

## Speech, Language and Communication

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# | Speech, Language and Communication

## Introduction

It is widely accepted that speech, language and communication needs (SLCN) can be viewed in three broad sub-groups (Lindsay, et al., 2010), (ICAN, 2006).

- a Children with primary SLCN where language difficulties occur in the absence of any identified neurodevelopmental or social cause, e.g. specific language impairment. These difficulties could be described as being specific and persistent in their nature.
- b Children with cognitive, sensory or physical impairment as their primary need and language difficulties as a secondary need, e.g. SLCN secondary to autism spectrum conditions, a hearing impairment or learning difficulty. These difficulties are likely to be persistent in their nature.
- c Children with SLCN associated with limited experiences, typically associated with socio-economic disadvantage (Lindsay, et al., 2010). These difficulties are transient, i.e. given the right support; children are likely to catch up.

Estimating local prevalence of SLCN is problematic as the term 'speech, language and communication needs' is used to encompass a wide range of difficulties relating to all aspects of communication (DCSF, 2008). Much of the research considers different sub-groups of SLCN within specific age bands.

### **What Does this Chapter Do?**

This chapter provides a summary of the SLCN Health Needs Assessment undertaken by Sexton, et al., 2013. It outlines why speech and communication is important for children and young people in the context of health inequalities, the groups that are at risk and why. It then goes on to estimate the size of the need in Kent whilst at the same time reporting on the limitations of the methodology that was applied. It ends with a set of recommendations which will lead to developing a more accurate estimation of need and clarity of commissioning in order to meet this need.

It is important to note that some of these recommendations are in progress. Please contact the author for any updates.

### **Why is it Important?**

Children's language skills develop particularly quickly in the first three years of their lives (Evangelou, et al., 2009). These skills are critical to how a child engages with his or her environment. Communication and language have two aspects: comprehension or understanding of how the language is spoken, heard or read; and use of language – that is, speaking and in some cases, in the early years, their own writing.

Communication begins with the crying of very new babies, the cooing noises as they grow a bit older, the sounds that become words and the words that become sentences. Infants

begin to develop an understanding of sounds and associate them with voices they hear regularly.

Language development and in particular multiple-word sentences at age two are a strong predictor of children's performance on entry to primary school (Lindsay, et al., 2011).

Vocabulary is a predictor of later-life outcomes, including, but not only, their success in learning to read (Hart and Risely, 2003). Children's phonological skills at age five are strong predictors of reading at age seven and their vocabulary skills at age five are similarly useful in anticipating the complex tasks of reading at age 11 (Evangelou, et al., 2009). Marchman and Fernald in the UK have demonstrated powerful links between vocabulary use at 25 months and a range of cognitive abilities including language use at age eight (Fernald & Marchman, 2008). Feinstein showed that vocabulary use at five years old was one of the two most powerful predictors of reading at 10 years old and a particularly powerful predictor of maths at that age (Feinstein, 2003). Vocabulary tests at age five are highly predictive of later life outcomes including income at age 30. Children who are shown to have language problems at age five (based on scores on the English Picture Vocabulary Test) have been shown to have comparatively low levels of language skills at age 34 (Feinstein and Duckworth, 2006), (Schoon, et al., 2010). Persistence of poor language and communication skills into adulthood has been linked to a higher rate of unemployment, low earnings and ill health (Caird, et al., 2011) (Gutman and Feinstein, 2007).

Children with poor language and communication also have more behavioural difficulties and problems with social communication (Lindsay, et al., 2011). Research on children with diagnosed speech and language impairments suggest that they struggle to develop friendships at the same rate and level as other children, even from pre-school days. Poor language skills can leave a child less sensitive to others' starting interactions, more likely to have inappropriate verbal responses and achieve fewer agreements (Conti-Ramsden and Durkin). While these children have specific impairments, the relationship between strong verbal skills and peer relationships is likely to exist with other children.

Poor language skills in adulthood are also closely associated with ill-health and with poor self-management of chronic conditions (Caird, et al., 2011).

