defend himself. He feared everyone. He desperately wanted to be independent, especially when travelling, as this would enable him to fulfil his dream of attending a music academy in London.

Daniel asked to visit the town where he lived, as this was familiar to him. His aim was to be able to confidently visit his local shops alone, particularly the music shop.

We travelled by train so he would gain experience of being close to other passengers. At this stage we only concentrated on the

journey itself rather than developing independence skills. Daniel felt at ease when walking alongside me, so we were then able to move forward.

The next stage was to increase Daniel's confidence sufficiently so that he was able to walk alone, a few steps ahead of me. This enabled him to feel secure knowing that I was only a few feet behind him. We continued to increase the distance of separation over a period of time.

This same principle was used when travelling on the trains. I started by sitting next to Daniel, then opposite, then behind him. Eventually we were at opposite ends of the carriage, then in separate carriages. This was achieved over a period of more than a year.

We used the same principles for bus travel, a less threatening mode of transport for

Daniel. On the first occasion I drove behind the bus so I was in his full view. Next, I followed further behind but near the end of the journey overtook the bus so that I was able to meet him coming off the bus. On the final journey I took a different route and he arrived at the stop before me.

Each step was planned and agreed, depending on the outcome of the previous trip. It was vital that he had complete trust in me to achieve this progress.

We then transferred these skills to travelling more independently on the train, a more emotionally demanding experience for Daniel. His confidence in walking alone enabled him to meet me at a pre-arranged meeting place some distance from the train station. This encouraged Daniel to complete the task with less anxiety.

Abbey Anderson encourages her students to travel independently by taking small steps at a time

Even so, there was one major setback. Daniel's fear of being mugged returned when another pupil in school hit him. This had a damaging effect on his self-confidence, to the extent that we had to return to the first stage. He was only able to overcome this setback with lots of encouragement and patience. It took several weeks to regain his confidence.

When we had met all our targets, we both felt we had gained a lot from our achievements. To see a nervous student transformed into a confident and assured young man is well worth all the effort and hard work. ■

Abbey Anderson
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Developing functional nutritive sucking skills in premature infants

Non-nutritive sucking therapy programmes have positive benefits for neonates' feeding development. **Celia Harding** explains

As an SLT with a strong interest in paediatric dysphagia, I was keen to explore some of the interventions that we recommend for the infants and children with whom we work.

Part of my job involves work in a neonatal unit that includes assessing the safety of an infant's sucking and swallowing skills and, in some instances, recommending a non-nutritive sucking programme to facilitate a stable and progressive transition to oral feeding.

As SLTs, we recognise that oral motor intervention in very young infants can enhance the pleasurable aspect of feeding with the main carer and, therefore, have a positive impact on the infant's psychosocial development (Bazyk, 1990; Lau, 1990; 1996).

It is also recognised that the early feeding process is an important part of bonding (Stroh, Robinson and Stroh, 1986; Evans-Morris and Dunn-Klein, 1987) and can, therefore, reduce the chances of developing negative experiences.

Researchers are frequently exploring how to improve the care of infants in neonatal care. A wide variety of studies explore the use of non-nutritive sucking either before, during and after, or a combination of times, during gavage feeding or other interventions to make the experience more stabilising and less challenging for the infant (Pickler, 1996; Webster, 1999; Measel, 1979; Bernbaum, 1983; Field, 1982).

The studies reveal that non-nutritive sucking has benefits in terms of:

- reduced hospital stay;
- quicker transition to oral feeds;
- better feeding performance;
- decreased times in fussy-awake states;
- quicker settling post feeds; and
- decreased defensive behaviours during tube feeds.

These studies have not specifically focused on oral motor development. Rather, they have explored the impact of non-nutritive sucking on weight gain, intestinal transit time, energy intake, heart rate, oxygen saturation and age at which the infant could take full oral feeds.

> *"SLTs recognise that oral motor intervention in very young infants can enhance the pleasurable aspect of feeding"*

None of the studies explores how the non-nutritive intervention should be carried out and how the outcomes should be measured. It is, therefore, difficult to draw a consistent conclusion that can determine clinical practice, as the studies cover a wide range of methodologies and implementations.

