



BEST PRACTICE
GUIDANCE FOR

Collaborative Working between Qualified Teachers of the Deaf and Speech and Language Therapists

In 2007, the British Association for Teachers of the Deaf (BATOD) and the Royal College of Speech and Language Therapists (RCSLT) produced a position paper entitled 'Collaborative Working between Speech and Language Therapists and Teachers of the Deaf' in order to promote effective collaboration between both professions.

In 2019, a small working group comprising members of the BATOD and the RCSLT worked to update the guidance document to ensure that it was reflective of the changes that have occurred in both professions during the past 10 years. All authors work with deaf children and young people and their parents/carers, and are highly experienced in collaborative working across the health, education and social care sectors. Input into this guidance has been sought from all UK nations and includes relevant legislation in England, Wales, Scotland and Northern Ireland. The authors, as well as the many other contributors, are thanked for their valuable input.

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AIM

The aim is to improve outcomes for deaf children and young people through the provision of best practice guidance on how to provide effective collaboration between Qualified Teachers of the Deaf (QToDs) and Speech and Language Therapists (SLTs).

TERMINOLOGY

The working group recognises that there are alternative terms, but for the purpose of this best practice guidance document, the following terminology is used:

- The term 'deaf child and young person/people' (DCYP) is used to refer to any individual(s) aged 0-25 who is deaf.
- The term 'deaf' is used to represent the entire spectrum of deafness.

AUDIENCE

The key audience for the guidance is QToDs and SLTs; however, it may also be useful for:

- DCYP and their parents/carers
- Children's services commissioners
- Managers responsible for QToDs and SLTs
- Any other professional or organisation working with DCYP.

The guidance may be useful for information-sharing forums such as the local offer in England and health board and local authority sites in Wales, Scotland and Northern Ireland.

MISSION STATEMENT

QToDs and SLTs will promote the achievement and wellbeing of DCYP in relation to deafness. Together they will work collaboratively with parents/carers to maximise language and communication outcomes for DCYP.

INTRODUCTION

This guidance reflects the International Consensus Statement on best practices in family-centred early intervention for deaf children and intends to promote widespread implementation of validated, evidence-based principles (Moeller et al, 2013).

This guidance endeavours to capture best practice across the four UK nations. It acknowledges that there is variation across each of the nations and in the flexibility that services provide across the nations.

This best practice guidance is not intended to be prescriptive or advise on specific interventions or modes of communication.

CONTEXT

Collaborative practice is essential in order to meet the needs of DCYP and their parents/carers, with the DCYP being at the centre. This should be in line with relevant local and national legislation and guidance. Examples are provided in Appendix 1.

Most professional organisations and research papers agree that collaborative working results in improved outcomes and life chances, is cost-effective and increases service satisfaction of DCYP and their parents/carers. The 'cost' part of cost-effectiveness is based on the idea that it is more economically efficient to share resources. The 'effectiveness' is based on the idea that it is best practice for professionals to work holistically for a DCYP (plus his or her family/carers) in a collaborative way (WHO, 2015).

