Speech & Language Therapy Services & Management in the Internal Market

A national survey

Nicholas Mays
Catherine Pope

King's Fund

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During the project, members of an Advisory Group met four times to discuss aspects of the research design, its scope and content. The Advisory Group comprised:

Sally Byng	(Chair of RCSLT Research Working Group)
Christine Skinner	(Chair of RCSLT October 1995 – October 1996)
Jenny Sheridan	(RCSLT, representing Ajahma Trust)
Pam Evans	(Professional Director, RCSLT)
Jenny Green	(Chair of TASLTM)
Avril Jennings	(representing RCSLT Council)

The project team canvassed opinions and advice from a wide range of sources, including individual members of the Advisory Group, and other members of the speech and language therapy profession and College staff. We are grateful to each of the members of the Advisory Group for their helpful comments and would also like to acknowledge the support of Shirley Davies, Professional Director of CSLT until 1994, in the early stages of the project's development.

The research team would especially like to thank all the therapists who took part in the project, giving up time for the interviews, assisting with questionnaire piloting, and above all for completing a fairly lengthy questionnaire despite the obvious pressures of their work.

Outline of the report

This report is divided into six parts. The introduction describes the context of the research and briefly reviews the literature which informed and seems most relevant to this project. Following this, the aims and objectives are presented. The next section describes the research design, dealing with the two phases of the project. It describes the development of the questionnaires based on depth interviews conducted in Northern Ireland and England during phase one. This section also discusses the sampling frame, survey administration and response rates. The survey results section presents the findings of the national survey, including a profile of the respondents. The report concludes with a discussion of these findings.

Summary

This report contains the findings of a postal questionnaire survey of all speech and language therapy managers in the National Health Service (NHS) in Great Britain carried out in November and December 1995. Its aim was to ascertain from the reports of service managers the position of their services and how these had changed since 1991 with the introduction of the internal market into the National Health Service following the 1990 NHS and Community Care Act.

The response rate of 87% (197/225) was high for a postal survey requiring answers to detailed factual questions and the responses were representative of speech therapy managers. The evidence from the survey indicates the following:

- speech therapy managers were overwhelmingly women (96%), 90% were full-time and the vast majority continued to have a clinical commitment which averaged about 30% of their working time, although there was considerable diversity in the allocation of time to clinical and managerial tasks
- relatively few managers had any formal managerial qualifications and 42% had received little or no managerial training to assist them in their roles as managers in the internal market since 1991 (only 15% had received any external management training in the period)
- although the previous structure of a District speech therapy service had disappeared, 39% of managers were directly accountable to a Trust Board level Director and 46% accountable to a senior manager one tier below Board level – there was little general sense that speech therapy managers had excessively lost influence at least not in the formal sense of their position in the management hierarchy, particularly not within Community Trusts
- most services were organised into a combined therapy services directorate/division within the Trust – less commonly, speech therapy comprised a separate directorate/ division, but sometimes services formed part of a locality or other sub-Trust structure – as a result, the job titles of managers varied widely
- there was little evidence that the advent of the internal market and Trust status had reduced the extent to which managers controlled their own staff and other budgets – the degree of control remained diverse, though 85% controlled their own staff budget
- managers' direct involvement in external NHS contract negotiations involving their services was modest in that 69% of contracts were reported to be negotiated entirely by other Trust colleagues; this was in marked contrast to contracts with the local education authority for services to clients with special educational needs in which

nearly 75% of managers reported that they had full responsibility for contract negotiations on behalf of their Trusts

- much of the NHS work of the speech therapy departments was dependent on service level agreements negotiated with Trust colleagues rather than external negotiations
- most contracts involving speech therapy services were block contracts based on past patterns of activity incorporating quality standards derived from national initiatives such as the *Patient's Charter* rather than from speech therapy-specific standards
- staff numbers, including qualified therapists, and the range of services provided by speech therapy departments have risen since 1991 as they did before the advent of the internal market despite an increase in the number of separate departments brought about by the move to NHS Trust arrangements – 74% of managers reported that they had gained therapist staff since 1991
- there was no evidence from managers' reports that specialist services had been adversely affected in a major way since 1991
- there was a clear distinction between the situation of services in Community or combined Acute/Community Trusts and those in Acute Trusts in that the latter were very much smaller and, understandably, played a far less prominent part in the output of their host Trust – their managers were less influential and more isolated from other members of the profession
- there were continuing changes in the balance of different types of services demanded of speech therapy departments, but these trends (e.g. an increase in demand for services associated with swallowing disorders, for adults with learning difficulties, through 'statementing' children with special educational needs, etc) seemed not to be directly the result of the introduction of the internal market
- despite the introduction of general management in the 1980s and an internal market in 1991/92, speech therapy services in the NHS remained directly managed by qualified and practising speech therapists not general managers or managers from other clinical disciplines in the vast majority of cases
- the precise effects of the internal market and other parallel policy changes on speech therapy managers and their services were diverse depending on the context of the individual department
- although there were more negative than positive comments on the effects of the NHS changes of 1991 on managers' work and their services, indicating that many managers perceived the period since 1991 as stressful, the responses to open-ended questions indicated that the changes had produced a complex mix of positive and negative effects. For most of those who responded the work of the managers had become more demanding and there was more administrative work to be done which many resented; managers had greater responsibility for the direction of their services and for demonstrating the value of speech therapy; a minority of managers gave positive comments on the changes which indicated that the new environment had

given them opportunities to develop their services in a more 'business-like' way and to gain greater satisfaction from their managerial roles

It is recommended that the NHS gives greater attention to meeting the training and support needs of speech therapy managers which are shaped by the expectation that they should continue their clinical commitments while taking on a more demanding managerial role. In its turn, the profession has to ensure that recruits and practising therapists are adequately aware of the managerial environment they are entering and are able to respond positively to the management challenge.

Chapter 1

Introduction: speech therapy and the 1991 NHS changes

National Health Service (NHS) speech therapists are a small and relatively specialised professional group within the complex division of clinical labour in the Health Service. Therapists are overwhelmingly female. In part, the demand for their services is derived from the actions and assessments of others, most notably doctors and nurses. However, unlike other professions allied to medicine, speech therapists make a direct contribution to services outside the NHS in the field of education over which doctors and nurses have little or no influence.

Most studies and commentary on the effects on staff and services of the introduction of quasi– or internal market changes in the NHS based on the separation of the purchaser and provider functions and the introduction of self-governing NHS Trusts have concentrated on the possible consequences for the medical and nursing professions. The professions allied to medicine have received relatively little attention in major commentaries.[1] The reform documents, starting with *Working for Patients* in 1989[2] tended to overlook the multi-disciplinary nature of most health care. As a result, members of the allied health professions became understandably concerned that the implementation of the internal market would inevitably be to the detriment of their professions and their services.

Previous Health Service managerial changes had largely taken place without direct influence from the allied health professions, making them at least potentially vulnerable to a loss of power and prospects.[3] Before *Working for Patients*, the most important change affecting the position of health professionals had been the introduction of general management following the NHS Management Enquiry.[4] Griffiths replaced consensus management, in which professional interests were formally involved in the management of health services, with general management based on private sector business principles. In this period (the 1980s) the therapy professions appeared to lose some of the autonomy which they had gained in the 1970s[5] to general managers. The subsequent development of NHS Trusts in 1991 decentralised the personnel functions within the NHS and enhanced the right of local general managers actively to manage their services and the purchaser-provider split encouraged providers to look critically at their costs which were largely accounted for by staff. Reviews of skill mix and staffing levels began to be undertaken with greater frequency and conflicts occurred with staff representatives.[6]

In nursing, these exercises led in some cases to reductions in the number of staff and the increasing use of Health Care Assistants. The effects of greater managerial control over the workforce were initially confined to issues of skill mix and staffing levels, but Trusts also began to acquire expertise relevant to determining pay locally. However, there has been relatively little practical change in methods of pay determination to date.

Despite the fact that there was little evidence of rapid or radical change in most Trusts in the first two or three years after 1991, professional concerns were aroused, in part because the NHS changes made it possible to organise therapy services in many different ways. In speech therapy, the purchaser-provider split, particularly the innovation of GP fundholding, the introduction of contracts for all clinical services and the possibility of competition between providers leading to cost pressures on Trusts led initially to a series of professional anxieties:

- the end of a vertically integrated Health Service meant that the traditional functional management structure of the District speech and language therapy (SLT) service headed by a District Speech Therapist with direct access to the District General Manager disappeared. There was considerable concern that the loss of a single, unified service structure would lead not only to fragmentation of the local SLT services, but also to a downgrading of the importance of SLT management and SLT services as they became dispersed among several providers
- the end of functional management would lead to smaller SLT management groups scattered among health care providers to the detriment of the technical expertise which any one provider could call on and to the detriment of the professional career structure
- the end of functional management of speech therapy could lead to its reorganisation around medical specialities, thereby not only fragmenting the service, but also threatening that control over SLT service budgets would pass from therapists to general managers or even doctors, thereby further weakening the position of speech therapy and its ability to influence its environment in the Trust
- the loss of the District Speech Therapists would remove the professional leadership of SLT at local level and erode the profession's ability to influence the nature of its own work. This, in turn, would make it difficult to sustain the quality and continuing development of SLT services
- related to the previous point, the advent of purchasers separate from providers risked the specification of services uninformed by appropriate professional knowledge. This, in turn, could lead to inappropriate use of speech therapists to the detriment of their professional status. GP fundholders would become important purchasers of SLT services with no guarantee that they possessed adequate knowledge of speech therapy

- on the provider side, the new acute Trusts had relatively small complements of speech therapists with relatively little scope for specialist posts. This might lead to pressure for an increasing proportion of therapists to become 'generic', taking on an ever wider range of formerly specialist roles, thereby reducing the quality of services
- within the new Trusts, SLT services might be managed by a therapy services manager from another allied health profession, or from medicine, or nursing, again serving to reduce the influence of speech therapy and the ability of therapists to control inappropriate demands on their services
- even if SLT services were managed by a speech therapist, this manager would have very limited or indirect access to the executive level of the Trust unlike the situation of the previous District Speech Therapist, thereby weakening the input of the profession to planning and resource allocation decisions affecting its destiny
- competition between Trusts could lead to downward pressure on costs and the reduction of provision for SLT services, or a narrowing of the range of services provided locally

These areas of concern, combined with the fast pace of the NHS changes, left little opportunity for the SLT profession to consider the NHS changes of 1991. Across the therapy professions, the changes were seen as a threat to professional and 'public service' values despite the fact that it also became increasingly apparent (at least to some observers and participants) that the new internal market opened up opportunities for therapy services and their managers.[5] There was a tendency, nonetheless, to see the circumstances of NHS speech therapists as deteriorating and to judge that this trend was due to the introduction of the internal market. However, although the internal market was a major alteration of the organisation of the NHS as a whole, there were a number of other changes in the mid-1990s which are likely to have had an important influence on the profession including the Education Act of 1993 with its requirement to prepare a 'statement' of special needs for children with learning difficulties, increasing demands for work in acute settings particularly for dysphagia, the national regrading exercise in speech therapy, the changing nature of SLT training and the role of students in training in the NHS and, finally, a long term upward trend in SLT staff numbers (up by 55% between 1984 and 1994[7]). In this respect, SLT and the other allied health professions have experienced a different trajectory from nursing in that the internal market was not associated with any check on the steady rise in numbers of SLT staff.

In order to understand more about the effects of the 1990 NHS and Community Care Act and other parallel developments on speech and language therapy in the NHS, the Council of the Royal College of Speech and Language Therapists (RCSLT) decided in 1993 to commission a wide-ranging review. Ideally, the RCSLT would have wished to study the effects of NHS reorganisation over time on the pattern and level of provision of SLT

services, on the work of individual therapists, on the management and organisation of the services and on the experiences and satisfaction of service users. The Council had identified a number of particular, inter-related concerns about which it had received adverse reports from members and which it wished to see investigated:

- changes in the management structure of SLT services due to the introduction of smaller SLT departments in NHS Trusts, especially the dismantling of senior management posts
- a decrease in the variety of work experience for therapists in smaller departments and Trusts, particularly affecting newly qualified therapists
- a trend towards generic rather than specialist therapist posts
- a reduction in the range of client groups served, brought about by the restrictions of new contracts for SLT services

In the event, it was only possible to obtain resources sufficient to study part of the wide range of topics identified by the Council, focusing particularly on service and managerial issues. The more limited aims and objectives of the research project which was eventually funded are given in the next section. It was not possible, for example, to study the changes in SLT services from the perspective of their users. Instead, it was decided to concentrate the research on the effects of the internal market changes since 1991 on management arrangements and the nature of the services provided. The chosen informants were to be senior therapists engaged in managing SLT services. It was not possible to collect data from the perspective of more junior therapists or those who did not have a clear managerial role.

The study was undertaken in two distinct phases. The initial phase was primarily exploratory and consisted of depth interviews with SLT managers. Its main aim was to identify issues for a large-scale survey. The second phase which is the main focus of this report comprised a structured, postal survey of all SLT service managers in Great Britain to provide an overview of changes since the NHS changes. Ideally, such surveys would have been repeated regularly starting before 1991 in order to study the impact of the changes over time. This was not possible in the current project which, therefore, amounts to a 'snapshot' of the position of SLT services at the end of 1995/early 1996, with retrospective information from managers on the situation of their services before 1991.

Chapter 2

Aims and objectives

AIMS

The aim of the research was to examine the impact of the NHS changes since 1991 on speech and language therapy services in hospital and in the community through the reports of senior managers of those services. The 1991 NHS changes were defined as the introduction of the internal market, specifically the introduction of a purchaser-provider split based on NHS Trusts with GP fundholders and health authorities operating as purchasers.

OBJECTIVES

1. To establish information from managers of speech and language therapy services about current service provision and management arrangements, and, where possible, to obtain retrospective data on the situation before the 1991 NHS changes

2. To indicate the nature of changes, if any, in service provision, and the long-term professional and policy implications of these changes

3. To recommend ways in which changes in the service could be further evaluated

QUESTIONS TO BE ANSWERED

In addition to areas of concern identified by the Royal College of Speech and Language Therapists, mentioned above, a preliminary review of the literature about the relationship between the NHS changes and the therapy professions, provided the following questions:

Management issues

What changes have been made in the management structure of the service?
What impact have these changes had on the organisation of services, staffing levels, professional autonomy or control over work, and morale?

Service provision

How have the NHS changes changed the service provided and the clients to whom it is provided?

How has the balance of services provided (e.g. to different client groups) been affected?
What input have speech and language therapy managers had to the contracting process?

Practice and training

What impact have the NHS changes had on professional collaboration and multi-disciplinary work?
What impact has the separation of purchaser and provider had on services, specialisation and training?
What are the major differences between services provided and staff terms and conditions in directly managed units and Trusts?

Chapter 3

Research design and methods

The first phase of the research used qualitative interviews as a way of gathering essential background information about the organisation and content of speech and language therapy services and issues of importance to managers. It consisted of a series of depth, semi-structured interviews with speech and language therapy service managers working in the four Health and Social Services Board areas in Northern Ireland and in two Regions in England. These interviews are not fully analysed or reported on here, but this report explains how they fed into the development of the questionnaire used in phase two of the project.