As an SLT working with this vulnerable caseload, I was interested in evaluating the development of functional nutritive sucking skills in premature infants through use of a speech and language therapy non-nutritive sucking programme during tube feeds.

I examined this in 14 infants, all of whom were from the same neonatal unit. They weighed between 1085g and 2205g at birth and were born between 27-35 weeks' gestation.

I matched the infants in pairs according to gestational age – with one infant receiving the intervention and the other receiving the usual care provided by the neonatal unit.

Parents and nursing staff in the intervention group implemented non-nutritive sucking for the first 10 minutes of a tube feed using a finger or pacifier after informal training sessions with the SLT.

Outcome measures included the differences between the two groups in number of days in hospital, the number of days taken to achieve full oral feeds, and the number of (normal) features of non-nutritive sucking using the Neonatal Oral Motor Assessment Schedule (NOMAS) (Meyer-Palmer, 1998).

I considered longitudinal aspects of weaning in one pair of babies using the Evans-Morris Parent Questionnaire (1987) where the infant who had received the intervention weaned more successfully than the infant who had not received the intervention.

Statistical analysis showed that the intervention group had fewer days in hospital (five) and fewer days to take oral feeds (three). The NOMAS scores revealed the change in score, from before to after intervention, was higher in the intervention

group than in the control group (a difference of 2.5 points on the scale).

The results suggest that, despite the small sample, non-nutritive sucking therapy programmes do have some positive benefit for neonates feeding development.

However, there is no clear link between intervention and outcomes. Many factors may have contributed, such as the influence of the therapist, nurses and parents working collaboratively to provide a supportive environment (Lau, 1996; Warren, 2000). Tactile feedback during handling also has an influence on an infant's sympathetic and adrenocortical system development (Kuhn, 1991; White, 1976), so increased handling during the intervention could have been a significant factor.

Further research would be beneficial in considering the impact and effectiveness of non-nutritive sucking programmes with premature baby populations, where there are infants with more complex and challenging needs. There is also the issue of breast-feeding within these groups. Further research can only support a more substantial clinical pathway to good practice.

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Looked after children: does speech and language therapy really look after them?

Jane Conway and **Jane Stokes** report on a pilot project in Lambeth looking at ways to improve access to speech and language therapy for looked after children

Lambeth speech and language therapy service has been concerned for some time that children who are looked after by the local authority (children formerly known as children 'in care') are likely to miss out on therapy because of frequent moves and long waits following transfers between services.

Work carried out by the health guardian for looked after children in Lambeth (Wildbore, 2002) revealed particular concerns associated with children moving in and out of the borough and their access to health services.

Many health professionals referring children into community health services found that as a result of a move, services were discontinued or prematurely duplicated, or that children were subjected to repeat assessments and unlikely to receive intervention.

It was with this in mind that the speech and language therapy services in Lambeth began to look at how processes could be put in place to address some of the factors that were affecting timely access to our services, and resulting in potentially poorer outcomes for these children.

In November 2002, the Department of Health (DH) published *Promoting the health of looked after children*. The guidance set out a revised legislative framework for safeguarding and promoting the health of these children.

The guidance is clear about the health assessment outcomes of a child being received into care: "Every effort should be made to ensure that being looked after does not disrupt existing arrangements or lose a place on the waiting list." (Chapter 8, 17.)

More recent government national guidance on the direction of children's services (DfES, 2004) is very clear about the need to set up a framework of universal services to prevent negative outcomes for children at risk. *Every Child Matters* suggests that agencies should provide services that both safeguard children and enable them to fulfil their potential.

Following discussion with the team with responsibility for the health of looked after children in Lambeth PCT we launched a one-year pilot project in April 2003.

The project aimed to look specifically at issues affecting access to speech and language therapy services for this group of children in Lambeth.

The pilot prioritised the needs of children under five accessing our services. We appointed a particular therapist who had some prior knowledge of working in child protection.

The project's specific aims were to:

- track the movements of looked after children across the borough;
- develop an advocacy role for this group of children; and
- pilot an initial prioritisation service.

The purpose of developing an advocacy role was to represent a child's needs and develop a role in brokering speech and language therapy care both in and out of the borough.

