Fieldwork summary

Applying behavioural insights to improve early speech and language in Greater Manchester

THE
BEHAVIOURAL
INSIGHTS
TEAM

Contents

01 / Summary

This report summarises the fieldwork done as part of the Behavioural Insights Team North (BIT: North) project looking at how behavioural insights could support early childhood speech and language development in Greater Manchester. The project was commissioned by the Greater Manchester Combined Authority (GMCA). This review should be read alongside the *Applying behavioral insights to improve early speech and language in GM* report and the literature review.

During the fieldwork we carried out the following activities:

- **Attended children's centre 'stay and play' style sessions**. We visited sessions which were open to anyone. While visiting centres, we spoke to parents, interviewed frontline staff and observed parent-child interactions

- **Interviewed speech & language experts**. The purpose of these interviews was to get insights and advice from professional experts.

- **Health visitor interviews and shadowing.** We interviewed 15 health visitors in Salford and Wigan and shadowed three health visitors during 9-months checks (observing a total of five visits).

The main findings from our fieldwork are:

- **There is a strong intention/action gap.** Most parents know what to do e.g. reading, singing, playing games but real life gets in the way.

- **There are still some key gaps in knowledge,** including the role that parents can have in supporting their child's language skills. In particular we think parents underestimate the importance of incidental communication and 'serve and return' interactions from a very young age.

- **The wider environment matters** and in areas with low levels of speech and language skills both parents and professionals may not realise when a child is behind.

During our fieldwork we investigated the existing tools which measure speech and language development. This was to help inform our outline evaluation plan (see the *Applying behavioral insights to improve early speech and language in GM* report for more detail on our proposed evaluation approach). There are two tools used across GM to measure speech and language development. The first is the Ages and Stages Questionnaire (ASQ). This is a universal tool which is used across England to evaluate child development as part of the Health Child Programme. The second is the WellComm screening tool. In GM, this is only used if a child is identified as being at risk of language development delays (using the ASQ).

- **Both the ASQ and WellComm are useful tools, but have their limitations** in relation to speech and language skills**. We do not think the ASQ is suitable for measuring the impact of our proposed approach.**

In the rest of this report we set out more detail about the methods we used and our findings.

02 / Introduction

Early speech and language is one of the key factors of successful development in early life. Indeed, the Early Intervention Foundation (EIF) argue that achieving the expected level of development in speech and language by age five should be treated as a child wellbeing indicator. Developmental delays in speech and language skills have both short term and long term implications. For example, children who have poor vocabulary skills at age five do worse at school and are also at more risk of mental health problems and unemployment in adulthood.[1]

Across Greater Manchester (GM), the number of children reaching a good level of development in speech and language by the end of their reception year is below the England average of 82 per cent. It also varies significantly across the region (from 75 per cent-86 per cent). While these figures have improved in recent years, the gap between GM and the England average persists.

The Greater Manchester Combined Authority and the Greater Manchester Health and Social Care partnership commissioned BIT to identify ways to use behavioural insights to support early childhood speech and language development. Alongside exploring the academic evidence, we completed a programme of practical fieldwork with families and early years professionals. The full literature review is available separately.

The existing research identifies the activities that parents should do with their children to promote language development. There are also a number of existing studies which have used behavioural insights to successfully increase particular activities e.g. reading. This fieldwork was designed to complement the evidence review and help us understand the situation in GM. We carried out the fieldwork to answer the following questions:

1. What activities do parents in GM currently do which support their children's speech and language development?

[1] Language as a child wellbeing indicator, Early Intervention Foundation, 2017

2. How do frontline practitioners work with families to support speech and language development?

3. How does speech and language fit into wider child development/family support?

4. How are speech and language development assessments carried out in GM?

Using behavioural insights is often about understanding how seemingly small details are having disproportionate effects on behaviour. These details can be about how services are delivered, the environment people are in, or the way information is presented. This face-to-face fieldwork was crucial in helping us identify the details and context which inform our proposed intervention.

03 / Summary of methods

In the fieldwork we spoke to parents and practitioners and used a number of research methods. Table 1 summarises our approach.

