Scottish COVID-19 Inquiry

Witness statement of Glenn Carter

Witness Number: EDU0028

Statement taken on 27 February 2024

1. My name is Glenn Carter, and I am 48 years of age. I work in Edinburgh. My contact details are known to the Inquiry.

2. I am the head of the Scotland office of the Royal College of Speech and Language Therapists (RCSLT). I've been in my current role for two and a half years. I am a qualified speech and language therapist and worked in the NHS in Scotland for 23 years. Most recently I led a children's speech and language therapy service in NHS Forth Valley.

3. I am giving this statement on behalf of the RCSLT (Charity registration no. SC041191).

PRE-PANDEMIC OVERVIEW

4. The RCSLT is the professional body representing speech and language therapists in the United Kingdom. It was founded in 1945. The objectives of the organisation are to promote the speech and language therapy profession, and to improve the lives of people with speech, language, communication, and swallowing needs. We have 22,000 members across the United Kingdom. We are overseen by our head office in London, but we have offices across the UK, including in Scotland. We have a smaller membership within Scotland of approximately 1100.

5. We are mainly funded by member subscriptions. Our members pay a fee to us and receive a range of services in response. We have also derived an income from a limited number of commercial activities, such as venue hire and royalties from publications.

6. Across the UK we have a professional department which has responsibility in ensuring the clinical practice guidelines, research and evidence are all up-to-date and of the highest possible quality. We have a public affairs department, which has the job of making sure that all decision makers and policy makers have the information they need around speech, language, communication, and swallowing needs to inform their decision making. We also have a communications team which has the job of promoting more widely the charity objectives of the RCSLT.

7. Speech and language therapists are primarily employed by the NHS in Scotland. However, most local authorities have a service level agreement with their health colleagues to provide speech and language therapy services within educational contexts. Those agreements are varied, as is the amount of money that they pay for speech and language therapy services. However, typically, local authorities pay for speech and language therapists to work in their special schools, mainstream schools, and early years settings to support the needs of children and young people with communication difficulties.

8. In education settings, speech and language therapists provide individualised forms of specialist support, as well as improving the workforce's knowledge and ability to engage and interact with children and young people who have speech and language difficulties. We would like to see speech and language therapy further integrated within the education setting but the extent to which this happens is

dependent on the funding available. The Scottish Government has published a report called 'Equity for All',[1] which highlights the variability in service provision across Scotland. The report found that areas in Scotland with the highest need had the lowest level of resource: "there is a clear inequity in how services are resources relative to predicted need", and "there are clearly a significant number of services where the resource simply is inadequate to meet the considerable needs of the population served".

9. In short, there is no streamlined or consistent model of speech and language provision across Scotland. In some ways this is helpful because the service should be designed to meet the needs of the population it is serving, for example, the needs in Orkney may be different from the needs of inner-city Glasgow. However, the RCSLT was concerned about the variability in service provision and funding before the pandemic.

10. Traditionally the provision of speech and language therapy follows a model where speech and language therapists see a child in a community clinic on a one-to-one basis, however, research and practice has moved on. We are now trying to move towards a model of delivering speech and language therapy in the environment in which the child is situated i.e. in the home or in an education setting. This is beneficial because the biggest impact of communication difficulties tends to occur in education. Scottish Speech and Language Therapy services have been moving towards this model for a number of years. This working model is not consistent across however Scotland and is dependent on resource. For example, if a service has a relatively low level of speech and language therapy resource they may have to centralise it and deliver from community clinics. Most

[1] Gascoigne, M. (2021). Equity for all: Children's Speech and Language Therapy Services in Scotland, Better Communication CIC (SCI-RCSLTx-000001)

services across Scotland have some offer of therapy and approaches in school. This could be, for example, for children with more complex needs. In short, the model of speech and language provision was inconsistent pre-pandemic. Most services have a mixture of education-based approaches and community clinic-based approaches. However, what we are seeing is that local authorities are reducing the amount of money they are paying NHS boards for speech and language therapy services which is driving some services to centralise their approach and deliver it in community clinics.