We envisaged this would be helpful for therapists working in the trust, and also potentially be useful to flag up the speech and language therapy needs of children who moved to foster carers in neighbouring trusts.

For the pilot phase we prioritised all looked after children under five referred to the service for initial assessment. We also cut down significantly on their wait for initial contact with a therapist. We also decided to include a module on speech and language development in training offered to Lambeth foster carers during 2003.

Our report at the end of the pilot scheme in 2004 assessed what we had learned.

The advocacy role for looked after children

During the pilot staff found it helpful to talk through the specific needs of looked after children. They commented:

"I learned more about the complexities of a child who is in the care system."

"It was useful to discuss how these children need not be disadvantaged with some thought around possible care pathways."

"I now feel more confident in looking more broadly at the needs of this group of children."

Tracking children's movements across the borough

We tracked children's movements through record forms completed by administrators and therapists. There were 22 looked after children fostered within the borough known to the department between April 2003 and April 2004 and five children moving within the borough.

Case study

James (not his real name) had been referred to the service for an assessment of his initial communication skills. The SLT prioritised James for initial assessment at clinic A, but then learned that he had been placed with a new foster carer in a different part of the borough.

There was a delay before the SLT could get details of the location of the new foster carer from James' allocated social worker. It transpired that the clinic closest to the new foster carer was in the same street as James' biological parents: this caused the foster carer some anxiety. It was not thought to be the

most appropriate venue for James in view of the proximity to his birth family and the difficulties this had caused in the past.

The looked after team, SLTs, social worker and clinic therapists involved discussed this case in the context of the pilot, and decided that James' initial assessment should go ahead as planned at clinic A.

James received his initial assessment sooner and in a more appropriate setting as a result of the pilot.

Children moving outside the borough - links with other trusts

We tracked the movements of looked after children under five who were fostered outside the borough, in line with recommendations in Promoting the health of looked after children (DH, 2002), and made every effort to flag up their speech and language therapy needs to receiving trusts.

In cases where looked after children transferred to departments bordering Lambeth PCT, we agreed in discussions with the social worker and foster carer that the appointment should go ahead if a Lambeth health venue could still be accessed easily by the carer.

In this way several children were able to get an initial assessment, with appropriate advice given to the foster carer more quickly. Where this was not possible, the looked after children SLT liaised with speech and language therapy managers in other trusts to raise their awareness of the responsibility to deliver a service to children entering their area so that, as far as possible, interventions were not disrupted.

"… Every effort should be made to ensure that being a looked after child does not disrupt existing arrangements or lose a place on a waiting list." (*Promoting the health of looked after children*, DH 2002.)

Effect on the service and future implications

Therapists who piloted the initial assessment protocol reported only minimal additional waits for children referred to the service who did not have looked after status. Therefore, we decided to mainstream the prioritisation protocol and retain the advocacy role.

Other areas have been identified for possible development in the future:

- a good practice pack for foster carers;
- extending the looked after children SLT, to include capacity for training and outreach to therapists managing these children on their caseloads; and
- looking at the needs of children over five.

This pilot showed it was possible to meet looked after children and foster carers' needs in a quicker and more qualitative way with only a minimal disruption to the core caseload.

We hope that the rolling out of selected aspects of this pilot will result in easier and quicker access to our service and that our recommendations for the future will continue to provide us with opportunities to improve healthcare outcomes for this group of children.

Looked after children are likely to miss out on therapy because of frequent moves

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Lambeth PCT

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Definition
"If a child is 'looked after' by a local authority (LA) they may be either on a care order or voluntarily accommodated. A care order places a child in the care of the LA and gives the LA parental responsibility for the child. The LA determines to what extent this responsibility is shared with parents." DfES, November 2001

Dysphagia education and training

The RCSLT Management Board and Committee of Representatives of Education in Speech and Language Therapy (CREST) held a joint meeting on 21 April 2005. Among items discussed was a London Managers' Dysphagia Working Group paper on the profession's perceived readiness of new graduates to work in dysphagia. This statement aims to clarify the current position.

In 1999, the RCSLT asked all speech and language therapy qualifying courses in the UK to modify their curricula so that students were given the opportunity to acquire some basic theoretical knowledge and skills in dysphagia during the course of their studies.

