Speech and Language Therapy for Children with Voice Disorders in Secondary Care

Criteria Based Access

Before consideration of referral for management in secondary care, please review advice on the Remedy website (www.remedy.bnssg.icb.nhs.uk /) or consider use of advice and guidance services where available.

If the patient in question is clinically exceptional compared to the cohort, then an Exceptional Funding Application may be appropriate. The only time when an EFR application should be submitted is when there is a strong argument for clinical exceptionality to be made. EFR applications will only be considered where evidence of clinical exceptionality is provided within the case history/primary care notes in conjunction with a fully populated EFR application form.

Section A – Criteria to Access Treatment

Funding approval for therapy will only be provided by the NHS for patients meeting the criteria set out below:

1) The Patient has been seen by a paediatric ENT surgeon.

AND

2) The Patient has been triaged by a Paediatric Speech and Language Therapist at the Bristol Royal Hospital for Children.

AND

3) The Patient presents with a voice disorder as described in the plain language summary.

BRAN

For any health- related decision, it is important to consider **"BRAN"** which stands for:

- **B**enefits
- **R**isks
- **A**lternatives
- Do **N**othing

Benefits

- Paediatric speech and language therapy will maximise the child's ability to clearly communicate with others. This will increase quality of life and ability to participate in everyday activities, particularly with regard to educational achievement and interaction with peers.
- The therapy may resolve the voice disorder completely and avoid the need for further medical intervention.
- Increased understanding of the nature of the communication difficulty will enable both the child and the primary carers, to manage the problems and associated problems more easily.

Risks

No significant risks have been identified.

Alternatives

None available.

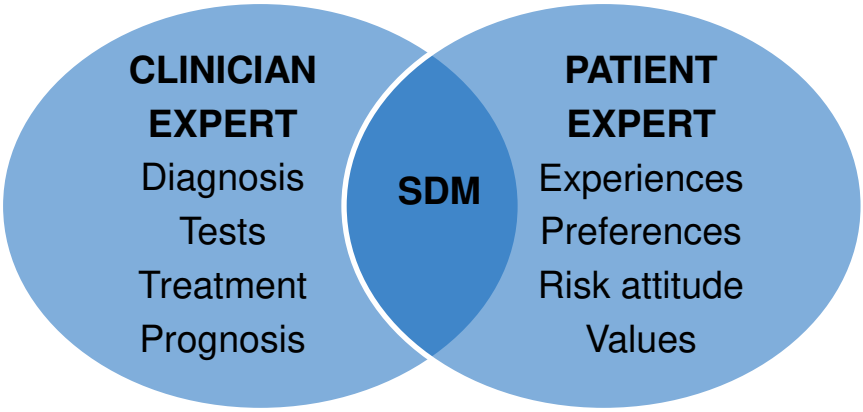
Do Nothing

- Continue to live with the voice disorder.
- Occasionally, in very young children, the option of 'wait and see' may be appropriate but generally, the longer the problem continues without intervention, the more likely the problem will get worse and potentially be harder to treat with just speech and language therapy alone.

Shared Decision Making

If a person fulfils the criteria for paediatric speech and language therapy, it is important to have a partnership approach between the person and the clinician.

Shared Decision Making (SDM) is the meeting of minds of two types of experts:



It puts people at the centre of decisions about their own treatment and care and respects what is unique about them. This includes their preferences and values. It means that people receiving care and clinicians delivering care can understand what is important to the other person.

The person and their clinician may find it helpful to use 'Ask 3 Questions':

1. What are my options?
2. What are the pros and cons of each option for **me**?
3. How do I get support to help me make a decision that is right for **me**?

Speech and Language Therapy for Children with Voice Disorders in Secondary Care – Plain Language Summary

A voice disorder may present as a total loss of voice (aphonia) or change to the voice (dysphonia) in terms of quality, pitch, resonance and volume. This can range from mild to severe and can be consistent or inconsistent. Voice is an integral part of a child's communication skills and any changes to voice will impact, to varying degrees on the child's ability to communicate.

Voice disorders in children can be as a result of:

- Voice abuse or misuse causing changes to voice quality.
- Organic changes or congenital abnormalities (i.e. that you are born with) to the anatomy and physiology of the larynx e.g. sulci, webs, cysts.
- Certain medical conditions e.g. vocal cord palsy, laryngo-tracheal stenosis.
- Certain neurological disorders affecting muscle tension in the head and neck or changes to respiratory function and coordination e.g. cerebral palsy.
- Common or rare childhood viral or bacterial infections e.g. papillomatosis.

There is not always a structural cause for voice disorders in children such as in children with dysfunctional breathing patterns and occasionally the cause is due to psychological stress.

In some children, the voice disorder may co-exist with other speech and language difficulties and/or dysphagia (difficulties with swallowing), which necessitates speech and language therapy input from a non- voice specialist speech and language therapist.

Effective speech and language therapy management of voice disorders in children requires input from specialist speech and language therapists who have an in depth knowledge of the anatomy and physiology of the larynx and upper airway of babies, children and young adults. It is best practice that this be done in an environment where there is joint working with and easy access to ENT surgeons. It is also essential that management includes working closely with the child's primary care givers such as parents, nursery and school/college.

This policy has been developed with the aid of the following references:

1. The Royal College of Speech and Language Therapists. (2019). *Resource Manual for Commissioning and Planning Services for SLCN*

Connected Policies

None

Due regard

In carrying out their functions, the Bristol North Somerset and South Gloucestershire Clinical Policy Review Group (CPRG) are committed to having due regard to the Public Sector Equality Duty (PSED), and NHSE Evidence-Based Interventions (EBI). This applies to all the activities for which the CCGs are responsible, including policy development and review.

Document Control

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Governance

Commissioning policies are assessed for their likely level of impact on BNSSG ICB and the population for which it is responsible. This determines the appropriate level of sign off. The below described the approval route for each score category.

Policy Category	Approval By
Level 1	Commissioning Policy Review Group.
Level 2	Chief Medical Officer, or Chief Nursing Officer, or System Executive Group Chair
Level 3	ICB Board

OPCS Procedure codes

Must have any of (primary only):
A705, A706

Support

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