11. If a child has a communication difficulty, then that is likely to affect their ability to learn and access the curriculum, their ability to interact with peers; and to manage and navigate the playground. The impact is wide reaching, and it is important to prevent harm. The Scottish Government, NHS, and local authorities have long sought to engage in preventative approaches. For these reasons, speech and language therapy has been working to transform their services to offer quality approaches at a universal, targeted, and individualised level.

12. Universal support can include adapting the environment in which the child learns and communicates. For example, using pictures and visuals in the classroom and ensuring those in their environment know how best to interact with these children to promote understanding but also expression of spoken language. We know that adult-child interactions are key and one of the most effective ways we can improve communication. Those skills need to be taught, modelled, and coached in context to achieve behavioural change. You can't do this with a medical model approach.

13. If the universal offer isn't sufficient to meet the needs of children in a certain education setting, then the speech and language therapy intervention would move to a targeted approach, which could be

group work or more focused training for a group of staff. If a targeted approach isn't adequate, then we would move to an individualised approach, which is what people traditionally understand speech and language therapy to be. The view of the RCSLT is that children should have access to all these levels of support.

14. The most effective way to achieve this is to embed therapists in an education setting so that they can build up relationships. You can attend formal meetings but also have those informal corridor conversations or conversations in the staff room to talk about what's required for a particular pupil. In this way you can build an environment that feels safe for staff to shift their practice. This is the type of provision that we are keen to build and the success of this is dependent on funding from education authorities. Sometimes funding is reduced, and speech and language therapy provision is pulled back to a community clinic setting, which has some benefit but is not best practice. Typically, the most significant impact on children with communication needs occurs in educational settings, so much of the improvement efforts should be focused there.

15. There were inequalities for children and young people with speech and language difficulties pre-pandemic. One of the most prominent inequalities relates to delays in spoken language skills. A Scottish study found that 50% of children who start school present with inadequate spoken language skills[2]. As a speech and language therapist I observed children who were 15 or 18 months behind their peers in respect of these skills. From the very beginning, these children have to play catch up.

[2] Law, J., McBean, K. & Rush, R. (2011). Communication skills in a population of primary school-aged children raised in an area of pronounced social disadvantage. International Journal of Language and Communication Disorders, 46(6), 657-664. (SCI-RCSLTx-000005)

16. The lack of communication skills has a significant impact on their ability to socialise, interact, and critically on their ability to learn. As the school curriculum is delivered mainly in spoken language, this has a huge impact, and this is the case even when you look at their ability with the written word. A child's spoken language skills are mirrored in their comprehension and expression of written text.

17. We know that this gap in spoken language skills can be closed, with the right interventions and support. To be effective these interventions need to be done at the right stage in a child's linguistic development, and they need be continuous, throughout the child's education.

18. Mental health is closely linked with communication skills. There is also a connection between spoken language abilities and behaviour. All behaviour is a form of communication, and we know when children have communication difficulties, they can become distressed and will find different ways to convey that their needs aren't being met. This might manifest itself in low mood, disengagement with learning, or in more disruptive behaviours.

19. The longitudinal data[3] found that vocabulary at age five correlates with employment, mental health, and literacy difficulties. We know that 60% of young people in contact with the justice system have spoken language difficulties[4], so you can see how one's employment prospects and future life chances can be traced right to early years education and the quality of support that is in place.

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[3] Law, J., Rush, R., Parsons, S., and Schoon, I. (2009). Modelling developmental language difficulties from school entry into adulthood: Literacy, mental health and employment outcomes. Journal of Speech, Language and Hearing Research 52, pp. 1401-16 (SCI-RCSLTx-000006)

[4] Bryan, K., Freer, J., & Furlong, C. (2007). Language and communication difficulties in juvenile offenders. *International Journal of Language & Communication Disorders, 42*(5), 505–520. (SCI-RCSLTx-000004)

20. The pandemic shone a light on these pre-existing inequalities. From what we understand these inequalities may have worsened since the pandemic and health visitors[5], early years practitioners[6], teachers and speech and language therapists are telling us there are more children with communication needs and their complexity has increased.