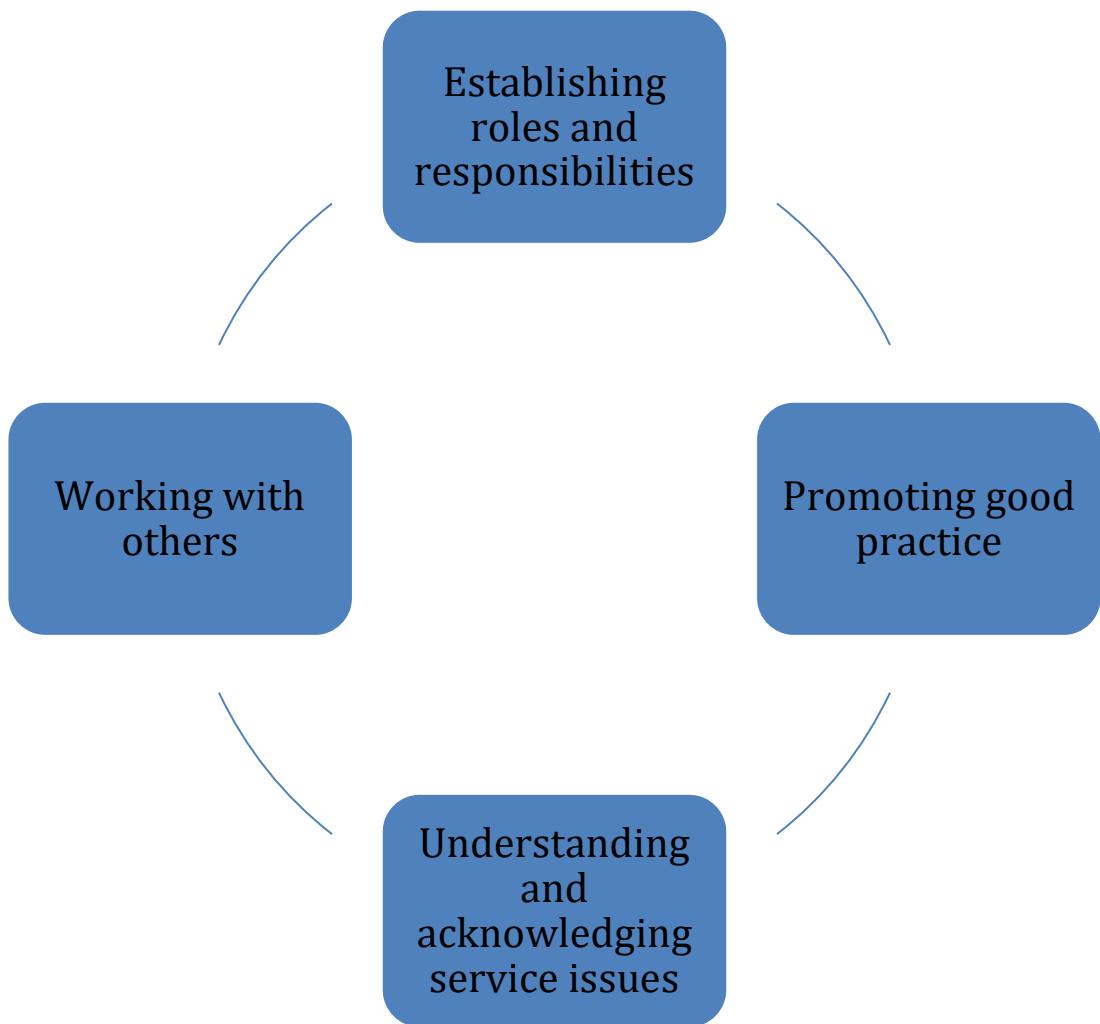
For readers who are interested in exploring the subject of collaboration in more depth, information and research on collaborative working are provided in Appendix 1.

There is a consensus among QToDs, SLTs and research findings (Bauer et al, 2010; Cheminais, 2009; McCartney, 1999) that the following challenges to collaborative practice exist:

- Time
- Service and workforce capacity
- Differences in locations between organisations/professionals
- Caseload covering a large geographical area
- Differing terminology used in different organisations
- Ability to share and store data and information
- Lack of understanding of expertise and skill set.

In order to address these challenges, a set of core principles underpinning the need for collaboration have been established by the working group, which can be used across all settings. The essence of person-centred planning is at the core of these principles. Local commissioning arrangements and service capacity will determine to what extent QToDS and SLTs can work to the principles. However, the principles should be seen as a framework for best practice for both professions, and should be used to support local service development and delivery.