Table 1: Summary of target groups and techniques used

	Informal chat	Semi-structured interview	Structured interview	Observation
Parents – stay & play sessions	X	X		X
Parents – home visits	X			X
Children's centre staff	X		X	X
Professionals		X	X	X

- **Attended children's centre 'stay and play' style sessions**. We visited sessions which were open to anyone (i.e. universal) and which combined free play with structured activities, such as singing or crafts. In total, we visited 6 children's centres in three areas of GM (Bolton, Rochdale and Manchester City) and often attended more than one session at each centre. While visiting centres we:
    - **Spoke to parents.** Informal discussions with parents attending the stay and play session about their favourite activities to do

with their children, their daily routines, and their thoughts on speech and language development. We spoke to over 50 parents in this way. During our visits, we spoke to parents from the following groups: White British, Black British, Asian British (urdu/punjabi/gujarati/bengali/hindi speakers), Eastern European background (polish/slovak speaking), Sub-Saharan African background (somali/amharic/arabic speaking), Middle Eastern background (arabic/farsi speakers). We also spoke to young mothers, grandparents, childminders and were able to attend a session specifically for dads.

    - **Interviewed frontline staff.** Semi-structured discussions (usually during preparation or clean up) with the outreach workers and language development workers who led the sessions about their experiences with parents and with speech and language development. We spoke to more than a dozen frontline staff.

    - **Observed parents and children.** Between informal chats, we observed parents interacting with their children at the sessions.

- **Interviewed speech & language experts**. We held hour-long interviews with speech and language experts, including borough speech and language leads, heads of nurseries, and health workers. The purpose of these interviews was to dig deeper into some of our findings from the fieldwork and get insights and advice from professional experts.

- **Health visitor interviews and shadowing.** While we were able to observe a diverse group of families at children's centres, we wanted to get insight into the behaviour of families that do not attend such sessions. We also wanted to understand how parents and children interact in the home learning environment. In GM, each family has at least three universal checks (antenatal, 6-8 weeks and 9-12 months). In many cases these visits are carried out by health visitors which means they get a broad snapshot of the population of their area. We interviewed 15 health visitors in Salford and Wigan and shadowed three health visitors during 9-months checks (observing a total of five visits).

3.1 Challenges and limitations of our fieldwork

During our visits to children's centres, we found it difficult to engage parents in discussions about speech and language. It was more difficult than we expected to get beyond high-level descriptions ('he likes reading'). Parents also seemed to adjust their responses based on what they thought they should be saying. These challenges are not uncommon and the difficulties of getting information about people's behaviour through self-reporting are well-established (for example people regularly overestimate their exercise levels and underestimate their calorie consumption). The outreach workers we spoke

to at children's centres also confirmed that parents can tell the staff what they think the staff want to hear, particularly when it comes to whether parents are doing exercises they had learned at the centre at home. For example, outreach workers said it was clear from a child's familiarity with activities whether or not they had been doing the activities regularly at home, and that some parents may say they had 'done the homework' when it was clear from the child's reactions that they had not.

Because of these limitations with self-reporting, we coupled our discussions with parents with observations of parents interacting with their children at the children's centre. We also interviewed children's centre staff, speech and language therapists, and health visitors, and were able to shadow a few health visitors on home visits to observe the home environment. These additional perspectives helped us to get a richer picture of the challenges and opportunities.

04 / Fieldwork observations

Below we summarise the findings from our fieldwork and the behavioural insights which underpin them.

4.1 There is a strong intention/action gap (it isn't all about knowledge)

Both parents and professionals generally agreed that most parents know the broad outlines of what is important for speech and language development. The issue is not primarily a lack of knowledge, but a lack of time, energy and the (mental and physical) space to engage. For example, most parents know that they should be reading stories and playing with their child. However, after a long day of work with errands, cleaning, cooking, etc., it can be difficult to find the motivation to sit down for 20 minutes to read a story or get down on the floor to play with toys.

From our fieldwork visits, we also identified two factors which reduce the amount of time parents spend playing, talking or reading with their children:

- **Siblings**: Having time and energy to engage is particularly difficult if you have more than one child. During our visits to children's centres, there were often parents who brought two (or more) children of different ages to the session. For parents who attend alone with more than one child, it is difficult to engage both children at the same time. In particular, if the parent has an older child who is talking and demanding attention, it is difficult to divert focus and engage with the younger, non-verbal toddler or infant. One parent of an infant and a two-year-old that we spoke to highlighted this difficulty, saying it was difficult to find time

to focus on reading to the younger child because each time she sat down to read the older one demanded her attention.