The second phase of the project involved a structured postal questionnaire to all speech and language therapy service managers in Great Britain. The research proposal had indicated that only managers in the English regions would be surveyed, but following representation from the Advisory Group and discussions with managers in Scotland and Wales, the scope of the survey was extended to include the whole of Great Britain. Northern Ireland was not included in the survey because it was felt that the postal questionnaire would unnecessarily duplicate the data collection from the earlier qualitative interviews since most of the Northern Ireland speech and language therapy managers had been included in the first phase.

The original proposal had also stated that the project would attempt to survey voluntary sector organisations representing client groups using speech and language therapy services in order to canvass their views on the impact of the NHS changes. Initial contact was made by letter with 50 voluntary groups to assess the feasibility of such a survey. Responses were very mixed, indicating that a single survey instrument would not be appropriate for all groups. The diverse nature and objectives of these groups meant that it was not feasible within the resource constraints of this project to pursue this avenue of research.

Box 1: Timetable of the research

April – June 1995	Phase 1: Interviews, Northern Ireland
July – Sept 1995	Phase 1: Interviews, England (2 regions) Phase 2: Questionnaire design
Oct – Dec 1995	Phase 2: Survey piloting and administration, follow up of non-respondents; coding and data input
Jan – Sept 1996	Analysis and report writing

PHASE 1: INTERVIEWS IN NORTHERN IRELAND AND ENGLAND

Interviews were conducted with 14 speech and language therapy managers in directly managed units (as they then were) or at Trusts in each of the four Health and Social Services Board areas in Northern Ireland. The inclusion of Northern Ireland, which has an integrated health and social services structure, meant it was possible to compare speech and language therapy services in two different organisational settings. In addition, the pace of change following the NHS changes was different in the two parts of the UK due to the slightly later timing of implementation in Northern Ireland. For example, GP fundholding was established in England before the first wave of this form of purchasing began in Northern Ireland. The inclusion of all four Boards ensured that the respondents came from a variety of urban and rural locations, reflecting both inner city, deprived and non-deprived areas of the Province, and the balance of hospital-based, acute and community-based services. Most of these interviews were group-based, typically with at least two managers, and in one case with four managers. All these interviews were conducted jointly by two members of the project team (NM and CP). In addition, during the visit to Northern Ireland the adviser on Professions Allied to Medicine (PAMs) to the Department of Health and Social Services (Northern Ireland) was interviewed.

The interviews in England centred on two regions and involved 14 managers. Five managers in one of the Thames regions, and 10 managers from a region outside London were interviewed. Some of the managers in the Thames regions approached the project team and offered to be interviewed, while the remaining respondents were purposively selected to ensure that the diversity of contexts and spread of different types of SLT service provision were reflected. Thus the interviews included acute and community-based services, specialist hospital provision, small and large services, and a range of geographical locations. Four of the Thames interviews were conducted by NM, and one was conducted jointly with CP. Of the remaining 10, 4 were joint interviews conducted by CP and DB and the remainder were conducted by DB.

The interviews were loosely structured around a topic list based on the questions/areas of concern previously identified. During the course of this data collection, new topics, themes and questions were identified and added to the list. The interviews lasted between 60 and 90 minutes. Notes were taken by the researchers and the interviews were tape recorded. Thus far the tapes have only been used to supplement notes taken during the interviews in order to identify key themes for the postal survey, although it is hoped that they can be fully transcribed and analysed at a later stage subject to the availability of further resources and time.

In addition to the interviews described above, a series of meetings was arranged with the Speech Therapy Adviser at the Department of Health in London. Additional interviews were conducted with members of the RCSLT, representing educational establishments and research interests.

Preliminary findings from the interviews used to inform the questionnaire development

A full analysis of the qualitative data collected during phase one has not been undertaken. It is therefore not appropriate to present direct quotes from this material. The following discussion simply provides a summary of the findings from the interviews, primarily to indicate how they were used to develop the second stage questionnaire for the national survey of managers.

The main finding from this phase of the project was the diversity of respondents' experiences: the impact of the NHS changes had not been the same for all speech and language therapy managers. The professional response to, and experience of, the NHS changes was not unified – indeed in some respects the effect of the changes had been to divide the profession. Some managers felt that their services had done well since the NHS changes and others reported negative effects stemming from local organisational and managerial changes. There appeared to be a contrast between the experiences of managers in different types of Trust, notably between acute and community-based services. The location of speech and language therapy services within the Trust structure, in terms of its position in the managerial hierarchy, and access to the Trust Board also appeared to shape managers' experiences of the NHS changes. Some of the differences in responses to the NHS changes also seemed to relate to a range of local, geographical and historical variables, notably the nature and culture of local services and the pace of change following the NHS changes. In addition, there were a number of issues raised concerning managerial capacity in speech and language therapy, related to specific personalities and abilities, the availability of managerial training and skills for leading the service, and the position of speech and language therapy managers within health services management more generally.

Some interviewees pointed out that it was quite difficult to disentangle the precise effects of the 1991 changes from previous changes in the NHS and in speech therapy itself. Particular concerns about the impact of professional regrading were expressed. It appeared to have compounded some of the problems experienced following implementation of the NHS and Community Care Act 1990. Concurrent legislation and changes to 'statementing' of clients with learning difficulties had also had considerable impact on the profession and the service. There were a number of comments about other broad changes to the

profession and to speech and language therapy work which were occurring alongside the 'reforms', and particular concerns were raised about new areas of demand (notably in mental health and dysphagia).

However, amongst these comments, there *were* specific issues related to the impact of the NHS changes, such as the role of speech and language therapy managers in contracting, and the importance of the relationship between therapy service managers and others involved in contract negotiations on their behalf within units/Trusts, such as business managers and contracts managers, as well as direct relations with purchasers in the form of GP fundholders. There also seemed to be clear differences in the experiences of those managers working in combined (acute plus community) units/Trusts versus those in separate acute service units/Trusts. The main difference seemed to be related to the scale of the service offered, which was considerably larger in combined units/Trusts. There were also issues about access to the senior echelons of management and, particularly, access to decision making about service development, with those in the community-based units/Trusts expressing some concerns about being marginalised in the negotiating and management process.

The comparison between Northern Ireland and England also proved fruitful. The slower pace of implementation of the NHS changes in Northern Ireland provided some useful insights into the early stages of reorganisation to compare and contrast with the more developed models found in England. Some of the managers in Northern Ireland were still working in directly managed units, of which there were far fewer in England. Trust status and GP fundholding models for purchasing were comparatively new in Northern Ireland so these data provided some indication of the early impact of this aspect of the NHS changes, both in terms of the forms which such purchasing could take and possible pitfalls or problems encountered. It was also clear that some of the issues raised in this comparative work were unique to the Northern Irish structure, for example, the presence of social workers rather than health care professionals in senior management posts dealing with therapy services. When the opportunity arises to analyse the tapes of these interviews directly it will be possible to do greater justice to the Northern Ireland – England comparison.

PHASE 2: THE NATIONAL SURVEY IN ENGLAND, WALES AND SCOTLAND

Developing the questionnaire

The qualitative work in phase one was a useful preliminary to the quantitative phase of the research. It provided a check on the questions/themes already identified by showing which issues were most pertinent and indicating other areas which had not previously

been considered. The discussions with managers were also helpful in suggesting the types of data available to speech and language therapy managers and the ease with which they would be able to answer a self-completion questionnaire. The interview notes were examined to identify key themes and issues for inclusion in the postal questionnaire. These provided the broad topic areas for the questionnaire which was intended to be a mix of factual questions (biographical data about managers themselves, and details about their service, e.g. staff numbers, clients served) and opinion questions (their impressions of the NHS changes, areas of impact, etc.).

In view of the diversity of experience identified in phase one it was decided that the questionnaire should include a mixture of open-ended questions, allowing for free text responses, and closed questions requiring yes/no answers or factual information.

The draft version of the questionnaire included the following topic areas:

- the manager's job (job title; work activities)
- the organisational structure (type of unit; place of SLT services within the organisation
- staffing (whole time equivalent posts pre and post 1991; staff grades)
- contracting (who the service has contracts with; the contract negotiation process; contract currency)
- range of services provided and level of service
- budget holding (staff; training)
- training (for managers and staff)

and a summary opinion question asking about the broad positive and negative effects of the 1991 changes. Additional items included, taken from the qualitative interviews were:

- multi-disciplinary working
- the role of managers in contract negotiation
- student training rotations
- supervision

The questionnaire was piloted by managers in three districts in one English region in early Autumn 1995 and discussed with both the Advisory Group and the Association of Speech and Language Therapy Managers (TASLTM) representatives. The pilot responses and the subsequent discussions enabled a number of improvements to be made to the layout and structure of the questionnaire. The managers in the pilot commented that the questionnaire was quite long and complex in places and that some of the information asked for was not available to them. In particular there were comments that contract details were not universally available to them. Whilst it was not possible to substantially

reduce the length of the questionnaire, some changes were made in response to these general concerns. In response to the specific concerns about questions on the details of contracts the research team decided to keep the questions in the questionnaire, on the grounds that it would be an interesting finding in itself if managers reported their inability to answer contract questions because the documentation was not available to them.

In addition to these comments, there were specific comments in the pilot about the following issues which were incorporated in the subsequent drafts of the questionnaire:

- staffing questions needed to include clerical and other staff categories as well as therapists
- questions about the range of services which tried to specify the geographical area served proved too complex and were therefore omitted
- the questions about budget holding needed to differentiate between different types of budget
- the opinion questions needed specific prompts (e.g. for multidisciplinary work, collaboration and morale, etc.)

The final questionnaire is reproduced in Appendix 1.

Sampling frame

The register of members of The Association of Speech and Language Therapy Managers (TASLTM) was used to identify senior managers of speech and language therapy services, or senior speech therapists with managerial responsibility for the service, working in each district within the fourteen former Regional Health Authority areas in England, the Scottish Health Boards and Welsh Health Authorities.* Changes in speech and language therapy service management since the NHS changes meant that this list required updating to ensure that as many as possible of the relevant managers were identified. Advertisements placed in the *RCSLT Bulletin* generated 11 additional names not on the TASLTM list, which were added to the sampling frame.

Administration and response rates

Questionnaires were sent out early in November 1995. A three-week deadline for completion of the questionnaire was given and replies not received by that deadline were followed up. Where the first mailing was not returned, districts were telephoned to check the names and addresses of speech and language therapy service managers so that a

*Throughout this report, references to 'health authority' or 'district' refer to either Ehglish and Welsh health authorities or Scottish health boards.

duplicate questionnaire could be sent out. Where the names and addresses were correct, the initial follow-up was conducted by telephone, simply to check that the addressee had received the questionnaire and to ask if it could be completed and returned. At the end of November, a reminder letter was sent to all those managers who had still not replied. At this stage the response rate was below 50%, so a second telephone follow up was conducted. In December, a letter was sent to all the managers informing them of progress on the project and thanking them for their co-operation. As a way of boosting the response rate a reminder was included to return the questionnaire if this had not already been done. After these follow ups the response rate by the end of the process in January 1996 was very high (87%) for an exercise of this type, reaching 100% of managers in some regions. Of the 11 additional names obtained from the advertisements in the *RCSLT Bulletin*, 7 responses were received. The lowest response came from Trent region with 3 out of 11 managers not responding (see Table 2 in the next section).

The questionnaires were coded and input to SPSS/PC+ and analysed using computing facilities at University of Leicester.

Chapter 4

Survey results

PROFILE OF RESPONDENTS

As noted in the previous section, the response to the survey was high, as Tables 1 and 2 indicate. In all regions, it was over 70%.

Table 1: Response rate

Total questionnaires sent	234
Eligible names*	225
Returned by 19/1/96	197
Response rate	87%

* This comprised 214 names from the TASLTM membership list and 11 additional names of managers derived from an advertisement in the *RCSLT Bulletin.*

Table 2: Responses by former English Regional Health Authority, Wales and Scotland

	No. responses	*No. eligible managers*	*% response*
Northern RHA	16	16	100
Yorkshire RHA	12	15	80
Trent RHA	8	11	72
E Anglia RHA	7	7	100
NW Thames RHA	10	11	91
NE Thames RHA	15	18	83
SE Thames RHA	15	16	94
SW Thames RHA	11	11	100
Wessex RHA	9	11	82
Oxford RHA	7	8	88
S Western RHA	9	10	90
W Midlands RHA	18	23	78
Mersey RHA	7	8	88
N Western RHA	17	18	94
Wales	18	19	95
Scotland	11	12	92
Total	190	214	–
Region not recorded*	7	11	64

* Region was not recorded for the 11 managers identified in the *RCSLT Bulletin*

Table 3: Gender of respondents

	No.	*%*
Male	7	3.6
Female	190	96.4
Total	197	100.0

The vast majority of respondents were women, although the number of male respondents was somewhat higher than anticipated. Earlier work on recruitment and retention of staff in the speech and language therapy profession had suggested that men with speech and language therapy qualifications represented 1.9% of the total workforce[8], a figure which accords with the 1991 Manpower Planning Advisory Group's finding of 1.89%.[9] Bebbington's work identified 21 men as current therapists, only 2 of whom were identified as service managers.[8] However her 'service manager' category was used to describe those with district managerial posts, and the larger number of male managers identified in the current project seems to reflect the rapid shift away from area and district level management towards smaller management groupings and the general growth in numbers of service managers at Trust level. This has been recognised elsewhere; for example, TASLTM has seen a steady increase in membership (Jenny Green, TASLTM, personal communication).

The age range of the respondents was 28-63 years, with a mean age of 44 years.* The length of time since qualifying reflects this age profile (Table 4). Most of the managers had first qualified with a diploma (Table 5) and this was particularly true for those in the older age group (Table 6).

Table 4: Length of time since qualifying

	No.	*%*
Less than 10 years	20	10.2
11-20 years	80	40.8
21-30 years	61	31.1
More than 31 years	35	17.9
Total	196	100.0

* One respondent did not answer this question

Table 5: SLT qualifications of managers

	No.	*%*
3 yr diploma	147	74.6
3 yr degree	14	7.1
4 yr degree	31	15.7
Postgraduate diploma	5	2.5
Total	197	100.0

Table 6: Age of managers by SLT qualification

	Qualification				
Age	*3 yr dip*	*4 yr degree*	*4 yr degree*	*Postgrad dip*	*Total*
<30	0	4	4	0	8
31-40	31	10	26	4	71
41-50	69	0	1	0	70
51-65	46	0	0	1	47
Total	146	14	31	5	196*

* One respondent did not answer this question

Table 7 shows that 117 respondents (59%) reported having obtained further qualifications since qualifying, and 28 (24%) of these were in the older age group (Table 8). Of the 46 'other' qualifications mentioned, the majority (n = 29) were certificates in management, including supervisory management and health services management, and a variety of counselling, teaching and special interest certificates and diplomas. Unfortunately, it was not possible to locate any data which would enable a comparison to be drawn between this pattern and level of qualifications with managers in any of the other professions allied to medicine.

Table 7: Further qualifications of managers

	No	*%*
Advanced Studies Diploma (ASD)	11	9.4
Postgraduate Certificate of Education (PGCE)	3	2.6
Bachelors Degree (including Open University) (BA/BSc)	18	15.4
MSc or PhD	26	23.3
MBA	3	1.5
Institute of Health Services Management (IHSM) or NVQ Management Level 4	10	8.5

cont.