## Who's at Risk and Why?

### Inequality in Speech, Language and Communication

Socio-economic adversity is negatively associated with children's language and communication development (Raviv, et al., 2004) (White, 1982). Compared with children with good language ability, those with very limited or poor language skills are more likely to grow up in relatively disadvantaged circumstances in socio-economic terms as well as in terms of their early literacy environment. One study of children growing up in poverty found that more than 50% of the children were language- delayed, although girls' receptive language abilities were significantly better than boys (Locke, et al., 2002).

Children from high socio-economic groups have been shown to use more types of words than children from middle socio-economic groups. A study by Hoff (see table below) showed children from higher socio-economic backgrounds have a greater variety of words than other children (Hoff, 2003).

Analysis of the Millennium Cohort Study also suggests that poorer children have worse vocabulary. Using the British Ability Skills (BAS) Early Years Version Naming Vocabulary tests, Dearden, et al 2001, found a gap between children from the highest socio-economic quintile and those from the lowest quintile at age three and this gap widened by age five.

Moreover the same research showed that children from lower socio-economic groups who were performing well on vocabulary tests at age three were more likely to be performing less well by age five than children with the same ability at age three from higher socio-economic groups. Similarly among those who were performing relatively poorly at age three, children from higher socio-economic groups were more likely to be performing relatively better at age five.

A number of studies have tried to explain why poor children lag behind their better off peers in the development of their language. Dearden, et al's work with the Millennium Cohort Study showed that parenting skills and the quality of the home learning environment explain a large percentage of the difference. But other family characteristics such as mother's age, parental education and number of siblings also seem to matter and are not entirely explained by differences in the parenting variables (Dearden, et al., 2011).

In their 2003 study of vocabulary in the United States, Hart and Risely echo this focus on children's experience at home. Children of poorer parents (classified as parents on welfare in the US context) heard half as many words per hour as their working-class peers and less than a third of the words of their peers from professional families (Hart and Risley, 2003).

The impact is cumulative so that by the age of four a child of a poorer family has on average heard 13 million fewer words than a child from a middle-income family.

## **Neurodevelopment, Learning, Physical, and Sensory Disabilities**

Speech, language and communication needs are a feature of and coexistence with a number of neurodevelopmental, learning, physical and sensory disabilities. These include autistic spectrum disorder, profound learning disability, cleft lip or palate and hearing loss.

### **Young offenders**

Young offenders in the community and in custody have high levels of speech, language and communication need. Research has been undertaken with young people in custodial settings who present the highest level of complexity and health need. An Intensive support programme for persistent young offenders has also been the subject of research and shows that 60% of new entrants have a communication need (Bryan and Gregory, 2009).

Over half of children and young people in custody in the youth justice system (YJS) have difficulties with speech, language and communication. A small scale study 'showed that up to 73 per cent had language test scores significantly below those expected for their age group'. The study went on to assess speech, language and communication needs (SLCN) in another young offender institution (YOI) and found that 'over half of those assessed (number 58) scored within the 'poor or very poor' range in terms of their speech (67%) and listening skills (62%) (as opposed to 9% of the typical adolescent population)' (Ryan and Tunnard, 2012).

An intensive support programme for persistent young offenders has also been the subject of research and shows that 60% of new entrants have a communication need (Bryan and Gregory 2009).

### **Estimation of Prevalence**

In order to properly assess whether a population's needs are being met, it is first necessary to know the details of the population and its needs. Identifying the total level of speech, language and communication needs (SLCN) in children and young people in a local area, however, is problematic. Firstly, SLCN is not consistently defined. It encompasses a wide range of needs, there is a high degree of co-morbidity and there are variations in the terms used to describe sub-groups of SLCN. In addition, a child's SLCN will usually change as they develop, meaning that numbers vary by age, type and severity of SLCN.