This move recognised that dysphagia has become an integral part of speech and language therapy, and an increasing element of caseloads. Prior to this, dysphagia was seen as a specialist area and training was only being delivered at a post-registration level.

This situation has now changed. New graduates should be able to work with clients with dysphagia during their first year, under the same levels of supervision and autonomy that newly-qualified therapists expect in all aspects of their clinical practice.

The RCSLT has recently launched a speech and language therapy competency framework to guide transition to full RCSLT membership (RCSLT, 2005). This aims to support the learning and development of newly-qualified practitioners in the first year of practice.

Managers are often unclear about what exposure new graduates will have had to dysphagia during their studies – both in terms of practical experience and taught theory. The RCSLT Management Board and CREST propose the following actions to try and address this issue.

CREST will recommend that higher education institutions (HEIs) are more explicit about the amount and type of dysphagia coverage in the curriculum. For example, it is suggested that HEIs provide students going on different types of placement with some indication of what practical experience and teaching on dysphagia they will have completed during their qualifying course.

The aim is to reiterate the message that students are now being equipped to work in dysphagia in the same way as other client groups, and also to give clinicians more confidence to get students involved in dysphagia related work during placements.

As with all other clinical areas, it is not possible to guarantee a uniformity of dysphagia experience for students across the UK as part of their clinical placements.

In some cases, experience may be acquired as part of in-house practical learning strategies used in HEIs rather than within an SLT service.

Increasing the availability of relevant clinical placements will increase the exposure of students to dysphagia and improve opportunities for direct hands-on practical experience.

Clinicians with a dysphagia caseload can be unsure in terms of clinical risk what level of responsibility students should undertake as part of their placement. However, tools are available to support students and supervisors, so check with your local HEI.

For example, a dysphagia checklist is being used by some placement providers in the London region based on the paper *Safe Swallowing? – An opportunity for students working with dysphagic clients* presented at the 2001 RCSLT conference (Gascoigne and Marks).

The paper demonstrated that students could reach a level of independent competence using a structured approach to dysphagia training, with checklists to establish that necessary competencies had been achieved.

This checklist offers a staged route to progress a student from observational activities through to hands-on experience while on clinical placements, and the ability to undertake a basic dysphagia assessment and recommend management strategies.

As an example of good practice, this dysphagia checklist will be circulated via the Management Board networks and CREST, with an emphasis on progressing students to the 'hands-on' level.

Services providing clinical placements and HEIs have a responsibility to work together so that newly-qualified therapists are competent to manage dysphagia at a basic level, in the same way they would be competent to manage communication disorders at a basic level in an adult with aphasia, or a child with a learning disability.

If you know of any examples of good practice or other tools to support students and their supervisors on dysphagia placements, email: bulletin@rcslt.org

Jennie Godden – *RCSLT Management Board Chair*
Siân Munro – *Chair of CREST (at time of joint meeting)*

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Note:

CREST membership consists of a senior SLT from each of the education establishments running speech and language therapy qualifying programmes.

Book Reviews

Comprehensive Aphasia Test

KATE SWINBURN, GILLIAN PORTER, DAVID HOWARD
Psychology Press, 2004
£150
ISBN: 1-84169-379-0

This assessment has three parts: a cognitive screen; a language battery (spoken and written comprehension and expression) and a disability questionnaire.

The language battery is a combination of the usual subtests from the classic American aphasia batteries but with more rigorous control of variables such as imageability, frequency, regularity and number of syllables, as in Psycholinguistic Assessments of Language Processing in Aphasia.

Clinicians familiar with formal tests of aphasia will find all the expected subtests and some welcome additions, eg action naming and a wide-ranging reading aloud section.

The addition of a cognitive screen and disability questionnaire provides the clinician with extra information that will help decision-making in management planning, shared goal-setting and therapy outcome expectation.

A section focusing on how the person uses their impaired language abilities functionally would have enhanced the data gained from this assessment.

We have reservations about the amount of detail in the line drawings in some sections and the layout of the language battery test book. The latter is very busy, often with detailed pictures on both sides, and so may be distracting.

In view of the level of language complexity in the instructions and subtests, this assessment will be most useful for people with mild or moderate aphasia.