Table 7: *cont.*

	No	*%*
Other qualification	46	39.3
Total	117	100.0
No further qualifications/missing	80	

Table 8: Age of managers by further qualification

	Qualification							
Age	*ASD*	*PGCE*	*BA/BSc*	*MSc/PhD*	*MBA*	*IHSM*	*Other*	*Total*
<30	0	0	0	1	0	1	3	5
31-40	7	2	1	11	3	2	15	41
41-50	2	0	9	12	0	5	15	43
51-65	2	1	8	2	0	2	13	28
Total	11	3	18	26	3	10	46	117

THE SPEECH AND LANGUAGE THERAPY MANAGER'S ROLE

Job titles

As the table of all the current job titles (Table 9) shows, a wide range of job titles are used. Of the 42 different titles in use, some are highly specific and appear to relate to the local Trust/unit structure and organisation, whilst others are generic titles such as 'SLT manager'. Some of the job titles predate the NHS changes and appeared to be disappearing, such as 'Area manager', whilst others relate to newly created organisational and managerial structures such as localities and clinical directorates. These job titles also indicate that it is relatively rare for the speech and language therapy manager also to have responsibility for other types of service. Table 10, below, provides a summary classification of titles which indicates that the majority of respondents had 'SLT manager' (71%) or 'SLT services manager' (12%) somewhere in their job title. Acting managers and chiefs undertaking managerial responsibility made up a further 13% of those surveyed. It was not possible to discern whether, in the case of chiefs, this was a permanent arrangement or due to the temporary absence of the post holder due to sickness or maternity leave.

Table 9: Current job title

	No	*%*
SLT Manager	40	20.3
SLT Service(s) Manager	44	22.3
Head of SLT (Service)	34	17.3
Acting (Professional) Manager SLT Service	8	4.1
Chief SLT	8	4.1
Director of SLT (Services)	6	3.0
Professional Head/Adviser (+ Manager)	5	2.5
(Lead) Professional Adviser	5	2.5
Manager/Head/Co-ordinator/Borough Paediatric Manager of Children's SLT Service/Paediatrics	5	2.5
Acting Professional Head of SLT	1	0.5
Head of Service	1	0.5
Therapy Manager	1	0.5
Clinical Manager SLT Services	1	0.5
Locality Manager	1	0.5
Trust Head of SLT & Community Clinic Manager	1	0.5
Unit SLT Manager	2	1.0
Clinical Director & SLT Services Manager	1	0.5
Clinical Director (Community)	1	0.5
Director of Child, Adolescent & Women's Health & SLT Professional Adviser	1	0.5
Director of Therapies/Paramedical Services & SLT Services Manager	2	1.0
SLT Adviser and Locality Manager	1	0.5
SLT Manager & Assistant Director Paramedical Services	1	0.5
Special Projects Manager & Professional Head of SLT Services	1	0.5
SLT & Nutrition/Dietetics Service Manager	2	1.0
Therapy and Disability Services Manager	1	0.5
Head of Children's Services & District ST	1	0.5
Specialist Services Manager	2	1.0
Chief SLT (Adults) & Professional Adviser	1	0.5
Divisional Manager of Clinical Support Services & SLT Manager	1	0.5
SLT Manager (Children's Services) & Professional Head	1	0.5
Children's SLT Services Manager & SLT Professional Adviser	1	0.5
Adult Services Co-ordinator, SLT Dept	1	0.5
Trust Adviser, Acute Service & Head of Elderly Team	1	0.5
Rehabilitation Manager	1	0.5

cont.

Table 9: *cont.*

	No	*%*
SLT Manager, Primary Care Team	1	0.5
District SLT	2	1.0
Area SLT	2	1.0
Acting Area SLT	1	0.5
Co-ordinator SLT	1	0.5
Principal SLT	3	1.5
Lead Practitioner, SLT	1	0.5
Team Leader	1	0.5
Title unclear	1	0.5
Total	197	100.0

Table 10: Current job titles (summary)

	No	*%*
SLT Manager	140	71.1
SLT Services Manager	24	12.2
Chief Therapist	14	7.1
Acting Manager	10	5.1
Others	9	4.6
Total	197	100.0

Table 11: Changes to job title since Trust status

	No	*%*
Yes	116	60.7
No	75	39.3
Total	191	100.0
Missing	6	

Respondents were asked about changes to their job title following the transfer to Trust status. Of the respondents, 116 (60.7%) said that their job title had changed and 75 (39.3%) said that their job title had not changed (of the remaining 6, 2 were still in DMUs so the question was not applicable and the other 4 were not able to provide information, typically because they had not been in post before the 1991 changes). Of those who said that their job title had changed, 114 were able to provide information on their previous job title. From these data, it seems that there was less variation prior to the NHS changes, with only 20 different titles (see Table 12). The summary in Table 13 suggests that the

majority (70%) of managerial posts before the NHS changes had 'district' in their title, reflecting the pattern of functional management introduced in 1974, which largely remained in place in SLT services until 1991/92.

Table 12: Previous job title (before Trust status)

	No.	*%*
District SLT/District Speech Therapist	59	51.8
DSLT Manager	7	6.1
SLT Services Manager	7	6.1
SLT Manager	7	6.1
Chief Speech and Language Therapist	8	7.0
Area Speech and Language Therapist	6	5.3
District Speech Therapist & Head of SLT	1	0.9
District Head of SLT Service	2	1.8
Head of SLT/Chief Speech and Language Therapist	2	1.8
Director of SLT Services	3	2.6
Communication Therapy Manager	1	0.9
Business Manager (Mental Health) & District Speech and Language Therapist	1	0.9
Head of SLT & Locality Manager	1	0.9
Manager of Adult SLT	1	0.9
Deputy District SLT Manager	2	1.8
Head of Care of the Elderly	1	0.9
Head of SLT Services	1	0.9
Principal Speech and Language Therapist	1	0.9
Specialist Speech and Language Therapist	1	0.9
Unit Head/Chief of SLT	2	1.8
Total	114	100.0

(percentages may not total 100 due to rounding)

Table 13: Previous job title (summary)

	No.	*%*
District Speech and Language Therapist	69	60.5
SLT Manager	24	21.1
SLT Services Manager	3	2.6
Deputy District Speech and Language Therapist	2	1.8
Other	16	14.0
Total	114	100.0

The speech and language therapy manager's activities

The vast majority of managers (90%) worked full time, and when the number of sessions worked by part-timers was examined, none worked less than half time; 45% worked between 5-6 sessions per week; and 55% worked 8-9 sessions.

Table 14: Employment status

	No	*%*
Full-time	177	89.8
Part-time	20	10.2
Total	197	100.0

Looking in more detail at the manager's job, the survey asked respondents to indicate the percentage of time spent on a range of different tasks. Respondents were asked to estimate to the nearest 10% the proportion of time spent on each task. For the purpose of analysis, blank values for each section of this question have been coded as zero and only positive values are presented in the Figures (1 to 5). The Figures indicate the number of respondents for whom data were available. Thus, for clinical work (Figure 1) there were 186 respondents, and 11 cases where the respondent did not answer this section or wrote zero. The majority of managers combined management with clinical work. For nearly a third of respondents, clinical work represents less than 10% of their work, but another third spend between 40% and 60% of their time treating patients, still very much following the tradition in SLT of practising clinician-managers (Figure 1).

Most of the managers reported spending between one fifth and one third of their time managing speech therapy staff (Figure 2). Of the other tasks identified – business planning and financial management, audit/quality assurance and managing other staff – the majority of managers spent less than 10% of their time on these tasks (Figures 3, 4 and 5).

Table 15 looks at the median for each of the activities and underlines the importance of the clinical work load. Some respondents spent up to 80% of their time on this side of their work, the median being 30% of their time.

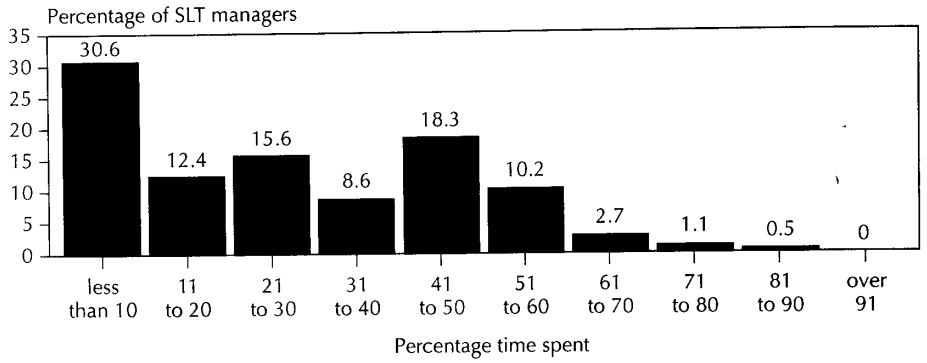

Figure 1: Time spent on clinical work (n=186)

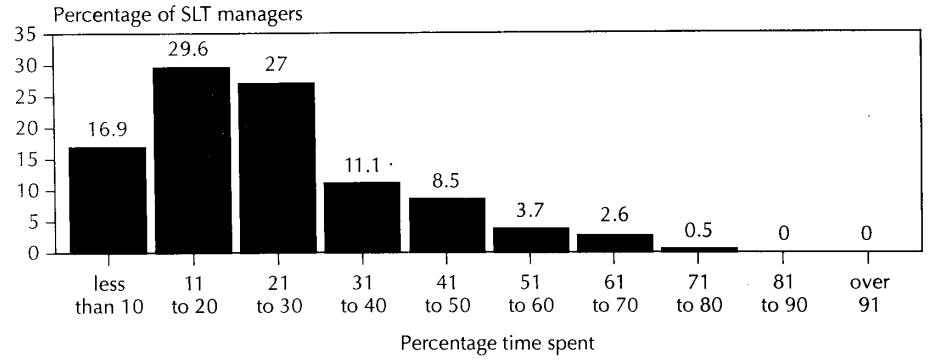

Figure 2: Time spent managing SLT staff (n=186)

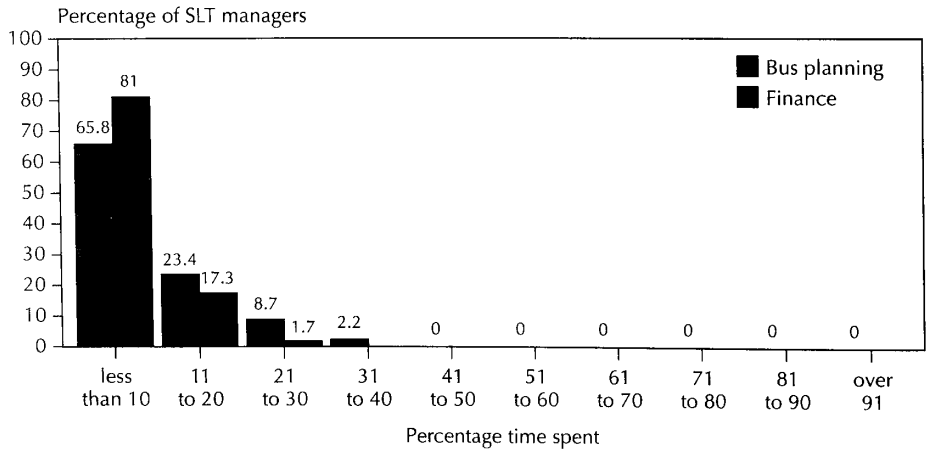

Figure 3: Time spent on business planning & finance (Bus planning n=184, Finance n=179))

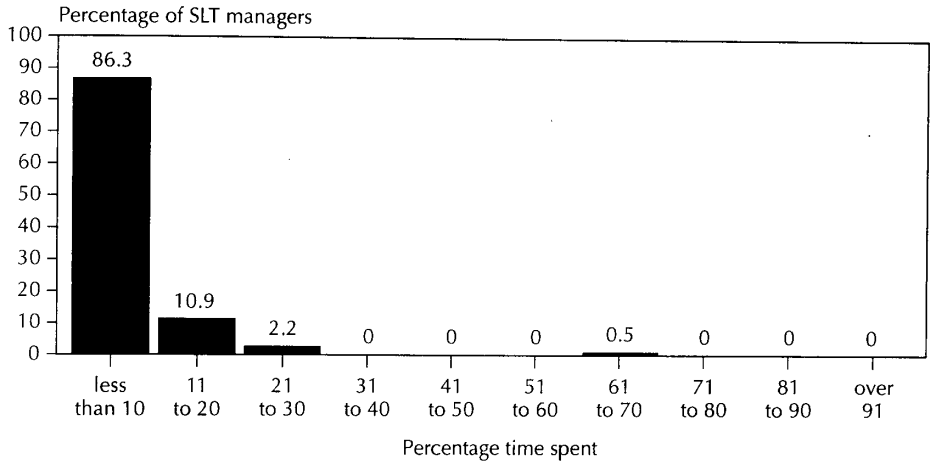

Figure 4: Time spent on Audit/Quality Assurance (n=183)

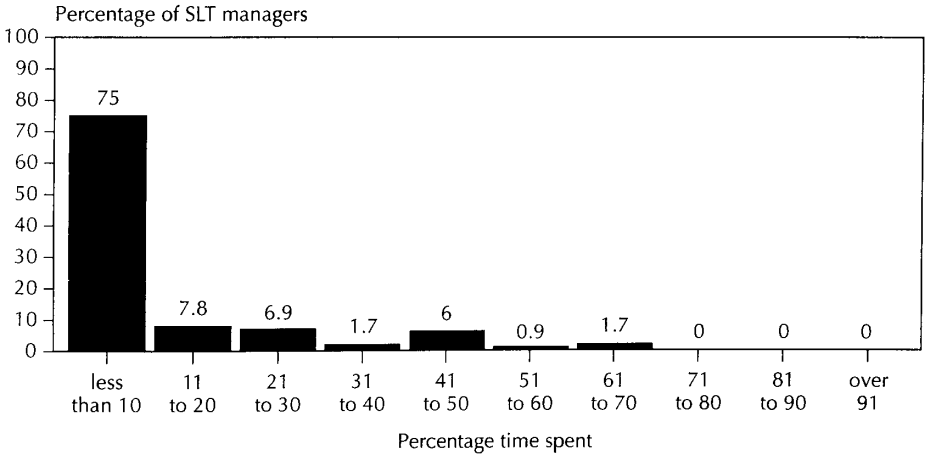

Figure 5: Time spent managing non-SLT staff (n=116)

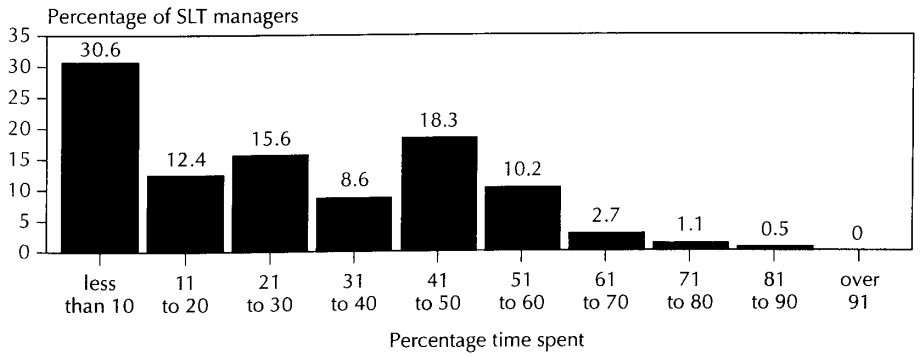

Figure 6: Change in w.t.e. therapy staff (n=156)

Table 15: Median time spent on different activities

Activities	*Median % of time*	*% Range of time*	*No. of missing cases*
Clinical work	30	0-90	11
Managing SLT staff	25	0-80	8
Business Planning	10	0-40	13
Financial management	10	0-30	18
Audit/Quality Assurance	10	0-70	14
Managing other services	0	0-70	81
Other (e.g. marketing)	10	0-75	67

It is worth noting that some of these activities may have workload implications which are seasonal in nature. Thus, for example, the amount of time spent on financial management may increase towards the end of the financial year, and business planning may take more time during specific periods of contract negotiation. The survey method used means that the figures provided may not take into account fluctuations in the amount of time spent on each activity over the course of a year; however they do provide some indication of the distribution of activities.