### **Estimated Prevalence for Transient Need**

Approximately 50% of children at school entry in socio-economically disadvantaged populations have speech and language skills (transient impairment) that are significantly lower than those of other children of the same age.

## Primary and Secondary Speech and Language Needs

National prevalence data (ICAN, 2006) (DCSF, 2008) suggests that:

- a About 6% of all children have specific and primary speech and language impairments.
- b Up to 10% of all children have a long-term persistent communication disability. This includes children with primary and secondary SLCN.

It is ambiguous whether these prevalence figures can be applied to young people between 11-19 years. Most research considers pre-school or primary school age children only, with limited evidence for the prevalence of SLCN at secondary school age and above.

There is a general consensus that between six and eight per cent of children are likely to have significant SLCN in the preschool and pre-secondary periods. In addition, one per cent of five year olds entering school are estimated to have severe, complex and long-term needs requiring specialist support in school and beyond (Commissioning Support Programme, 2010). These children may not understand very much of what is said to them, have very little spoken language and often need to use alternative and augmentative means of communication (DCSF, 2008).

Exactly which prevalence figures are best used for estimating a whole population is debatable, though all are high. It is possible to judge the Kent population to be anything from a conservative 11,070 children with significant SLCN (6% of children under 11) to 35,000 with primary or secondary SLCN (10% of children under 20).

Moving on to specific sub-groups within SLCN, it is possible to estimate indicative numbers of children with specific conditions that are likely to produce a service requirement to meet SLCN. Utilising a method of calculating prevalence given by Chartered Society of Physiotherapy (CSP, 2010) and Royal College of Speech and Language Therapists (RCSLT, 2009), the following can be estimated. It is not intended that the table below be used as a reference for the SLCN population in Kent. The totals cannot be added as there would be significant double counting, and there is a lack of prevalence data for older children – therefore this is not an exhaustive list of sub-groups within SLCN. Rather, this table serves to demonstrate how national figures can be translated to estimates for the local population, as well as to highlight the complexity of doing so.

**Table 1: Shows the prevalence estimates for the Speech and Language Impairments**

	Prevalence %	0-5yrs	Prevalence %	6-11yrs	Prevalence %	12-19yrs	Total
Total Population		103,310		98,342		148,833	350,485
Dysfluency	5.0	5,166					5,166
Speech Impairment	1.5 - 4.5	1,550 - 4,649	4.5 - 12.6	4,425 - 12,391	7.3	10,865	16,840 - 27,911
Language Impairment	5.9	6,095	5.9	5,802			11,897
Autistic Spectrum Disorder	0.2 - 1.0	207 - 1,033	0.2 - 1.0	197 - 983	0.2 - 1.0	298 - 1,488	702 - 3,504
Learning Disability (mild)	2.0	2,066	2.0	1,967	2.0	2,977	7,010
Learning Disability (moderate/profound)	0.35	362	0.35	344	0.35	521	1,227
Stammer	5.00	5,166					5,166
Stammer - persistent	1.00	1,033	1.00	983	1.00	1,488	3,504
Cleft lip or palate	0.14 - 0.19	145 - 196					145 - 196
Hearing Loss (moderate/severe/ profound)	2.6/1000 per year	269	2.6/1000 per year	256	2.6/1000 per year	387	911

## Service Provision in Kent

There are many professionals working with children across the age range who with parents and carers promote speech, language and communication to meet the needs of children with additional needs. This includes, in the 0-5 age group, health visitors, Children's Centre workers and early education providers; in five to 19 age group, teachers, school support staff, Special Educational Needs Co-ordinators (SENCOs) and children's social care.