CORE PRINCIPLES



1. ESTABLISHING ROLES AND RESPONSIBILITIES

Professional skills

Understanding the skills, knowledge and expertise of the professionals in the team will help everyone to appreciate, utilise and maximise the skill mix. This will allow local arrangements in collaborative practice to be streamlined in line with the specific experience and expertise of individual QToDs and SLTs. It will also allow both QToDs and SLTs to signpost DCYP and their parents/carers to other professionals and/or services when required.

QUALIFIED TEACHERS OF THE DEAF

QToDs are qualified teachers who hold the mandatory qualification in teaching DCYP which is registered and recognised by the Department for Education in England, the Education Workforce Council in Wales and the General Teaching Council in Scotland. In Northern Ireland, the Education Authority has agreed that any teacher employed to work with DCYP must either have the mandatory qualification or undertake to complete the mandatory training within three years of appointment. This is monitored by the Head of Sensory Service, of which there is just one for the whole of Northern Ireland. Teachers of the Deaf in training are qualified teachers undertaking the mandatory qualification in teaching DCYP.

QToDs have the necessary breadth of knowledge, skills and experience to work with DCYP from 0-25 years of age. They may also have experience in working with children and young people with additional complex needs and their families. Ongoing professional development is appropriate for QToDs to keep up to date with developments in the field (for example BATOD or General Teaching Council for Scotland continuing professional development [CPD] logs).

SPEECH AND LANGUAGE THERAPISTS

In order to practice as an SLT in the UK, it is a mandatory requirement to be registered with the Health and Care Professions Council (HCPC). Within this, members must:

- Have completed a registered, accredited degree level course
- Demonstrate CPD in order to maintain registration and professional standards.

It is further recommended that an SLT is a registered member of the RCSLT. Membership of the RCSLT is not compulsory for SLTs, but many speech and language therapy services within the NHS have made RCSLT membership an essential criterion for employment (see: www.rcslt.org/about-us/membership-overview).

The RCSLT and National Deaf Children's Society (NDCS) have developed guidance for commissioning specialist speech and language therapy services for DCYP (RCSLT & NDCS, 2018). This has also been adapted in Scotland (RCSLT, 2018). Both sets of guidance contain a person specification detailing recommended skills required to work as a specialist SLT in deafness.

The RCSLT recommends that a specialist SLT working with DCYP should have:

- Substantial postgraduate experience of working as an SLT
- Detailed knowledge of different types of hearing loss
- Experience of working with DCYP
- Experience of working collaboratively with other agencies.

Roles and responsibilities

It is important to acknowledge that there are a number of areas of overlap in the roles of QToDs and SLTs. It is essential that clear roles and responsibilities are established for each DCYP and their parents/carers to ensure the best outcomes for them and to provide clarity for:

- DCYP and their parents/carers
- Health professionals and allied health professionals
- Local authority and education professionals.

Joint working will also help provide a coordinated approach with parents/carers, thus keeping the DCYP at the centre of assessment, decision-making and planning.

Roles and responsibilities may vary depending on differences across UK nations, local agreements and the needs of the DCYP. Where overlap occurs, the key is to identify the most appropriate professional to support the DCYP in achieving their outcomes. The following template may be used locally as an aid to clarify roles and responsibilities, and should be completed on an individual DCYP basis. It should be updated and adapted as required to reflect the changing needs of DCYP and their parents/carers.

Establishing roles and responsibilities – template

Child's name:

DoB:

Date of document:

Chronological age:

Date for review of document:

Meet the team		
Name	Role	Contact details
Roles and responsibilities		
Outcome	Who will lead?	Who will support?
Assessment		
Family support		
Intervention/advice		
Other		

Refer to Appendix 2 for a worked example of this template. An editable Word version of this template is also available.

2. PROMOTING GOOD PRACTICE

Referral/request for assistance

There is a need for regular liaison between QToDs, SLTs and other professionals working with DCYP to enable referrals/requests for assistance to be made in a timely manner.

