Chit Chat Implementation Guide

An Early Intervention Speech and Language Therapy Model

Chit Chat

2016
CHILDHOOD DEVELOPMENT INITIATIVE

Any citation of this report should use the following reference:
Smith, G. (2016). *Chit Chat Implementation Guide: Early Intervention Speech and Language Therapy: Implementation Guide. Dublin*: Childhood Development Initiative.

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Published by Childhood Development Initiative, Dublin

ISBN 978-0-9928763-6-4

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Glossary

Early Years' Services: This is an overarching term that includes pre-schools, play groups, nurseries, crèches, day-care and similar services which cater for children aged 0-6.

Evidence-based programme (EBP): Programmes which are based on research and are proven to work.

Fidelity: The degree to which a programme is delivered compared to the essential elements of the original programme.

Manualised approach: Where service delivery is guided by a manual. The manual should contain clearly defined outcomes to be achieved, clear target criteria, a strong logic model and well-defined service components.

Lámh: Lámh is a manual sign system used by children and adults with intellectual disability and communication needs in Ireland. Lámh signs are used to support communication.

Logic Model: is a tool for programme planning, implementation and evaluation, clearly describing a programme's goals, tasks, activities and anticipated outcomes, linking to evidence and best practice.

PECS: Picture exchange augmentative/alternative communication intervention package for individuals with autism spectrum disorder and related developmental disabilities.

Quality: The standard of something as measured against other things of a similar kind.

Acronyms

ABC	Area Based Childhood Programme
AP	The Atlantic Philanthropies
CDI	Childhood Development Initiative
CES	Centre for Effective Services
DCYA	Department of Children and Youth Affairs
EBP	Evidence-based programme(s)
EIP	Evidence Informed Practice
EIS<M	Early Intervention Speech and Language Therapy Model
ENT	Ear, Nose and Throat
HSE	Health Services Executive
IASLT	The Irish Association of Speech and Language Therapists
IG	Implementation Guide
MOU	Memorandum of Understanding
PECS	Picture Exchange Communication System
PCF	Parent/Carer Facilitator
PEIP	Prevention and Early Intervention Programme
PSLT	Principle Speech and Language Therapist
SLT	Speech and Language Therapy/Therapists
TOR	Terms of Reference
TW	Tallaght West

Acknowledgments

CDI would like to thank the CDI Speech and Language Therapists (present and past); the HSE Principal S< early year's services; schools and parent/carer facilitators; children and parents who have contributed to the continued success of the CDI Speech and Language model of delivery and have made this Implementation Guide possible, and indeed necessary. CDI would also like to thank CDI SLTs – Michelle Quinn and Caitriona Mulhall; HSE Principal SLT – Rosemary Curry and her team; and expert reviewers – Aisling Gillen (Tusla) and the Irish Association of Speech and Language Therapists (IASLT); who have taken the time to read this Implementation Guide and provide feedback.

Finally, this Guide would not have been possible without the financial support of the Department of Children and Youth Affairs and The Atlantic Philanthropies. Their focus on prevention and early intervention to support children and families has provided a solid policy context within which CDI has been able to develop its work. We acknowledge and thank them for both the resources provided and their support for using evidence-informed approaches to improving outcomes for children and families.

Suzanne Guerin
Chair
CDI Board of
Management

Introduction

This Implementation Guide will give an introduction to implementation and the science or theory behind it, and will specifically describe the implementation of Chit Chat: CDI's Early Intervention Speech and Language Therapy Model. It will explain the steps necessary to set up and implement the model and what is required in terms of on-going support to ensure effective service delivery. There are of course various models of Speech and Language (S&L) service delivery, however, this document is based on CDI's approach and experience. CDI's *Quality Services, Better Outcomes Workbook* (Murphy *et al*, 2011) acts as a companion to this Guide, informing all stages in the process of ensuring quality service provision. It can be found at www.twcdi.ie

The Guide is presented in six sections, with accompanying appendices, as follows:

- This **Introduction** provides an overview of the Childhood Development Initiative (CDI) and Chit Chat and then goes on to discuss implementation, how to use this Guide and logic modeling.
- **Section 1** provides an overview of Chit Chat. It goes on to outline the steps to be taken in **exploring and preparing** for the introduction of the service by discussing community readiness, the identification of key stakeholders, the development of promotional materials, and the partnership approach.
- **Section 2** looks at what is involved in **planning and resourcing** Chit Chat, including the structures to support delivery; budget; identifying appropriate staff and completing the recruitment process; and putting in place the necessary resources.
- **Section 3** is about **implementing and operationalising** the service. It discusses the delivery of the service along with monitoring and quality supports.
- **Section 4** concerns **'business as usual'** and discusses consolidation and what it will take to ensure that the service is sustainable.
- **Section 5** concludes the Guide with a list of things to consider to keep your model of S&L delivery running smoothly, and to maximise its' sustainability.

The Childhood Development Initiative:

The Childhood Development Initiative (CDI) is funded under the Government's Area-Based Childhood (ABC) Programme, which builds on the learning to date from the Prevention and Early Intervention Programme (PEIP). The initiative aims to break the cycle of child poverty in areas where it is most deeply entrenched and to improve the outcomes for children and young people where these are currently significantly poorer than they are for children and young people living elsewhere in the State (DCYA, 2013).

CDI was initially established through a partnership between the Department of Children and Youth Affairs (DCYA) and The Atlantic Philanthropies (AP) under the PEIP, which was set up with the objective of testing innovative ways of delivering services and early interventions for children and young people, including wider family and community settings. CDI designed, delivered and evaluated a suite of programmes across a spectrum of local needs on language, literacy, health, early years, conflict management and community safety. All CDI programmes are evidence-informed and delivered through existing structures and services and some are manualised.

This Implementation Guide draws on the independent evaluations of CDI's programmes (available at www.twcdi.ie/resources-information-centre/evaluationreports) and lengthy experience in supporting the delivery of high-quality evidence-informed services.

The following sections will give a generic overview of processes which support quality delivery and will be followed by detail in relation to operationalising Chit Chat: CDI's Early Intervention Speech and Language Therapy Model.

Background and Underpinning Principles:

CDI arose from the professionalism, passion and persistence of a group of committed individuals and organisations in Tallaght West. Coming together with a vision of creating a safe and healthy place for children, this consortium led the thinking, consultation and negotiations that culminated in Tallaght West being designated as one of three Prevention and Early Intervention locations, subsequently to receive funding under the Area Based Childhood Programme (ABC).

These roots in the community have defined the ethos and practice of CDI, with community development principles and a child-centred approach being at the core of the entire organisation's work. Tensions, however, have been experienced at times in CDI's development, particularly in relation to the centrality of research, rigorous evaluation and utilisation of replicable methods of programme delivery. Managing the balance between these sometimes conflicting approaches is well described in CDI's process evaluation report, *Leading Community Change* (Canavan *et al*, 2014). The report refers to the difficulties inherent in supporting the delivery of a manualised programme, whilst also wishing to emphasise the importance of individualised, differentiated learning; being true to the principles of community development, while also integrating international research and best practice; and offering a voice to the community alongside the responsibilities of sharing the learning.

These are constant struggles, and sometimes we managed them better than others. CDI is fortunate in having many people who act as our 'conscience', who remind us of our roots, who support us in living out our vision and who do so without judgement or blame.

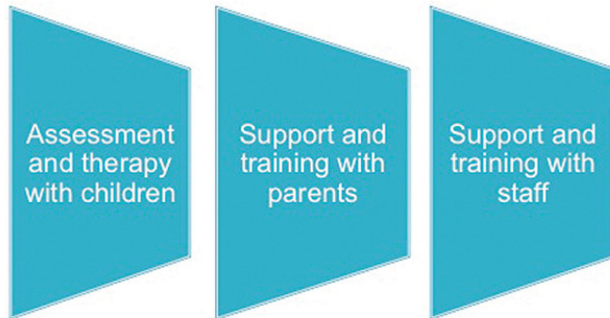
Our experience has been that there is no single way through which to engage communities effectively and that the job of doing so is never-ending; that there are phases and cycles which happen organically, during which consultation will hold differing levels of importance; and that it is possible to deliver evidence-based programmes to children and families that are respectful, appropriate and of high quality, but doing so takes skill, training and ongoing reflection. We hope that this Implementation Guide will support others in undertaking this exciting, challenging work, bringing together the science and the spirit in order to improve outcomes for children and families.

What is CDI's Chit Chat?

Chit Chat involves on-site delivery of a speech and language therapy service, whereby therapists attend Early Year's services (EY services) and primary schools, carrying out assessments and therapy with children referred to the service. The service is designed to give parents a key role in their child's language development. As well as some children receiving one to one assessment and intervention from the therapist, information sessions are held for parents, including those whose children are not receiving direct therapy. The third element to this three-pronged

approach involves providing training and support to staff – both in the early years' and school settings (see Figure 1). The logic model, research and approach underpinning Chit Chat is described later in this Guide.

Figure 1: Elements of CDI's Chit Chat



Introduction to Implementation:

Implementation refers to the process of carrying out a plan and focuses on the 'how' rather than the 'what' of the programme or service in question (Burke *et al*, 2012). In this case, it relates to all aspects of getting Chit Chat into practice.

An Implementation Guide sets out the 'how to' of getting programme delivery underway. It supports the set up phases and guides the user through a step by step process to bring the programme to the 'business as usual' phase. Implementation is seen as crucial in the delivery of a programme as it can have a huge impact on whether or not the programme reaches its' intended outcomes. This Implementation Guide draws on work undertaken by the Centre for Effective Services (CES) with the phases described in the following sections adapted from *An Introductory Guide to Implementation: Terms, Concepts and Frameworks* (Burke *et al*, 2012).

This Guide is presented in four phases, focusing on (1) start-up of service (exploring and preparing); (2) planning and resourcing; (3) implementing and operationalising; and (4) sustaining the programme ('business as usual'). These phases operate in a parallel rather than linear fashion, and so the community or organisation may move back and forth between them (see Figure 2). Each of these phases is described in detail in the following sections of the Guide as they relate to Chit Chat,

Figure 2: Phases of Implementation of CDI's Chit Chat

Source: Burke *et al* (2012)

How to use this Implementation Guide:

The information contained in this Guide is based on CDI's experience of establishing Chit Chat within a community with an identified need. Working with various stakeholders to make the programme a success, CDI drew on international research and best practice in relation to the delivery of evidence-based programmes. The Guide outlines the processes needed to establish relationships, identify key stakeholders and get people involved. It also describes the training and quality assurance methods used to ensure that the best possible service is developed and delivered to children and their families.

Each phase of the implementation process concludes with a checklist to track progress, as well as acting as a way of identifying any areas in need of further support. While the work of implementing Chit Chat is described in discrete phases, elements of each phase will cross over and some aspects will be ongoing throughout. It is therefore recommended to read the entire Guide prior to establishing service delivery and to refer back to the relevant sections for detailed consideration as implementation progresses.

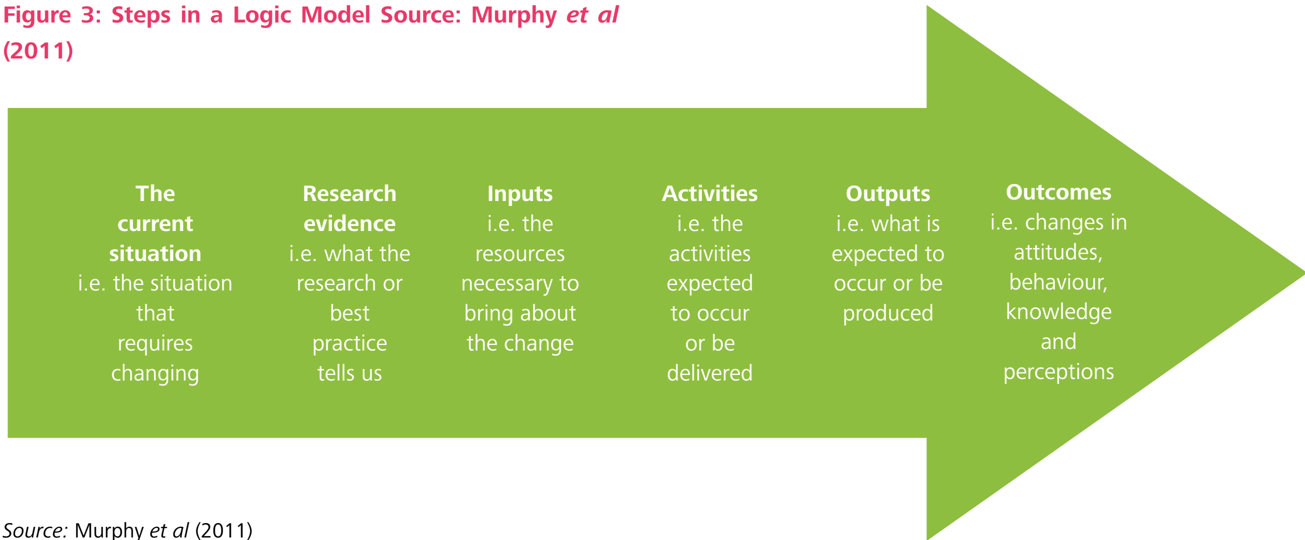
Introduction to Logic Modelling:

Logic modelling is a relatively new term for child and family services, and is a central element of developing and implementing evidence-based programmes. Many organisations, having experienced the benefits that come with the clarity and focus of a logic model, have now integrated logic modelling into their management processes. Some organisations have been using similar methods, such as developing a theory of change or even a business plan, and processes that include identifying specific objectives, activities to achieve them and the rationale for the activities. All of these are very similar to the logic model approach.