Kent County Council (KCC) Special Educational Needs (SEN) is developing the use of a nationally recognised framework called the Balanced System<sup>®</sup>. This is for commissioning and quality assurance measures for provision related to Speech, Language and Communication Needs (SLCN). The Balanced System<sup>®</sup> is a framework and suite of tools and templates that can be used to improve the commissioning and delivery of services that benefit from an integrated approach to delivering outcomes. This includes all related levels of support for students with specific language and communication needs and those with communication needs related to Autism Spectrum Disorders (ASD). KCC are working with Better Communication, CIC and Kent CCGs towards:

1. Construction and roll out of a relevant and evidence based service specification for providers of support services for children with SLCN.
2. Expand the adoption of an agreement to this framework for commissioning from all types of commissioners for all age groups of Children and Young People's Services for SLCN in Kent. This would be consistently implemented and reviewed as the basis for further joint commissioning with all partners for the whole range of SLCN presenting to KCC SEN, health providers, schools and social care settings for 0 to 25 year olds.

As part of this process Better Communication CIC has carried out some quantitative analysis. The following tables are taken from this analysis.

Table 2 below shows the level of predicted need in each district. This demonstrates that predicted need (as a percentage of the total child population) is highest in Thanet and Swale and lowest in West Kent districts.



**Table 2:**

BALANCED SYSTEM® SLCN PREDICTED NEED BY DISTRICT														
NUMBER OF CHILDREN PREDICTED TO HAVE SLCN IN EACH LOCAL AUTHORITY DISTRICT <sup>13</sup>														
	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Sevenoaks	Shepway	Swale	Thanet	Tonbridge & Malling	Tunbridge Wells	Whole Area Total Kent	
Predicted need by district and age band (no. of children)	0-4 yrs	2,116	1,991	2,068	2,036	2,422	2,412	1,069	2,071	3,666	3,890	1,039	883	25,663
	5-9 yrs	2,170	2,043	1,848	2,136	2,288	2,341	1,099	2,106	3,546	3,797	1,123	960	25,457
	10-14 yrs	1,318	1,314	1,020	1,232	1,260	1,421	736	1,200	1,921	2,079	834	723	15,058
	15-18 yrs	765	914	607	775	758	864	508	729	1,126	1,212	601	532	9,391
	19-24 yrs													
ALL need (0-18 yrs)	6,369	6,262	5,543	6,179	6,728	7,038	3,412	6,106	10,259	10,978	3,597	3,098	75,569	
ALL need (0-24 yrs)														
% of local child pop'n (0-18) with predicted SLCN	21%	20%	22%	25%	26%	19%	12%	27%	31%	35%	12%	11%	22%	
% of all predicted SLCN need (across Kent) within this district	8%	8%	7%	8%	9%	9%	5%	8%	14%	15%	5%	4%	100%	
% of child pop'n (across Kent) in this district	9%	9%	7%	7%	7%	11%	8%	7%	10%	9%	9%	8%	100%	

Table 3 below shows the number of children with special educational needs (SEN), with Education, Health and Care Plans (EHCPs) or Statements of SEN and with SEN with SLCN as the primary need. This demonstrates that the percentage of the local child population who have SEN with SLCN as their primary need is also highest in Thanet and Swale and lowest in the West Kent districts.

**Table 3:**

SPECIAL EDUCATIONAL NEED DATA <sup>22</sup>													
Children with Special Educational Need, with Education, Health and Care Plans or Statements of SEN and with SEN with SLCN as the primary need													
	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Sevenoaks	Shepway	Swale	Thanet	Tonbridge & Malling	Tunbridge Wells	Whole Area Total for Kent
<b>SEN SUPPORT</b>													
Total number of children with SEN support (0-18 years)	2,160	2,530	1,965	1,720	2,050	2,790	1,665	2,030	2,855	2,805	2,250	2,505	27,325
% of local child population with SEN Support	7.15%	8.08%	7.86%	7.05%	7.98%	7.56%	6.10%	8.94%	8.50%	8.90%	7.38%	8.91%	7.87%
<b>EHCP / STATEMENT OF SEN</b>													
Total number of children with an EHC Plan / Statement of SEN (0-18 years)	625	625	320	515	450	680	615	480	625	855	505	495	6,790
% of local child population with a EHC Plan / Statement of SEN	2.07%	2.00%	1.28%	2.11%	1.75%	1.84%	2.25%	2.11%	1.86%	2.71%	1.66%	1.76%	1.96%
<b>SLCN</b>													
Total number of children with SEN SLCN as their primary need category (0-18 years)	537	549	342	369	465	410	290	368	732	808	397	298	5,565
% of local child population with SEN SLCN	1.78%	1.75%	1.37%	1.51%	1.81%	1.11%	1.06%	1.62%	2.18%	2.57%	1.30%	1.06%	1.60%
Number of children with SLCN primary need who have SEN support (0-18 years)	1900	1985	1630	1270	1840	2210	1130	1805	2575	2580	1705	1325	21,955
Number of children with SLCN who have an EHC plan / Statement of SEN (0-18 years)	170	535	205	160	335	435	345	320	555	580	270	415	4,325