- **Boredom & exhaustion**: One, potentially underweighted, difficulty is just the effort required to engage in play. Practitioners advise parents to get down to eye level when speaking to their child (CITE), which often entails crouching or sitting on the ground. Parents are also encouraged to let the child lead the play activity, while the parent supports by having conversations about what is going on around them. Getting down on the ground (where play often takes place) and keeping up with a toddler's imagination is tiring, both physically and mentally. Even during a one hour stay and play, we observed parents starting off enthusiastically, but slowly getting tired as the session went on e.g. spending less time crouching down, talking to other adults.

4.2 There are still key gaps in knowledge

While parents do generally know that activities like reading and singing support speech and language development, there are some nuances that they are less familiar with. These include what speech and language development means, what activities best support speech and language, and how to engage.

4.2.1 What speech and language development means

Many of the professionals we interviewed said that parents often think speech and language development is about learning the alphabet or pronunciation. We observed some of this during our fieldwork. One grandmother, after realising we were working on speech and language development, asked us about proper pronunciation of the 'th' sound. Parents were often proud if their child could recite their numbers or letters and asked the child to show us. Many of the professionals we interviewed felt that parents did not understand that the core of speech and language development was a child being able to respond to questions and communicate effectively.

4.2.2 What activities best support speech and language

The misperceptions about speech and language development can lead parents to investing in activities that are unnecessary or even harmful for a child's development. For example, professionals noted that parents often invest in electronic toys that sing letters or perform other word games, which does not support speech and language development. Toys that prompt parent/child interaction e.g. building blocks are better choices to help with communication and imaginative play. Professionals also noted that parents did not realise the importance of so-called 'contingent talk' - taking cues from what the infant or toddler is looking at and talking about that (even if it doesn't seem especially interesting). This is vital to help young children learn the words for objects around them even before they can talk. In some cases parents ask their children lots of questions but this is not particularly helpful when children can't talk (and so can't respond to the questions).

All of the health visitors we spoke to spontaneously mentioned screen time as an issue they speak to parents about. One key issue is that parents often believe that children's television programmes and apps are good for learning (this is not the case). The professionals we spoke to said that in many cases children use screens for extended periods of time e.g. the television is on all the time.

4.2.3 How to engage

During our fieldwork, we observed marked differences in how well parents engaged with their child(ren). We found this particularly stark when we observed childminders next to parents: childminders could engage multiple children at the same time, easily incorporate the toys available at the children's centre into the conversation, and effortlessly calibrate the level of conversation they had with children of different ages. For some parents, this type of engagement was much more difficult.

From our observation, we seemed to observe three main barriers that parents faced when trying to play and interact with their child:

- **Figuring out what to say and do**: for all parents, it is both physically and mentally tiring to interact and play with their child. In addition, it can require some creativity to figure out what to say, especially if the child is repeating the same activity over an extended period of time. Parents may start out really engaged, but then run out of ideas about what to talk about.

- **Feeling awkward**: engaging in play and toddler talk appeared to make some parents feel a bit awkward (we observed this even in children's centres, which should be one of the most supportive spaces for this type of activity). It seemed that some parents were more comfortable than others speaking in voices, playing with toys or engaging in imaginative play.

- **Lacking confidence**: Several of the frontline workers we spoke to said that parents often bring a friend or family member for the first few stay and play sessions they attend because they don't feel comfortable coming alone. We saw an example of this at one of the sessions we attended, where one of the fathers was coming for the first time and had brought his mother along for the session. These examples indicate that engaging in these activities requires some confidence on the part of parents, and it may be important to ensure that parents feels psychologically safe before they can engage.

4.3 The wider environment matters

One of the key lessons of behavioural science is that the environment we're in can have surprisingly large effects on our behaviour. This is no different in speech and language, where our fieldwork indicated that aspects of the environment, gender and wider cultural context had an influence on parent-child interactions.

4.3.1 Technology

The role of technology was important in most of our discussions with professionals. When we asked professionals for one thing they wished parents would stop doing, all of them spontaneously mentioned reducing technology use: phones, tablets and television. For many, the use of screens as a baby sitter (e.g. placing your child in front of the screen while you are doing other things) was the main culprit. Most also mentioned how the parent's own use of screens (mobile phones and tablets) reduced opportunities for incidental parent-child interactions.