A logic model is defined as a framework or tool that may be used for programme planning, implementation and evaluation (Alter and Egan, 1997; Julian, 1997; McLaughlin and Jordan, 1999). It links the evidence (i.e. what research and best practice tells us about a programme or approach – issues/anticipated outcomes), inputs (i.e. the resources available to and required by the programme) and activities (i.e. what you deliver) to the anticipated outputs and outcomes (Hernandez, 2000; McLaughlin and Jordan, 1999). In other words, the logic model process provides the rationale for delivering specific programme activities (i.e. that X will lead to Z if Y is implemented).

CDI and many others have used the logic model framework to agree objectives, to maximise the potential to improve outcomes for children, manage programmes and shape their associated evaluations, and to ensure accountability of resources and outcomes. Figure 3 gives an outline of the various elements to be considered when completing a logic model, which can be used at a strategic organisational level or for a specific piece of work. CDI's *Quality Services, Better Outcomes* (Murphy *et al*, 2011), which acts as a companion to this Guide, provides further information on developing and maintaining a logic model.

Figure 3: Steps in a Logic Model Source: Murphy *et al* (2011)



Source: Murphy *et al* (2011)

The clear description of a programme's goals, tasks or activities, and anticipated outcomes provides an opportunity to involve programme managers, staff and other key stakeholders in the identification of the necessary resources (i.e. What do we need?), the assignment of responsibilities (i.e. Who is responsible for what?) and the clarification of relationships between specific activities and expected outcomes (i.e. Will implementing these activities produce the desired results?) (Millar *et al*, 2001). However, it is important to note that an examination of existing practice in terms of, for example, how resources are allocated, the way in which activities are implemented or whether anticipated outcomes are achieved may encounter resistance at an organisational or individual level (Kaplan *et al*, 2004) and so we need to be prepared for this.

PHASE ONE: EXPLORING AND PREPARING

1.1 Introduction:

'Exploring and preparing' refers to the phase in which local needs are identified and an appropriate programme or service that addresses them is agreed. Reading all of this Implementation Guide is recommended at this stage, as the information contained will assist you in exploring what Chit Chat can offer individuals, organisations and communities in terms of improved outcomes. When considering the development of a new service, or the realignment of an existing one, the initial steps will include checking for organisational readiness.

By the end of Phase 1, you will have:

- Developed a logic model through which Chit Chat is identified as an appropriate response to locally identified need;
- Completed your Organisational Readiness analysis;
- Developed an understanding of Chit Chat;
- Recognised the benefits of delivering Chit Chat and the evidence for it as a model of best practice;
- Identified the key stakeholders and potential programme leaders specific to your community, organisation or service;
- Consulted with the key stakeholders and established their necessary buy-in to the programme.

1.2 Identifying need and agreeing response:

Developing a logic model involves assessing the needs of the target group, considering the key people to consult with and identifying possible models to address the need. Consultation with key stakeholders is important at this stage because it will promote buy-in and help to identify programme champions who can, in turn, support and drive the implementation of the service (Burke *et al*, 2012). Chit Chat's logic model (Table 1) outlines the objectives and the outcomes you can expect and the required activities to deliver the programme. Table 1 provides the details for the logic model for Chit Chat.

Table1: Logic Model for Chit Chat - an Early Intervention Speech and Language Therapy Model

Vision/Overall Aim of Tallaght West Consortium: Early Intervention Speech and Language Therapy maximising children's development.

Monitoring and evaluation: Individual child assessments; training evaluations; parent questionnaires; teacher questionnaires; HSE meetings; management meetings.

Early Intervention Speech and Language Therapy

Objectives	Inputs	Key Activities and Outputs	Short-term Outcomes (by 2016)	Longer-term Outcomes
To identify at an early opportunity children with a speech and language need; To offer appropriate assessment and/or intervention at the earliest point; To develop the capacity of teachers and EY providers to identify and respond to need; To support parents to positively engage in developing their child's speech and language.	Funding; Speech and language therapists; Accredited training for EY practitioners and teachers; Commitment of schools and EY to support the service; Buy-in from HSE Primary Care to support the service and clarity of roles e.g. Memorandum of Understanding (MoU); Terms of reference (ToR), etc.	Delivery of accredited training to all Early Years staff; Engage key teachers in accredited S&L training; Awareness raising and capacity building activities take place for all parents; Tailored supports provided to parents of children receiving an intervention; Ongoing engagement with HSE, including review of dual policy and transfer of children; Ongoing data collection to monitor individual and service outcomes.	EY staff and teachers have enhanced knowledge, skills and understanding in children's speech and language development and how to support it; Reduction in inappropriate referrals to SLT; Increase in early identification of SLT needs; Parents feel greater confidence in supporting their child's S&L development; Parents of children receiving an intervention are well informed and feel competent in supporting this intervention; Reduced stigma than with clinic-based services, due to on-site provision; Improved attendance at assessment and interventions; Model is replicated in other communities.	EY and teaching staff are skilled in identifying children with an S&L need, and in supporting these developments; Parents in TW have capacity and motivation to support children's S&L; Early intervention, onsite delivery of SLT and other specialist services becomes a regular feature of primary care.

Evidence: Evaluation of CDI's SLT Model.

(Hayes *et al*, 2012 and Hayes *et al*, 2016)

1.3 Organisational readiness and capacity-building:

Organisational readiness to implement an evidence informed programme is crucial. This includes having an implementation plan, strong leadership, adequately trained and supervised staff and effective ways of giving and receiving feedback. Research literature has identified several factors that are important for effective implementation of Evidence Informed Practices (EIP). The organisational readiness assessment tools developed by Austin and Claassen, (2008) and Barwick, (2011) have been adapted to fit the Irish context (see Table 2 below). This model has eight key factors, which are system level capacity; organisational capacity; organisational culture/ climate; senior leadership; staff capacity; operational considerations; training and having an implementation plan.

Table 2: Organisational Readiness Checklist

A	A. **SYSTEM LEVEL CAPACITY** **To what extent do you think:**	Not even close	Some way to go	Nearly there	We're there
		1	2	3	4
A1	The service funder recognises the **importance of Evidence Informed Programmes** (EIPs), such as CDI's Chit Chat?				
A2	**Financial resources** are adequate and available to introduce and sustain the implementation of Chit Chat? The service funder and/or administrator recognise that the implementation of Chit Chat may necessitate additional budget and/or shifting along budget lines?				
A3	**Technical assistance** (e.g. training, coaching, and ongoing support) is available for the implementation of Chit Chat?				
A4	All **stakeholders** having a role to play have been consulted about their views on Chit Chat?				
	SUB-TOTALS **Totals for A**				

B	B. ORGANISATIONAL CAPACITY To what extent do you think:	Not even close	Some way to go	Nearly there	We're there
		1	2	3	4
B1	**Change** at this time is **appropriate and feasible** in the life of the organisation? Consider competing priorities and their timelines.				
	SUB-TOTALS				
	Totals for B				
C	**C. ORGANISATIONAL CULTURE/CLIMATE** **To what extent do you think:**	**Not even close**	**Some way to go**	**Nearly there**	**We're there**
		1	**2**	**3**	**4**
C1	There is **leadership support** from top management in the form of a designated person responsible for implementation?				
C2	This organisation's mission reflects a commitment to being a **learning organisation** and is supportive of implementing Chit Chat?				
C3	Generally speaking, staff understand the mission and goals of this organisation and how they relate to **evidence-informed practice**?				
C4	Generally speaking, staff in this organisation understand what **evidence-based practices** are and hold positive attitudes toward their use?				
C5	Staff in this organisation are given high levels of **autonomy** in their work and encouraged to ask questions?				
C6	There are open lines of **communication** in place in this organisation?				
C7	**Innovation** is rewarded?				
	SUB-TOTALS				
	Totals for C				
D	**D. SENIOR LEADERSHIP** **To what extent do you think senior leadership considers:**	**Not even close**	**Some way to go**	**Nearly there**	**We're there**
		1	**2**	**3**	**4**
D1	The evidence-based practice selected for implementation **addresses an important problem/issue/gap in service delivery**?				
D2	Implementing Chit Chat is **aligned with organisational, regional or system goals**?				
D3	The implementation of Chit Chat will result in **better outcomes for our clients**?				

D4	Senior leaders are willing and able to **lead and shape implementation**?				
	SUB-TOTALS **Totals for D**				
E	**E. STAFF CAPACITY** **To what extent do you think:**	**Not even close**	**Some way to go**	**Nearly there**	**We're there**
		1	**2**	**3**	**4**
E1	**Professional growth and development are desired** by staff in this organisation?				
E2	**Staff preferences for learning and practice change** were taken into consideration when selecting this service and in developing the implementation plan?				
E3	Staff demonstrate **readiness for practice change** and a commitment to use this service?				
E4	The appropriate staff with the necessary **qualifications and experience** have been selected to implement this service?				
E5	Staff demonstrate **evidence-based practice skills** (e.g. client engagement, critical thinking, use of positive reinforcements, analytical thinking and reflective practice)?				
E6	**Human resources** are adequate and available to introduce and sustain the delivery of Chit Chat. This means: (a) Management intend to select staff that have the required competency levels to implement the service; (b) Management are prepared to deal with changes to job requirements and staffing where necessary; (c) Management are prepared to provide the appropriate management and supervision of staff involved in the service.				
	SUB-TOTALS **Totals for E**				
F	**F. OPERATIONAL CONSIDERATIONS** **To what extent do you think:**	**Not even close**	**Some way to go**	**Nearly there**	**We're there**
		1	**2**	**3**	**4**
F1	Management will ensure that the **service is delivered in full** as outlined in the Implementation Guide?				
F2	There is a system in place to **share client outcomes** with staff, boards and clients?				

F3	There is a Quality Assurance Plan in place that will enable the **monitoring of service delivery**?				
F4	There is intent to **use outcome data** to inform service planning and delivery?				
F5	The organisation will consider whether policies or service/vendor **contracts require revision** for the implementation of evidence-based practices?				
	SUB-TOTALS				
	Totals for F				
G	**G. TRAINING** **To what extent do you think:**	**Not even close**	**Some way to go**	**Nearly there**	**We're there**
		1	**2**	**3**	**4**
G1	Staff require training in the **theory of evidence-based practice**?				
G2	Staff need training and support in **delivering** Chit Chat?				
G3	Line managers need training and support to **supervise** staff effectively and support delivery of the service?				
G4	Staff need training to integrate **reflective practice**?				
G5	**Adequate time** will be allocated for training, reflection, practice and assimilation of new skills?				
	SUB-TOTALS				
	Totals for G				
H	**H. IMPLEMENTATION PLAN** **To what extent do you think:**	**Not even close**	**Some way to go**	**Nearly there**	**We're there**
		1	**2**	**3**	**4**
H1	There is a comprehensive **implementation team** in place (i.e. an identified group of staff with a range of skills who will support the delivery of the service)?				
H2	There is an **implementation framework** selected to guide the implementation process through the different phases?				
H3	There is a **communications plan** to share progress of the implementation plan with multiple stakeholders, regardless of their direct involvement (e.g. consider communication to your funder, board of directors, clients, community partners)?				
H4	There is agreement on how to **monitor service outcomes**?				
	SUB-TOTALS				
	Totals for H				

Analysis of this checklist will assist you in identifying areas for development. A plan of activities may be required in order to address the areas which need to improve in order to enable and maximise implementation.