In each local area, clear and robust referral/request for assistance pathways to QToDs and speech and language therapy services are required. Pathways and related criteria should be evidence-based to enable the professionals and parents/carers of DCYP to make appropriate and timely referrals/requests for assistance.

Where support for DCYP is commissioned through different pathways such as health, education, sensory support services, individual schools or a combination of these services, waiting times following referral can vary widely.

Assessment

Assessment must be holistic, dynamic and ongoing to ensure that goals always reflect the need of the DCYP and their parents/carers. Both QToDs and SLTs use an array of formal and informal assessments and observations to assess the communication and listening needs of DCYP on their caseloads. Many published speech, language and communication assessments are used by QToDs and SLTs. It is the responsibility of both the QToD and the SLT to liaise with each other regarding which assessment(s) they are going to use prior to assessing the DCYP. It is also the responsibility of both the QToD and the SLT to share the results of completed assessment(s) with each other.

Collaborating in this way will ensure:

- Assessments administered are not duplicated
- Results/observations are in line with each other
- Results/observations are accurately recorded
- Results/observations are accurately shared with the DCYP, their parents/carers and other professionals.

As some assessments are available to members of both professions, it is essential that there are clear protocols and arrangements in place locally which establish who will administer the assessments and when. In addition to this, an agreement should be made to outline how results are to be documented, shared and used. Relevant data protection legislation and local information-sharing protocols must be referred to regarding information sharing.

Assessments must be carried out according to the manual/directions for the assessments (as appropriate) in order to avoid invalidating results. Where specific qualifications are required by those who will administer the assessments, such as a recognised degree in speech and language therapy, any protocol needs to take account of these factors.

Standardised assessments are designed in such a way that the questions, conditions for administering, scoring procedures and interpretations are consistent and are carried out and scored in a predetermined, standard manner. Older editions of standardised assessments have not been standardised on DCYP and therefore results should be interpreted and analysed with caution. However, the development of more recent editions of assessments will have been carried out with large groups, which will have included DCYP and other children with special educational needs and disabilities, and reliability and validity studies carried out. They allow for comparisons to be made between individuals and between individuals and groups. Using tests standardised on large groups of children allows us to compare DCYP with peers, which is essential in order to raise standards for DCYP and close the attainment gap. It is essential that professionals refer to assessment manuals for details regarding standardisation.

It is recommended that local services outline protocols for the use of assessments relevant to them. For additional information and guidance on assessments for DCYP, please refer to the NDCS (2019) resource 'Assessments of deaf children and young people'.

There are some cases where it is considered best practice for the QToD and SLT to complete joint assessment(s) and/or observation(s).

The benefits of conducting joint assessments and observations include:

- Allowing professionals to compare observations, providing a more holistic view of DCYP in the home and/or education environment
- Immediate sharing of assessment results and observations
- Agreeing ways forward for DCYP (decision-making, goal setting and intervention)
- Agreeing future support for DCYP (i.e. determining the best person to provide this support)
- Providing opportunities for CPD for both professionals.

Local protocols should determine when joint assessment (including observation) should be carried out, as it may not be possible or needed for every DCYP where both professions are involved.

Decision-making, goal setting and intervention

DCYP may have access to a QToD from 0-25 years in England and 0-19 years in Wales, Scotland and Northern Ireland. The level of involvement from the QToD will

depend on the degree, type and functional impact of the hearing loss, but is always focused on improving outcomes for the DCYP.

Access to speech and language therapy services should be needs-led and focused on impact and outcomes. When the DCYP is on an active caseload, the SLT has a moral and legal obligation to ensure the safety and wellbeing of the DCYP for any given episode of care (HCPC, 2016). When discharging the DCYP, the SLT needs to make clear the reasons for discharge to the DCYP, their parents/carers and all other professionals involved in the support of the DCYP.

The QToD and the SLT should signpost the DCYP and their parents/carers to any additional services as required.