Managers were asked to comment on how their managerial, clinical or professional/ advisory roles and responsibilities (or those of the previous manager if they had come into post after 1991) had altered as a result of the 1991 NHS changes. One hundred and eighty three of the 197 respondents provided comments which varied widely. Most respondents appeared to be encountering more administrative work and some were experiencing increasing tensions between their managerial and clinical roles as a consequence. There was a spread between those who appeared to have been given greater managerial responsibility which they welcomed, those for whom little had changed and those who simply reported that they had more work to do, less control over their services and less time for their own clinical work, in part depending on the internal structuring of their Trust. Tentatively, it might be said that there were at least two distinct groups of managers (and there may be others) – those who regard the managerial side of their work (and any increase in it) as an unwelcome necessity, but whose preference remains clinical work, and those who can derive additional job satisfaction from taking on new managerial challenges on behalf of their service. It was apparent that most Trusts expected their SLT managers to continue to undertake significant amounts of clinical work which most managers readily accepted given their traditional bias in favour of clinical work.

ORGANISATION AND STRUCTURE OF SERVICES

Type of Trust/unit

Following on from issues identified in the qualitative interviews, it seemed important to look at the position of speech and language therapy in different types of Trust/unit (Table 16). The survey thus sought to distinguish between acute only, community only, combined Trusts and the few remaining directly managed units (DMUs). The responses show that in addition to these four categories, a number of Trusts combine community services with other services such as mental health, learning disability, rehabilitation and so on. For the purposes of analysis, this category has been kept separate from the 'community only' Trust category and is referred to as 'community plus'. The number of responses from acute only Trusts is low, even given the 'traditional' community base of many speech and language therapy services. It seems possible that the survey failed to identify managers in some acute Trusts, notably those with very small speech and language therapy departments.

Table 16: Trust/unit type of services managed

	No.	*%*
Community	78	39.6
Combined acute & community	58	29.4
Community plus*	43	21.8
Acute	16	8.1
DMU	2	1.0
Total	197	100.0

* (i.e. combined community and learning disability services Trust, or combined community and mental health services Trust or a mental health services Trust)

Managers were asked to say whether they provided speech and language therapy services to other Trusts/units: 122 (62.2%) said that they did and 74 (37.8%) said that they did not. Of those who provided services for other Trusts/units, 120 provided information on the type of Trust they provided services to. The coding frame allowed the specification of up to four Trusts/unit types to whom services were provided, but only a few speech and language therapy services (35 cases) provided to more than one other Trust/unit.

Table 17: Provision of SLT services to other Trusts/units

Type of Trust receiving service	*Type of Trust providing service*					
	Comm No.	*Acute No.*	*Combined No.*	*Comm plus* No.*	*Total No.*	*%*
Community	0	3	1	0	4	3.3
Acute	67	1	2	34	104	86.7
Combined A&C	0	0	0	1	1	0.8
Community plus	0	0	3	1	4	3.3
Other	2	1	4	0	7	5.8
Total	69	5	10	36	120	100.0

(as cell sizes are small, column percentages not given)
* see footnote to Table 16 for definition

Respondents were asked to sketch or supply organisational charts to indicate the position of speech and language therapy services within the Trust/unit management structure and to indicate the way in which the speech and language therapy service itself was organised. These were classified to provide an indication of the extent to which functional structures were present and the position of speech and language therapy services within the managerial hierarchy (Table 18).

Table 18: Position of SLT manager in management structure by type of Trust

Type of Trust/ Unit	*Position of SLT manager **					
	Accountable to...					
	On the Trust Board No.	*Manager on Board No.*	*Manager 1st tier No.*	*Manager 2nd tier No.*	*Manager 3rd tier No.*	*Total No.*
Community	0	30	41	4	1	76
Combined	0	20	25	11	0	56
Comm plus**	1	18	16	6	1	42
Acute	0	6	5	3	2	16
DMU	0	0	1	1	0	2
	1	74	88	25	4	192

* see Appendix 2 for classification of organisational structures of Trusts/DMUs used in this analysis
** see footnote to Table 16 for definition

Although there had been concerns, raised during the phase one interviews, that speech and language therapy managers were being marginalised in new management structures, these data (Table 18) suggest that SLT managers are still relatively high in the provider organisational hierarchy, with most being directly accountable to either a manager on

the Trust/Unit Board (74, 38.5%), or to a manager in the first tier below Board level (88, 45.8%). While formal accountability does not necessarily correlate with power within an organisation, this evidence suggests that speech and language therapy managers do have access to senior decision makers within their organisations.

STAFF

Qualified Therapists

To gain a picture of the size of the SLT service, respondents were asked about their whole time equivalent (w.t.e) staff numbers currently and before 1991. Missing data are higher for the period before 1991 as information was not readily available to some managers, particularly those appointed after 1991. Given these missing data and the possibility of recall bias, these data need to be interpreted with some caution. However, there does seem to have been a shift towards larger services, particularly towards those employing more than 20 therapists, even with the apparent increase in the overall number of separately managed services (Table 19) brought about by the development of the purchaser-provider separation in the NHS.

Table 19: Numbers of therapy staff

Number of therapists (w.t.e)	*Pre 1991*		*1995*	
	No.	*%*	*No.*	*%*
less than 10	56	35.9	49	25.3
11-20	71	45.5	85	43.8
21-30	19	12.2	36	18.6
More than 31	10	6.4	24	12.4
Total	156	100.0	194	100.0
Missing	41		3	

(percentages may not total 100 due to rounding)

Figure 6 shows that 74% of managers in total reported a gain in therapy staff in the period and only 6% reported any losses.

In addition to qualified staff numbers, respondents were asked whether the balance of temporary versus permanent staff had changed since 1991 and whether the grading structure had altered. Less than half the managers provided information on this. Again, the responses varied, but there was a sense among those who had written comments that the staffing structure had become flatter since 1991 with fewer different grades of staff. There appeared too to be greater use of temporary or fixed-term contract staff,

particularly for new staff, although the core of the service remained permanent staff. For some managers, the opportunity to use agency or fixed-term contract staff was seen as an advantage, bringing greater flexibility. For others, it was a sign of the deterioration of the NHS. Likewise, use of SLT assistants produced divergent responses.

In general, managers who commented were of the opinion that the changes in grading structure were less a direct consequence of the NHS changes of 1991 and far more a direct effect of the national regrading exercise which had recently taken place.

Current therapy staff numbers were cross-tabulated with Trust type (Table 20) to see the extent to which service size reflected the sector of provision. Information was available from 194 managers and shows that acute-only Trusts tended to have lower staff numbers, as expected.

Table 20: Current numbers of therapy staff by Trust/unit type

	Type of Trust/unit					
Numbers of therapists (w.t.e.)	*Comm No.*	*Acute No.*	*Combined No.*	*Comm plus* No.*	*DMU No.*	*Total*
Less than 10	8	12	24	3	2	49
11-20	34	2	28	21	0	85
21-30	21	1	5	9	0	36
More than 31	13	1	1	9	0	24
Total	76	16	58	42	2	194

(as cell sizes are small, percentages are not given)
* see footnote to Table 16 for definition

In 187 cases it was possible to look at the impact of staff size on activities, particularly on time spent managing staff (Table 21). The crude assumption that larger services would require more managerial input was not borne out by these data. There was no consistent allocation of management time by staff numbers. It appears that time spent managing staff within the speciality is determined by factors other than service size, such as the existence of tasks which must be done and which do not take less time with a smaller size of service. Alternatively, this may, in part, reflect the capacity of managers to delegate some managerial tasks to other senior staff in the larger services.

Table 21: Proportion of time spent managing SLT staff by number of w.t.e. therapists

	Number of therapists (w.t.e)				
% time spent	*<10*	*11-20*	*21-30*	*>31*	*Total*
<10	11	15	1	5	32
11-19	17	23	11	4	55
20-29	15	22	8	5	50
30-39	3	8	6	4	21
40-49	0	6	6	4	16
50-59	1	3	2	1	7
60-69	1	2	2	0	5
70-79	0	1	0	0	1
Total	48	80	36	23	187

Unqualified Staff

The questionnaire also asked for information about numbers of therapy assistants and clerical/support staff (Tables 22 to 24). Again, more data were missing from the pre 1991 period. Comparing the two time periods, there were fewer services with no assistant posts or clerical support in 1995 than 1991 and there appears to have been an overall increase in numbers of these staff. The 'other staff' category included a variety of support and associated staff such as patient advocates, project assistants, hearing therapists and NNEB qualified staff, although it should be pointed out that there were very few responses to this part of the question.

Table 22: Numbers of speech and language therapy assistants

	Pre 1991		*1995*	
Number of assistants (w.t.e.)	*No. of respondents*	*%*	*No. of respondents*	*%*
0	70	48.6	33	18.2
1	25	17.4	40	22.1
2	31	21.5	40	22.1
3	13	9.0	35	19.3
4	3	2.1	15	8.3
5	2	1.4	18	9.9
Total	144	100.0	181	100.0
Missing	53		16	

Table 23: Numbers of clerical and administrative staff

	Pre 1991		*1995*	
Number of clerical staff (w.t.e)	*No. of respondents*	*%*	*No. of respondents*	*%*
0	21	13.8	12	6.4
1	47	30.9	38	20.3
2	56	36.8	66	35.3
3	20	13.2	42	22.5
4	6	0.9	19	10.2
5	2	1.3	10	5.3
Total	152	96.9	187	100.0
Missing	45		10	

Table 24: Numbers of other staff other than therapists, assistants and administrative/clerical staff

	Pre 1991		*1995*	
Number of 'other' staff (w.t.e.)	*No. of respondents*	*%*	*No. of respondents*	*%*
0	18	66.7	16	44.4
1	3	11.1	8	22.2
2	4	14.8	7	19.4
3	1	3.7	3	8.3
4	0	0.0	1	2.8
5	1	3.7	1	2.8
Total	27	100.0	36	100.0
Missing/ Not applicable	70		161	

For cases where data were available for both time periods, it was possible to look at change in w.t.e staff numbers in more detail. Figure 6 shows that most services had made a gain in therapy staff numbers in this period of between 1 and 5 additional w.t.e. therapy staff. These findings are consistent with the results from the Department of Health's annual non-medical workforce census which shows that, between 1984 and 1994, the number of therapists increased from 2,150 to 3,340, an increase of 55%.[7]

A similar, although less dramatic pattern emerged when looking at staff other than trained therapists, where there seems to have been some growth in numbers of assistants (Table 25) and in clerical staff (Table 26). Beyond assistants and clerical staff, there appears to have been an increase in the residual 'other staff' category which was not defined in the questionnaire (see Table 24).

Overall, it appears that the increase in assistants has been accompanied by a similar increase in qualified staff. This suggests that the expansion of SLT services has by no means been achieved by substituting less costly untrained staff for trained staff. Nonetheless, the simple staff numbers suggest that SLT assistants now play a larger part in providing SLT services than previously. The value of assistants was assessed by Davies and van der Gaag[10] whose work suggested that assistants require training and supervision which imposes time costs on qualified staff.

Table 25: Losses/gains in number of w.t.e speech and language therapy assistants

Loss/gain	*No. of respondents*	*%*
loss of 1	3	4.1
no change	47	64.1
gain of 1	11	15.1
gain of 2	6	8.2
gain of 3 plus	6	8.2
Total	73	100.0
Missing	124	

Table 26: Losses/gains in number of w.t.e administrative/clerical staff

Loss/gain	*No. of respondents*	*%*
loss	0	0.0
no change	98	75.4
gain of 1	23	17.7
gain of 2	6	4.6
gain of 3 plus	3	2.3
Total	130	100.0
Missing	67	

CONTRACTING

Contracts and service level agreements

The qualitative work in phase one had suggested that the amount of information available to managers about the nature of contracts for speech and language therapy services varied. In part, this appeared to be because contract negotiations with health authorities were handled by colleagues in the Trusts, not by SLT managers. There also appeared to be

some confusion amongst service managers about the contracting process. As anticipated, the level of detail of responses to questions about contracts in the survey reflects this. Respondents were asked to specify the number of contracts which each type of purchaser placed with them. This resulted in considerable missing data, and among those responses which did specify a number, there was substantial variation, with most services having less than 10 contracts, but some reporting substantially more (see Table 27). The nature of some of the responses suggests that some error may have been introduced by respondents reading 'contract' as 'contacts' – hence the outlying figures at the foot of Table 27. It should therefore be emphasised that these data give only an approximate guide to the numbers of contracts.

Table 27: Numbers of SLT contracts by type of purchaser

Type of purchaser	*No. of managers giving information on their nos. of contracts*	*Range of nos. of contracts specified by each manager*
Own Trust (all types)	23	1-7
Local Health Authority/ Health Board	108	1-6 *
GPs**	116	1-43 ***
Other Acute Trust	45	1-5
Other Health Authority/ Health Board	23	1-8
Local Education Authority	69	1-12
Social Services	1	1
Other (inc other Comm Trust)	41	1-11

* outliers include 65, 99, 13,655 and 1440 contracts
** includes GP Total Purchasers as well as standard fundholders
*** outliers include 1052 and 2160 contracts

Because of the variation in reported numbers of contracts and the amount of missing data, blank values for each contract type were coded as zero and positive values or ticks were counted as a single item, indicating that at least one of this type of contract was held. Table 28 presents data on contracts and service level agreements (SLAs) held with each type of purchaser (percentages are calculated out of 197 – the total number of respondents). It seems unlikely that speech and language therapy services are formally sub-contracted within their own Trust/unit and, therefore, the figure of 25 contracts held with 'Own Trust' in the first column should be interpreted with caution, as it is likely that these 'contracts' are in fact service level agreements. Service level agreements are quite usual *within* a provider organisation for such things as support services and services such as speech and language therapy which may be provided across a number of externally

contracted services. This may explain the figure of 18.3% SLAs within the respondents' own Trusts.

Table 28: SLT contracts and service level agreements by type of purchaser

Type of purchaser	*No. of contracts*	*% of total respondents*	*No. of SLAs*	*% of total respondents*
Own Trust (whichever type)	25	12.7	36	18.3
Local Health Authority/ Health Board	114	57.9	19	9.6
GPs	127	64.3	21	10.6
Acute Trust	47	23.9	57	28.9
Other Health Authority/ Health Board	25	12.7	7	3.6
Local Education Authority	71	36.0	29	14.7
Social Services	2	1.0	2	1.0
Other (inc Community Trust)	42	21.3	15	7.6

However, these data (Table 28) do show the wide range of purchasers contracting for speech and language therapy services and the patterning of formal contracts (which imply transfers of funds) and service level agreements (which may not involve additional funding for the service). There are fewer service level agreements overall. Approximately 50% of respondents reported additional contracts or service level agreements with Acute Trusts, and the education sector accounts for a similar level of contracts and SLAs. The majority of contracts are with the local health authority and GPs*.