21. There was also a pre-existing inequality, which was exacerbated by the pandemic, in respect of the level of provision provided in areas of socioeconomic deprivation, i.e., areas with the highest need have the lowest level of speech and language therapy resource available[7]. Families living in poverty really struggle to access services where they have to travel distances or to pay for that travel. This is another reason why it is so important that speech and language therapists can work where children are situated.

IMPACT OF COVID-19

Increase in speech and language difficulties

22. We saw a significant increase in number of children who present with communication difficulties as a result of the pandemic and lockdown. In terms of the data, the best evidence we have is from Public Health Scotland[8], which monitors data, mainly from health visitors. During the pandemic they saw a sharp increase in concern in speech and language development of those aged around the 27-to-30-month mark. Communication has always been the highest level of concern for health visitors but what is significant is that they saw a spike

[5] Speech, Language and communication development among children in Scotland during the COVID-19 pandemic (Public Health Scotland, 2023) (SCI-RCSLTx-000007)
[6] RCSLT Scotland and Early Years Scotland Survey (May 2022) (SCI-RCSLTx-000003)
[7] SCI-RCSLTx-000001
[8] SCI-RCSLTx-000007

around the 27 to 30 month which particularly concerning because it is such a critical stage in a child's development. Public Health Scotland has also noted a decrease in attainment in Primary 1 to Primary 4, so there is potentially a connection there.

23. RCSLT in Scotland conducted a survey[9] in May 2022, alongside Early Years Scotland, which received responses from 245 early years practitioners. The results of this survey showed that 89% of practitioners in early years settings had seen an increase or significant increase in the numbers and complexity of children with communication needs. They also highlighted increased difficulty in children's ability to interact with others; their behaviour; their ability to participate; their learning; their friendships; and wellbeing.

24. I have been asked what impact changes to health visitor visits, and newborn hearing screening tests, had on the identification of speech and language needs. We know that during the pandemic that health visitors would have struggled to access children and families and fewer of those checks were happening. I have explained, at paragraphs 29-34 below, how speech and language therapy services were impacted during lockdown. But when they did manage to get access, health visitors reported really high levels of concern about communication difficulties. That is, the percentage of 27-30 month child health reviews with recorded speech, language and communication concerns increased significantly. This is reported in the Public Health Scotland data summary paper published in January 2023.

[9] RCSLT Scotland and Early Years Scotland Survey (May 2022) (SCI-RCSLTx-000003)

25. I've been asked to provide the RCSLT's view as to the reason for the increase in the need for speech and language difficulties since the pandemic. I suppose it's important to understand the different types of speech, language, communication difficulties that we work with; it's a very broad range. We assist children with delayed spoken language skills who present as much younger than they are when they come to school or to nursery. There are quite a lot of environmental factors that play a part in that. We also assist children with specific speech and language difficulties where there's a genetic element and they are born with those needs. We also work with children who have very complex high-level needs, where you might have to use augmented and alternative communication.

26. In respect of children with specific speech language difficulties, where there is a genetic factor, we know that they would have these difficulties regardless. But our members have reported that their needs are much more complex because they have been identified at a later stage and this has a knock-on effect on their mental health, participation and learning.

27. The pandemic resulted in reduced opportunities for interaction for these children. Their worlds got much smaller. They weren't seeing their families and friends. They weren't exploring the world, which is a really good way to learn language. These reduced opportunities for interactions have impacted their ability to develop and improve their communication skills. Reduced access to critical services, such as education and speech and language therapy, will have also had a big impact. Then there's also the stress on society, which is very significant. This is stress experienced by families because of cost-of-living crisis, mental health challenges, poverty etc. All these things are interlinked with the pandemic, and we know that prolonged periods of stress impact on how we interact with each other. Stress

is a normal, typical part of everyday life but when it's prolonged and significant, what tends to happen is you have fewer opportunities to engage in those positive interactions like singing, talking, reading, playing, which promote communication and good spoken language and good outcomes for children. This has had an impact on the level of need our members are seeing in educational settings.

