**Care Pathway encompassing Local Guidelines for**

**Children with a Developmental Speech and Language Impairment**

The care pathway outlined below is designed for any child referred to the Speech and Language Therapy Service who subsequently presents with a developmental speech and language impairment.

This care pathway should be read alongside and in combination with the care pathways for Severe and Specific Speech and Language Impairment; Hearing Impairment; Fluency Disorders; Selective Mutism; Severe and Complex Needs; and Cleft Palate.

By definition, these children will present with failure to make age appropriate progress in speech, language and communication. These children are likely to have inadequate communication for their circumstances and relative to other children of their age. These difficulties may be identified as being delayed or disordered. The speech and language difficulty may arise independently i.e. primarily, or as a consequence or concurrently with other identified difficulties, such as learning, physical, sensory, attention or behavioural difficulties. It may or may not have an identifiable aetiology. Difficulties may arise with receptive language, expressive language, social communication, speech, fluency, or voice (Communicating Quality 3, 2006).

1. **Referral**

As with other client groups, referrals for children with developmental speech and language impairment should come via a health professional for preschool children, or, for school age children, via a CAF or EHA form.

1. **Referral accepted**

Referrals received are screened by a senior Paediatric Therapist using the information on the referral form. The Care Aims model Section 1 form is used to prioritise referrals. Accepted referrals are allocated to either a group triage appointment or an assessment appointment, depending on the level of risk indicated by information on the referral.

1. **Diagnostic assessment**

The majority of referrals accepted will be offered an SLT triage appointment as the first contact with the service. This triage appointment is 20 minutes in length and is provided via a video conference to the parents/carers. The child **MUST** be present for this triage appointment to take place.

A limited number fo face to face triage slots will be offered in local children;s Centre however these will only be allocated where it is apparent from the referral information that a video conference appointment would not be clinically appropriate. Where parents/carers decline a video conference triage appointment and request a face to face appointment, this will be offered however parents/carers will be advised that this will extend their overall waiting time for first contact with the service and therefore the video conference offer should be carefully considered.

The purpose of the SLT triage video conference appointment is for the triaging SLT (band 6 or above) to speak to parents/carers, observe the child and make a judgement as to whether a full clinic based assessment of communication presentation is required. The outcomes from an SLT video conference triage will be one of the following;

* Discharge from service with reassurance/advice – as no role for SLT service
* Re triage within a set time frame (generally 3 – 6 months) – where minor communication concerns are identified and advice is given for implementation in the home/setting to resolve these. It is anticipated that at the point of re triage the case will be closed with the SLT service
* Full assessment at local clinic identified as appropriate
* Discharge from service for children where parents/carers do not attend the offered triage and do not respond to SLT service contact to rebook an appointment

For those children identified either at point of referral or following at triage as requiring a full clinic assessment the following applies;

The initial assessment will usually be completed in a clinic environment (and where clinically appropriate via a video conference offer), via observation, parental report, informal and formal assessment as deemed appropriate by the assessing therapist. A case history is completed during the initial assessment process, using the Paediatric Service questionnaire on SystmOne.

Given the known impact of developmental speech and language impairment on all areas of school life additional diagnostic information may be gathered from the pre-school / school environment. This should be carried out through observation and discussion with staff.

The purpose of the initial assessment is to gather information about the nature and severity of the child’s speech and language difficulties and how these impact upon their functional communication. It is also relevant to seek information on the child’s general developmental profile, and non-verbal IQ skills, in order to ascertain any discrepancy between verbal and non-verbal skills. Assessment may involve all of the subcomponents of language including:

* Receptive language
* Expressive language
* Word-finding
* Speech/phonology
* Pragmatics
* Attention and listening
* Auditory memory
* Play
* Fluency

In order to do this, formal assessment may include, but not limited to the Assessment of Comprehension and Expression (ACE 6 - 11), Communication Development Profile (CDP), Test of Reception of Grammar (TROG), Clinical Evaluation of Language Fundamentals (CELF) and the Nuffield Dyspraxia Assessment.

The therapist will ascertain whether any previous therapy has been accessed, and the outcome of any such intervention. Parental expectations for therapy will be discussed and motivation for change will be considered.

Following the diagnostic assessment, the child / parents / carers will be given information about management options if assessment findings indicate the individual will benefit from Speech and Language Therapy intervention.

Those children who do not need the intervention of the Speech and Language Therapist to continue to develop communication skills will be discharged from the service at this point. For example, children who have a communication difficulty but for whom input may have no real benefit or effect on their skills and/or rate of progress will be discharged.

At this point in the pathway, the local clinician may seek the advice of a specialist therapist, via a supervision discussion or second opinion if indicated, or may continue to manage the case at a local clinic level. If appropriate to the individual’s needs, a child may be transferred to a different care pathway at this point. Opinion of a specialist therapist can also be sought later in the pathway if required.