If a department was looking to buy one aphasia assessment, we would recommend this one for its construction, Britishness and comprehensiveness, but departments already with a range of published tests need not add it to their inventory.

CONTENTS:	READABILITY:	VALUE:
****⋆	***⋆⋆	****⋆

LINDA ARMSTRONG – Aphasia adviser and colleagues in the Tayside SLT aphasia clinical network, Perth Royal Infirmary

The Children's Communication Checklist, 2nd edition (CCC-2)

DOROTHY BISHOP
Psychological Corporation, 2004
£90
ISBN: 0-74912-610-8

This is a screening tool to assist in identifying children who may merit further assessment for a language and/or autistic spectrum disorder.

There are 10 scales – four assess language structure, four consider pragmatic aspects of communication and two examine behaviour.

A parent completes the CCC-2, and it should be scored and interpreted by SLTs, psychologists or paediatricians. The test comprises 70 questions, some highlighting negative aspects of communication and others the positive aspects.

We carried out assessments on nine children and the results gave an accurate indication of the children's difficulties.

The CCC-2 should be scored using a PC but this could prove difficult for people without extensive knowledge of spreadsheets.

However, once mastered, the automated scoring system gave a rapid, accurate summary sheet. Scoring manually proved laborious and time consuming and does not follow the pattern of the more familiar standardised assessments used in clinic. The need to convert the positive ratings to negative scores could be confusing. Care also needs to be taken to start scoring on the last page.

For specialists it is unlikely this test would provide additional information, but it may confirm clinical judgement. For generalists, producing a good, clear analysis would be beneficial to establish clinical direction. However, at half an hour per test, manual scoring probably makes this test impractical for a clinic SLT to administer.

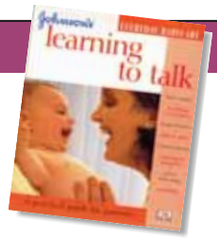
CONTENTS:	READABILITY:	VALUE:
*****⋆	***⋆⋆	***⋆⋆

BARBARA HOWSE
Specialist SLT, St Dominic's School

BOOK OF THE MONTH

Learning to talk, a practical guide for parents

JAMES LAW
£5.99
Dorling Kindersley, 2004
ISBN 0-75133-888-5



This beautifully illustrated book is one of the Johnson's Everyday Babycare series. It aims to be a reference for parents, and to provide reassurance on developing their child's language skills.

The book gives clear information and advice throughout. There are expert tips, checklists, and question and answer sections on almost every page.

The first four chapters follow language development from birth through to around five years. The final chapter provides information on checking a child's progress and milestones. Although organised in a developmental sequence, the book is easy to dip into and out of.

It includes information on issues that concern parents or that appears in the media, for example: is TV bad for pre-school children? the importance of looking at books; should I use baby talk? The authors could also have included comment on the use of dummies.

My only criticism is that some of the language used may not be easily accessible to all parents and although explained in the text, a glossary may have been a useful addition.

That said, many parents will find much of interest in this book, which clearly succeeds in its aim and represents excellent value for money.

CONTENTS:	READABILITY:	VALUE:
*****	*****	*****

DR DEB GIBBARD
Chief SLT (Paediatrics) Portsmouth City and RCSLT adviser

Any Questions?

Want some information? Why not ask your colleagues?

Email your brief query to **bulletin@rcslt.org**. RCSLT also holds a database of clinical advisers who may be able to help. Contact the information department, tel: **0207 378 3012**.

Early years SIG

Are you interested in joining a South Wales early years SIG, planned to commence this autumn?

Delyth Lewis

EMAIL: **Delyth.Lewis@nglam-tr.wales.nhs.uk**

Integrated service

Do you have any ideas on moving towards an integrated mainstream service or care pathways?

Alison Ford, Kate Goodhew

EMAIL: **alison.ford@staffordshire.gov.uk**

EMAIL: **kate.goodhew@ssh-tr.nhs.uk**

Mainstream schools funding

The Bath paediatric SLT service is developing a service to mainstream schools post Standards Fund and delegated funds to schools. What are other trusts' funding arrangements in their area and how are your services organised?