Looking in more detail at the types of contracts (Table 29), respondents were asked to specify the form which contracts took. Most contracts containing speech and language therapy were block contracts, although contracts with GPs seemed to utilise a wider range of possible contract forms including cost per case and cost and volume. This finding mirrors other work on GP fundholders' contracts.[11]

This pattern of contracting is interesting given that in the depth interviews in phase one, several issues were raised about the types of contracts set for speech and language therapy services. The long-term nature of much speech and language therapy treatment, and the lack of standardised packages of care were seen as making block contracting problematic. Two reasons for this emerged. Firstly, the lack of a direct association between the

*The GP category includes GP fundholders (107 [54.3%] contracts, 18 [9.1%] SLAs) and GP total purchasing pilot (GPTPP) sites (20 [10.2%] contracts and 3 [1.5%] SLAs). Given that GPTPPs were not well developed at the time of the survey these latter figures appear to overestimate the numbers of contracts and SLAs and should be interpreted with some caution, as this may well, again, reflect confusion on the part of respondents to the question.

contract sum and case mix or severity mix of patients was seen as a problem, as block contracts did not generally spell out how providers should deal with such issues. Secondly, related to this, there was no flexibility in block contracts to deal with the possibility that there could be a change in case numbers or severity. The lack of adequate baseline information about service use, and changes in demand were also seen as presenting difficulties in the contracting process.

Table 29: Types of contract

	Block		*Cost per Case*		*Other**	
Type of purchaser	*No. of respondents*	*%*	*No. of respondents*	*%*	*No. of respondents*	*%*
Own Trust	55	27.9	1	0.5	7	3.6
Local Health Authority/Board	136	69.0	4	2.0	13	6.6
GPs	112	56.9	96	48.8	48	24.3
Acute Trust	72	36.5	2	1.0	16	8.1
Other Health Authority/Board	13	6.6	10	5.1	9	4.6
Local Education Authority	61	31.0	9	4.6	18	9.1
Social Services	1	0.1	–	–	1	0.5
Other	31	15.7	6	3.0	17	8.6

* mainly cost and volume contracts

Table 30 shows that nearly 80% of contracts were based on the preceding year's activity levels, although in line with the comments noted above, attempts were being made to move towards contract models which more adequately reflected actual practice by distinguishing, for example, between different client groups and severity, in calculating volumes and costs.

Table 30: Whether contracts were based on last year's activity

	No.	*%*
Yes	152	79.6
No	39	20.4
Total	191	100.0
Missing	6	

Quality standards in contracts

Respondents were asked about the inclusion of quality standards in contracts and 165 (85.9%) reported that there were standards in the contracts which covered SLT. Of these managers, 145 provided free text information about the types and sources of these quality specifications. It was not possible to categorise all the comments made or, indeed, to be sure in all cases whether the standards referred to were national, local, specific to SLT or not, since some respondents gave detailed answers and others simply said that the standards were those of the local health authority. However, it was possible to identify the most salient standards (see Table 31). The most frequently cited standard specifically related to SLT was a specification of the maximum waiting time from referral to SLT assessment for new clients, followed by use of the NHS *Patient's Charter* standards and local SLT standards. The vast majority of the standards mentioned related to process issues such as waiting time and were heavily influenced by national initiatives such as the *Patient's Charter*. Only six respondents mentioned RCLST registration and only three mentioned monitoring of outcomes. Two managers mentioned the use of clinical protocols in contracts. Seven respondents mentioned measures of service quality other than waiting time.

Table 31: Main types of quality standards in contracts mentioned by managers*

	No.
Waiting time from referral to first assessment for SLT	63
Patient's Charter standards	17
Specific SLT standards	14
General service standards (not specific to SLT)	14
Other/unclassifiable	96

* 145/197 respondents provided one or more comments on this topic

Extra contractual referrals (ECRs)

One of the issues related to contracting for speech and language therapy services raised in the phase one interviews was those cases which fell outside contract arrangements. Whereas before the reforms clients from neighbouring districts could be seen and the costs accounted for subsequently through the calculation of cross-boundary flow adjustments in health authority allocations, the contracting process now meant that potential demand for service had to be agreed and pre-specified to enable payment to follow the patient. Overall, 60% of respondents reported having had extra contractual referrals for speech and language therapy (Table 32).

Table 32: Whether service received any ECRs

	No.	*%*
Yes	117	62.2
No	68	36.2
Don't Know	3	1.6
Total	188	100.0
Missing	9	

Contracts with GP fundholders

The questionnaire looked at the purchasing of speech and language therapy service by GPs, both in the form of GP fundholding (GPFH) introduced after the 1990 Act and in the more recent development of GP total purchasing currently being piloted in several sites in Great Britain.[12] The questionnaire asked about purchasing by both GP fundholders and GP total purchasing pilot projects (GP TPPs). At the time of the survey the GP TPPs were relatively new and only a handful were actively purchasing, but responses suggested that this mode of purchasing accounted for just over 10% of contracts. As noted earlier, the relatively high contracts/SLA figure (10.2% contracts plus 1.5% SLAs) for GPTPPs suggests that there was some confusion about the term GP total purchasing or that respondents were referring to contracts with 'unofficial' GP TPPs. These proportions should probably, therefore, be added to the proportions for ordinary GPFH. Respondents were asked whether the balance of purchasing of SLT between the health authority and fundholders was changing and, if so, how. In almost all cases, it was and the proportion of work accounted for by GP fundholders was rising. In some services as much as 80% of the work was purchased in this way.

In the qualitative interviews undertaken before the survey, some respondents had noted specific problems dealing with direct referrals from health visitors, as these had, in the initial implementation of the NHS changes, not been included in the GPFH scheme. Asked about this aspect of GP purchasing 153 (77.7%) of respondents said that their contracts with fundholders now allowed for direct referrals from health visitors (Table 33). Of these, 106 (69.3%) made specific comments about the pattern of health visitor referrals. Despite earlier concerns, the majority of respondents (87.7%) suggested that these referrals had stayed constant since they had been introduced and less than 10% reported any problems or a decrease in such referrals (Table 34).

Table 33: Whether GPFH contracts allow for direct health visitor referrals

	No.	*%*
Yes	153	86.0
No	20	11.2
Don't Know	5	2.8
Total	178	100.0
Missing	19	

Table 34: Pattern of health visitor referrals for fundholders

	No.	*%*
No change in referrals	93	87.7
Decrease in referrals	3	2.8
Problems with referrals	7	6.6
Varies	3	2.8
Total	106	100.0
Missing	91	

Speech and language therapy manager's role in contracting

Looking at who negotiates contracts (Table 35), it is apparent that the speech and language therapy manager has more input to some types of contracts than others. It was noted earlier that the principal purchasers of speech and language therapy services are the local health authority/health board and GPFHs. None of the speech and language therapy managers in this survey negotiated the local health authority/health board contracts alone; in fact the majority of these contracts (68.5%) were negotiated by individuals other than the speech and language therapy manager – typically the business manager, contracting team or members of the executive board of the Trust – reflecting the position of the speech and language therapy service in Trust structures (see above). In only a third of cases did the speech and language therapy manager have direct input to the negotiation of these contracts. This may be partly explained by the fact that health authorities were using predominantly block contracts in which SLT services comprised only a small part of much larger packages of care. A similar pattern emerged from the data on GPFH contracts where again, the majority of negotiation was carried out without the involvement of the speech and language therapy manager, although the speech and language therapy managers were more involved than with health authority contracts.

In contrast, the negotiation of contracts for speech and language services with the local education authorities (LEAs) for therapy provision within special and mainstream schools typically involved the speech and language therapy manager directly. Nearly 75% of these contracts were drawn up with the direct input of the speech and language therapy manager. This is presumably the case for two reasons: firstly, the education contracts are exclusively for speech and language therapy services; and secondly, their content is specialised and the speech and language therapy managers are likely to be the only 'experts' in the field in the Trust.

Table 35: Contract negotiators

	Identity of contract negotiators						
	SLT Manager		*SLT manager plus colleagues*		*Other colleagues*		*Missing*
Type of purchaser	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*
Local Health Authority/Board	0	0.0	53	31.5	115	68.5	29
GPFH	4	2.4	53	32.1	108	65.5	32
GPTPPs	0	0.0	16	31.4	35	68.6	146
Acute Trust	9	8.6	38	36.2	58	55.2	92
Other Health Authority/Board	2	4.3	11	23.9	33	71.7	151
Local Education Authority	40	42.6	31	33.0	23	24.5	103
Other	21	38.2	22	40.0	12	21.8	142

To follow up this analysis, respondents were asked if they were able to promote their service with local purchasers (e.g. GPs). In Table 36, most (70.7%) said that they were able to promote their service, notwithstanding their lack of involvement in some of the contract negotiations.

Table 36: Whether able to promote SLT service

	No	*%*
Yes	133	70.7
No	55	29.3
Total	188	100.0
Missing	9	

Respondents were offered the chance to make any additional comments on the contracting process as it affected SLT services. By and large, the free text comments support the finding

that managers had limited input into NHS as against LEA contracts. Many managers felt that they had insufficient involvement and influence on the process and that those staff directly involved did not consult them adequately or have enough knowledge of SLT to write good contracts. The difficulty, particularly in larger and acute trusts, was the fact that SLT was generally a minor part of a much larger contract. Managers also expressed the view that the contracting process was too crude (e.g. reliance on block contracts) and that the information on which contracts were based was poor (e.g. past activity levels). Other common comments related to the paperwork generated by the contracting process. Overall, the free text comments were mostly critical of the contracting process, although a minority of managers had become directly and productively involved in the process. Many were left at the margins in relative ignorance of how it might shape their services.

SERVICES

Range of services

Respondents were asked to detail the range of services provided from a list of different SLT specialisms, client groups and/or speech and language therapy needs (Table 37).

Table 37: Range of services provided/client groups served

	Provided		*Not provided*	
Service/client group	*No.*	*%*	*No.*	*%*
Child development	174	88.3	23	11.7
Adult neurology	182	92.4	15	7.6
Elderly neurology	180	91.4	17	8.6
Specific language impairment	174	88.3	23	11.7
Child learning difficulty	166	84.3	31	15.7
Adult learning difficulty	142	71.1	55	28.9
Dysphagia	187	94.9	10	5.1
Fluency	182	92.4	15	7.6
Voice	190	97.5	7	2.5
Head injury	176	89.3	21	10.7
Laryngectomy	167	84.8	30	15.2
Hearing impairment	139	70.6	58	29.4
Physical disability	154	78.2	43	21.8
Cleft palate	165	83.8	32	16.2
Mental illness	61	31.0	136	69.0
Communication aids	147	74.6	50	25.4
Others	37	18.8	160	81.2

Following concerns raised in phase one about the scope of services provided in terms of the range of client groups or needs served, the responses were summed to indicate the proportion of departments able to offer several or only a few of the services specified. Blank responses were taken to indicate that a service was not provided and the remaining responses were scored as one to indicate that the service was provided. Table 38 shows that two-thirds of respondents reported providing 14 or more of the 17 services specified, and relatively few (n = 7, 3.6%) offered less than 5.

Table 38: Number of services provided

*Number of services/ client groups served**	*No. of responses*	*%*
Less than 5	7	3.6
6-9	18	9.2
10-13	41	20.9
14 to 17	130	66.3
Total	196	100.0

* out of a possible 17 identified in Table 37

Specialisation

Respondents were also asked to specify whether the service was provided at 'general' or 'specialist' therapist level. In the absence of a ready-made, generally accepted definition of 'specialist services', the designation 'specialist' was self-defined by the respondents and no additional information was gathered on the level of specialism or the amount of specialist training undertaken. These figures simply give a guide as to the numbers of departments which state that they can offer what they would regard as 'specialist' speech and language therapy for the different service needs or client groups listed (Table 39). Developmental speech and language problems and adult neurology were typically characterised by both general and specialist provision (58.6% and 47.8%), whereas dysphagia, laryngectomy and adult learning disabled cases were more likely to be provided via specialist services (62%, 50.9% and 65.5%, respectively). Half the therapy provided for fluency disorders and cleft palate cases was generalist only (i.e. non-specialist). The survey also asked about the provision of communication aids and the level of therapy service associated with such provision. In all, 147 (74.6%) services provided some sort of communication aids services. Nearly half provided specialist therapist support for this and a further 15% could offer both general and specialist provision. Overall, it appears that, despite concerns raised in phase one, specialist services seem to be surviving in the internal market. However, data were not available on the situation before 1991.

Table 39: Extent of specialist and generalist therapy provision

	Specialist		*Generalist*		*Both*	
Service/client group	*No.*	*%*	*No.*	*%*	*No.*	*%*
Child development	22	12.6	50	28.7	102	58.6
Adult neurology	69	37.9	26	14.3	87	47.8
Elderly neurology	62	34.4	42	23.3	76	42.2
Specific language impairment	85	48.9	18	10.3	71	40.8
Child learning difficulty	72	43.4	21	12.7	73	44.0
Adult learning difficulty	93	65.5	13	9.2	36	25.4
Dysphagia	116	62.0	21	11.2	50	26.7
Fluency	47	25.8	91	50.0	44	24.2
Voice	85	44.7	55	28.9	50	26.3
Head injury	82	46.6	67	38.1	27	15.3
Laryngectomy	85	50.9	55	32.9	27	16.2
Hearing impairment	71	51.1	42	30.2	26	18.7
Physical disability	73	47.4	45	29.2	36	23.4
Cleft palate	60	36.4	85	51.5	20	12.1
Mental illness	33	54.1	27	44.3	1	1.6*
Communication aids	73	49.7	52	35.4	22	15.0
Others	28	75.7	2	5.4	7	18.9*

(* Note small numbers)

Finally, on services provided, respondents were asked to give a broad indication of whether the proportion of clinical work within their SLT service accounted for by any of the service areas set out in Tables 37 and 39 had altered since the 1991 changes. Aside from a fairly common perception that the demand for their services as a whole had risen and would continue to rise, respondents stated that the proportion of SLT devoted to dysphagia, adults with learning difficulties, people with autism, people with neurological disorders and 'statementing' children with 'special educational needs' under Part III of the Education Act of 1993 had all increased. Those who commented further on these trends suggested that the introduction of the internal market in health services had contributed relatively little directly to these trends. For example, the demand for SLT involvement with patients with swallowing problems had been rising for some time before 1991. The recent 1993 Education Act had led directly to the need for SLT input to 'statementing' of children with 'special needs' and the community care reforms had generated increased demand for SLT for adults with learning difficulties.

A few managers reported that the contracting process had actually led to services being lost to another Trust or a successful bid against competition from another Trust. However, the

vast majority of respondents made no such remarks. For them, the internal market was not an important factor driving service change within and between Trusts.