1.4 What does CDI's Chit Chat involve?

The model utilises a three pronged approach, involving:

- Assessment and therapy with children;
- Support and training with parents;
- Support and training with staff.

Chit Chat involves on site delivery of a speech and language therapy service, whereby therapists attend EY services and primary schools, carrying out assessments and therapy to children referred to the service. Referrals are accepted from the EY practitioners teachers in junior infants and parents. Training is provided to all EY services and primary schools receiving Chit Chat on typical development and how to identify a child with a communication delay.

Chit Chat is designed to give parents a key role in their child's language development, and so parents whose children are receiving one to one support from the therapist will also be involved in these sessions, as well as participating in information sessions which include those whose children are not receiving direct therapy. At the start of each academic year, coffee mornings are held with parents to introduce the service and therapist to support trust building and normalise the intervention. In this way, parents are aided in their ability to identify their children's S&L needs, to refer children to Chit Chat and to support their child's development. As Chit Chat is an early intervention service, children in the preschool year are eligible. If other cases emerge in younger children, they are transferred to the local HSE Primary Care Clinic for further management. If a preschool child is receiving a service from Chit Chat and transitions into a primary school where this service is not available, they are transferred to the local HSE Primary Care Clinic for further management.

The third element to the three-pronged approach involves providing training and support to staff – both in the early years' and school settings. Staff in the EY services receive both certified and accredited training, in Hanen[1] and Elklan[2] respectively. This enables them to apply key strategies to provide a rich and stimulating language learning environment for young children; encourage language development; build early literacy skills; and provide a physical and social environment that encourages peer interaction. Similar accredited training is also offered to primary school teachers. Informal training is delivered to EY staff and teachers by the SLTs as necessary, for example, supporting children with English as a second language, and supporting language development in the classroom, to name but a few.

A senior Speech and Language Therapist (SLT) is employed to deliver the CDI S&L service in three early years' services and three primary schools and a second staff grade therapist is employed to deliver the service to six early years' services. CDI's Quality Specialist provides support in the design, delivery and management of implementation issues of the CDI S&L service. The senior SLT receives role support from the HSE community Principal SLT and in turn provides role support to the staff grade SLT. Both SLTs work closely with the HSE speech and language therapy

[1] Hanen training provides practitioners with practical, interactive strategies for promoting children's language development which also helps lay the foundations of literacy.

[2] Elklan training helps practitioners promote the communication skills of all young children but particularly those with speech and language difficulties.

team and attend team meetings, which is important for both professional development and support, and enabling strong links across the services. In addition, the CDI SLTs submit quarterly reports CDI on referrals, assessment/ therapy, children's progress and training delivered.

Interagency collaboration is a central aspect of CDI's work with the S&L service. At the very outset, discussions with the local Health Service Executive's (HSE) Principal Speech and Language Therapist (PSLT) were held to design and establish the model of service delivery. In terms of employment, it is worth bearing in mind that there are options available;such as secondment from the HSE; direct employment through a community organisation or funder with clinical supervision being provided by either the HSE, a specialist service or on a consultancy basis etc. Therefore, it is worth reviewing the best option for you.

1.5 Why choose this Model?

Much has been written about the impact speech and language difficulties have on educational attainment and its prevalence in disadvantaged areas, whereby up to 50% of children in such communities have been identified as having a Speech and Language (S&L) need (Conti-Ramsden *et al*., 2001; Locke *et al*., 2002; Leitao & Fletcher, 2004). Additionally, Bishop and Adams (1990) contest that if a child's speech and language difficulties are not resolved by the time they enter primary school, their problem could become more entrenched and so affect their learning and literacy development.

Chit Chat seeks to promote children's speech and language development and provide intervention where necessary. It also aims to equip staff and parents with skills and tips to promote speech and language therapy within early years, schools and home settings. It is underpinned by a recognition that an ability to communicate is central to the achievement of many milestones and the potential for children to fully participate in their education.

1.5.1 What the research found about this model of delivery:

Chit Chat was independently evaluated from 2009-2012 by the Centre for Social and Educational Research (CSER), at the Dublin Institute of Technology, and a further study was completed in 2015. The first evaluation was a retrospective impact study which reported key characteristics and data on the children who attended the CDI S&L service. (For more details on the evaluation please see the full report, Hayes, *et al* 2012) http://www.twcdi.ie/images/uploads/general/CDI-SLT-Report-09.11-web.pdf

Please see Appendix 1 for a summary of the main findings.

Children were referred to the CDI service aged on average two years nine months and were seen within two to four weeks, while some children whose difficulty was not fully apparent were reviewed after six months. Receiving therapy at such a young age meant that some children did not need long-term interventions, and 18% were discharged as "within normal limits" after six weeks. The evaluation showed 83% of children attended 75 to 100 per cent of appointments. Parents were encouraged to attend therapy sessions and if they could not make the appointment the therapy still went ahead, ensuring that the child did not miss out.

Having early and convenient access to the S&L service was found to make a significant positive impact on children, families and staff. Attendance at appointments and uptake of the community based S&L service has always been problematic for both the service provider and families. However, in this model, onsite delivery supported improved

attendance with minimal disturbance to the child's day. Parents often spoke about feeling stigmatised when they had to bring their child to a clinic or the hospital, but felt much less so with the onsite delivery model. A positive knock-on effect of the service was reported by parents who felt that their child, having better language outcomes, would be less likely to be bullied: "*I think we realised his talking was different …* [we were] *so afraid … that he'd be bullied,*" (Hayes *et al*, 2012: 42).

The evaluation found that environments were more visibly literacy rich, with staff labeling areas and games, using pictures and symbols to promote phonetics and that staff training resulted in staff feeling more confident in identifying speech and language concerns, and having an increased ability to support parents in making a referral to the service. This resulted in a reduction in inappropriate referrals.

A follow up study was undertaken in 2015 in an attempt to carry out a deeper comparable analysis (Hayes and Irwin, 2016). The findings were similar to the 2012 evaluation, which found shorter waiting times for the CDI model with 'under' referral of children who were not previously identified as having an SLT need remaining high. (For more details on the evaluation, please see full report: www.twcdi.ie)

1.6 Identifying Key Stakeholders:

In order for this model to be delivered effectively there are a number of elements that need to be considered. The first stage in getting started involves creating awareness of the approach and making sure that the message you deliver about the model, its benefits and what it has to offer the various stakeholders is clear. When starting a new initiative, it is important to ensure that all of the relevant stakeholders are consulted from the outset. This will lead to increased buy-in and investment from all parties in ensuring the delivery of the service. It is advisable to identify 'champions' – those that will support and 'sell' the model, at this stage, in order to gather momentum for the proposal. The key stakeholders include:

- Funder: this model could be funded in a range of ways. For example, it could be embedded within mainstream services which would involve the HSE S&L service incorporating onsite delivery as well as capacity building amongst early years' staff and primary school teachers. Alternatively an organisation which is well established within the community could seek funding to deliver this model, the main cost of this model being salaries and a small programme budget. Whichever model is decided upon, it is also worth considering and costing the time given by the HSE, EY's, Primary Schools and other stakeholders to support the design, implementation and building this into communities;
- HSE Principal Speech and Language Therapist (HSE - PSLT): it is vital to have the PSLT on board at the very outset, as they can give support around recruitment, policies and provision of clinical supervision to the SLTs. In addition, all structures listed below will require their input and support;
- Area Manager, HSE: the local PSLT may wish to consult with their Area Manager before agreeing to support the design and implementation of the model;
- Early Years (EY) providers/School Principals: having these stakeholders involved is central, as they will have to commit to allocating a space for the SLT; support referrals to and uptake of the service, particularly in relation to parental involvement, as

well as making a commitment that staff will attend training. Practical issues such as access to stationary, photocopying, secretarial support may also need to be agreed at the outset.

As well as involving the 'essential' stakeholders relevant to designing the model, you need to consider your engagement with the target audience. These include:

- Children aged 2-6 years: It is important to consider the number of EY services and schools involved; the potential number of children to be referred and their geographical location. As the service requires the therapist to be mobile, close geographical locations will considerably support efficiencies. For example, on average, one therapist can manage a caseload of approximately 30-65 children, but this will depend on the locations. It is best to have this discussion with the local HSE Principal Speech and Language Therapist and City/ County Childcare Committee. In CDI's experience, ring fencing the ages of children to be included in assessment and therapy from 2-6 years, is vital. This fits well with the principles of early intervention, in addition to avoiding the therapist being stretched too thinly, so maximising the potential for positive outcomes;
- Parents: Both of children receiving therapy and generally attending EY providers/school. Having parental involvement is crucial to supporting their children's speech and language development. It is helpful to identify the best times and locations to engage with parents, and asking colleagues already working with parents to facilitate this for you. This will provide an opportunity for the therapist to gain an understanding of parents' concerns and what their capacities are;
- EY practitioners and teachers: Having their involvement will promote the effective delivery of the service, through attendance at training; identifying children for assessment; engaging parents in educational opportunities; understanding referral pathways; and supporting to children and families to take up appointments;
- HSE SLT's: Whether the funding mechanism is the HSE or not, SLTs should be aware of the service model as they will play an important part in accepting referrals from and making referrals to this service. It is important that the SLTs from both service models form a good working relationship in order to ensure a cohesive approach to service delivery. It is strongly recommended that where possible the therapists employed to deliver Chit Chat are part of the HSE team to avail of Continuous Professional Development (CPD) opportunities, as well as keep up to date with changes in structures, for collegial support, etc.;
- Other health services: Such as audiology, psychology, assessment of need, etc., need to be aware of the early intervention S&L service to facilitate good communication, in the event of onward referrals by the SLT, or if a child is attending one of these services;
- Specialist services, such as intellectual disabilities: It is advisable to have clear communication channels to ensure effective delivery of the service, avoidance of duplication and ensuring no child 'slips through' services. Sharing policies, procedures and referral criteria/forms will assist in this;
- The Child and Family Agency (Tusla): Family support and child protection services should also be made aware of the service, to facilitate effective referral processes and inter-agency networking.

1.7 Checklist and next Steps:

Track your progress throughout Phase one by completing the Exploring and Preparing Checklist in Table 3. This will help to ensure that the essential steps have all been considered, taken or progressed during this first phase.

Table 3: Phase 1 - Exploring and Preparing Checklist

Stage	Description	Implementation Status: Fully (F), Partially (P), or Not at all (n)			Agency Capacity to implement Chit Chat	Comments
		F	P	N		
Organisational readiness	Has the local community/target group been identified as having a need for Chit Chat?	F	P	N		
	Has the organisational readiness checklist been completed? (see table 2)	F	P	N		
Understanding the logic model	Are you and the relevant stakeholders familiar with Chit Chat's logic model?	F	P	N		
Developing an understanding of Chit Chat	Have you read the information on Chit Chat?	F	P	N		
Developing an understanding of the evaluation findings	Have you read the evaluation of Chit Chat?	F	P	N		
Identifying stakeholders	Have you identified all relevant stakeholders and shared all appropriate information with them?	F	P	N		
Identifying programme champions	Have you identified champions for Chit Chat?					

Now you can move on to Phase Two – Planning and Resourcing your Chit Chat service.

PHASE TWO: PLANNING AND RESOURCING

The second phase focuses on gathering the resources, preparing documents and ensuring that the elements needed for delivery are in place. This phase will also involve ensuring the structures, processes, resources and practices to support delivery are established which will include confirming the budget and securing funding and establishing a Memorandum of Understanding (MoU) with relevant stakeholders; identifying appropriate staff and completing the recruitment process; and identifying and arranging the necessary resources (Burke, *et al*, 2012).

At the end of Phase 2, you will:

- Have agreed budgets;
- Developed and agreed mechanisms to support communication with all relevant stakeholders;
- Recruited the Speech and Language Therapists and agreed quality assurance mechanisms;
- Identified an appropriate space for the therapist to work in the early years' services and primary schools;
- Compiled all relevant policies and procedures, including referral processes.