Olwyn Donnelly

TEL: **01225 840721**

EMAIL: **olwyn.donnelly@banes-pct.nhs.uk**

Informed consent assessment

We are looking at assessing the ability of adults with learning disabilities to make informed consent. What assessments are other therapists using for this?

Geraldine McCluskey

EMAIL: **geraldine.mccluskey@homefirst.n-i.nhs.uk**

Working late/compressed hours

Are you working either late or compressed hours? Have you encountered any difficulties regarding health and safety and reporting in after clinics/visits? How do you get round them?

Esther O'Hara

TEL: **01236 712138/9**

EMAIL: **estherohara@blueyonder.co.uk**

Visispeech Thinkpad

Our Visispeech Thinkpad is broken and attempts to contact the company for help have been unsuccessful. Do you know how we can get in touch with them, or how we could get it fixed?

Jacqueline Galway

TEL: **028 3083 5087**

EMAIL: **jacqueline.galway@dhh.n-i.nhs.uk**

Assistants support

How does your team support SLT assistants working in special schools with regard to training, induction, competencies and clinical supervision?

Hilary Boulton

TEL: **01243 815260**

EMAIL: **hilary.boulton@wsx-pct.nhs.uk**

Intermediate care

I would like to liaise with SLTs working in multidisciplinary community intermediate care teams who provide input to adult clients for six-week periods.

Gillian Coulson

EMAIL: **gillian.coulson@banes-pct.nhs.uk**

Nurse swallow screen

Do you use a nurse swallow screen? We are revamping our screen and nurse training programme and are keen to share ideas and experiences, particularly on the identification of acute versus chronic dysphagia.

Bindi Patel, Cationa Fleming

TEL: **01244 365235**

EMAIL: **bindi.patel@coch.nhs.uk**

Communications policy

Have you written, or do you use a communication policy across your service provision?

Drafts or working policies gratefully received.

Patricia Finnegan

TEL: **0117 928 5000**

EMAIL: **Pat.Finnegan@bristolswpct.nhs.uk**

Intensive therapy aids longer-term aphasia recovery

Short-term intensive speech and language therapy, based on learning principles, can lead to substantial and lasting improvements in language functions in stroke patients with chronic aphasia.

This is the conclusion of a small-scale study undertaken at the University of Konstanz in Germany, and published in the June edition of the American Heart Association journal, *Stroke*.

Researchers looked at the progress of 27 patients: 16 men and 11 women with an average age of 51 who after a stroke, had suffered from varying degrees of aphasia, for about four years. During the study all received 30 hours of intensive training over 10 days.

Sam Tanner

Twelve patients received intensive language training, constraint-induced aphasia therapy (CIAT). According to the study authors, this program is founded on the learning principles of prevention of compensatory communication, massed practice, and shaping.

For the other 15 patients, the training included a module of written language and additional training in everyday communication, which involved the assistance of family members (CIATplus). For example, they went out into real-life situations with their families and were given tasks such as asking a tourist office for suggestions on sightseeing.

The results of the study – using standardised neurolinguistic testing and ratings of the quality and the amount of daily communication – showed that language functions improved significantly after training for both groups and remained stable over a six-month follow-up period.

Single case analyses revealed statistically significant improvements in 85% of the participants.

Patients and relatives of both groups also rated the quality and amount of communication as improved after therapy. This increase was even more pronounced for patients of the group CIATplus in the follow-up.

According to the study authors, the use of family and friends in the training provided an additional valuable element.

"This effective intervention can be successfully used in the rehabilitation of chronic aphasia patients. Additionally, its short-term design makes it economically attractive for service providers" the authors conclude.

REFERENCE: Meinzer, M, *et al*. Long-Term Stability of Improved Language Functions in Chronic Aphasia After Constraint-Induced Aphasia Therapy. *Stroke* 2005; 36:1462.

SLI memory limitations not restricted to verbal memory

Intervention programmes for young children with specific language impairment (SLI) need to extend beyond language in order to help them develop strategies for processing information in different situations, according to Australian research published in the *International Journal of Language and Communication Disorders*.

Researchers used six spatio-visual tasks to compare the performance of 42 children in two groups. The first group of 21 children with SLI had a mean age of 54.1 months. The other age-matched group featured non-impaired children.