BUDGETS

The questionnaire asked about the current budget holders for the speech and language therapy service. Respondents were asked to indicate who held budgets for therapy and support staff, staff training and other types of expenditure. Looking at Table 40, it appears that the vast majority of budgets for clinical staff (84.5%), and for administrative and clerical grades (68.8%) are held by the speech and language therapy manager. There are relatively few budgets for which responsibility is shared with others. However, in the area of training, just under half (45.7%) the budgets are held by other (non-speech and language therapy) managers.

Table 40: Identity of budget holders

	Budget holder						
	SLT manager alone		*Others*		*SLT manager with others*		*Missing*
Budget	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*
Staff	163	84.5	26	13.5	4	2.0	4
Training	96	50.5	87	45.7	7	3.8	7
Admin & Clerical	130	68.8	51	28.0	8	4.0	8
Travel	33	94.3	1*	2.8	1*	2.8	162
Communication Aids	16	94.1	0	0.0	1*	5.9	180

(*note small numbers)

Respondents were also asked to specify the nature of any changes to budget holding since the NHS changes. Table 41 indicates the wide variety of comments made by 117 respondents to this question. These suggest that changes to budget holding have been very mixed in different locations. While 44 respondents (37.6%) reported no changes to budget holding, 15 (12.8%) said that the speech and language therapy manager no longer held the budget and a further 2 suggested they had less control over the budget, despite retaining it. In contrast, 11 (9.4%) said that the budget was now held by the SLT manager and an additional 7 felt they had more control over the budget since the NHS changes.

Table 41: Changes to budget holding since the 1991 NHS changes

Type of changes	*No.*	*%*
No changes	44	37.6
SLT manager no longer holds SLT budget	15	12.8
Budget now held by SLT manager	11	9.4
Devolved from District SLT manager to speciality manager	10	8.5
Training budget centralised	9	7.7
More control over budget	7	6.0
More access to training budget	5	4.3
Retained budget but less control	5	4.3
Budget now held by SLT manager and others	3	2.6
No longer held but still controlled	2	1.7
Lost non-pay budget	1	0.9
Training budget devolved to directorates	1	0.9
General devolution of budgets	1	0.9
Budget devolved to localities	1	0.9
SLT budget now part of therapies directorate budget	1	0.9
No SLT budget before	1	0.9
Total	117	100.0
Missing/Don't know	80	

ACCESS TO TRAINING

Training for speech and language therapy staff

The questionnaire asked about access to in-service training for speech and language therapy staff following the NHS changes. Given that only half of the speech and language therapy managers reported currently holding the training budget (Table 40), it is interesting that over half of the respondents (59.9%) suggested that access to staff training had not been affected by the NHS changes (Table 42). Roughly equal percentages reported that access to such training had got better or worse.

Table 42: Effect of 1991 NHS changes on access to in-service training

Effect	*No.*	*%*
Not affected	115	59.9
Better	30	15.6
Worse	36	18.8
Not clear	11	5.7
Total	192	100.0
Missing	5	

Training for speech and language therapy managers

The survey also looked at the training speech and language therapy managers received specifically to cope with the new requirements produced by the NHS changes. Table 43 shows that while nearly half had received some training, either in-house (38.1%) or by participating in national external training (15.5%), nearly half described their management training to deal with the requirements of the new NHS as non-existent or minimal (41.8%).

Table 43: Training for SLT managers related to the 1991 NHS changes

Nature of training received	*No.*	*%*
None/minimal	81	41.8
In-house	74	38.1
External	30	15.5
Relevant training before 'reforms'	2	1.0
Combination	7	3.6
Total	194	100.0
Missing	3	

There were some concerns that particular groups of managers may have missed out on opportunities for training to cope with the NHS changes, such as those in the older age groups with considerable length of service. When these data on training were cross-tabulated by age group of respondent, no such pattern emerged, and it seems that where there has been access to management training, this has been available across the different age groups.

Table 44: Training received by SLT managers by age

	Numbers of managers by age				
Training received	*Under 30*	*31-40*	*41-50*	*51-65*	*Total*
None/minimal	4	30	32	15	81
In-house	3	24	26	20	73
External	0	15	5	10	30
Relevant training before 'reforms'	1	0	1	0	2
Combination	0	1	4	2	7
Total					193
Missing					4

PERCEPTIONS OF THE 1991 NHS CHANGES

Respondents were asked for any general comments they wished to make about the effect of the NHS changes on their jobs as SLT managers. There were no prompts, simply two spaces to write in, one marked 'positive' and the other 'negative'. One hundred and seventy managers gave either a positive or negative comment or comments, or both. Respondents could give as many positive or negative comments as they wished. These free text responses were subsequently grouped and coded and their frequency recorded in Tables 45 and 46.

The wide range of positive and negative comments indicate that the NHS changes were perceived as having had a complex effect on managers' roles with a mixture of welcome and unwelcome developments. The NHS changes were by no means regarded as a uniformly negative experience by managers. However, not surprisingly, given the open nature of the question and the nature of the internal market changes from a professional perspective, those who responded found it easier to identify negative features of the NHS changes as they affected their own jobs and gave more negative comments than positive comments (288 negative and 217 positive comments). By far the most commonly expressed negative feature of the NHS changes was the increasing complexity of the management system required to support the internal market, particularly the increase in paperwork related to the contracting process. Managers also perceived an increase in responsibility and work and felt that they were operating in a more pressurised environment in which the pace of change had accelerated. Some managers clearly felt that they were exerting less influence over decisions affecting SLT than previously.

On the other hand, managers (frequently the same people describing the negative features of the NHS changes) could identify many positive features stemming from the changes, especially the opportunity to develop their own managerial role and to become more 'businesslike' in the way that they ran their service. Related to this was their view that

they now had a clearer sense of purpose or set of objectives for their service, associated in part with the purchaser-provider split. Numbers of managers reported that their jobs were more challenging and more interesting. Managers believed not only that the demand for their services had risen, but that their value was better understood than before. Some managers felt that they now had greater flexibility to manage their service appropriately.

The overall sense from Tables 45 and 46 is of managers' jobs becoming more intellectually challenging and more demanding (e.g. longer hours), but also becoming more rewarding to those willing and able to respond to changed circumstances. The comments made by respondents echo those made by middle managers in many organisations in the 1990s and appear to show a common trend towards managerial work which is more complex, more rapidly changing and more taxing. SLT is not immune from these broader trends which extend far outside the NHS.

Table 45: Effects of the NHS changes on job as a manager*: frequency of positive comments**

Comment	*Frequency*
Enabled to develop managerial role into more business-like, effective role	37
Clearer objectives/better sense of purpose and how SLT fits into other services/ability to plan service in relation to contracts	27
More challenging or interesting job	24
More contact with other disciplines and other groups including other managers and purchasers	21
Higher profile for SLT, increased demand for service and higher recognition of value of SLT	21
Greater flexibility and managerial freedom (e.g. to recruit appropriate staff, use budget surpluses)	17
Greater emphasis on quality of service and development of QA, audit, standard setting and outcomes assessment	16
Better access to (Trust) decision-makers/more involvement in decisions affecting SLT	15
More accountable for quality of service etc.	12
Greater emphasis on users' perspectives/service more related to views and needs of users	6
Better communication	5
Improved information systems relevant to the job (e.g. cost and activity data)	4
Miscellaneous	9
TOTAL POSITIVE COMMENTS	214
No response/missing	44

* 27/197 gave neither positive nor negative comments in response to this question
** Six people replied that they were 'unable to think of any positive things about the reforms'

Table 46: Effects of the NHS changes on job as a manager*: frequency of negative comments**

Comment	*Frequency*
Increasingly complex and bureaucratic managerial system with increased paperwork and meetings (e.g. caused by negotiating with fundholders, contracting, invoicing, contract monitoring etc.)	54
Increased workload/responsibility and longer hours	30
General increase in perceived pressure and stress	25
Rapid change and pace of decision-making required	22
Reduced influence over decisions/lack of involvement in decisions affecting SLT	20
Difficulty balancing professional and general management requirements (e.g. balancing service quality and finance available)	19
Increased difficulty balancing own clinical work and managerial commitments, including having to reduce own clinical time	16
Pressure for efficiency improvements (e.g. more work for same money or cost reductions)	13
Greater sense of insecurity (e.g. of role of SLT manager)	12
Reduction in influence of professional advice/eroding of role as professional SLT advisor/removal of district SLT function	9
Inadequate information system to do the job/lack of information	8
Inadequate administrative/clerical support to do the job	8
Conflict between SLT and purchasers' priorities/funding decisions	6
Competition with other providers/need to win (more) contracts/competition reducing trust between colleagues	5
More work for which manager is untrained	5
Unrealistic expectations from Trust management or purchasers	3
Inability to expand or develop SLT service	3
Miscellaneous (including fragmentation of service)	21
TOTAL NEGATIVE COMMENTS	279
No response/missing	30

* 27/197 gave neither positive nor negative comments in response to this question
** Five people replied that they were 'unable to find anything negative to say about the reforms'

Chapter 5

Discussion

The NHS internal market changes were not introduced experimentally to enable a rigorous assessment of their consequences to be made. Although the rate of implementation varied in different parts of the UK, all regions were affected in some way by the internal market from April 1991. To make matters still more complicated for evaluation, other major policy changes have continued to occur in parallel with the internal market changes, thereby adding to the difficulty of attributing changes to the advent of the market. In these circumstances, the best that could have been done to attempt to tease out the effects of the internal market, contracting for services and the development of NHS Trusts on SLT services and their management would have been to set up a survey before 1991 which continued throughout the period. However, such research is costly and was not an option in this case. Instead, it was only possible in this study to undertake a two-stage, cross-sectional study using SLT managers as key informants, with data collected over approximately six months in two separate exercises – a series of depth semi-structured interviews in the summer of 1995 and a national survey of SLT service managers at the very end of 1995, approximately four years into the reform process. As a result, although this study includes much material relevant to assessing the impact of the changes in the organisation of the NHS over the last five years on SLT services and their management, it is primarily a 'snapshot' of management and services during a period of change which included a number of other important developments affecting speech therapy staff and demands for services (e.g. a national regrading exercise and the new Education Act of 1993). It should not be assumed that all the findings reported here are a direct result of the introduction of the internal market. Some trends would have occurred in any event.

QUALITY OF THE DATA

The main aim of this report has been to present the findings from phase two of the project – the national survey of SLT managers in Great Britain. Since the aim of this survey was to obtain valid information on the current situation of SLT managers and their services, the quality of the data is important. The sample frame was, as near as possible, a 100% sample of British speech therapists who could be identified as having a major managerial role in the NHS, irrespective of whether they had the formal job title of speech therapy manager. There is a possibility that a small number of senior therapists managing small services in acute Trusts may have been overlooked, but it is a research exercise in itself to identify such individuals. The sample frame used in the survey was more complete and up-to-date than the membership lists of the main management body in the field, TASLTM.

The 87% (197/225) response rate was high for a survey of this type and representative of the sample frame as a whole. For example, although the regional response rate varied from 72% to 100% of managers, there did not appear to be an obvious bias in response by type of Trust. As well as a high response rate, the completeness of the returned questionnaires was high, suggesting that the respondents took the exercise seriously. However, surveys are crucially reliant on the recall and honesty of the respondents and it was not possible in this study to validate any of the items against alternative sources of information (e.g. routine NHS data). The problem of recall must obviously be borne in mind when assessing the completeness and validity of the answers to the questions which asked managers to describe their services before 1991. Again, given the resources and the design of the study, there was nothing which could be done, except to encourage respondents to answer to the best of their knowledge.

In the section on contract numbers, there are some doubts as to whether all the respondents understood or had read sufficiently carefully the questions posed since some of the answers are plainly and conscientiously implausible, suggesting that managers mistook a question about the number of 'contracts' to read 'contacts'! In the same section, there appear to have been impossibly high numbers of contracts with GP total purchasing pilot projects given the small number of official total purchasing projects then in existence, unless there were large numbers of informal, local schemes of this type which did not form part of the national total purchasing initiative.

A final observation on the data is simply to point out that the survey concentrated primarily, but not exclusively, on managers' accounts of the nature of the services they managed. It did not and could not include extensive questioning on how the changes since 1991 had affected their perceptions of morale and degree of stress they and their colleagues experienced.

THE FINDINGS

Despite the presumption in many parts of the profession that the period after the 1991 introduction of the internal market would be marked by a deterioration in the position of the SLT service and its managers, phase one of the current study (which is briefly summarised in this report) demonstrated that the experience of SLT managers in one of the Thames regions, another English region outside London and in Northern Ireland was diverse, with some managers reporting that they and the services which they ran had benefited in the period since the NHS changes and others dwelling on the negative effects of reorganisation of the SLT service, rising bureaucracy and loss of control over professional issues. In so far as it was possible to identify a thread running through these reports, it appeared that managers in community or combined community and acute

Trusts were faring better than managers in acute Trusts who generally found themselves managing far smaller services in environments where their activities were relatively invisible and unimportant set against the scale of acute sector activity. However, in both sorts of Trusts, it was apparent that SLT managers were rarely directly involved in the contract negotiations with the relevant health authority purchasers which were intended to influence their services.

The quantitative data from the survey of Great Britain which is discussed in the remainder of this section largely confirms this basic picture.

The managers, their roles and their position in the Trust hierarchy

As expected, the vast majority of SLT managers were women (96%) and 90% were full-time. Almost half had qualified more than 20 years ago. Although 117/197 had acquired further qualifications since then, there were relatively few with any formal managerial qualifications or training (Table 7). Forty-two per cent had received no or minimal training to assist them in their roles as managers since 1991, despite the fact that the number of separately managed SLT services appeared to have risen in line with the abolition of District-wide services and the move to separate acute and community Trusts (Table 19). Only 15% had received any sort of external management training opportunity in the period.

The diversity of their situations was reflected in the wide range of job titles (Table 9), although the titles consistently reflected the shift away from the notion of the District speech therapist. There was further diversity in their allocation of time to different roles (Table 15). Despite the fact that most managers continued to have a clinical commitment, this varied widely. The median clinical commitment amounted to 30% of a manager's time with 25% spent managing staff, 10% on business planning, 10% on financial management and 10% on audit/quality assurance. However, while 18% spent between 41% and 50% of their time on clinical work, 30% spent less than 10% seeing patients. The size of the service did not seem to be related to the amount of time which managers spent managing their staff (Table 21). Although it was not possible given the cross-sectional nature of the survey to collect detailed workload data from before the NHS changes, it was apparent from the responses of managers to general questions about how their roles had altered that most had had to continue a clinical commitment while taking on a more demanding administrative and managerial role.

It was believed in the profession that the advent of Trusts would lead to the SLT manager losing influence in the management hierarchy. The evidence from the national survey suggests that this fear may have been exaggerated since 39% of managers were directly accountable to a Trust Board level Director, with 46% accountable to a manager

one tier below Board level (Table 18). Admittedly, the previous organisational model of the District therapy service had disappeared and Trust SLT services were organised in most cases as part of a combined therapy services directorate/division, with fewer services organised either as a wholly separate SLT directorate/division or as part of a locality or other sub-Trust structure unrelated to therapy services (e.g. children's services). Box 2 summarises the 8 possible models of organisation of therapy services potentially available to SLT services at the beginning of the NHS changes.[5] While there may be numbers of speech therapists in private practice offering services directly to fundholding general practices, the vast majority of therapists are still working in NHS Trusts within models C1, C2 or B. Models D1 and D2 may be regarded as present, at least in part, in that 62% of respondents reported providing services to other Trusts. This generally involved community Trusts providing services to the acute Trusts thereby enabling the community Trusts to retain a larger complement of staff. However, in this situation, the SLT service remained an integral part of the community Trust. Models D3 and, more radically, E are occasionally discussed, but did not appear to be in existence at the time of the survey. However, this could be because of the way in which the sample frame was based on a modified version of the TASLTM members' list and, thereby, would normally exclude staff not directly employed by the NHS. Again, including such individuals in a sampling frame would be time-consuming.