When both the QToD and the SLT are involved in the support of the DCYP, there must be clear local decision-making procedures in place for collaborating on and agreeing:

- Outcomes (goal setting) and how they are measured (outcome measures)
- How the needs of the DCYP will be met (intervention)
- Who is responsible for delivering which aspects of intervention
- Appropriate timescales
- Appropriate information-sharing methods.

DCYPs and their parents/carers must have a key role in the decision-making process, working with the QToD and the SLT to identify and agree outcomes that matter to them in line with person and family-centred practice.

When a request for an assessment of special educational needs is required, professionals should follow the specific legislation and guidance relevant to their nation.

The benefits of collaborative decision-making, goal setting and intervention for DCYP and their parents/carers are:

- Expectations are established from the outset
- There is clarity about agreed goals and expected outcomes, and the measurement of these
- There is clarity about the planned intervention required to achieve the outcomes
- There is clarity about who is responsible for the delivery of services
- There is clarity about timescales for achieving particular outcomes.

In addition to this, collaborative decision-making, goal setting and intervention have professional benefits for QToDs and SLTs by way of:

- Skill sharing
- Developing new strategies for intervention
- Relationship building.

There are establishments where a QToD and an SLT are able to work together on a regular basis, such as auditory implant centres, schools for the deaf and resource base provisions. When DCYP are in mainstream schools and being supported by peripatetic QToDs and their local speech and language therapy service, then distance, time and resources may not allow this to be possible on a routine basis. However, every effort should be made to achieve this by QToDs and SLTs, making use of advances in technology to ensure effective joint working arrangements.

Report writing and record keeping

It is the responsibility of both the QToD and the SLT to share, discuss and agree information with each other prior to writing and distributing their reports.

Collaborating in this way ensures:

- Information from both professionals is aligned
- Key points can be agreed before reports are distributed
- Key points can be reiterated by both professionals
- Information is more concise and accessible.

QToDs and SLTs are individually responsible for the accurate recording and storing of information relating to their work with the DCYP (both direct and indirect contact). Records must be in line with local information governance policies and professional standards.

Sharing information

Information sharing is key to delivering improved outcomes and more efficient services that are coordinated around the needs of DCYP. It is essential to enable early and timely intervention and safeguarding practices, and to promote welfare and better outcomes for DCYP.

Prior to sharing information, QToDs and SLTs are individually responsible for:

- Checking that the DCYP's contact details are correct
- Gaining consent from the DCYP or parents/carers.

DCYP and their parents/carers should be encouraged to inform relevant professionals if any of their team contact details have changed. QToDs and SLTs should highlight to the DCYP and their parents/carers the positive aspects of sharing information between professionals.

With the appropriate consent, the sharing of information should involve not only QToDs and SLTs but also the whole multidisciplinary team (MDT), including the DCYP and their parents/carers. The types of information to be shared include:

- Assessment and observation results and conclusions
- Goals
- Intended outcomes
- Intervention, materials and resources
- Relevant research or changes in practice.

Relevant data protection legislation and local information-sharing protocols must be adhered to regarding information sharing.

Training

Training received

When relevant, it is useful for QToDs and SLTs to receive shared training. Shared training allows QToDs and SLTs to learn with, from and about each other to improve collaboration, and therefore outcomes for DCYP. The benefits of attending shared training are:

- Professional learning
- Developing a joint evidence base
- Sharing good practice
- Opportunity to discuss challenges
- Sharing skills and knowledge
- Development of services.

The importance of receiving joint training should be reflected in local protocols.

Training delivered by QToDs and SLTs

Both QToDs and SLTs will provide training for parents/carers of DCYP and a broad range of professionals and settings supporting the DCYP. The joint planning and delivery of training demonstrates a unified approach in achieving outcomes for DCYP, as well as creating opportunities to explore and share ideas, and for professionals to learn from one another.

It is recommended that local protocols are established in order to agree:

- The need for delivering joint training
- The content of such training
- Who delivers the training
- How training is followed up.