2.1 Agreeing budgets:

The main cost for this service relates to salaries for SLTs and materials:

- Salaries: This should include employer's PRSI. In order to maintain a level of fairness and equity, it is strongly recommended that the salary scales are in line with the HSE and these can be downloaded from the website: http://www.hse.ie/eng/staff/Benefits_Services/pay/salary_scales_new_entrant2011.pdf

  Please note that these salary scales are subject to change, so ensure the most current scale is applied. In addition, it is advisable to be clear if increments, employer pension contributions and non-statutory redundancy form part of the employee contract as this could add further to the overall costs.
- Materials: These are both at initial set up and ongoing costs. Initial materials include laptops; colour printer; mobile phone; internet access; toys used during assessment/therapy; assessment tools, of which there are a variety. It is advisable that the assessment tools used are in line with those used by the HSE. Ongoing costs include: office rent; travel and subsistence; and stationery, which can be quite significant so ensure a sufficient budget is in place;
- Continuous Professional Development: Being able to support the SLTs in their continuous professional development is an important responsibility, particularly when delivering innovative, evidenced-based services. Examples of training which may be required include: Training of Trainers in a range of accredited programmes, including but not exclusively: Hanen; Elklan; Derbyshire; LAMH; PECS (See Glossary of Terms). It is advisable to agree at the outset the CPD budget for each therapist annually. Given the clinical and specific nature of training, all CPD requests should be approved by someone who is appropriately qualified;
- Training budget for EY's practitioners/teachers: This should consider the cost for EY practitioners and teachers to receive the above training, which

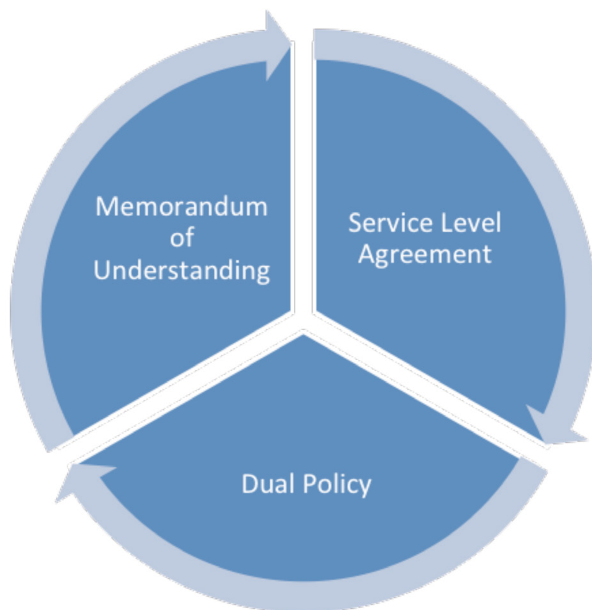
may include materials, venue and in some cases relief/cover staff in order to free staff up to attend training.

The items noted above require an allocated budget. However as is so often the case with inter-agency initiatives, a great deal of the resources come from the time and commitment which personnel provide from within their already busy responsibilities. This may not require funding, but should be acknowledged and sustained.

2.2 Mechanisms to support communication:

Being clear about expectations, roles and responsibilities is vital. Figure 4 lists some of the mechanisms to promote and support clarity:

Figure 4: Mechanisms to Promote and Support Clarity:



- **Memorandum of Understanding (MoU)**:
  This will clearly outline all roles and responsibilities, including those of the funder; employer; HSE and SLTs. (See sample in sample in Appendix 2). Having a clear MoU, which is signed off by all parties will help establish communication channels, ensure clarity for all concerned as to everyone's roles and responsibilities, help to reduce risks arising and name mechanisms to support the management of any challenges. It is advised that the MoU is devised and agreed at the very outset, so that when the service commences delivery, everyone knows where to go to/who to talk to and involve, in the event of issues arising;
- **Service Level Agreement (SLA)**:
  This is different to the above mentioned MoU, as it is a working agreement between the therapist and the 'host' of the service (i.e. preschool and /or primary school). In the absence of a contract, the SLA outlines each person's responsibilities and expectations, for example; provision of office and clinical space within services/schools; participation of teachers and EY staff in training aimed at enhancing Chit Chat's impact; secretarial support for appointments and access to photocopying. EY's managers and school Principals will need to commit to ensuring that staff take up the training as stipulated in the Service Level Agreement (See sample in Appendix 3). It is important that EY providers and schools are clear about what is expected of them and what is being provided to them. As with the MoU, the SLA should be signed off by all parties involved;
- **Dual Policy**:
  As Chit Chat operates in parallel with mainstream provision, this policy will be extremely important in outlining the process and pathway for referrals

and transferring cases between agencies – specifically, the HSE, the early intervention SLT service and specialist agencies such as audiology or Assessment of Need. (See sample in Appendix 4). If a child transitions from an EY service to Junior Infants or from Junior Infants into Senior Infants and still requires SLT, they will be referred to the Community HSE. In order to ensure continuity of service, the date of referral to the Chit Chat service will be used as the basis of entry to the HSE service. Having a clear pathway for therapy will ensure there is no duplication of service delivery and that no child 'slips' through the service; nor should a child be penalised for engaging in any particular service. It is recommended that this policy is developed through a collaborative approach which includes all relevant stakeholders.

2.3 Recruitment and quality assurance mechanisms:

Given the nature of this model of service delivery, it is advisable to employ a Senior SLT who can provide support and clinical supervision to a Staff grade post. In terms of recruitment, there are a few options that can be explored, the SLT's can be employed directly, or seconded from the HSE. It is strongly recommended that the recruitment process is carried out in consultation with the HSE Principal SLT and follows best practice in relation to recruitment processes. See Appendix 5 for the job description used for the Chit Chat service. Ideally the Senior SLT should hold other professional training skills, such as Hanen, Elklan and should have completed training in clinical supervision etc. Also experience of training other professionals working with parents; and interagency collaboration.

- **Support and supervision:**
  Clinical supervision must be set up for the therapists, and this will require some consideration. What are the appropriate methods for providing this? For example how will this link to mainstream policies? Is there a need to indemnify anyone, and if so who and how? What local stakeholders might be able to provide this? Identify the risks and benefits for each alternative. One option could be the Principal HSE SLT providing clinical support and supervision to the Senior SLT who then supervises the staff grade SLT. Support and supervision around programme delivery/performance is also important to ensure the therapist has an opportunity to discuss programme implementation issues and review programme budget, etc. This part of the support and supervision could be undertaken by the purveyor or commissioner of the early intervention service and requires an understanding of the logic model, fidelity and monitoring approaches. Having all these systems in place at the outset will support clarity and appropriate governance of the service delivery;
- **File management:**
  Reporting templates on SLT statistics need to be agreed, including agreeing what data is provided, such as number of referrals, interventions, discharges, etc. (See sample in Appendix 6). As far as possible it is recommended that all files relating to service delivery are in line with the HSE recording systems in order to ensure a smooth handover, enable comparisons across services as well as consistent service delivery. It is advised that all relevant reporting templates are agreed, as well as timelines for submission;

- **Induction:**
  A robust and effective induction process needs to be undertaken with the therapists employed. It should include an understanding of the aims of the model; staff handbook; introduction to relevant stakeholders; relevant polices and procedures; reporting structures; contact details, etc. The induction is the responsibility of the employer and ideally also involves an induction by the HSE in terms of clinical practice and local structures.

2.4 Identifying an appropriate space for the therapist to work:

Given the onsite nature of the service, a therapy room needs to be allocated for the therapists to work from. This needs to be agreed with the early year's services and primary schools. Ideally a separate room is preferable, with some informal furnishings like chairs, tables and it should be child friendly with books, posters, etc. It also needs to be relatively quiet, in order to facilitate therapeutic interventions and enable an appropriate environment. A dedicated space is a rare luxury so a parents room library or other space may need to be agreed. Agreeing working arrangements should also include practical considerations such as access to photocopying or phones, administrative support such as managing appointments, and storage space.

2.5 Policies and Procedures:

As well as the above communication mechanisms, it is important to consider other policies that need to be developed. Early Years (EY) services and schools need to be familiar with the referral process, so therapists need to draw up clear guidelines for and staff should be agreed including eligibility criteria; referral mechanisms; schedule for services indicating when therapy will be delivered in each location; how slots for assessment/ therapy are allocated; how to postpone appointments; what to do if you can't make an appointment etc. While the therapists will adhere to their employer's child protection policy, they will also need to be familiar with the EY service/schools' policy on child protection.

Agreement on the storage and ownership of individual case files is critical, particularly given that the therapist travels to various locations. Being clear on having safe and secure procedures for files is important.

2.6 Checklist and Next Steps:

Progress should be tracked throughout this Phase by completing the **Planning and Resourcing Checklist** in Table 4. This will help to ensure that the essential steps have been considered and progressed during this phase. We recommend that you aim to have all items on the checklist completed in advance of commencing the delivery of Chit Chat.

Table 4: Phase 2: Planning and Resourcing Checklist:

Stage	Description	Implementation Status: Fully (F), Partially (P), or Not at all (n)			Agency Capacity to implement Chit Chat	Comments
		F	P	N		
Agreeing Budgets	Costs – have budgets been agreed and finalised?	F	P	N		
Materials	Have all materials for delivery been purchased?	F	P	N		
Mechanisms to support communication	Has a MoU been developed and have all parties signed up to it?	F	P	N		
	Has a Dual Policy been developed and have all parties signed up to it?	F	P	N		
	Has a SLA been developed and agreed by all relevant stakeholders?	F	P	N		
Recruitment and quality assurance mechanisms	Has an appropriate recruitment plan been developed?	F	P	N		
	Have all relevant HR policies, procedures and supports been considered and agreed?	F	P	N		
	Are all quality assurance mechanisms established and agreed?	F	P	N		
Induction	Has a robust induction process been established?	F	P	N		
Templates and timelines	Have all reporting templates and timelines been agreed?	F	P	N		
Identifying an appropriate space for the therapist to work	Has a space been allocated in all early years services and primary schools?	F	P	N		
	Are all relevant materials in place?	F	P	N		

Stage	Description	Implementation Status: Fully (F), Partially (P), or Not at all (n)			Agency Capacity to implement Chit Chat	Comments
		F	P	N		
Policies and procedures, including referral processes	Have all relevant policies and procedures been developed?	F	P	N		
	Have referral pathways been developed and understood by all relevant staff?	F	P	N		

Now you can move on to Phase Three – Implementing and Operationalising Chit Chat.

PHASE THREE IMPLEMENTING AND OPERATIONALISING

When you have reached this third phase, Chit Chat should be ready to begin day-to-day delivery. This means that all the equipment, staff and resources necessary are in place. Burke *et al* (2012) have identified the following key activities for this phase:

- Providing on-going coaching and assistance to staff;
- Monitoring on-going implementation;
- Changing systems/culture as necessary;
- Creating feedback mechanisms to inform future actions.

By the end of Phase 3, you will:

- Have begun delivering the Chit Chat Model;
- Have begun accepting referrals to the service;
- Scheduled dates for parent sessions;
- Have identified training needs and scheduled staff training sessions;
- Be aware of and adhering to reporting templates and timelines.

3.1 Fidelity and Monitoring:

Maintaining fidelity (i.e. the degree to which the programme or service is delivered as was originally intended) is necessary in order that all elements of the model are delivered in full, and so maximising the potential for positive child outcomes. In order to promote quality and maintain fidelity, you should consider some of the following structures:

- **Clinical and non clinical supervision for the SLTs:**
  Depending on your funding and employment arrangements, it is worth considering whether both clinical and non clinical supervision can be done by the same person. Clinical supervision requires specialist input from a practicing therapist. Both supervision structures provides the opportunity for the HSE, funder and the SLT to discuss service delivery and trouble shoot difficulties in referrals; case loads; dual policy; CPD; budgets; annual/study leave and programme related logistics, etc.;
- **Monitoring of service delivery:**
  This can be done through regular service review meetings between the SLTs and the funder and/ or HSE where consideration and discussion is given to the number of referrals, assessments, interventions, parental engagement; staff training needs, etc. Monitoring also needs to include workplan/ targets etc; consideration of individual child assessments; feedback at and after training; focus groups with parents to assess progess etc. Additionally, opportunities to present at conferences, submit journal articles, offer outreach services and other non-routine tasks, can also be discussed at these meetings. The logic model should be reviewed on a regular basis;
- **Regular scheduled file audits:**
  This process is intended to ensure that all case files (files on children) are kept in accordance with best practice, in line with HSE practice and data protection, and that they are legible and have a coherent process. A local arrangement needs to be agreed which recognises that as case files contain clinical information, an appropriately qualified SLT must oversee the audit process.