<sup>22</sup> Data Sourced from Special Educational Needs in England 201 Available online from: <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2015> from SFR25\_2015\_UD mapped to district level by ward, published July 2015.

Table 4 shows data on speech and language therapy referrals by team and age band. This shows that the majority of referrals are for children aged 0 to 4 years.

**Table 4:**

SLT SERVICE DATA: REFERRALS																	
REFERRALS IN 12 MONTHS, BY SLT TEAM AND AGE BAND <sup>23</sup>																	
		NHS Ashford		NHS Canterbury and Coastal		NHS Dartford, Gravesham & Swanley		NHS South Kent Coast		NHS Swale		NHS Thanet		NHS West Kent		Whole Area Kent	
		No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages
Number of referrals	0-4	411	59.1%	394	46%	674	79%	529	60%	-	-	361	56%	874	72.0%	3,243	55.23%
	5-9	152	21.9%	361	42%	158	18%	200	23%	-	-	279	44%	258	21.5%	1,801	30.67%
	10-14	103	18.8%			22	2.6%	126	14%	1	0.1%			73	6%		
	15-18	28	4.0%			3	0.4%	31	3%	-	-			6	0.5%		
	19-24	1	0.1%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	0.02%
	No age given	-	-	107	12%	-	-	-	-	720	99.9%	-	-	-	-	720	12.26%
All ages	695	100%	862	100%	857	100%	886	100%	721	100%	640	100%	1211	100%	5,872	100%	
Proportion of all referrals (whole area) conducted by this team (%)	0-4	13%		12%		21%		16%		-		11%		27%		100%	
	5-9	16%		20%		10%		20%		-		15%		19%		100%	
	10-14	16%		20%		10%		20%		-		15%		19%		100%	
	15-18	16%		20%		10%		20%		-		15%		19%		100%	
	19-24	100%		0%		0%		0%		0%		0%		0%		100%	
	No age given	0%		0%		0%		0%		100%		0%		0%		100%	
All ages	12%		15%		15%		15%		12%		11%		21%		100%		

<sup>23</sup> All referrals data is provided by service providers, of which there are 3: Medway Community Healthcare is as at February 2016 and covers part of Swale. East Kent Hospital Trust (EKHT) is as at April 2016 and covers Ashford & South Kent Coast with a few additional numbers for Canterbury Coastal, Dartford, Gravesham & Swanley, Swale, Thanet and West Kent. Kent Community Health Foundation Trust (KCHFT) is as at February 2016 and covers Canterbury Coastal, Dartford, Gravesham & Swanley, Thanet and West Kent. Figures for KCHFT include both USLT and ITACC. Please note that where there are multiple providers in one CCG figures have been added together and where a provider crosses CCG's the total is proportioned according to child population percentage. So East Kent crosses Thanet and Canterbury which has been split so that Thanet has 43% and Canterbury has 57% of the provider's figures.