3. UNDERSTANDING AND ACKNOWLEDGING SERVICE ISSUES

Integrating services at management level

It is recommended that collaboration extends to management level where both the QToD and SLT leads work together, holding regular joint meetings to:

- Ensure that collaborative protocols are written, implemented and reviewed
- Gather data about service delivery and outcomes
- Instigate and drive joint projects and research that build evidence-based practices
- Monitor and modify services to ensure effective delivery and development of services in liaison with senior managers and other professionals.

Patterns of service delivery

Service delivery varies from area to area and is constantly evolving. It is recommended that DCYP are seen in the environment in which professionals can effect most change, and where the best outcomes for DCYP can be achieved.

In each setting where a DCYP is known to both a QToD and an SLT, they will work collaboratively to ensure that outcomes for the DCYP are achieved. The variety of activities and services that DCYP are provided with is as follows, and is dependent on the individual need and outcome(s) that have been identified:

- Mentoring parents/carers and DCYP
- Mentoring education staff and other professionals to build capacity in settings
- Teaching and training parents/carers and education staff
- Attendance and discussion at local MDT meetings where joint decisions can be made in relation to DCYP
- Assessment and observation
- Direct teaching/intervention with the DCYP (individual, paired or group)
- Monitoring/review.

Audit and outcome measures

Audit is essential for quality improvement and quality assurance, as it seeks to improve outcomes for DCYP and provides an opportunity to evaluate and improve service provision.

In addition to this, QToDs and SLTs are expected to collect outcome data. This outcome data should be provided to improve services, and thereby outcomes for DCYP.

When working collaboratively, it is recommended that QToDs and SLTs complete joint audits and collect outcome and quality improvement data relating to:

- Improving outcomes for DCYP in relation to their listening, speech, language and communication skills
- Impact/effectiveness of multi-agency working
- DCYP's and parents/carers' experience and satisfaction.

This should be agreed when developing local protocols and be reviewed as appropriate.

Quality assurance

Collaborative working should align with national quality standards to ensure that quality collaborative working practices are maintained and updated in response to changes within either profession. For further information on relevant quality standards, refer to Appendix 3.

It is recommended that local protocols are developed and reviewed regularly to reflect changes in each service over time and to ensure that high quality collaborative working is achieved.

4. WORKING WITH OTHERS

Working as part of a multidisciplinary team can improve outcomes for DCYP and their parents/carers through timely, efficient, integrated and holistic interventions. In some areas MDT meetings are established with this in mind. The composition of MDTs is likely to vary across regions and nations but must include the DCYP and their parents/carers. MDT meetings provide a valuable forum to collaborate on multi-agency support plans and to clarify roles and responsibilities in taking actions forward. When working with colleagues from other professions, it is important that both the QToD and the SLT ensure each other's involvement where appropriate. Other professionals include audiologists, auditory implant teams, paediatricians, educational psychologists, early support workers, deaf child and adolescent mental health services, health visitors and social care professionals. Assessments, goals and reports will be shared with all relevant agencies subject to parent/carer consent being given, in line with relevant data protection legislation and local information-sharing protocols.

CONCLUSION

Collaborative working between QToDs and SLTs is essential for improving outcomes for DCYP and their parents/carers. Working in collaboration reduces duplication of work, and enhances professional working relationships and professional and personal development. Effective collaboration provides value within organisations by improving the effectiveness of the service that can be offered.