3.2 Quality and Communication:

Essential to any service delivery is maintenance and monitoring of quality and this can be achieved through many processes:

- **Training:**
  This is important for both staff and parents. As discussed earlier, it is advisable that the SLTs are skilled in delivering both accredited and non-accredited training, which should feature strongly in the SLTs plan of work. Staff capacity, foundation qualifications and training can vary considerably within EY services, therefore, it is recommended to commence by undertaking an audit of existing skills and competencies and identifying priority needs. Training may include delivering generic language and communication development, through to accredited training. Training and support to parents will probably be less formal, but should be underpinned by a needs assessment. In order to enhance capacity building amongst teachers and EY staff, it is recommended that the SLT's work alongside teachers in the classroom, providing modelling and coaching to staff on a regular basis;
- **Effective and efficient referral processes:**
  In order to minimise the amount of inappropriate referrals, it is recommended that clear referral criteria are set out. SLTs should explain this carefully to all staff in the EY services and schools and have supporting documentation to leave with them (See Appendix 7). Generally speaking the only criteria for referral to the service is that there is a primary concern about the child's speech and language development. As Chit Chat is specifically for speech and language issues, it is not recommended for children with multi-disciplinary needs;
- **Communication between SLTs and EY practitioners/teachers:**
  It will be more efficient for the SLT to have one lead person to liaise with, therefore each EY service and school should identify a SLT liaison person who is responsible for the referrals and supporting attendance (EY manager, support worker, Home School Community Liaison, etc.);
- **Parental engagement:**
  Consideration should be given to effective engagement and communication mechanisms. Holding coffee mornings and informal events possibly with a particular theme or input, can be an effective way to identify needs and concerns amongst parents, as well as building a connection and trust between them and the SLT. Where possible, this will be all the more effective if it is facilitated by someone already working with the parents, such as EY manager/Parent Support Worker/Home School Liaison, etc. Schools and EY services will be supported by Chit Chat to promote the importance of communication and literacy development to parents. Reading weeks are an example of this, where schools promote 'reading with your child' every night for a week and a certificate is awarded to participating children and parents at the end of the week. Schools have also been encouraged to invite parents into the classroom to read with their child. It is important to get regular feedback from parents about the service, which is not only best practice and good governance, but it also promotes an ownership of the service. Again, this can be done informally by checking in with parents as the opportunity arises, or more formally as part of a service review or evaluation process;
- **Tracking:**
  Data collection and analysis is essential to evaluate

the effectiveness of the service. Consideration should be given to capturing the outcomes of the service and data should be collected accordingly. E.g., child outcomes, parent outcomes, attendance rates, training feedback etc. The number of referrals; training sessions; attendance at training; coffee mornings; attendance at coffee mornings and so on, should be captured in the SLTs reports (See Appendix 7), and considered on a quarterly or termly basis.

3.3 Checklist and Next Steps:

Track your progress throughout Phase Three by completing the **Implementing and Operationalising Checklist** in Table 5. This will help to ensure that the essential steps have all been considered, taken or progressed during this third phase.

Table 5: Phase 3: Implementation and Operationalising Checklist:

Stage	Description	Implementation Status: Fully (F), Partially (P), or Not at all (n)			Comments
		F	P	N	
Fidelity and Monitoring	Have structures been developed to support fidelity?	F	P	N	
	Have support and supervision structures for the SLTs been put in place?	F	P	N	
	Have structures for service review been put in place?	F	P	N	
Service Delivery	Have parent referral/consent forms been developed and given to all services/schools?	F	P	N	
	Have parents been briefed on the service and how to refer?	F	P	N	
	Do services understand the referral process?	F	P	N	
	Have arrangements for family sessions been agreed?	F	P	N	
	Has a staff training needs audit been carried out?	F	P	N	
	Have dates for staff training been agreed?	F	P	N	
Quality Assurance	Have all relevant staff been made aware of the various quality assurance measures?	F	P	N	
	Have reporting requirements been agreed?	F	P	N	

Now that your Chit Chat Model is fully operational, you can move on to Phase Four – 'Business as Usual' or sustaining service delivery.

PHASE FOUR: BUSINESS AS USUAL

Phase Four is the final phase of implementation and will mean that Chit Chat is fully operational. It relates to consolidating the model and maximising the potential for sustainability. By the end of Phase Four you will be ready to reflect on the implementation process and how the model is meeting the needs of your target group. The main focus of this process will involve engaging with the key stakeholders who may be instrumental in supporting continuation of the service. The following section suggests mechanisms to enable continued engagement with the key stakeholders and ways to further develop their commitment to the service. This will allow each group to establish local links that may be a key mechanism in securing the sustainability of the service.

By the end of Phase Four, you will:

- Have reflected on the implementation process and how Chit Chat is meeting the needs of your target group;
- Have considered identifying actions to integrate the service into ongoing structures and delivery.

4.1 Engaging with your stakeholders:

Maintaining close working links with your key stakeholders while establishing this service will support sustainability plans. These stakeholders can also act as champions for the service and will include anyone who has an interest in or involvement with the service and could include the following:

- HSE Primary Care;
- Tusla;
- County Childcare Committees;
- Local Partnerships;
- Early Year's Managers;
- Early Year's Staff;
- School principals;
- Teachers;
- Parents;
- Children;
- Library services;
- Specialist Services.

No doubt there will be other organisations in your area which will be relevant to involve.

4.2 Maintaining Stakeholder Support:

Suggested below are some ways of maintaining the support of your key stakeholders:

- Regular meetings to discuss design, implementation and ongoing monitoring;
- Memorandum of Understanding/Dual Policies;
- Clarity in relation to roles and expectations and scheduled review of same;
- Clear lines for communication and information sharing;
- Opportunities for involvement that are relevant to the individual group;
- Celebration of achievements and opportunities to hear testimonies from participants;
- Robust record keeping and data collection;
- Dissemination on outcomes, service data and case studies, and;
- Involvement in reviews and service planning.

4.3 Sustainability:

CDI has a commitment and requirement to support the integration of its proven programmes into existing services so that these models become 'business as usual'. In the anticipated absence of ongoing, additional funding to support this integration, this will require creativity, reflection, and possibly some hard choices. Chit Chat can be supported in a number of ways including:

- **Champions:**
  The sustainability of the Speech and Language Service is closely linked to how it has become embedded within the community it is being delivered in. Champions are key to this, as is sharing the successes of the children and parents who have participated in the service. Identifying these supporters will help the process of advocating the continuation of the service and it is advisable to ensure that there are champions identified in a range of areas, from state agencies to parents, schools and community groups. Different "voices" will resonate for different people. Developing networks which could include a committee of key managers from the relevant sectors may help to support and sustain delivery;
- **Capacity Building:**
  Another important step in sustainability is ensuring that capacity is increased with staff working in EY services and schools, through the provision of accredited and nonaccredited training as well as role modelling and mentoring. Embedding the training and learning will support staff to understand speech and language development; to appropriately identify and refer children with S&L needs; to support children with S&L needs and to support parents to refer children and contribute to their achievement of milestones. Over time, these improvements will impact on speech and language supports and classroom dynamics, so creating strong arguments for the service;
- **Creating awareness:**
  Ensuring that the local community is aware of Chit Chat and the benefits that participation in the service brings for the families involved is important in making sure that the service continues. This can be achieved through regular updates in the form of newsletters and through the use of social media. Identifying on-going opportunities to promote the work done within the groups can also support this process, and this can link with the effective use of your identified champions;
- **Influencing:**
  The IASLT, SLT training colleges, the Department of Health and HSE are key stakeholders in shaping policy and practice. Promoting the value of this model may gain support to realign funding and/or resources to utilise different approaches, i.e. onsite delivery with a focus on improving staff capacity. As the HSE are the main source of delivering S&L services, they are a natural fit. The referral mechanisms and strong working relationship already established between the HSE and Chit Chat will also strengthen the case for this model of service delivery.

4.4 Checklist and Next Steps:

Reaching the end of Phase Four will mean that the Chit Chat model is becoming fully embedded in your community or organisation. Track your progress through this final phase by completing the **Business as Usual Checklist** in Table 6. This will help to ensure that attention is paid to all ongoing tasks for the maintenance and development of your service and that it becomes the norm in your

community or organisation. Of course, we recognise that sustainability is influenced by many factors, a great deal of which are beyond the control of local communities and organisations. Staying focused on the logic model, being open to review and revision, and tracking outcomes will all support this process.

Table 6: Phase 4 – Business as Usual Checklist

Stage	Description	Implementation Status: Fully (F), Partially (P), or Not at all (n)			Comments
		F	P	N	
Consolidation	Have the relevant stakeholders been identified?	F	P	N	
	Has support for Chit Chat been secured from all stakeholders?	F	P	N	
Sustainability	Have programme champions been identified?	F	P	N	
	Is the local community aware of this model?	F	P	N	
	Has consideration been given to long-term resourcing service delivery?	F	P	N	
	Have any funding streams been identified?	F	P	N	
	Have discussions taken place with the HSE regarding realignment of their existing service?	F	P	N	
	Have findings relating to outcomes for children been collated and presented to management, EY's, schools, parents, HSE	F	P	N	
	Have training of trainers in the relevant courses e.g. Elklan	F	P	N	
	Have a panel of trainers developed locally of parents, EY's, HSE SLTs and teachers	F	P	N	

SOME THINGS FOR CONSIDERATION:

Implementing the CDI Chit Chat Model in your community or organisation can be a challenge. The four phases given in this Guide provide a solid framework on which to develop your service and the following may support the sustainability of the approach:

Planning: Careful consideration needs to be given to the process of implementing a new service. As the implementation process progresses, a number of phases can be active at the same time and you may move back and forth between them. Track progress by following the checklists and be prepared for items that will come up in subsequent phases. This can be helped through the use of some of the resources included in this Implementation Guide, but can also be assisted through contact with someone else who has implemented the Model;

Time: Implementing a new service takes time. This can relate to all aspects of the implementation process, but is particularly true as implementation commences. Perseverance is the key – stick with it! The experience to date is that the first few months of delivering a different model of service delivery are tough, but that this quickly becomes easier. There may also be a need to refer back to the activities of the previous phases in the implementation process or for some stages to run simultaneously;

Communication: Good communication is essential in ensuring that stakeholders, service champions and participants are kept on board. Consider feedback loops and appropriate ways for keeping the key people you are working with engaged with the Chit Chat Model. Newsletters, open days, public celebrations, local media interest and work displays are just some of the ways of keeping people motivated;

Support: Trying something new, however familiar it is can be daunting, irritating, frustrating and exciting – perhaps all at the same time! Use your contacts, check in with other areas delivering an early intervention S&L model; identify supports; think about how best to use your time and stay in touch with CDI for support and resources.

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Appendix 1

Summary of findings from Hayes, *et al*. 2012

- Significantly more boys (n=120, 62.5%) were referred to the CDI Speech and Language Therapy (SLT) Service than girls (n=72, 37.5%).
- 87% of boys (n=104) and 73.6% of girls (n=53) were accepted for therapy, giving a total of 157 children in SLT.
- 13 boys (12.5% of boys accepted) and 15 girls (28.3% of girls accepted) were discharged from the CDI SLT Service with their speech and language within normal limits after therapy.
- Most of the children referred to the CDI SLT Service (54.6%-60%) had not been previously referred to other speech and language therapy services.
- The CDI SLT Service saw children at a significantly younger age than HSE community services.
- The CDI SLT Service had a shorter waiting time than all other services except for in-patient speech and language services.
- The number of new referrals, average age and waiting times suggest that without the CDI SLT Service children would not yet have received therapy or even been identified as having a need.
- Children were most commonly referred to the CDI SLT Service by their parents (n=143, 74.5%) with the support of practitioners.
- A quarter of the children had severe difficulties initially (n=33, 25.3%); 19 children (14.6%) had moderate difficulties; and 14 children (10.7%) had multiple difficulties, with differing degrees of severity.
- 18% of children (n=28) were discharged from the CDI SLT Service because their speech and language had reached normal limits after intervention, requiring an average of less than 6 weeks of speech and language therapy.
- This finding must be considered as particularly positive in the context of Tallaght West, which has an overrepresentation of children at risk of suffering from multiple disadvantages (CDI, 2004 and 2005).
- 39 children were also referred by CDI SLTs to various allied health services, the most common of which were ear, nose and throat (n=12), audiology services (n=7) and to psychologists for an assessment of need (n=8).
- The CDI SLT Service had similar parental attendance rates at direct therapy than most other services involved in the research.
- The CDI SLT Service held at least 100 hours of training through 28 events for staff and parents between September 2008 and June 2011. Training included one-off sessions and courses. When the number of training sessions run by the 10 comparison speech and language therapy services was combined, the number of events was significantly lower than in the CDI service (12 events per year altogether).
- Staff in schools and pre-schools who received the service reported a better understanding of speech and language issues and had more confidence in responding to children with additional needs.