28. The evidence base is emerging because the research is ongoing and obviously that cohort of children is continuing to grow up. Therefore, by definition, we simply do not yet know what the medium and long-term impact may be.

Impact on provision of speech and language therapy

29. There was a redeployment of speech and language therapists in Scotland. The redeployment was variable across the country. Some children's health services were stopped almost entirely, and the focus switched to adult services. Most services had some staff redeployed elsewhere, for example, to vaccination clinics, intermediate care or acute settings. Most services had to reduce their offer considerably. I believe that many services maintained some level of offer for the highest priority children, such as those with the most complex needs, or those with swallowing and drinking difficulties. Quite often an in-person offer was available for these children, usually delivered within the home or in a hub setting, where that was possible. However, some parents of children with complex needs were quite anxious about this type of close contact. This was something that speech and language therapists needed to navigate. But the offer was available in many areas if it was required. The offer was communicated in different ways such as direct phone calls from speech and language therapists to families on their caseload or via social media.

30. There was a remote offer available, this was called 'Telehealth'. Again, the availability of this service was variable. Some services already had technology in place and some services had absolutely nothing and as a result, their ability to engage in remote access was significantly restricted. Children and young people living in poverty struggled to access some of the services that were redesigned rapidly for remote access. i.e. they may not have had access to technology required to participate with online learning or speech and language therapy input, or they might have had to share one device with the whole family.

31. For the services that were set up to provide remote provision, this included being accessible via social media. Parents were keen to get advice, and strategies, so the online advice provision became a lot more popular during the pandemic and was helpful.

32. In terms of the impact on the workforce, I think it's fair to say that wellbeing was significantly impacted. We had a lot of exhausted members, low morale, and staff shortages due to redeployment.

33. The RCSLT carried out a small survey which had 80 respondents from Scotland. These respondents were mainly the parents of children and young people with communication needs, and they were all digitally able and literate adults.

34. The survey results showed that before COVID-19, most of the speech and language services they were receiving were delivered face to face. I believe around 1% were receiving online therapeutic input. Of the respondents 87% said they received less speech and language therapy during the lockdowns and during the pandemic. 63% said they didn't receive any specialist level of speech and

language therapy during lockdown. These figures should be read with the caveat that respondents perhaps did not understand what speech and language therapy was, in its broader sense, and felt that if they weren't receiving face to face, provision they weren't getting speech language therapy at all. That is, there are services in Scotland that worked with education pre-COVID to establish interventions and approaches that supported children's communication as part of a whole class or small group setting. Several of these sustainable approaches were able to continue even when the speech and language therapist wasn't given access to the educational placement.

Access to services

35. I have been asked what impact a parent's literacy level, or language ability, might have on their ability to access support for their child during the pandemic. Parents who have poor literacy, or who do not speak English, would certainly have experienced greater difficulties in accessing services, however, we can't evidence that from the pandemic. We do know that parents' spoken language levels and literacy levels impact their ability to access services and impacts how they can best support their children.

36. Our members still had access to interpreters during the pandemic and were able to engage their services remotely, but online provision adds another layer of complexity. I suspect those parents really struggled to access what they needed.

Mental health and wellbeing

37. I have been asked what impacts children and young people experienced in relation to their mental health and wellbeing as a result of a reduction in speech and language therapy input. One of

the surveys carried out by the RCSLT asked questions about this issue. The key pieces of information that respondents shared with us were around the impact that the loss of speech and language therapy input had on social life and friendships for children and young people, followed by access to education, then impact on home and domestic life, and finally, their mental health. These were the highest rated areas that the respondents cited as having been affected by reduced access to speech and language therapy.

38. In the same survey, we also asked a question about the impact on the family more broadly and the four key areas that were impacted were domestic life, mental health, social life, and education.