Table 5 shows the number of children on SLT caseloads by team and age band and table 6 shows the number of children on waiting lists

**Table 5:**

SLT SERVICE DATA: CASELOAD																	
CHILDREN ON CASELOAD, BY SLT TEAM AND AGE BAND <sup>24</sup>																	
		NHS Ashford		NHS Canterbury and Coastal		NHS Dartford, Gravesham & Swanley		NHS South Kent Coast		NHS Swale		NHS Thanet		NHS West Kent		Whole Area Kent	
		No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages
Number on caseload	0-4	295	26.4%	5	0.5%	40	3%	398	29.7%	242	35.0%	92	11.1%	552	43.7%	1,624	21.7%
	5-9	480	43.0%	19	1.9%	11	1%	602	45.0%	360	52.0%	128	16.3%	710	56.3%	3,102	41.5%
	10-14	230	20.6%	29	2.9%			243	18.2%	84	12.0%						
	15-18	108	9.7%	4	0.4%			89	6.7%	5	1.0%						
	19-24	4	0.4%	0	0.0%	-	-	6	0.4%	-	-	0	0%	0	0%	10	0.1%
	No age given	-	-	927	94.2%	1241	96%	-	-	-	-	563	72.9%	-	-	2,731	36.6%
All ages	1,117	100%	984	100%	1,292	100%	1,338	100%	691	100%	783	100%	1,262	100%	7,467	100%	
Proportion of children on caseload (whole area) with this team (%)	0-4	18%		0.3%		2%		25%		15%		6%		34%		100%	
	5-9	18%		0.3%		2%		25%		15%		6%		34%		100%	
	10-14	26%		2%		0%		30%		15%		4%		23%		100%	
	15-18	26%		2%		0%		30%		15%		4%		23%		100%	
	19-24	40%		0%		-		60%		-		0%		0%		100%	
	No age given	-		34%		45%		-		-		21%		-		100%	
All ages	15%		13%		17%		18%		9%		10%		17%		100%		

<sup>24</sup> [1] All caseload data is provided by service providers, of which there are 3: Medway Community Healthcare is as at February 2016 and covers part of Swale. East Kent Hospital Trust (EKHT) is as at April 2016 and covers Ashford & South Kent Coast with a few additional numbers for Canterbury Coastal, Dartford, Gravesham & Swanley, Swale, Thanet and West Kent. Kent Community Health Foundation Trust (KCHFT) is as at February 2016 and covers Canterbury Coastal, Dartford, Gravesham & Swanley, Thanet and West Kent. Figures for KCHFT include both USLT and ITACC. Please note that where there are multiple providers in one CCG figures have been added together and where a provider crosses CCG's the total is proportioned according to child population percentage. So East Kent crosses Thanet and Canterbury which has been split so that Thanet has 43% and Canterbury has 57% of the provider's figures.

**Table 6:**

SLT SERVICE DATA: WAITING LISTS																		
WAITING LISTS, BY SLT TEAM AND AGE BAND <sup>25</sup>																		
		NHS Ashford		NHS Canterbury and Coastal <sup>26</sup>		NHS Dartford, Gravesham & Swanley		NHS South Kent Coast		NHS Swale		NHS Thanet		NHS West Kent		Whole Area Kent		
		No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	No.	% of all ages	
Number of children on all waiting lists (for assessment and therapy)	0-4	70	36%	344	92%	119	30%	123	45%	177	65%	260	89%	478	90%	1,571	68%	
	5-9	65	34%	30	8%	55	14%	85	31%	96	35%	31	11%	53	10%	537	23%	
	10-14	36	19%					45	16%	-	-							
	15-18	20	10%					21	8%	-	-							
	19-24	1	1%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	0%	
	No age given	-	-	-	-	217	55%	-	-	-	-	-	-	-	-	-	217	9%
	All ages	192	100%	374	100%	391	100%	274	100%	273	100%	291	100%	531	100%	2,326	100%	
Proportion of all children on wait lists (whole area) waiting with this team (%)	0-4	4%		22%		8%		8%		11%		17%		30%		100%		
	5-9	23%		6%		10%		28%		18%		6%		10%		100%		
	10-14	100%		0%		0%		0%		-		0%		-		100%		
	15-18	-		-		100%		-		-		-		-		100%		
	19-24	-		-		-		-		-		-		-		100%		
	No age given	-		-		-		-		-		-		-		100%		
	All ages	8%		16%		17%		12%		12%		13%		23%		100%		