- Staff felt training and support provided by the CDI SLTs was beneficial in supporting children's speech and language development. Staff reported changes in their own practice as a result of the training provided by the CDI SLTs.
- Staff also viewed the CDI service as more accessible than alternatives.
- Parents of children who had received speech and language therapy felt they had developed a better understanding of speech and language issues and were more confident in responding to their child's difficulties.
- Parents felt the school/pre-school based nature of the CDI SLT Service benefited the children both in terms of their development and was less disruptive for children than alternatives.
- Parents felt that their child was more ready for school as a result of the speech and language therapy received and, in particular, that this would result in a lower likelihood of their child being bullied or being singled out for being different.
- The CDI SLT Service had a short-term positive impact on the waiting times for other community speech and language therapy services. At least 20 children from one HSE funded agency were moved from the HSE waiting list to be seen by CDI SLTs and another HSE funded agency indicated that it had transferred some children to the CDI SLT Service from the waiting list.

Summary of findings from Hayes, *et al*. 2016

- Significantly more boys (n=26, 72.2%) were referred to the CDI Speech and Language Therapy Service than girls (n=10, 27.8%), with all children aged between three and six years of age. Similarly with the HSE group, 57.1% (n=16) were boys with fewer girls being referred at 42.9% (n=12).
- The majority of children in the study were attending preschool, with 86.12% of CDI children in pre-school and 71.4% in the HSE group.
- Children were most commonly referred to CDI by their parents with 'mother' being the main referral source. Support was provided by the CDI parent support staff in making referrals.
- HSE figures show that the Public Health Nurse (PHN) was the main source of referral (n=28) with only one instance where a parent made the referral. The remaining referral came from a category entitled 'other'.
- Speech and language outcomes for CDI children indicated an overall decrease in the severe category into the moderate and mild categories. Children moving into the within normal functioning (WNF) category also increased slightly showing a positive trend in scores and subsequent diagnosis across time for the CDI sample.
- CDI statistics from 2014/2015 show that 72% of the children referred to the CDI SLT service had not been identified to the HSE Speech and Language Therapy Service. In this study, it was found that the majority of children in the CDI sample 86.1% (n=27) did not have a previous referral.
- Families were assisted in making referrals for their children by the CDI facilitators on site in the pre-schools and schools. The Public Health Nurse (PHN) acted as a link person in facilitating referrals in the HSE community clinics. However, the PHN system primarily engages with families of children from birth to three years and does not,

generally speaking, work with families where children are over three years of age. This may be a gap in referral opportunity, which early years services, particularly with the proposed extension of the Free Pre School Year [FPSY], could fill. The HSE also provide a monthly advisory drop-in clinic for parents who may have concerns for their child's language development.

- Parental involvement in the HSE sample differed slightly from that of CDI as participation at both assessment and intervention services are required. In the CDI model, parents are also always asked to attend, and generally they do, but children will be seen if the parents are unable to attend where children attend appointments with a therapist on their own during pre-school or school hours.
- Of the six HSE cases studied, four showed a positive and active level of parental involvement. [Given the importance of parental involvement in the process, it is important that any speech, language and communication programme is designed with them in mind. Parents play a key role in the outcomes for their children.]
- This study indicates that the HSE Speech and Language Service may be the first port of call for local PHN's who are made aware of, or observe that a child is presenting with a developmental difficulty. It was also apparent that therapists are effective in identifying indicators of other difficulties and referring on to the appropriate service.
- In two of the six HSE cases, children presented with comorbid conditions of Autism Spectrum Disorder (ASD) and intellectual disability. Therapists described how children would not co-operate with the standardised test. As a result it was deemed inappropriate to continue and individual therapists administered qualitative methods as a way of providing an informal diagnosis/indicator of needs.
- HSE SLTs found that some of the families they work with need to attend a number of different appointments in any one week.
- Children with more complex needs may start education later and may not attend early years services due to difficulties they may have with toilet training and so forth.

Appendix 2

Speech and Language Therapy Service Memorandum of Understanding (MoU)

This MoU outlines the roles and responsibilities of the following, in relation to the provision of a dedicated Speech and Language Therapy (SLT) service to children up to and including six years of age, in early year's services and primary schools:

- Employer;
- HSE;
- Dedicated Senior SLT post holder (SSLT);
- Dedicated Staff Grade SLT post holder.

The Employer will:

Finance and Administration:

- Provide the funding for the posts and clarity re: budget headings;
- Provide a payroll mechanism for the post holders, and hold the contracts of employment;
- Provide a financial system, to equip the SLTs to deliver an appropriate service;
- Process the payment of the SLT expenditure requests which have been approved by the agreed approval mechanisms i.e. in conjunction with the HSE and employer as appropriate e.g. assessment materials, travel and subsistence, etc.;
- Make all relevant payments to the Revenue Commissioners.

HR:

- Lead in the recruitment process of SLT post holders;
- Work with the HSE in relation to ensuring clinical and professional development support for the SLT;
- Support the provision of a comprehensive induction programme, which will include clarity on roles and responsibilities of all relevant personnel involved in the early year's services and primary schools;
- Monitor time management, attendance, annual leave etc., of the post holders;
- Provide non-clinical support to the staff grade SLT in the absence of the SSLT;
- Contact the HSE in the event of SLTs on sick leave or service delivery issues/difficulties arising.

Reporting:

- Chair quarterly review meetings with the HSE, or more frequently as required.

Strategy and Business Planning:

- Support the business induction, to include finance and reporting systems, and child protection policy;
- Engage in and support the development of a phased sustainability plan for the service;
- Meet with the SLTs every four to six weeks in relation to implementation, quality assurance and monitoring;
- Ensure that the learning from the service is shared appropriately in order to inform both policy and practice;
- Negotiate and 'trouble shoot' where blocks are identified.

The Principal SLT (PSLT), HSE will, to the termination of contract or the end date of contract, whichever is first:

- Provide awareness, acceptance and support to work within the employer's service delivery approach;
- In association with the employer, establish a quality assurance mechanism for the SLT service;
- Provide ongoing clinical support to the SSLT, and to the Staff grade in the absence of the SSLT;
- Work to an agreed supervision contract inclusive of the following:
    - Support the SSLT in identifying clinical and practice issues and developing a strategy to address them;
    - Support the SSLT to identify their skills and competencies in their role;
    - Support the SSLT in clarifying professional issues, responsibilities and boundary issues in respect of their role and that of others;
    - Assess and support how the SSLT engages with the role support process;
    - Provide constructive feedback to the SSLT in relation to clinical and practice issues.
- Attend quarterly review meetings with the employer, or more frequently as required;
- Engage in and support the development of a phased sustainability plan for the service;
- Support induction for incoming SLTs if applicable.

All files and information related to the work of the SSLT and Staff Grade SLT will be owned and held securely and confidentially by the HSE.

The Senior SLT will:

- Carry out all duties in accordance with the job description;
- Work to an agreed employment contract;
- Work to an agreed line management structure;
- Provide quarterly progress reports for review by the employer, the HSE and SLTs;
- Work to an agreed clinical supervision contract as per HSE structure;
- Support and supervise Staff Grade SLT – holding regular, scheduled, documented meetings;
- Contact the HSE and/or employer in the event of any issues/difficulties arising;
- Comply with employer's staff handbook, child protection, health and safety and IT policies and procedures, and be aware of and support each EY services'/schools' policies and procedures;
- Work with the employer, the HSE, staff grade SLT and EY service managers/school principals regarding the strategic development of the service;
- Engage in and support the development of a phased sustainability plan for the service.

The Staff Grade SLT will:

- Carry out all duties in accordance with the job description;
- Work to an agreed contract;
- Work to an agreed line management structure;
- Provide quarterly progress reports for review by the employer, the HSE and SLTs;
- Work to an agreed clinical supervision contract as per HSE structure;
- Attend regular, scheduled and documented supervision meetings with the SSLT;
- Contact the HSE or employer in the event of any issues/difficulties arising;
- Comply with employer's staff handbook, child protection, health and safety and IT policies and procedures, and be aware of and support each EY services'/schools' policies and procedures;
- Work with the employer, the HSE, senior SLT and EY service managers/school principals regarding the strategic development of the service.

Meeting Schedule:

- Service Delivery: Employer and SLTs to meet at least every four to six weeks;
- Strategic Planning: Employer and HSE (PSLT) to meet quarterly, or more regularly in the event of issues arising.

Contacts

	Name:	Mobile:	Email:
Employer			
HSE PSLT			
Acting Senior SLT			
Staff Grade SLT			

Appendix 3

Speech and Language Therapy Service Provision to Early Years Services/Primary School

Service Level Agreement

Funder/HSE/Employer Partnership

Speech and Language Therapy

1. Allocation of the Speech and Language Therapist

The CDI Early Intervention Speech and Language Therapist (CDI SLT) is funded by ** and provides a service to designated Early Years (EY) services and primary schools. The CDI SLT is employed by ** and also works as part of the Health Service Executive (HSE) Community Speech and Language Therapy Team in **. The CDI SLT receives role support and supervision from the Principal Speech and Language Therapist. The Speech and Language Therapist also reports to the funder.

2. Role of the SLT

A SLT has been assigned to work within EY services and primary schools. Responsibilities include:

- Carrying out formal and informal assessment of referred children's speech, language and communication development in co-operation with parents/guardians and EY and school staff.
- Providing assessment summaries and reports as necessary.
- Onward referral of children to other professionals and agencies as appropriate e.g. audiology, Ear Nose Throat (ENT), psychologist etc.
- Liaising with other professionals and agencies including attending case conferences, individual education plan meetings and other progress management meetings as required.
- Implementing therapy as according to identified needs. This may take the form of individual and/or group sessions, home and/or classroom programme, alongside parent and/or staff training.
- Regularly reviewing/monitoring children's progress.
- Providing a health promotion/education/advisory role to support the development of speech, language and communication in all children attending the EY services and schools. This will include staff and parent training modules.

- Developing and reviewing the speech and language therapy service provision for EY services and schools in conjunction with EY Managers school staff, funder and the HSE Principal Speech and Language Therapist.

The CDI SLT also has duties outside of the early intervention speech and language service including continued professional development, supervising student SLTs and participating in the development of the HSE ** Speech and Language Therapy Department.

3. Collaboration

The successful operation of the Speech and Language Therapy Service in EY services and schools depends on effective working relationships, good communication, mutual understanding and respect for different training backgrounds, skills and work duties.

It is important that the CDI SLT is familiar with the classroom environment, daily schedule, curriculum and any issues which may impact on the child's participation and achievement in the EY service and school.

It is vital that the CDI SLT liaise with relevant people involved with the referred children e.g. parents, key workers, teachers, other professionals. The CDI SLT should be invited to attend case management meetings, school transition meetings etc. and if they cannot attend reports should be provided.

For targets of speech and language therapy to be achieved, speech and language therapy programmes must be seen as relevant to all aspects of the child's EY/schools programme. Therapy targets should be practiced and reinforced throughout the child's daily routines and followed up at home where appropriate. Speech and language therapy supports will be provided and modelled for staff. EY staff/teachers are encouraged (with parental consent) to observe individual therapy sessions where appropriate to aid their understanding of the speech and language therapy programme. EY staff/teachers are required to attend offered education modules throughout the year. The support of the EY Manager/principal is required to accommodate times when the relevant staff can meet with the therapist to discuss children's therapy targets and progress and for staff to be able to attend training modules where possible.

4. Communications

Good communication is vital for the success of the service. It is important that each EY service/school nominates one dedicated liaison person to communicate with the CDI SLT service. The person should be made known to the CDI SLT in September of each year. All communications regarding the SLT service will be directed through the nominated liaison person.

The CDI SLT will offer drop in clinics to each EY service/school on a bi-monthly basis to facilitate questions from both parents

and staff. Informal questions may be directed to the CDI SLT on the day he/she is present in your school. If it is a lengthy matter please contact the CDI SLT to make an appointment in advance as time will be limited due to the high volume of therapy sessions.

The support of the EY Manager/principal/liaison person is required to accommodate times when the relevant staff can meet with the therapist to discuss children's therapy targets and progress and for staff to be able to attend training modules where possible.

EY services/schools will be furnished with a copy of the child's initial assessment SLT report.

5. Appointments

EY services/schools will be allocated therapy times in advance. The CDI SLT will endeavour to allocate regular times that are convenient for your site however this may not always be possible as the CDI SLT is providing a service to a number of EY services and schools.

It is the responsibility of the liaison person in the EY service/school to inform the CDI SLT in advance of any closures of the service/school, including school holidays, training days etc. If any unforeseen closures should arise the CDI SLT should be notified as soon as possible.