39. In 2020, we surveyed our membership to ask them about the impact of the pandemic and lockdown on the children and young people with communication needs. The respondents to this survey noted deteriorating mental health and an increase in challenging behaviours. The respondents also raised concerns about barriers to accessing services; about the deterioration of communication skills and swallowing needs; and an increase in safeguarding concerns. In addition to these matters, they also noted a reduction in referrals and requests for assistance to their services, during the pandemic, because people assumed the service wasn't functioning at all or indeed became aware that the speech and language therapy service was offering a partial service due to staff redeployment and restrictions.

Impact of restrictions on reopening of education settings

40. I have been asked what impact the restriction measures that were put in place when schools and other facilities reopened had on the provision of speech and language services. The restriction measures

of course impacted the ability of speech and language therapists to assess children. Assessments were taking place virtually, but for some children that doesn’t work, and we therefore saw an increased number of children receiving late diagnoses and delayed identification of their needs.

41. Speech and language therapists had restricted access to education settings in some cases. We observed that different local authorities interpreted the guidance differently, and access for speech and language therapy depended on whether that particular local authority viewed the speech and language therapist as a core member of their team or not. In areas where the relationship between speech and language therapy and education was strong, our members got much quicker access to educational establishments. However, in some local authority areas, where they didn't see speech and language therapists as core members of their team, it took a lot longer to get access to the school and as a result, the ability to identify and meet the needs of children would have been significantly impacted. Based on the intelligence we received at the time, the experience of the profession in respect of access to establishments when education settings reopened, and experiences of redeployment were not materially different in any of the four nations of the UK.

Guidance

42. I think there are some interesting reflections around PPE usage and safety precautions given that health staff had different guidance to education staff. This caused quite a lot of challenge for speech language therapists. Speech and language therapists had to ask themselves, ‘how do we do this? Do we adopt what education are doing, i.e., the context we're working in, or do we follow health

guidance?' The health setting guidance was much stricter. That caused a lot of anxiety and confusion at a time when we were having to advise therapists to try and make pragmatic decisions locally about how to facilitate partnership working. It's very hard to facilitate partnership working if one team member is in full PPE, including their uniform, mask, apron, gloves, and their education colleagues are not. That was one example of confusion that ought to be avoided in any future response to a health crisis.

Increased waiting times

43. As pandemic started to ebb, we were aware of the concerns around waiting times for speech and language therapy. Anecdotally, we were hearing that waiting times were increasing and that the funding for speech and language therapy was decreasing. In response to this, in May 2023, we made comprehensive freedom of information requests to all the health boards, health and social care partnerships, and local authorities. We asked questions about funding and waiting time and received high-quality information back.

44. The information from the requests allowed us to demonstrate that 6503 children were waiting for speech and language therapy in Scotland. The average wait for initial contact was one year, one month, and the average longest wait for individualised therapy was one year, five months. Depending on how it is measured locally, this can represent a double wait. Wait for assessment and a wait for therapy.
45. This figure is well outside the government targets where 95% of new outpatients should wait no longer than 12 weeks from referral to being seen[10]. We know that waiting that length of time for children is

[10] RCSLT Scotland Survey of Parents of Children and Young People with Communication Needs (unpublished) (SCI-RCSLTx-000008)

too long, particularly given how rapidly children develop before they get to school. Our data showed a deterioration in waiting times over the last five years. The average longest wait for initial contact increased in those last five years by seven and a half months. We also found that the average longest wait for individualised therapy has increased in the last five years by 10.2 months. These extensive wait times have an impact on the efficacy of any speech and language therapy ultimately provided.

46. A combination of factors has led to this increase in wait times. There is the pausing of services and the significant increase in demand as restrictions eased, but there are also challenges related to the funding for speech and language therapy. The redeployment of staff away from children's services also played a role. Overall, I'd say that it's quite easy to be able to demonstrate the link between the increased waiting times and the redeployment of children's speech and language therapists and the restricted access to education.