One of the health visitors we spoke to had been living overseas for several years and had recently come back to the UK. She felt that screen use by both parents and children in the home had gotten noticeably worse since she began working a few decades ago. Some health visitors felt that this was because all-day children's TV channels (like CBBC) and streaming services (like iPlayer) mean that that children's programmes are now easily available at any time. Indeed, on some of the home visits where we shadowed health visitors, the TV was on for the entirety of the visit.

Official guidance tends to recommend that children under the age of 2 should not watch any television or that screen-time should be very strictly limited. However, many of the S&L therapists we spoke to said that zero screen time was an impractical recommendation for many families. While they emphasised that screen time should be strictly limited, they also suggested a range of ways to make screen time more productive:

- Signpost parents to age-appropriate and educational kids' programmes;
- Use programmes as a prompt for parent-child interactions, e.g. watching together and having a conversation about what is going on;
- Role model good screen habits, i.e. if you spend less time looking at a screen, your child will find it easier to follow suit.

One of the health visitors we spoke to mentioned that some families like having the TV on as background noise in the house. She said she suggests that these families switch to the radio, which is less distracting for the child. However, parents can find TV a helpful distraction for children and a rational strategy to give them some much needed rest or alone time (e.g. one parent we spoke to worked night shifts and mentioned that she put her baby in the crib with the TV on while she napped for an hour after her shift). Most professionals we spoke to agreed that neither TV, smartphones nor tablets were going anywhere, so any intervention should take into account the ubiquity of these devices in people's homes.

4.3.2 Gender

When examining the influence of gender on parent-child interactions, we were interested both in the gender of the parent and the gender of the child.

- **Gender of the child:** Research has found that boys usually develop language more slowly than girls.[1] While we did not have data on this for GM, the speech and language therapists we interviewed confirmed that this the case both in the UK in general and in GM. While it is difficult to determine whether this is biologically-driven rather than socially constructed,[2] the therapists we spoke to felt there were elements of both. Some of the professionals we spoke to said that parents were more protective of boys and that this meant they were more likely to refuse referrals and diagnoses for boys. One professional believed that this difference may have something to do with our expectations about how much a child should or can sit: boys are expected to run around more, while girls are expected to like more sedentary tasks which lend themselves more to parent-child interactions.

- **Gender of the parent:** We visited one stay and play session specifically for dads during our fieldwork. There were also some dads present at the other sessions we observed. Several professionals we spoke to highlighted differences in parent-child interactions between mums and dads and encouraged us to look into this area. Our main observation was that some of the inspiration, comfort and confidence issues we observed among parents seemed to be amplified when dads were not the primary caregiver. Because some dads may have less exposure to and experience with sitting on the ground playing, singing nursery rhymes and engaging in casual conversation with their children, they tend to be less comfortable doing them. On the other hand, some health visitors said that dads could also be better at play because they had more undisturbed one-on-one time (largely because they were less distracted by home routines once they got home from work).

4.3.3 Culture

Another topic we explored in our fieldwork was the potential impact of culture and cultural heritage on parenting styles. Many of the professionals we interviewed, when asked if culture influenced parenting, actually said that the biggest influence on a person's parenting was their own experience of being parented (i.e. what their parents did). In addition to this, professionals also noted some specific ways that cultural context influences parenting:

- **Extended family**: living in a multi-family household can influence parenting. It could mean extra help with childcare and more variation in the vocabulary a child is exposed to, as a grandparent will often use different words than the parents in everyday conversation. On the other hand, it could indicate that parents face additional challenges as they have extra caring responsibilities in looking after an elderly relative. The regular presence of extended family can also mean that the parents are not the sole decision makers about how a child is brought up. Health visitors mentioned that grandparents beliefs about what constitutes good parenting, often based on research from a generation ago, sometimes contradict the more up-to-date advice they are giving parents. This clash can make it harder to convince parents to change their behaviour.

- **Discipline**: being well-behaved is often associated with the ability to sit still and keep quiet. Some of the professionals we spoke to noted that there are some cultures for whom discipline is more highly valued. As such, a child's speech may be more or less encouraged depending on cultural beliefs about discipline and being well-behaved.

- **Play**: parental involvement in their child's play emerged as at least partially related to cultural norms. For some cultures, play is seen as reserved for children only, and thus parents may be less open to suggestions of getting involved in play as part of speech and language development.