It is the CDI SLT's responsibility to schedule appointments with parents/carers and to inform the liaison person in the EY service/school of these appointments so they can support the parents in attending by reminding them the day before or the day of the appointment. The variety of working relationships for the CDI SLT means that the therapist who visits your service/school will be required to attend external meetings, training days, etc. On such occasions the SLT will inform you of this.

6. Attendance

As the CDI SLT works throughout the year his/her holidays are not always confined to school terms.

It is the responsibility of the CDI SLT to inform the liaison person in the EY service/school of any absence on days they had allocated to the service. Equally, it is the responsibility of the liaison person to notify the CDI SLT if any children are absent on the day of therapy.

7. Accommodation

In order to provide a quality SLT service appropriate accommodation will need to be made available before the CDI SLT arrives

for scheduled sessions. The room should have a table and chairs, all of appropriate size and height for therapist, parents/carers and children to work at. The room should be free from interruptions as much as possible, and be relatively quiet.

8. Dual Service

The CDI SLT in collaboration with funder and the HSE have established a dual service policy. This policy guides the therapist on children's eligibility for speech and language therapy in the event of them being in receipt of speech and language therapy from other agencies e.g. HSE, Children's Hospital, Lucena Clinic etc. It is generally advised that children attend only one service at a time unless a collaborative approach has been established (e.g. with national services e.g. national cochlear implant unit at Beaumount Hospital, National Rehabilitation Hospital, Dun Laoghaire etc. where the children may attend only for a review). The CDI SLT will discuss each case with the EY liaison person/manager/principal as needed to support their understanding of service provision.

9. Parental/Guardian Involvement

Within the EY service/school:

Parents/Carers/Guardians will be offered opportunities to develop their knowledge skills in supporting their child's speech and language development. Collaboration between EY staff/teachers and the CDI SLT is vital to maximise the attendance at, and benefit from, these opportunities.

Specific Intervention:

Written parental/guardian consent is required prior to any specific intervention. This will be obtained as part of the referral process. Parents/Carers must attend the initial speech and language therapy assessment appointment unless in exceptional circumstances. Parents/Carers are encouraged to attend all following sessions to aid the progress of their child, and they will be informed of procedures for contacting the SLT/service/school to cancel appointments, arrange reviews etc. EY staff/teachers and the CDI SLT will work in collaboration to encourage parents/carers/guardians to engage with the speech and language therapy process.

10. Confidentiality and Freedom of Information

Parental/Carer consent will be obtained prior to sharing information regarding a child between the CDI SLT and the EY staff/teachers or other professionals.

The CDI SLT requires access to paediatric development, psychological and other reports that are provided to the EY service/school regarding children on the speech and language therapy caseload, with Parent/Carer consent.

Speech and language therapy files will be kept in a locked filing cabinet in the therapist's administration office to be accessed only by the CDI SLT and the HSE community PSLT as adhering to the ownership of file policy established between CDI and the HSE.

11. Child Protection

The CDI SLT will have received Garda Clearance before commencing direct work with the children.

The CDI SLT will have completed Children First training provided by Tusla and will therefore be trained in recognising and reporting Child Protection Issues. The CDI SLT must be provided with a copy of the EY service's/school's Child Protection policy. In the event of a child welfare or protection concern, the CDI SLT informs the designated officer in the EY service/school and their employer's Designated Liaison Officer.

The CDI SLT may work with individual children and small groups or in the classroom; however their presence will be in addition to childcare or teaching staff and should not be counted as part of the staffing ratio.

12. Health and Safety

The CDI SLT will adhere to the Health and Safety Policy of the EY service/school and must be aware of the designated first aid officer.

13. Other relevant policies

The CDI SLT will adhere to other relevant EY service/school policies made available to them by the service.

14. Student speech and language therapists

Supervising student SLTs is a component of the CDI SLT's role. Providing placements for student SLTs is of benefit for the student therapist, the supervising therapist and the development of the profession of speech and language therapy. The CDI SLT will request permission from the EY manager/principal for a student SLT to attend a service/school and seek permission from parents of relevant children for the student SLT to observe and participate in sessions. The student SLT is, at all times, the responsibility of the supervising therapist and will not be left alone at a site. The EY manager/principal should provide relevant EY/school policies to the student SLT and it is the responsibility of the supervising therapist to ensure the student therapist has reviewed these policies on commencement of placement.

Appendix 4

EY/School-SLT Checklist

Date: ....

EY Service/School: ....

EY Manager/Principal: ....

SLT Liaison Person: ....

CDI Speech and Language Therapist (SLT): ....

Item	Signed
SLT Service policy provided by CDI SLT	
SLT Service policy reviewed by all staff	**1.** **2.** **3.**
Accommodation allocated (please specify):	
Responsibility for accommodation allocated (please specify)	
Children First Designated Liaison Person (DLP) designated by Manager/Principal	
Children First Deputy Designated Liaison Person (DLP) designated by Manager/Principal	
Child Welfare and Protection Policy provided by Manager/Principal	
Child Welfare and Protection Policy reviewed by CDI SLT	
Health and Safety policy provided by Manager/Principal to CDI SLT	
Health and Safety policy reviewed by CDI SLT	
First Aid Officer designated by Manager/Principal (please specify)	
Other relevant policies provided by Manager/Principal to CDI SLT	
All relevant policies reviewed by CDI SLT	
Location for files allocated: (please specify):	

This service agreement will be reviewed at the end of each term or as requested by EY Manager/Principal or SLT.

Appendix 5

Dual Service Policy

1. Children who are eligible for both HSE SLT and Early Intervention (EI) SLT, services will follow pathways according to Table 1. Co-operative discussion/ networking will take place as appropriate.
2. Children who have been referred to Specialist Services and who will be seen by EI SLT will follow pathways according to Table 2. Cooperative discussion/networking will take place as appropriate.
3. Children attending national specialist services may be jointly managed by the specialist service and the EI SLT service e.g. Cochlear Implant, Cleft Palate, and National Rehabilitation Hospital according to Table 3. Cooperative discussion/ networking will take place as appropriate.

Table 1

Scenario in HSE:	Pathway:
Referral received waiting to be screened	CDI SLT
Waiting for Assessment	CDI SLT
Waiting for Therapy	CDI SLT
Had assessment and therapy is scheduled within x amount of weeks	CDI SLT
Had therapy, awaiting further therapy within unknown weeks	CDI SLT
Had assessment, scheduled for review	HSE remains the lead. CDI SLT team will support parent in attending review
Had Assessment review on request	HSE
Did not contact re assessment and discharged	CDI SLT
Did not contact re assessment and awaiting discharge	CDI SLT
Did Not Attend agreed assessment	CDI SLT
Offered therapy did not attend and discharged	CDI SLT
Offered therapy did not complete, re-waitlisted	CDI SLT
Inconsistent attendance	CDI SLT
Gap in service	CDI SLT
Parent requests to attend HSE	HSE with liaison and transfer from CDI SLT

Table 2

Situation Specialist service: Scenario with	Pathway:
Waiting for assessment in specified amount of time	Specialists
Waiting for assessment in unknown amount of time	CDI SLT if determined appropriate after liaison between CDI SLT team and specialist team and liaison between CDI SLT and clinical supports
Had assessment and therapy scheduled within x weeks	Specialists
Had assessment and waiting for therapy	CDI SLT if determined appropriate (i.e. does not require MDT service) after liaison between CDI SLT team and specialist team and liaison between CDI SLT and clinical supports
Had therapy awaiting further therapy within unknown weeks	Specialists
Had assessment, scheduled for review	Specialists
Had assessment review on request	Specialists
Did not contact re assessment and discharged (depends on service policy)	Specialists however CDI SLT team will support attendance at specialist service
Did not contact re assessment and awaiting discharge (i.e. parents might phone before discharge confirmed)	Specialists however CDI SLT team will support attendance at specialist service
Did not attend agreed assessment	Specialists however CDI SLT team will support attendance at specialist service. If client is to await Assessment again see awaiting Assessment above.
Offered therapy did not attend and discharged	Specialists however CDI SLT team will support attendance at specialist service
Offered therapy did not complete re-waitlisted	Specialists however CDI SLT team will support attendance at specialist service
Inconsistent attendance	Specialists however CDI SLT team will support attendance at specialist service
Gap in service	CDI SLT if determined appropriate after liaison between EI SLT team and specialist team and liaison between CDI SLT and clinical supports
Offered assessment/ therapy in specialist service and parents refuse	Specialists however CDI SLT team will support attendance at specialist service
Discharged as requiring on-going SLT but not from a specialist service (would usually refer back to HSE community team)	Refer back to HSE/ CDI SLT dual service policy (i.e. if on waiting list for Therapy may attend CDI SLT)

Table 3

Scenario in EI SLT Service:	Specialists Response:	Best Pathway:
Screened referral identify the need for specialist intervention	Can accept referral and offer assessment within known amount of time	Specialists
Screened referral and needs specialist	Cannot offer assessment within known amount of time	CDI SLT if determined appropriate after liaison between CDI SLT team and specialist team and liaison between CDI SLT and clinical supports
Attends assessment and need for specialist arises	Can offer assessment within known amount of time	Specialists
Attends assessment need for specialist arises	Can offer assessment in known amount of time: will be waitlisted	CDI SLT if determined appropriate after liaison between CDI SLT team and specialist team and liaison between CDI SLT and clinical supports
Attending therapy and need for specialist arises	Can offer assessment within known amount of time	Specialists
Attending therapy and need for specialist arises	Cannot offer assessment in unknown amount of time: will be waitlisted	CDI SLT if determined appropriate after liaison between CDI SLT team and specialist team and liaison between CDI SLT and clinical supports

Appendix 6

CDI Job Description for Senior SLT

<table>
<tr><td>Job Title, Grade</td><td>Senior Speech and Language Therapist</td></tr>
<tr><td>Competition Reference</td><td>The Childhood Development Initiative (CDI)</td></tr>
<tr><td>Location of Post</td><td>The Speech and Language Therapist will be based in Tallaght West.</td></tr>
<tr><td>Reporting Relationship</td><td>Principal Speech and Language Therapist (PSLT) HSE, Dublin South West.

S/he will work in collaboration/partnership with CDI management, Early Year's Services and School Principals where relevant.

The Speech and Language Therapist will be employed by CDI.

A Memorandum of Understanding (MOU) has been drawn up which will inform the reporting relationship contract.</td></tr>
<tr><td>Purpose of the Post</td><td>The provision of a speech and language therapy service within the Childhood Development Initiative's supported Early Years Services and Schools in Tallaght West.

The Senior Speech and Language Therapist will provide a comprehensive, high quality and evidenced based speech and language therapy service to a designated population of preschool age children and children at Junior infant's level.

To work with PSLT, CDI management, Early Years management and School Management in co-ordinating the SLT service to meet the needs of the service user and the objectives of the organisation.

To support and supervise staff grade SLT.

To support and supervise SLT students as designated and to promote continuing professional development.</td></tr>
<tr><td>Principal Duties and Responsibilities</td><td><u>Professional / Clinical</u>
The Senior Speech & Language Therapist will:
• Be responsible for assessment, diagnosis, planning, implementation and evaluation of treatment / intervention programmes for service users according to professional standards.
• Arrange and carry out assessment and treatment / intervention programmes in appropriate settings (e.g. Early Years Service, school, home) in line with local policy / guidelines.
• Communicate results of assessments and recommendations to the service user and relevant others as appropriate.</td></tr>
</table>

- Document all assessments, diagnoses, treatment / intervention plans, clinical notes, relevant contacts and summaries in accordance with SLT Department and professional standards.
- Collaborate in a timely and inclusive way with service user, family, carers and other staff in goal setting and treatment / intervention planning.
- Adhere to the CDI model of early intervention SLT.
- Provide clinical leadership in the day-to-day running of the service by supporting and supervising staff, prioritising and allocating work and promoting positive staff morale.
- Deliver (accredited) appropriate training to parents and staff in line with evidence base practice.
- Line manage staff grade SLT.
- Be responsible for maintenance of standards of practice of self and designated staff.
- Foster close working relationships with colleagues and other relevant professionals in maximising the service users potential.
- Actively engage in team based performance management.
- Actively participate in Personal Development Programme.
- Provide support and information in relation to communication and / or feeding, eating, drinking and swallowing disorders etc. to service users and relevant others.
- Participate in teams as appropriate, communicating and working in collaboration with the service user and other team members as part of an integrated package of care.
- Participate in the evaluation process regarding the CDI Early Intervention Speech and Language Therapy Service.
- Attend clinics and participate in relevant meetings, case conferences as appropriate.
- In conjunction with the PSLT contribute to the development and implementation of procedures, policies and guidelines while adhering to existing standards and protocols.
- Maintain professional standards in relation to confidentiality, ethics and legislation.
- Seek advice and assistance from the PSLT with any assigned cases or issues that prove to be beyond the scope of his / her professional competence in line with principles of best practice and clinical governance.
- Operate within the scope of Speech & Language Therapy practice as set out by the Irish Association of Speech & Language Therapists.
- Provide and present reports in relation to the SLT service.
- Attend and organise relevant meetings and conferences as required.
- Participate in and develop activities which support health promotion.
- Carry out other duties as assigned by the PSLT.