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APPENDIX 1

For readers who are interested in legislation and guidance, as well as exploring the subject of collaboration in more depth, please refer to the reading list below:

- Additional Support for Learning (ASL): Statutory Guidance 2017
- Best Practices in Family-Centred Early Intervention for Children who are Deaf or Hard of Hearing: An International Consensus Statement (2013)
- Children and Families Act (2014)
- Convention on the Rights of Persons with Disabilities (2006)
- Department for Education (2016). Specification for mandatory qualifications for specialist teachers of children and young people who are deaf
- Draft Additional Learning Needs (ALN) Code (2018)
- Equality Act (2010)
- Getting it right for every child (GIRFEC)
- Guidance on partnership working between allied health professions and education (2010)
- Ready to Act (2016). A transformational plan for children and young people, their parents, carers and families who require support from allied health professionals (AHPs)
- RCSLT Collaborative Working Guidance
- RCSLT Deafness Guidance
- RCSLT Delivering Quality Services
- Special Educational Needs and Disability (SEND) Code of Practice (2015)
- Special Educational Needs and Disability (SEND) Act (2016)
- 20 Ways for Classroom Teachers to Collaborate with Speech-Language Pathologists (2010)

Full references can be found in the reference section of this guidance document.

APPENDIX 2

i) Establishing roles and responsibilities – template

A Word version of this template is available as a separate document.

Child's name:

DoB:

Date of document:

Chronological age:

Date for review of document:

Meet the team		
Name	Role	Contact details
ADD MORE ROWS AS NEEDED		

Roles and responsibilities		
Outcome	Who will lead?	Who will support?
Assessment		
ADD MORE ROWS AS NEEDED		
Family support		
ADD MORE ROWS AS NEEDED		
Intervention/advice		
ADD MORE ROWS AS NEEDED		
Other		
ADD MORE ROWS AS NEEDED		

ii) Establishing roles and responsibilities – worked example

Child's name: A

DoB: 20/12/12

Date of document: 30/5/19

Chronological age: 6 years, 5 months

Date for review of document: 10/9/19

Meet the team		
Name	Role	Contact details
A	Child	
Mr and Mrs A	Parent	
	Class Teacher (CT)	
	Learning Support Assistant (LSA)	
	Qualified Teacher of the Deaf (QToD)	
	Speech and Language Therapist (SLT)	
	Head Teacher (HT)	

Roles and responsibilities		
Outcome	Who will lead?	Who will support?
Assessment		
Professionals involved will have a detailed knowledge and understanding of child A's level of functional communication and what they are able to achieve given a certain level of support.	QToD and SLT	QToD and SLT, parents, CT, LSA
Family support		
Child A's parents will attend a MDT meeting at school once per term to agree his future goals and predicted outcomes	HT*	CT, LSA, QToD, SLT
Intervention/advice		
Child A will be able to follow 4 word level instructions containing: a) everyday vocabulary b) topic based vocabulary in different listening environments with 80% accuracy.	SLT	Parents, QToD, CT, LSA
Using pre and post teaching, child A will understand, retain and use 10 new topic based words per week.	QToD	Parents, CT, LSA, SLT
Using a core vocabulary approach, Child A will make his best productions of 10 topic based words per week.	SLT	Parents, CT, LSA
Other		
Child A will be able to independently and consistently alert adults in school/at home when his hearing aids are not working.	QToD	QToD, parents, SLT, CT, LSA
Child A will respond to listening checks with his radio aid and alert staff when he finds it difficult to hear.	QToD	QToD, SLT, CT, LSA

*where other professionals are involved, they would need to agree who takes the lead

APPENDIX 3

The following quality standards should be used to ensure that quality collaborative working practices are maintained and updated in response to developments within both professions:

- National Deaf Children's Society. Quality Standards: Early years support for children with a hearing loss (2016)
- National Sensory Impairment Partnership (NatSIP). Quality Standards for Sensory Support Services (2016)
- Welsh Government. Quality Standards for Children's Hearing Services (2016).
- Department for Education. Standard for teachers' professional development (2016)
- Health and Care Professions Council (HCPC). Standards of conduct, performance and ethics (2016)
- Health and Care Professions Council (HCPC). Standards of proficiency – Speech and language therapists (2016)
- Scottish Government. Quality Standards for Paediatric Audiology Services (2009)

Full references can be found in the reference section of this guidance document.