<sup>25</sup>All Waiting List data is provided by service providers, of which there are 3: Medway Community Healthcare is as at February 2016 and covers part of Swale. East Kent Hospital Trust (EKHT) is as at April 2016 and covers Ashford & South Kent Coast with a few additional numbers for Canterbury Coastal, Dartford, Gravesham & Swanley, Swale, Thanet and West Kent. Kent Community Health Foundation Trust (KCHFT) is as at February 2016 and covers Canterbury Coastal, Dartford, Gravesham & Swanley, Thanet and West Kent. Figures for KCHFT include both USLT and ITACC. Please note that where there are multiple providers in one CCG figures have been added together and where a provider crosses CCG's the total is proportioned according to child population percentage. So East Kent crosses Thanet and Canterbury which has been split so that Thanet has 43% and Canterbury has 57% of the provider's figures.

<sup>26</sup>Please note that there is no data available for the Canterbury & Coastal ITACC under awaiting therapy so this data is lower than the actual.

Table 7 compares the distribution of the child population across Kent with the distribution of children on SLT caseloads, referrals and waiting lists. This demonstrates that the proportion of children on the total Kent caseload who come from Thanet and Swale is roughly similar to the proportion of the total child population who live in these two areas. Given that predicted need is considerably higher in Thanet and Swale it would be expected that they should form a bigger proportion of the total Kent caseload than is actually the case. This suggests there is likely to be considerable unmet need in these areas.

**Table 7:**

**Kent Comparison Tables: SLT distributions vs. Population**

TABLE 14														
SLT DISTRIBUTIONS BY DISTRICTS & CCGs: Kent <sup>29</sup>														
		Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Sevenoaks	Shepway	Swale	Thanet	Tonbridge & Malling	Tunbridge Wells	WHOLE AREA Kent
Proportion of Kent total in each district (%)	District Proportion of Kent total child population 0-19 (%)	9%	9%	7%	7%	7%	11%	8%	7%	10%	9%	9%	8%	100%
	Deprivation based estimated proportion of Kent SLCN (%)	8%	8%	7%	8%	9%	9%	5%	8%	14%	15%	5%	4%	100%
	District proportion of Kent children with a Statement of SEN / EHCP	9.2%	9.2%	4.7%	7.6%	6.6%	10.0%	9.1%	7.1%	9.2%	12.6%	7.4%	7.3%	100%
	District proportion of Kent children with a Statement of SEN / EHCP for SLCN	3.9%	12.4%	4.7%	3.7%	7.7%	10.1%	8.0%	7.4%	12.8%	13.4%	6.2%	9.6%	100%
	Proportion of Kent total SLT Workforce (WTE)	Workforce data not supplied												
Proportion of project area (Kent) total in each district (%)		NHS Ashford	NHS Canterbury & Coastal	NHS Dartford, Gravesham & Swanley	NHS South Kent Coast	NHS Swale	NHS Thanet	NHS West Kent	WHOLE AREA Kent					
	Proportion of Kent total child population 0-19 (%)	9%	12%	18%	13%	8%	9%	33%	100%					
	Proportion of Kent total SLT team Referrals (%)	12%	15%	15%	15%	12%	11%	21%	100%					
	Proportion of Kent total SLT team assessment Waiting Lists (%)	8%	16%	17%	12%	12%	13%	23%	100%					
	Proportion of Kent total SLT team Caseloads (%)	15%	13%	17%	18%	9%	10%	17%	100%					

<sup>29</sup> Please note this table is a summary table and use the previous quantitative tables information. Referrals, Waiting Lists and Caseload data is as at February 2016 from Medway Community Healthcare and Kent Community Health Foundation Trust and for April from East Kent Hospital Trust.