Education and Training

The Senior Speech & Language Therapist will:

- Participate in mandatory and recommended training programmes in accordance with departmental/organisational guidelines.
- Maintain and develop professional expertise and knowledge by actively engaging in continuing professional development e.g. reflective practice, by attending and presenting at in-service events, training courses, conferences, professional courses or other courses relevant to practice, participating in research etc.
- Manage, participate and play a key role in the practice education of student therapists and promote and engage in the teaching / training / support of others as appropriate.
- Avail of and participate in own supervision with the PSLT.
- Engage in planning and performance reviews, as required with the PSLT and CDI.

Health & Safety

The Senior Speech & Language Therapist will:

- Comply with the policies, procedures and safe professional practice of the Irish Healthcare System by adhering to relevant legislation, regulations and standards.
- Comply with the health and safety policies and procedures of pre/school sites.
- Document appropriately and report any near misses, hazards and accidents and bring them to the attention of relevant / designated individual(s) in line with best practice.
- Work in a safe manner with due care and attention to the safety of self and others.
- Be aware of risk management issues, identify risks and take appropriate action.
- Comply with department procedures with regard to assessment, recommendation and / or manufacturing of all assistive devices.
- Promote a culture that values diversity and respect.

Administrative

The Senior Speech & Language Therapist will, in consultation with the PSLT:

- Be responsible for the co-ordination and delivery of service in the designated Early Year's and school sites.
- Ensure good working practice and adherence to standards of best practice.
- Promote quality by reviewing and evaluating the Speech & Language Therapy service, identifying changing needs and opportunities to improve services.
- Assist the PSLT and CDI in service development, including policy development and implementation.

	• Ensure the maintenance of accurate records in line with best clinical governance, the organisation's requirements and the Freedom of Information Act, and provide reports and other information / statistics as required. • Provide relevant statistical data to PSLT and CDI as required. • Engage in service audit and demonstrate the achievement of the service objectives. • Represent the department / profession / team at meetings and conferences as appropriate. • Participate in the control and ordering of clinical equipment. • Be responsible for organisation and maintenance of own clinical equipment, and identification of equipment needs as appropriate. • Engage in technological developments as they apply to the service user and service administration. • Keep up to date with change and developments within the Irish Health Service.
Eligibility Criteria, Qualifications and/ or experience	• Qualifications: Candidates must: (a) possess the BSc degree (Clinical Speech and Language Studies) from the University of Dublin OR (b) possess the BSc degree (Remedial Linguistics) from the University of Dublin OR (c) possess the Licentiateship of the College of Speech Therapists OR (d) possess a qualification in Speech Therapy at least equivalent to (a), (b) or (C) and (e) have had at least three years satisfactory post qualification experience; (f) have the clinical and administrative capacity to discharge the functions of the post. • Qualifications from outside the Republic of Ireland require Department of Health and Children (DoHC) validation. • Applicants whose first language is not English and/or who have not undergone their Speech and Language Therapy training through English must have achieved the following: O A minimum score of 8.0 in the International English Language Testing System (IELTS); O A pass in the Clinical English Language Competence Exam (CECE).
Post Specific Requirements	• Experience with Paediatric Caseload.
Other requirements specific to the post	• Driving Licence and access to vehicle is essential.

Skills, competencies and/or knowledge	• Demonstrate sufficient command of the English language to effectively carry out the duties and responsibilities of the role. • Demonstrate sufficient clinical knowledge and evidence based practice to carry out the duties and responsibilities of the role. • Demonstrate an ability to apply knowledge to evidence based practice. • Display effective communication and interpersonal skills including the ability to collaborate with colleagues, families, carers, etc. • Demonstrate the ability to plan and deliver care in an effective and resourceful manner. • Demonstrate the ability to problem solve. • Demonstrate an ability to manage and develop self and others in a busy working environment. • Demonstrate the ability to effectively evaluate information and make appropriate decisions. • Demonstrate a commitment to assuring high standards and strive for a user centred service. • Demonstrate effective team skills. • Display awareness and appreciation of the service user and the ability to empathise with and treat service users / others with dignity and respect. • Demonstrate flexibility and openness to change. • Demonstrate ability to utilise supervision effectively. • Demonstrate a willingness to develop IT skills relevant to the role.
Code of Practice	• Ref. Employer
This job description is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned.	

Terms and Conditions of Employment
Senior Speech and Language Therapist

Remuneration	The Salary scale for the post is:
Working Week	The standard working week applying to the post is: 35 Hrs per week
Annual Leave	The annual leave associated with this post is:
Probation	The candidate will serve a six month probationary period, commencing the date employment begins. Any time during this period the Employer, shall upon giving one week's notice, or payment in lieu thereof, be entitled to terminate employment.
Health	A candidate for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.
Character	Each candidate for and any person holding the office must be of good character and will be subject to Garda vetting.

Appendix 7

Speech and Language Therapy Monthly Review Report

Date:

SLT Caseload Activity

Attendance at Therapy for June 2015

- Offered:
- Attendance:
- Cancellations / could not attend:
- Failure to attend / did not attend:

Active Caseload

Service Name	Active caseload at start of month	Discharged	Active caseload at end of month

Meetings attended

- Clinical Supervision:
- Service review meetings:
- Other:

Issues arising

Strategies to address issues

Trainings attended

Trainings 0ffered

Other

Future targets

Appendix 8

Sample Referral Policy

1. Referrals to CDI SLT service will be accepted for children aged 2.5 to 6 currently enrolled in:________________________ (Name of EY service/school).

2. Referrals will only be accepted on designated referral forms (see below).

3. Referrals will be accepted from individuals involved with the child's care e.g. Parents, teachers, EY staff, Public Health Nurses, Family Support Workers etc.

4. Referrals must have a consent form attached signed by the parent or a carer with the power to consent on behalf of the parent (see below).

5. Referrals will be acknowledged by letter/ in person/by phone within one month of referral.

6. Children who have been referred to, or are currently attending, the HSE community SLT service will be managed in line with the dual service policy. Co-operative discussion/networking will take place as appropriate with parental consent.

7. Children who have a specific diagnosis of:
   - autism spectrum disorder;
   - psychiatric/ psychological/ emotional/ behavioural disorder;
   - moderate/severe/profound learning disability;

   are not eligible for the CDI SLT service as a multidisciplinary specialist team is necessary to ensure these children's needs are met. The SLT will support onward referral by the referring agent to appropriate services for these children.

8. Children whose referrals indicate they may require referral for multi disciplinary diagnostic assessment, or are currently awaiting a diagnosis of the above difficulties will be managed in line with the dual service policy. Co-operative discussion/ networking will take place as appropriate with parental consent.

9. Children who have undergone paediatric diagnostic assessment resulting in a diagnosis of developing within normal limits or a diagnosis excluding those referred to in point 7, require a diagnostic report before referral to CDI SLT service will be accepted or before SLT intervention can be provided/continued.

10. Children who have attended and been discharged from specialist services require a letter of discharge from these services before referral to SLT service will be accepted.

11. Children whose speech and language difficulties are attributable to specific medical conditions (e.g. epilepsy, LLandau Kleffner syndrome, acquired brain injury) are more appropriately seen by hospital speech and language therapy services.

12. Children attending national specialist services may be managed jointly by the CDI SLT service and specialist speech and language therapy service. Co-operative discussion/ networking will take place as appropriate.

    National specialist services include:

- Cochlear implant services;
- Cleft palate services;
- National rehabilitation services.

Appendix 9

SAMPLE SPEECH AND LANGUAGE THERAPY REFERRAL FORM

Name of Child: ______________________________

Date of Birth ______________ ☐ Male ☐ Female

(Pre) School Attending: ______________________________

Time Child Attends (Pre)School: ☐ Morning ☐ Afternoon

Time: ______________________________

Full Address: ______________________________

Mother's first name: ______________ Mother's surname: ______________

Father's first name: ______________ Father's surname: ______________

Guardian's first name: ______________ Guardian's surname: ______________

Mother's Phone Number Landline: ______________ Mobile: ______________

Father's Phone Number Landline: ______________ Mobile: ______________

Guardian's Phone Number Landline: ______________ Mobile: ______________

Parents' First Language: ______________ Child's First Language: ______________

Do you require an interpreter for assessment appointment?: ☐ Yes ☐ No

Speech and Language therapy works best when the child's parents attend for therapy and practice the skills learned at home with their child.

I am willing and able to attend for speech and language therapy with my child:

☐ Yes ☐ No

Comments: ______________________________

Name of person making referral: ______________________________

Relationship to child: e.g. parent; key worker; teacher; PHN; etc.: ______________

Contact No. ______________________________

Did anybody recommend that this referral be made: ______________

☐ Yes ☐ No

If yes, who: ______________________________

FOR SLT ONLY: Date Received ______________________________

- Has your child been referred to any other speech and language therapy service?

  ☐ Yes ☐ No

  If yes, please give details ______________________________

- Is your child attending any other speech and language therapy service?

  ☐ Yes ☐ No

  If yes, please give details ______________________________

- Is your child attending any specialist service / hospital?

  ☐ Yes ☐ No

  If yes, please give details ______________________________

Are you concerned with any of the following

Please tick the following box:		**Please give details:**
Speech Sounds:	☐	______________________________
Understanding:	☐	______________________________
Vocabulary:	☐	______________________________
Sentence development/grammar	☐	______________________________
Using language (e.g. turn taking, telling stories, and answering questions):	☐	______________________________
Fluency / Stuttering:	☐	______________________________
Voice (hoarse quality, high-pitch, nasal sound):	☐	______________________________
Hearing:	☐	______________________________
Listening:	☐	______________________________
Attention:	☐	______________________________
Memory:	☐	______________________________

Please give details of any other concerns regarding your child's speech and language development:

____

____

Signed: ______________________________ Date: ______________________________

Appendix 10

SAMPLE SPEECH AND LANGUAGE THERAPY - CONSENT FORMS

Name of Child: ______________________________ Date of Birth: ______________________

Consent to Assessment and Therapy

I hereby consent to my child undergoing Speech and Language Therapy assessment and participating in Speech and Language Therapy Intervention when indicated as necessary.

Parent/ Carer Signature: ________________________ Date: _________________________

Consent to Sharing of Information with (Pre) School Staff

I hereby consent to sharing of relevant information about my child between the **CDI Speech and Language Therapist and my child's (pre)school staff**.

Parent/ Carer Signature: ________________________ Date: _________________________

Consent to Sharing and Receiving of Information

I hereby consent to the sharing and receiving of relevant information about my child between **CDI Speech and Language Therapy and HSE Community Speech and Language Therapy service**.

Parent/ Carer Signature: ________________________ Date: _________________________

Consent to Transfer

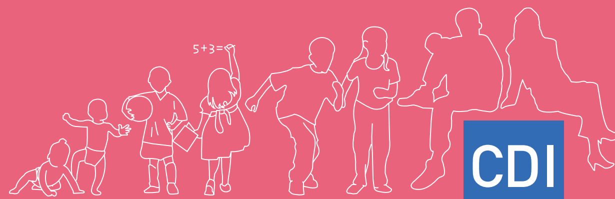
Upon my child leaving, or upon termination of the CDI SLT Programme, I hereby consent to allow the CDI Speech and Language Therapist to **transfer my child's file and caseload to my local health centre**.

Parent/ Carer Signature: ________________________ Date: _________________________

Consent to Transition Support

Upon my child leaving this (pre)school and transitioning to another, I hereby consent to allow sharing of relevant information about my child between the **CDI Speech and Language Therapist and my child's new preschool or primary school.**

Parent/ Carer Signature: ________________________ Date: _________________________


5+3=
CDI
CHILDHOOD DEVELOPMENT INITIATIVE
Responding To Needs, Driving Change