1. **Intervention episodes**

Information from the diagnostic assessment is used to guide an informed decision about the level of clinical risk each individual child has at that time.

Children may be offered indirect or direct treatment at any time based on their level of clinical risk and need, and the therapist’s informed decision about which intervention strategy is most appropriate at that time.

Different direct treatment options are available, and are outlined on the care pathway flow chart. A therapist may work alongside colleagues in Health and Education Services when working with this client group.

Due to the recognised ongoing and pervasive impact of developmental speech and language impairment on learning and all areas of the National Curriculum, the preferred option is to integrate therapy targets into the curriculum through collaborative practice.

1. **Management commenced with goal negotiation**

Management is guided by assessment findings. Any intervention begins with an agreement of long and short- term goals for each episode of care.

All goal setting is agreed with the individuals involved in therapy. The Malcolmess Care Aims model is followed. It is likely that intervention will aim to maximise the child’s communicative potential, and minimise the impact of the developmental speech and language impairment on their interactions and educational success.

* 1. Indirect

The therapist may make an informed decision that an individual’s case is most appropriately managed by offering indirect therapy. This may involve advising the child or parents / carers of strategies to implement in the home setting with monitoring at individually agreed intervals by the therapist; or implementing indirect intervention strategies at school / nursery, by verbal or written liaison with education colleagues.

* 1. Direct

Direct therapy may involve 1:1, group or pair work in the clinic or a demonstration session if needed (via video conference offered to the educational setting), at intervals agreed between the therapist and child and parents/carers. Direct intervention may be carried out by a Speech and Language Therapist, Assistant Practitioner, or Assistant, under the supervision of the therapist responsible for the case.

Different therapy approaches are used as judged most appropriate for the individual, based on assessment findings and discussion with the child and / or parents/ carers.

Therapists have responsibility to ensure intervention is evidence-based. Intervention options offered locally include:

* Colourful Semantics (Bryan, 1997)
* Derbyshire Language Scheme (Knowles & Masidlover, 1982)
* Meaningful minimal contrast therapy (Weiner & Bankson 1981)
* Parent Child Interaction Therapy – PCI (Kelman & Nicholas, 2008)
* Nuffield Dyspraxia Programme (Williams & Stephens, 2004)
* Shape coding (Ebbels, 1997)
* Narrative Intervention (Shanks, 2001).

The period of direct intervention will be individualised based on a child’s presentation, the evidence base for intervention, carer support and motivation and therefore there will be variations between cases on every open community clinic caseload. As an example an episode of care may take the form of a period of direct intervention (either face to face or via video conference) for up to 8 sessions in a 12 week period, including a consolidation period of up to 8 weeks before the individual’s status and clinical risk is reviewed.

1. **Reassessment**

Following an episode of care the individual’s needs are reassessed. If there is an ongoing clinical risk they may re-enter the care pathway for a further episode of care.

1. **Discharge**

Local discharge procedure is followed when aims of intervention are achieved; no further difficulties present; discharge is requested by the patient (this may be implied through non-attendance) or it is agreed that an individual is able to self-manage their own communication needs. Additionally, a child may be discharged at assessment if it is felt they do not present with communication difficulties and Speech and Language Therapy will not be of benefit to them.

1. **Referral for specialist assessment outside Trust**

Where it is felt that a more specialist opinion is required than can be offered locally, a child may be referred for assessment at a Specialist Centre at any point in the pathway. This may, for example, involve a referral to the Nuffield Hearing and Speech Centre at the Royal National Throat, Nose and Ear Hospital.

**At any point in the pathway, referral may be instigated to other relevant agencies to support needs which go beyond the scope of Speech and Language Therapy, e.g. the Local Authority for Education.**

Referral (i)

Discharge (vii)

Group Triage

Referral accepted (ii)

Diagnostic Assessment (iii)

Local community clinic therapist

Advice sought from local specialist at any relevant point in pathway

Intervention Episodes RISK BASED (iv)

Referral tertiary specialist centres where appropriate (viii)

Management commenced with goal negotiation (v)

**Indirect** (va)

**Direct** (vb)

Liaison with Education, strategies to introduce at home

e.g. PCI, colourful semantics, minimal contrast therapy, Nuffield Dyspraxia Programme

Reassessment (vi)

**References**

Knowles, W. & Masidlover, M. (1982) *The Derbyshire Language Scheme*. Derbyshire County Council.

Weiner, F. & Bankson (1981) Treatment of Phonological Disability using the method of meaningful minimal contrast. *The Journal of Speech and Hearing Disorders.* ASHA.

Williams, P. & Stephens, H. (2004) *Nuffield Centre Dyspraxia Programme 3rd Edition 2004-2009*. NCDP Limited.

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Shanks, B. (2001) *Speaking and Listening through narrative*. Blacksheep Press.

Royal College of Speech and Language Therapists (2006) *Communicating Quality 3.* RCSLT.

Ebbels, S. (1997) *Introduction to Shape Coding*. Moorehouse School.

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