Box 2: Summary of models of organisation for therapy services

A Individual private practitioner

Self-employed; decides own working arrangements

B Directorate or locality-managed within NHS Trust

Employed by Trust and managed by a sub-division of the Trust based on a locality or a service (e.g. children's services); therapy services provided as part of the overall services of the locality or directorate; therapists normally managed by a non-therapist

C1 Single therapy divisions within NHS Trust

Each therapy profession (e.g. SLT) has its own division within the Trust structure with a manager or head therapist; the therapy service is like a directorate for planning and financial purposes

cont.

Box 2: *cont.*

C2 Combined therapies division/directorate within NHS Trust

As in C1 but *all* therapy professions are in one division/directorate within the Trust

D1 Single therapy district service based in an NHS Trust

One Trust acts as base for therapy-specific services which provide to all local Trusts

D2 Combined District therapy service based in an NHS Trust

As in D1, but all/most therapy services are managed together

D3 Therapy service agency

Service (either single therapy or combined therapies) is linked to a host Trust but not managed by it; services headed by a therapist

E Independent group practice

Therapists (either single profession or across the professions) form their own for-profit or not-for-profit group practice

Source: Ovretveit J (1992). *Therapy services: organisation, management and autonomy.* Reading: Harwood, p62 (adapted)

Just as it did not appear that SLT managers in general had been marginalised within Trusts, so too, there was little sense that the recent changes had altered the degree of budgetary control exercised by SLT managers (38% reported no change [Table 41]). The degree of control remained diverse. Eighty-five per cent held their own staff budget, but only 50% controlled their own training budget. However, 60% of managers reported that their access to resources for training as against controlling the budget, had not altered since the NHS changes. Sixteen per cent even reported that their level of access to training monies had improved!

Involvement of managers in contracting for SLT services

More important perhaps than their formal organisational position for the standing of their service might be the extent to which managers were directly involved in external contract negotiations which might affect their services, depending on the degree to which purchasers took a specific interest in SLT services. Internal 'contracting' or negotiation

of 'service level agreements' *within* the Trusts could also be an important way for SLT managers to advance the needs of their services. None of the managers reported being able to negotiate the contracts with health authorities on their own (69% were negotiated entirely by other managerial colleagues). This is, in part, because the majority of such contracts will be for clinical services within which SLT services play only a small part. Only a third of managers reported that they had any direct input to the contracts with their local health authority which included SLT services. Thirty per cent claimed that they were not permitted to promote or market their service to either local purchasers or other Trusts. This was in marked contrast to their position in negotiating SLT service contracts with the local education authorities where nearly 75% were able to draw up the contract alone without the contribution of colleagues. Presumably, this discrepancy arises primarily because the LEA contracts are exclusively for SLT services and the SLT managers have a monopoly of expertise in this field.

Another reason for the low level of direct and solo involvement of SLT managers in external contracting is likely to be the high administrative or transaction costs which would be generated if each individual profession involved in a particular speciality negotiated a separate contract directly with purchasers. Where allied health professions are separately identified in contracts, this tends to be through an overall therapy services' contract negotiated on behalf of the Trust by the manager of an umbrella or collective allied health services structure (e.g. directorate). This approach to contracting is likely to be closely associated with organisational models C2 and D2 in Box 2, above. The therapy services' manager may or may not be a speech therapist. In certain situations, the existence of a unified allied health services structure capable of entering into external contracts can offer opportunities for income generation which are not available otherwise, such as the ability to negotiate to meet the strong demand for therapy services from GP fundholders.[13]

For governing SLT services provided to the Trust in which the therapists were located, service level agreements (SLAs) were more commonly mentioned than formal contracts (Table 28). In the case of internal SLAs, the SLT manager would normally be directly involved in negotiating with business managers or with a unified therapy services' manager within the Trust the level and type of resources required for the SLT service. Given that the majority of the external contracts either with health authorities or fundholding general practices were negotiated by colleagues in the Trust without direct input from the SLT manager, the key detailed negotiations affecting the SLT service were thus *internal* to the Trust and depended on SLT managers' ability to win the confidence of their colleagues. In this sense, for most of their work (except their work for the local education authorities), speech and language therapists in the NHS are sub-contractors in contracts between an external purchaser and a therapy services directorate or medical speciality grouping (e.g. neurology). Evidence from other studies of the allied health

professions suggests that in these circumstances, the therapy services can benefit, provided that they have a set of quality standards or service specifications or protocols which they can use to define and promote their services.[13] This, in turn, presumes that there are capable SLT managers able to devise, adapt and promote these tools. There was little sense from the material on contracting (see below) that extensive use was being made of SLT-specific quality standards.

Types of contracts for services

A wide range of purchasers were contracting for SLT services (Table 28), including local health authorities/health boards, acute Trusts, other health authorities/health boards and local education authorities (LEAs) (36% of contracts were with education services). The relative lack of involvement of SLT managers in contracting with health authorities is partly explained by the fact that the majority of contracts which included SLT services were block contracts based on historic patterns of activity (Table 29). In this sense, SLT services are like many other services purchased by health authorities where block contracts are still common. Fundholders were far more likely to use a wider range of contract types.

The predominance of block contracts which included SLT services meant that SLT managers were largely dependent on the judgements of their managerial colleagues within the Trust for their eventual budget allocations. Marketing was thus at least as much an *internal* as an external activity (see above). Block contracts, despite some other limitations, are an effective way for the purchaser to pass the problem of managing volume and/or cost increases to the provider; in this case, the Trust and, in turn, the SLT manager. Many of the managers reported being worried about how to cope with increases in patient numbers and/or changes in case-mix within a fixed annual budget generated by block contracting. The evidence from the managers indicated that there was an increased demand for many of their services. This suggests a very important role for the manager in monitoring overall activity, the types of cases being treated and their costs and in then being able to take effective action either to obtain more resources or to adjust the pattern of work to stay within budget while treating the most appropriate patients.

If block contracts are generally regarded as crude instruments for influencing the nature of health care provided, in part, this might be offset by setting detailed quality standards within them. While there is far more to assuring the quality of services from a professional provider's point of view than simply including quality standards in contracts, such standards can help professionals endeavouring to maintain the standard of their services in their negotiations with purchasers. The survey found that the large majority of standards in contracts were derived from national targets and policies such as the *Patient's Charter*

rather than from SLT and that they tended to focus almost exclusively on process measures of quality such as client waiting times or throughput rather than more ambitious indicators of either professional or client quality. Only 28% of contracts included any SLT-specific or local Trust standards (Table 31). This is interesting given that over 95% managers reported that they were involved in different ways in quality assurance and audit-type activities (Table 15) and that the profession has also invested in developing service standards and methods for assessing them.[14] This *Communicating Quality* initiative[14] was frequently mentioned in the phase one, face-to-face interviews showing that managers were familiar with its contents, but it appeared to have had less influence in the construction of contracts. Again, this may be a reflection of the limited input to contract negotiations with health authorities reported by managers. It may also be associated with the relatively small proportion of managers who reported having received training specifically to equip them to deal with the internal market, the purchaser-provider split and contracting. Finally, it may be a reflection of the fact that managers typically only devoted about 10% of their time to activities labelled as quality assurance/audit. On the other hand, it might be argued that this level would have been higher had the use of quality standards been more prevalent in contracts!

All in all, the findings from the current survey suggest that the contracts which included SLT services were unlikely to have been constructed in such a way as to have had a direct bearing on how SLT services were provided except in so far as managers were expected to deliver an increasing volume of service with downward pressure on unit costs. This situation is unlikely to be confined to SLT and is corroborated by a recent national survey of contracting in the NHS internal market which showed that most contracts between purchasers and providers were insufficiently specific to enable the micro-management of clinical activity to occur.[15] There was still considerable scope for clinical discretion as to which services to provide, and how, within broad service areas.

Services provided and staff available

The upward trend in the numbers of allied health professionals in the decade 1984 to 1994 reported in official publications was particularly notable among occupational therapists and, to a lesser degree, speech and language therapists.[7] These findings were mirrored in the current survey and, in turn, in the evidence that the size of services had increased despite the fact that a number of previously integrated District-wide services had been split between different providers when the internal market was introduced. Although the trend data in the survey may be prone to recall bias, the managers reported that 24/194 (12%) of services in 1995/96 had more than 31 trained staff as against only 10/156 (6%) before 1991 (Table 19). Figure 6 reinforces this by showing that 74% of managers reported that they had gained therapist staff since 1991. Only 6% reported having lost staff.

The overall increases in numbers of trained staff had also been accompanied by a rise in support staff. Far fewer services than in 1991 were without SLT assistants and clerical staff (49% versus 18%).

Despite the fact that there had been fears expressed among representatives of the profession that the internal market might reduce the range of services provided, there was no evidence of this having happened. Overall demand was perceived to be increasing and two-thirds of managers reported that they provided at least 14 of the 17 types of SLT service specified in the survey as being available within the NHS (Table 38). There was no sign that this range of services had narrowed since 1991. Related to this, was evidence that specialist service provision also appeared to have survived the NHS changes (Table 39).

Change *was* occurring in the balance of service effort in that the percentage of work accounted for by swallowing disorders, services for adults with learning difficulties, 'statementing' children with 'special needs', managing people with autism and services for people with neurological disorders were all said to be rising. There was little sense that these rises were directly due to the existence of an internal market in the NHS or the effects of competition between rival Trusts. Respondents did not link changes in the balance of work to GP fundholders either. In general, it did not appear that fundholding was presenting many problems for managers. For example, although the phase one interviews revealed the possibility that health visitor referrals under the fundholding scheme might cause problems for SLT services, less than 10% of the survey respondents reported that these had posed any difficulties for them (e.g. because of inappropriateness).

Perceptions of the NHS changes

One hundred and seventy managers out of the 197 who completed questionnaires provided unprompted comments on the effects of the NHS changes of 1991 for their work and services (Tables 45 and 46). The comments were wide-ranging. It is interesting to note that they were far from being consistently negative. Although, perhaps unsurprisingly, given the professional background of the managers, there were more identifiable negative comments (n=288) than positive ones (n=217), taken together they show that managers' perceptions of the consequences of the changes for their work and services amounted to a complex picture. Their working lives had become more complicated, more pressurised and more bureaucratic. They appeared to be describing circumstances in which they were being expected to assume greater responsibility for the direction and development of their SLT services. To offset the relatively gloomy picture of rising pressure, complexity and paperwork, there were comments from a minority of managers who had identified a definite improvement in the manager's role. They commented on

being able to behave in a more business-like way, to set clearer goals for their departments and to enjoy a more interesting and challenging job.

Such comments are consistent with the organisational data collected in this survey which showed that the professional management of SLT services has been retained despite the managerial changes brought about by the advent of general management and the internal market. The vast majority of SLT services are directly managed by speech therapists who retain some clinical commitment and not by general managers. Seventy-four out of 192 managers (39%) (Table 18) are directly accountable to a Board level Director. However, the environment, both within the Trust and externally, has become more demanding of the managerial skills of therapy services managers, in general, and SLT managers in particular. In these circumstances, the competence of the manager and their interest in, and willingness to undertake key management tasks such as working strategically to demonstrate that their service is genuinely needed, become ever more important. The comments from a good proportion of the managers summarised in Tables 45 and 46 suggested that there are significant opportunities for therapists willing to take them to enhance both the SLT service and their managerial role in the post-'reforms' NHS.

Chapter 6

Conclusions

According to well informed observers of the therapy professions, the 1970s was a decade in which these professions were increasingly able to emerge from the control of the medical profession and begin to manage themselves along functional lines in the NHS. Ever since, it is argued, medical dominance of the therapy professions has been in decline.[5] By contrast, the 1980s could be characterised as a period in which professional self-management of the therapy professions, including SLT and of the medical profession was, to some degree, supplanted by general management in the NHS. At the same time, the success of therapy services in a more challenging managerial culture came to rely increasingly on the skills of the therapist-manager. Ovretveit, whose research together with that of earlier colleagues at Brunel's Institute of Organisation and Social Studies over 20 years charted the progress of the therapy professions, argues that in the 1980s the activities of the therapist-managers drawn from the ranks of each professional group were principally responsible for the rising number of therapists employed in the NHS. Staff growth primarily reflected managers' ability to argue their case for posts rather than objective data on the demand for their services or even the effects of the increasing supply of qualified therapists. Between 1984 and 1994, the number of speech and language therapists in the NHS rose from 2,150 to 3,340, 'a rise of 55%.[7] In the 1990s, good therapy managers appear to be equally vital, but in different ways.

Writing in 1991, Ovretveit speculated on the possible consequences for the management and organisation of the therapy professions in general of the development of the internal market in the NHS, based on his earlier research and the recent history of these professions.[5] He speculated that the internal market would not have apocalyptic consequences for the allied health professions, but that the following trends would be observed:

- an expansion of the numbers of unqualified assistants due to a pressure on providers to reduce the unit costs of services in a more competitive environment
- a complementary tendency to use qualified staff more selectively to manage more complex cases
- a requirement for managers and senior staff, particularly, to obtain new managerial skills such as in the field of quality assurance (e.g. to be able to ensure a good quality of service from assistants)
- the increasing influence of provider organisations on the number of students trained rather than a reliance on professional estimates

- an increasing requirement from purchasers for independent, informed advice about the 'need' for therapy services
- an increasing opportunity for therapy professionals to justify and market themselves and their services to purchasers
- a need for research-based measures of the outcome of services to contribute to making the case for therapy services
- closer critical scrutiny of the merits and ways of working of multi-disciplinary teams
- increasing pressure to demonstrate service quality
- an increasing range of organisational options for the provision of therapy services
- a growing need for management and business skills among senior therapists and a need to abandon the prevailing ambivalence about acquiring management skills
- rising demand for therapy services

Aside from his point about multi-disciplinary team working which was not a direct focus for attention in the current survey, there are findings in the current survey of SLT managers and their services which have a bearing on all these possibilities. In each case, it may be said that Ovretveit's predictions have been borne out in reality. For example, increases in the numbers of untrained assistants have occurred, although against a background of rising demand for SLT services and an increase too in qualified speech therapists. The other speculations between them amount to a prediction of a more testing, perhaps more evidence-based managerial environment in which management skills are increasingly relevant to maintaining and developing SLT services if they are to remain responsive to professional as well as wider organisational imperatives. The findings from 1995/96 indicate that such an environment has begun to emerge, but that not all SLT managers appear to be equally well equipped to work effectively within it. The fact that the majority still have appreciable clinical commitments which are relatively inflexible means that responding to the imperatives of the management systems of the Trusts can be awkward.