The tasks ranged in difficulty from simple recall to a search-based working memory task. All were administered though a laptop computer and responses were non-verbal using a touch screen.

The researchers found that the children with SLI were not significantly slower than the comparison group. However, they were significantly less accurate than the comparison group in recalling patterns, but not in recalling locations. The accuracy for both groups was lower on spatial recall than on pattern recall.

The children with SLI were also significantly less able to learn to associate a particular pattern with a particular location, and to have a shorter spatial span.

The study authors suggest their results indicate that the memory limitations of children with SLI are not restricted to verbal memory, and that this fact has implications for its aetiology.

REFERENCE: Bavin EL, *et al*. Spatio-visual memory of children with specific language impairment: evidence for generalized processing problems. *International Journal of Language and Communication Disorders* 2005; 40:3, 319-332.

Gesture foreshadows changes in children's speech

Gesture is at the cutting edge of early language development, providing stepping-stones to increasingly complex linguistic constructions, American psychologists argue.

Researchers looked at a sample of 40 typically-developing children, each observed at 14, 18, and 22 months, and found the number of supplementary gesture-speech combinations the children produced increased significantly from 14 to 22 months.

More importantly, according to the researchers, the types of supplementary combinations the children produced changed over time and foreshadowed changes in their speech.

"Gesture thus serves as a signal that a child will soon be ready to begin producing multi-word sentences," the authors comment. "The question is what happens next?"

REFERENCE: Özçalışkan Ş, Goldin-Meadow S. Gesture is at the cutting edge of early language development. *Cognition* 2005; 96:3 B101-B113.

Yorkshire SLTs Working with Dysfluency – {Affiliated to National SIG in Dysfluency (UKRI 6)}
9 September, 9.30 - 2.30pm
Cluttering – follow up discussion from our own cases following presentation by Daniel Hunter at our last meeting; Case discussions – *Exploring the link between ASD and disfluency*
Tadcaster Health Centre
Cost: Free
Contact Eileen Hope, tel: 01756 792233 ext 208, email: eileen.hope@anhst.nhs.uk

North West Dysfluency SIG (N34)
12 September, 1.30pm (room available from 12.30 if you wish to bring lunch)
Swindon fluency pack and course; feedback from courses; what works in difficult cases
SLT Dept, Royal Oldham Hospital, Rochdale Road, Oldham OL1 2JH, (All meetings will now be held here)
Cost: Free
Contact Win Ashmore, tel: 0161 627 8971

SIG AAD (L4)
13 September, 10 - 5pm
Dysphagia research and AGM, Paula Leslie, Justin Roe and Chetan Vyas
Undergraduate Lecture Theatre, Whittington Hospital, Highgate Hill
Cost: Members £10/non members £20/students £5
For application forms email: Sig_aad@yahoo.co.uk
Contact Deirdre Cotter, Charing Cross Hospital, Fulham Palace Rd, London W6 8RF

The Yorkshire Paediatric Dysphagia SIG (N16)
19 September, 1.30pm
Interprofessional dysphagia competencies, Liz Boaden, SLT
Tadcaster Health Centre
Contact Sue Craig, Chair, tel: 01274 365461

Lancashire Dysphagia SIG (N27)
21 September, 9am (registration) to 4.30pm
AM: Kate Malcomess – *Clinical decision-making, risk management and duty of care in acquired dysphagia*; PM: *AGM; Issues affecting current practice*
Birchwood Conference Centre, Birchwood, Warrington
Annual membership now due: £10; Course fee: Members £5/non-members £15. Book early, places limited to 40
Contact Liz Jones, tel: 01704 383763; email: elizabeth.jones@southportandformbypct.nhs.uk

Wales SIG in Autism (WA1)
30 September, 9.30 - 3.30pm
Positive strategies to change behaviour that challenges, Clare Jones, SLT, Liverpool. For anyone who works with a child with behaviour that is hard to manage in their setting
RNIB Cymru, Trident Court, East Moors Road, Cardiff
Members £30/non-members £35/annual membership £10 (includes lunch, drinks machine available)
Tel: 029 20371221 to book a place and send cheque, made payable to 'Wales SIG in Autism' to Lynette Hutchings, Treasurer, SIG, Ashgrove School, Sully Road, Penarth, Vale of Glamorgan CF64 2TP