47. There was inevitably going to be a spike of pent-up demand coming out of the pandemic due to reduced access to education and specialist services. Our members have been telling us that those who require speech and language therapy are presenting with increased complexity and the general trend has been a worsening of waiting time.

ENGAGEMENT WITH SCOTTISH GOVERNMENT

48. I have been asked what engagement the RCSLT had with Scottish Government during the period the Inquiry is investigating. I wasn't employed by the RCSLT during that period; however, I am aware that the RCSLT was part of a group called the Allied Health Professions Federation Scotland (AHPFS), and that this group had very regular

meetings with Scottish Government about these issues. The AHPFS met weekly with the Scottish Government to feedback information from their members.

49. Initially, the RCSLT supported the redeployment of therapists into relevant positions during the pandemic. However, as our members expressed concerns about the impact on individuals with communication and swallowing needs, we actively challenged and sought additional information regarding the deployment of speech and language therapists. Our efforts primarily involved collaboration with AHPFS, but the RCSLT also independently engaged with the Scottish Government. We were concerned about the impact and the harm that was occurring to people with communication, eating, and drinking needs.

50. I have been asked to provide the view of the RCSLT as to whether their members, and the children and young people that that their members support, were adequately considered when decisions were being made by the Scottish Government in response to the COVID-19 pandemic. There should have been clearer messaging about the importance of children's services and more effort put into maintaining them once we had learnt more about the virus.

LESSONS TO BE LEARNED

51. I have been asked to provide the RCSLT's view as to the lessons that can be learned, if any, from the Scottish Government's strategic response to the pandemic.

52. RCSLT'S view is that some lessons could be learned around protective equipment and transmission. For example, as part of assessing a person's swallow a patient can produce a cough which is

an aerosol-generating procedure and therapists should therefore receive adequate protection, particularly with FFP3 mask. Also, some direct speech and language therapy requires the child to be able to see the therapists face, such as speech sounds work. It is critical that therapists have early access to transparent face coverings. These are issues we raised with the Scottish Government at the time. Those conversations about developing best practice in respect of PPE and procedures would benefit from further clarity.

53. Everyone was aware we were in an unprecedented pandemic and decisions had to made at pace. However, after that initial lockdown period, it would have been useful to have had a period of reflection. The best use of the workforce should have been reconsidered and staff should have been returned to services where their skills would have been of most value.

54. I think lessons could be drawn from the pandemic, emphasising the importance of maintaining children's services, and the importance of maintaining a level of integrated teams around children. In the event of another pandemic, we should protect children’s services to prevent short- and long-term harm to children and young people. Additionally, it is essential to recognise that speech and language therapy bridges health and education and should not be solely perceived as a health service. The rigid view that speech and language therapy is solely a health service impacted therapists’ ability to work within other settings such as education. We believe speech and language therapy should be viewed as an integral part of the education team and therefore grant early access to educational placements. I think there's lessons to be learned around that.

55. It is interesting to note that during the pandemic, speech and language therapy services that remained most effective had adopted

a preventative approach pre-pandemic. In these areas education staff had been upskilled to address the needs of children. This proactive model ensures a sustainable level of provision, even if the therapist doesn't have direct access to a placement.

56. The research undertaken by Public Health Scotland, and our own survey conducted alongside Early Years Scotland, shone a light on how critical children's spoken language skills are in respect of outcomes for children. We know that environmental factors can positively and negatively influence these outcomes. My hope is that we will learn those lessons and not forget about this, because it really highlighted how critical those needs are, and how bad it can get.

57. These issues will not just disappear now that the pandemic has ended. We need to learn the lessons and develop a nationwide approach to meet the needs of children with communication needs.

58. I believe that the facts stated in this witness statement are true. I understand that this statement will form part of the evidence before the Inquiry and be published on the Inquiry's website.

59. By typing my name and the date below, I accept that this is my signature duly given.

Signed: **Redacted**

Date: 22/07/24