NHS SLT services have survived the advent of the internal market and, indeed, appear, in most cases to have expanded and to be in greater demand than ever, as Ovretveit predicted. As in so many other areas of health care, there are more staff in post than before and the range of services provided is at least as wide as before the 1991 changes. Specialists and their services also appear to be surviving in the new purchaser-provider environment. Services remain the *direct* responsibility of qualified speech therapists not general managers or managers from other clinical disciplines. Many of the changes which have occurred in the content of SLT services either had their roots before 1991 or were only peripherally influenced by the internal market (e.g. changes in the way in which seriously ill people with swallowing difficulties are nursed). Of course, services may survive and, indeed, be seen to expand, but in very different and more inimical

circumstances. Ovretveit has argued, for example, that both quasi-market and bureaucratic forms of organisation are inappropriate for the provision of high quality community health services, including many of the therapy services[16]. Viewed in this light, SLT services are operating in an environment which, by design, cuts across a number of their previous characteristics and values, namely, professional discretion, flexibility and an emphasis on co-operation and interdependence across professional and organisational boundaries. In addition, the timetables of general managers and the requirements of everyday clinical work can often conflict. This explains the continuing concerns of many SLT managers and their paradoxical sense that their services may be developing in objective terms, but that, subjectively, things feel worse.

Where the NHS changes have had more direct consequences for the management of SLT services through the development of NHS Trusts responsible for their own destiny in the internal market, the pressures for change have largely been as predicted by Ovretveit, but the *effects* have been varied and complex at local level. The picture is diverse whichever aspect of the management of services is considered and go beyond the differential effect of the NHS changes on SLT services in acute and community Trusts discussed above. These conclusions are in agreement with a number of recent pieces of research on the effects of the internal market. One of the most relevant to the current discussion is a study of contracting for community health services in three districts in one NHS region over the period 1992-95.[17] Despite the fact that health services and especially the community health services are generally complex and their content is difficult to define contractually, the three districts approached the service specification stage of the contracting process very differently. In one district, a collaborative approach to improving service specifications was adopted between purchasers and providers as part of a local preference for a relational or partnership style of contracting, perhaps in recognition of the 'indeterminacy' of such services. By contrast, in another nearby district, the health authority was far more adversarial in its demands about the services to be provided and progress towards refining the service specifications was slow. In the third area studied, the purchaser and the provider both supported a collaborative approach, but the purchaser placed great emphasis on purchasing for 'health gain' and insisted that services relate to measurable health outcomes. The Trust was sympathetic, but sceptical about the realism of such demands and the eventual contract specifications remained general and relatively conventional. In these three different sets of circumstances, the opportunities and experiences of the therapy services managers would have been very different and such evidence may go some way to explaining the diversity of accounts in the current survey. Levels of trust between purchasers and providers, and *within* provider organisations between general managers and clinical staff, vary and Flynn *et al.*[17] show that levels of trust vary over time as relationships wax and wane and staff change.

The responses of some of the managers in the current survey show that they have been able to take advantage of the opportunities generated by the NHS changes to manage their departments in a more 'businesslike' way and have derived greater job satisfaction from so doing. For example, the advent of Trusts has, if anything, increased the extent of budgetary devolution to clinicians and given service managers greater control over the resources available for their services. It has not been feasible for purchasers or general management in Trusts to involve themselves in the detail of SLT services. On the other hand, other (and sometimes the same) SLT managers have resented the increased volume of what they term 'administration' and the demands on their time for other than clinical work generated by the internal market environment. If Ovretveit[5] is correct, and such an attitude is unrealistic in the current Health Service, then greater attention needs to be paid, both by the NHS and other professions, to the training and development of SLT managers than has occurred so far, if SLT services are to flourish in the next century.

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Appendix I

CONFIDENTIAL ☐☐

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UNIVERSITY OF LEICESTER, DEPT OF EPIDEMIOLOGY AND PUBLIC HEALTH AND KING'S FUND POLICY INSTITUTE

THE EFFECTS OF THE NHS CHANGES ON SPEECH AND LANGUAGE THERAPY SERVICES

Questionnaire to NHS Speech and Language Therapy Managers, 1995

No individuals or their services will be identified in any report of this project. We would, however, like to be able to contact you if there are any aspects of this questionnaire which need clarifying. The questionnaire has a unique identifying number for that purpose. The link between your name and the number is only known to the project researchers and will not be divulged to anyone else. Thank you for your co-operation.

On behalf of the Royal College of Speech and Language Therapists, we are interested in the effects on speech and language therapy (SLT) services of the NHS changes implemented through the 1990 NHS and Community Care Act (eg the introduction of the internal market, the creation of Trusts, the purchaser-provider split, GP fundholding etc). Several questions ask you to indicate any changes by telling us, as far as you know, what your service was like before the reforms and what it has been like after the reforms. Where you do not know because you were not in post or in another area, please answer to the best of your knowledge.

First, we are interested in any effects the changes may have had on the management of SLT services and would like to ask some questions about your job.

1. Please give your job title: .....

2. Has your job title changed since trust status was granted?

   1 ☐ Yes (*please give former job title*) .....
   2 ☐ No

3. Please indicate whether you are:

   1 ☐ Full-time
   2 ☐ Part-time (*please give w.t.e., eg 0.8*) .....

4. Approximately what proportion of work time do you spend on the following activities? We appreciate there may be some overlap, but please estimate as well as you can.

Activity	Proportion of time *(to nearest 10%)*
Managing SLT staff Business planning and contracting	
Financial management/dealing with invoices	
Audit/quality assurance	
Clinical work	
Managing other services *(please specify)*	
Other (eg promoting SLT/patient information *(please specify)*	

Total – 100%

5. We would like you to comment on how your roles and responsibilities (or those of the previous SLT manager if you have come into post since 1991) have changed as a result of the reforms (eg managerial, clinical or professional/advisory roles):
.....
.....
.....
.....

This section asks about how SLT fits into the overall structure of the Trust/Unit and the way the SLT service is organised.

6. Is your service part of one of the following?:

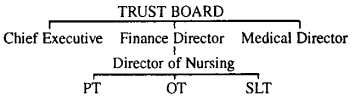
1 ☐ A community trust
2 ☐ A combined acute and community trust
3 ☐ A community and learning disability trust
4 ☐ A mental health trust
5 ☐ A community and mental health trust
6 ☐ An acute trust
7 ☐ A directly managed unit (ie not a trust)
8 ☐ Other *(please specify)* .....

7. Is your service part of one Trust/Unit but providing SLT services to another?

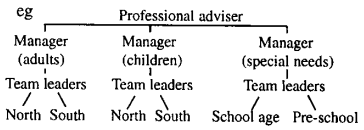
2 ☐ No
1 ☐ Yes.

If *Yes*, to what sort of Trust/Unit do you provide services?
.....
.....

8. We are interested in knowing the composition of the Trust/Unit Board to which you are accountable and the identity of other professions in your group, division or directorate. Please show where SLT fits into the organisational structure by drawing a simple diagram or by attaching a printed one, if available, from the Board of Directors to the level at which SLT services are provided, eg



9. We would like to know how your SLT team is organised, starting from your post and indicating those staff for whom you have line management or advisory responsibility. Please show if your team is organised by client group, specialism locality, age of client, etc by drawing a simple diagram as in the example or attaching a printed one, if available. *If helpful, please use ~~to denote~~ a managerial relationship and ~~for an ad~~visory relationship*



10. We are interested to know the approximate numbers of w.t.e. staff currently employed in your service. We would also like to find out to the best of your knowledge how many staff were employed *before* the reforms (given as 'pre-1991'):

Staff	W.t.e. pre-1991	W.t.e. currently
Qualified Therapists		
Assistants		
Clerical and secretarial staff		
Other (*please specify*)		

11. Please could you give the current top spine point in your service (your own if this is the highest): .....

12. Have the NHS changes had any effect on the following? (If *Yes*, please tick and give brief details on the lines provided.)

☐ Grading structure .....
.....
.....

☐ Balance of temporary and permanent staff .....
.....
.....

This section is about how speech and language therapy services have been affected by the contracting process.

13. We would like you to indicate, if possible, the number of contracts you have with the purchasers listed below and the percentage of your SLT service that each purchaser buys (eg local health authority – 60%, GP fundholders – 30%, education – 10%). If you do not have this information, please write 'don't know'.

Purchasers	No. of contracts	No. of service-level agreements	% of SLT work
Own Trust			
Local Health Authority/Health Board			
GP Fundholders			
GP Total Purchasing Pilot Sites			
Acute Trust			
Other Health Authorities/Boards			
Local Education Authorities			
Other (*please specify*)			

Total = 100%

14. Have you had any extracontractual referrals (eg for communication aids)?

1 ☐ Yes (*please give details*) .....

.....

2 ☐ No

3 ☐ Don't know

15. Is the balance of SLT purchased changing (eg increase in services purchased by GP fundholders and a decrease in purchasing by the Health Authority/Health Board)?

1 ☐ Yes (*please give details*) .....

.....

2 ☐ No

3 ☐ Don't know

16. If you have contracts with GP fundholders, do these allow for direct referrals from health visitors?

1 ☐ Yes If *Yes*, how has this worked out? .....

.....

.....

2 ☐ No

3 ☐ Don't know

17. We would also like to know the types of contract or service level agreement you have with each purchaser (eg cost per case). Please tick the types(s) of contracts on the next page and, if possible, give the number of contracts in brackets (eg Local Health Authority: block (3), cost per case (2)).

Purchasers	Type of Contract/Service Level Agreement		
	Block	*Cost per case*	*Other (eg cost & vol)*
Own Trust			
Local Health Authority/Health Board			
GP Fundholders			
GP Total Purchasing Pilot Site			
Acute Trust			
Other Health Authorities/Boards			
Local Education Authorities			
Other (*please specify below*)			

18. Are all your contracts or agreements based on last year's activity levels?

1 ☐ Yes

2 ☐ No If *No*, what are they based on? .....

.....

.....

19. Are quality standards included in contracts with any of your purchasers?

2 ☐ No

1 ☐ Yes (*please give details*) .....

.....

20. What is your role in influencing the contracting process? (If no role, write 'none')

.....

.....

21. Please indicate who actually negotiates your contracts (eg 'myself and business managers') with the following purchasers:

Purchaser	Contract Negotiators	Not known
Local Health Authority/Board		
GP fundholders		
GP Total Purchasing Pilot Sites		
Acute Trust		
Other Health Authorities/Boards		
Local Education Authorities		
Other (*please specify below*)		

22. Are you able to promote your SLT service directly with purchasers?

2 ☐ No

1 ☐ Yes If *Yes*, how is this working out? .....

.....

.....

23. Please make any further comments you want about the contracting process in your Trust/Unit as it affects SLT services.

.....

.....

.....

This section asks about the services your team provides.

24. Please tick those client groups for whom you are contracted to provide services, either within specialist teams or via general provision. Where you do not provide a service, leave the line blank.

	Type of provision	
Services for people with:	*Specialist*	*General*
Developmental speech/language problems		
Neurological disorders (adults)		
Neurological disorders (elderly)		
Specific language impairment		
Learning disability (children)		
Learning disability (adults)		
Dysphagia		
Fluency disorders		
Voice disorders		
Head injury		
Laryngectomy		
Hearing impairment		
Physical disability		
Mental illness		
Cleft palate		
Other(s) (*please specify)*		
Other services:		
Communication aids		

25. Has the proportion of SLT work for any of the above increased or decreased since the reforms (eg if you provide services to people with learning disability, has the proportion of work devoted to this gone up or down?)?

.....

.....

.....

.....

In the next section, we would like to know about other areas which may have been affected by the reforms, including budgetary responsibility, staff training and interprofessional working.

26. Please indicate who the budget holder is (eg myself, therapy services manager etc) for the following:

Type of budget	Budget holder
Staff	
Training	
Admin & Clerical	
Other (*please specify below*)	

27. If the budget holders have changed since the reforms, please give details of the main changes: .....

.....

.....

28. Has access to in-service training for your staff been affected by the reforms?

2 ☐ No

1 ☐ Yes (*please give details*) .....

.....

29. What training did you receive as a manager specifically to cope with the new requirements produced by the reforms? .....

.....

.....

.....

30. Do you feel the reforms have had any effects on the following? (*If* Yes, *please tick and give brief details on the lines provided*)

☐ Working with other professionals .....

.....

.....

☐ Collaboration between therapists in different Trusts .....

.....

.....

☐ Rotations for newly-qualified therapists .....

.....

.....

☐ Student placements .....

.....

.....

☐ Support and supervision for therapists .....

.....

.....

☐ Staff morale .....

.....

.....

☐ Range of approaches to therapy offered by your service (eg group, intensive, domiciliary) .....

.....

.....

31. We would be grateful for any general comments you may wish to make about the effects of the reforms, both positive and negative, first of all on *your job as a manager*:

Positive: .....

.....

.....

Negative: .....

.....

.....

and, secondly, *on your service*:

Positive: .....

.....

.....

Negative: .....

.....

.....

The last section covers basic information about yourself.

32. Are you? 1 ☐ Male 2 ☐ Female

33. How old are you? ..... years

34. What type of course did you take to qualify as a speech and language therapist?

1 ☐ three year diploma
2 ☐ three year degree
3 ☐ four year degree
4 ☐ postgraduate diploma
5 ☐ other (*please specify*)

35. How long is it since you qualified as a speech and language therapist? ..... yrs

36. Have you gained any other qualifications since you completed your qualifying speech and language therapy course?

2 ☐ No
1 ☐ Yes (*if so, please specify below*)
- 1 ☐ CSLT Advanced Studies Diploma
- 2 ☐ Postgraduate Certificate of Education
- 3 ☐ MSc
- 4 ☐ PhD
- 5 ☐ MBA
- 6 ☐ Other (*please specify*)

37. Finally, please feel free to make comments on anything you think we have missed out using the space below:

Please return the questionnaire in the pre-paid envelope by **20 November 1995** to:

Diane Bebbington
Research Associate
SLT and the NHS changes
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University of Leicester
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Leicester
LE1 6TP

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Appendix II

Classification of organisational structures of Trusts/units used in Table 18

1 SLT manager on Trust/unit board (e.g. as an executive director)
2 SLT manager accountable directly to someone on Trust/unit board (i.e. to an executive director, including director of nursing, director of therapy services, director of specific service [i.e. community], director of operations)
3 SLT manager accountable to manager one tier below board level (i.e. middle manager including therapy services manager, service manager e.g. community, manager of operations, locality manager)
4 SLT manager accountable to manager two tiers below board level
5 SLT manager accountable to manager three tiers below board level (including split SLT service management, e.g. adults and paediatrics managed separately)

What impact have the NHS reforms made on specialist services provided by speech and language therapists?

How has the internal market affected the organisation of services, staffing levels, control over work and staff morale?

Have speech and language therapists benefited from the health changes or is the profession struggling under the weight of the management demands created by the reforms?

Speech and Language Therapy Services and Management in the Internal Market examines the findings of a national survey of NHS speech and language therapy managers and assesses the impact made by the reforms on this highly specialised profession. It discusses how the survey was drawn up, analyses the factual evidence and makes recommendations for the future.

While the NHS reforms have attracted widespread comment since they were introduced, little has been published about their effect on specialist services provided by speech and language therapists. This major study, carried out by the Royal College of Speech and Language Therapists, provides the answers to many of the questions asked by the profession during this period of change in the NHS.

It is essential reading for all speech and language therapists and is useful for other therapy professions.

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