Table 8 compares the extent to which distribution of the SLT caseload differs from both child population and predicted need. This shows that children in Thanet, Swale and West Kent form a lower than expected proportion of speech and language therapy caseloads once level of need has been taken into account.

**Table 8:**

SLT DISTRIBUTIONS SUMMARY TABLE FOR KENT <sup>32</sup>								
		NHS Ashford	NHS Canterbury and Coastal	NHS Dartford, Gravesham & Swanley	NHS South Kent Coast	NHS Swale	NHS Thanet	NHS West Kent
Proportion of total (across Kent) within each SLT area (%)	Proportion of Kent total child population 0-19 (%)	8.7%	12.0%	17.5%	12.5%	7.8%	9.1%	32.5%
	Deprivation based estimated proportion of Kent SLCN (%)	8.0%	8.0%	16.0%	16.0%	14.0%	15.0%	23.0%
	Proportion of Kent total SLT team Caseloads (%)	15.0%	13.0%	17.0%	18.0%	9.0%	10.0%	17.0%
	Proportion of Kent total SLT Workforce (WTE)	Workforce data not supplied						
Extent to which distribution differs from child population distribution (%)	Proportion of Kent total SLT team Caseloads (%)	72.4%	8.3%	-2.9%	44.0%	15.4%	9.9%	-47.7%
	Proportion of Kent total SLT Workforce (WTE)	Workforce data not supplied						
Extent to which distribution differs from predicted SLCN (%)	Proportion of Kent total SLT team Caseloads (%)	87.5%	62.5%	6.3%	12.5%	-35.7%	-33.3%	-26.1%
	Proportion of Kent total SLT Workforce (WTE)	Workforce data not supplied						

## Evidence of What Works

### Transient Need

The evidence suggests that parents are the strongest drivers and enablers of children's communication and language development (Raviv, et al., 2004).

Direct intervention to build children's language and breadth of vocabulary may have limited impact. In the US study discussed above, children retained new words that they were directly taught but there was no impact on the pace at which they developed their own vocabulary outside of the sessions. As Hart and Risely write:

'However many new words we taught the children in the pre-school, it was clear a year later, when the children were in kindergarten that the effects of the boost in vocabulary resource would have washed out' (Hart & Risely, 2003).

The Effective Provision of Pre-School Education (EPPE) study suggests that pre-school can have a significant impact on children's language development with the effective size growing as children spend more time in pre-school. The work points to teaching songs and nursery rhymes as particularly linked to improved language. The evidence suggests that attendance for more than one year is particularly important for pre-reading. EPPE also looked at the impact of a mother having a degree versus no qualification. Only attendance for three years at pre-school had greater effect than a mother having a degree.

Those children's centres not providing pre-school need to be aware of how their communication can help or hinder children's development. In the main, children's centres should focus their efforts on supporting parents to provide a high-quality home learning environment, increasing their own range of vocabulary and conversation and should encourage parents to take advantage of free, high-quality pre-school provision or paid provision where it can be afforded (Adamson, 2008).

## Recommendations for Commissioning

### a Data Refinement

A Kent-wide dataset needs to be developed and utilised across the commissioning of Speech and Language Therapy (SALT). This will enable the on-going estimation of population need.

### b Social Disadvantage/Transience and Access to SALT

Children's and early education centres have a crucial role to play in levelling up children born into materially disadvantage so that they are school ready by the age of four to five. Accordingly SALT services must be available or at least accessible from every children's centre and these workers need the skills to promote speech, language and communication development as well as assess additional needs.

### c Two and a Half Year Health Visitor Check

The two and a half year check has the potential to identify speech and language needs in order to intervene early. The check needs to be computerised in order to identify population need and trends.

**d Ethnicity**

Ethnicity and Speech Language Communication Need in Kent needs further investigation. There is some evidence from the data to suggest that currently SLCN and SALT access may not be sufficient and not reflective of the needs of children growing up in communities where English may not be the first spoken language within a family.

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