Southwest ASD SIG
12 October, 10 - 4pm
AM – Debbie Onslow (RCSLT); PM – *Feedback on courses/initiatives*
Cost: £10 payable on the day tea/coffee provided, lunch can be pre-ordered in morning session
Hankeridge Arms, Taunton
Places restricted so confirm your place with Becky Hill, tel: 07786 982333

Northwest Voice SIG (N20)
31 October and 1 November, (9.30 - 4.30pm both days)
Advanced laryngeal manipulation course, facilitator Jacob Lieberman
Education and Research Centre
Wythenshaw Hospital, Southmore Rd
Manchester
Members £30/non-members £60
Will include AGM
For an application form contact Colette Fielding, tel: 0161 331 5156, email: colette.fielding@exchange.tgcps-tr.nwest.nhs.uk

Local Groups

Mid and West Kent Local Group
12 September, 7.45 for 8pm
Working in Harmony
Contributions of ideas and examples of working together and with other professionals welcome
The next meeting for all NHS and independent therapists in the area is in the Meetings Room at Sevenoaks Hospital
For further information and to let us know numbers, contact: Cherry O'Neill, tel: 01732 838756 email cherry.oneill@btinternet.com

To advertise your RCSLT-registered SIG event for free send your notice by email only in the following format:

Name of group and registration number, Date and time of event, Address of event, Title of event and speakers, Costs, Contact details

Details may be edited

Send to: viv.robinson@rcslt.org by the beginning of the month before publication. For example, by Monday 8 August 2005 for the September *Bulletin*.

ROYAL COLLEGE OF SPEECH & LANGUAGE THERAPISTS

RCSLT ONE-DAY CONFERENCE 2005

The Communication Context

11 October 2005, at the Royal College of Surgeons

35-43 Lincoln's Inn Fields, London WC2A 3PE

Join the Royal College of Speech and Language Therapists to examine the communication environment and help us to identify good practice and solutions to problems that exist. Open to SLTs and all members of the multidisciplinary team.

Programme

09.30	Registration
10.00	Welcome
10.05	Professor Sally Byng OBE: The Communication Context
11.00	Breakout session: 1 Adults with learning disability; 2 Children: Adults with acquired disorders
12.00 -13.45	Lunch /
12.15- 13.00	RCSLT AGM
13.45	Keynote Speaker: The policy context on choice and equity
14.25	Keynote Speaker: Princess Royal's Trust Carer Network
14.45	Coffee/ Tea
15.00	Breakout session: repeat of morning breakout sessions
16.00	Keynote Speaker: Harry Cayton
16.25	Summing up and next steps
16.30	Close

Name: ..... Organisation: .....

Address: .....

Telephone: ..... Email: .....

Special requirements (e.g. diet, mobility) .....

I would like to register as:

- ☐ RCSLT member (£35)
- ☐ non-member (£62)
- ☐ AGM only (free)
- ☐ AGM only with lunch (£10)

Total payment enclosed .....

Return slip to: Shirley Pollaya, RCSLT, 2 White Hart Yard, London SE1 1NX
or email your details to shirley.pollaya@rcslt.org

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ROYAL COLLEGE OF SPEECH & LANGUAGE THERAPISTS

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Conference outline: We communicate in a varied and complex environment that is often poorly prepared to accommodate individuals with communication problems. Speech and language therapists aim to prepare people with communication, eating, drinking and swallowing problems to lead independent lives. However, many of these people find themselves in hostile or ill-informed environments. Join the Royal College of Speech and Language Therapists to examine the communication environment – from supermarkets and cinemas to schools and hospitals. Help us to identify the barriers, good practice and identify solutions to the problems that exist. The aim of the day will be to produce a statement of good practice.

Costs: RCSLT members £35; non-members £62. The day will include the RCSLT annual general meeting from 12.15 - 1pm. Attendance to the AGM-only is free. If you also require lunch, this will cost £10

For more details or to book your place email: shirley.pollaya@rcslt.org or tel: 0207 378 3024

www.rcslt.org