4.3.4 English as an Additional Language

We encountered a wide variety of languages in our fieldwork, including many parents who had English as an additional language (EAL). During our observations at children's centres, parents seemed to use English more than they might at home (as courtesy to other parents and to the children's centre staff). Several of the parents we observed and spoke to said that they often alternated between languages, often English and another mother tongue, in a single conversation. Many of the parents we spoke to were able to speak more than one language but could only read English (because they had been taught to read at school).

The professionals we spoke to all agreed that parents should speak to their child in whatever language comes most naturally. They noted that parents who did not have English as their own first language sometimes worried about their child learning English. However, there did not seem to be any significant barriers in convincing parents to speak in their mother tongue with their children. This is explored further in the literature review.

In terms of access to parenting services, there were some indications that the language skills of frontline staff may play a role in reaching parents. One of the children's centres we visited noted that lots of Arabic speaking parents began showing up to stay and play sessions after they hired a new outreach worker who spoke Arabic. This didn't happen immediately, but the numbers seemed to grow as news spread around the community, even though there was no official announcement or marketing by the centre itself.

4.3.5 Social norms

During our interviews and discussions with professionals, many of them noted that parents get cues about what 'normal' looks like for their child's development by observing the other children around them: including siblings, cousins, neighbours, as well as other children at the children's centre, the playground or nursery.

This can works in two ways. On the one hand, it means parents may be anxious if their child is not sitting, standing or crawling when others of a similar age are doing so. But on the other hand, it can mean that parents are unaware that their child is not developing at the expected level if the same is true of many children in the area. When speech and language development in an area

is low, parents may not realise their children are behind because all the other children around them are also behind. Health visitors we interviewed mentioned that parents sometimes rejected a referral to speech and language courses or a WellComm assessment precisely because they believed their child was at the same level as their peers in the area. When the average level of development is low, parental expectations follow, and it can be difficult to convince parents that their child is behind where they should be. In a handful of cases, professionals also acknowledged that they too might be influenced by these norms.

05 / Measuring speech and language development

The aim of this project is to identify ways to use behavioural insights to support early childhood speech and language development. Part of the project has involved developing an outline evaluation plan for our recommended approach. To inform the evaluation outline, we considered existing tools which measure speech and language development. We now set out the findings from our research.

There are two tools used across GM to measure speech and language development. The first is the Ages and Stages Questionnaire (ASQ). This is a universal tool which is used across England to evaluate child development as part of the Healthy Child Programme. The second is the WellComm screening tool. In GM, this is only used if a child is identified as being at risk of language development delays (using the ASQ)

5.1 Ages and Stages Questionnaire (ASQ)

5.1.1 How it works

The ASQ is completed at the 9-12 month and the 24-30 month health check as part of the Healthy Child Programme. The ASQ includes six questions on communication for different stages of child development. Parents are usually asked to complete the questions themselves, and these are then reviewed together with a professional (usually in a home visit but sometimes in a clinic).

Figure 1: ASQ communication questions - 9 months

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	○	○	○	___
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	○	○	○	___
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? *(The sounds do not need to mean anything.)*	○	○	○	___
4. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peeka-boo," "clap your hands," "So Big")?	○	○	○	___
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," *without* your using gestures?	○	○	○	___
6. Does your baby say three words, such as "Mama," "Dada," and "Baba"? *(A "word" is a sound or sounds your baby says consistently to mean someone or something.)*	○	○	○	___
			COMMUNICATION TOTAL	___

As part of the ASQ, parents are asked to record their responses to each question. Each answer has the following scores:

- Yes (10 points);
- Sometimes (5 points); or
- Not Yet (0 points)

If a child scores in the black (0-14 points) or grey zone (14-30 points) for communication (see Figure 2), they are offered a WellComm screening.

Figure 2: ASQ scoring - 9 months

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	13.97		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	17.82		●	●	●	●	○	○	○	○	○	○	○	○	○
Fine Motor	31.32		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	28.72		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	18.91		●	●	●	●	○	○	○	○	○	○	○	○	○

5.5.2 Potential difficulties in using ASQ to measure a GM wide programme

There are a number of reasons why ASQ might not be a good way to measure the impact of any GM wide approach to improving speech and language skills. We have set them out below.

- **Prioritisation**. During each Healthy Child Programme check, staff have many topics to cover beyond speech and language. Staff are looking for cues about parental mental health, child safety and wellbeing and other aspects of child development. We observed this during the 9-12 month check home visits we participated in: for some of the visits, issues unrelated to the child (e.g. parental mental health, health issues of older siblings, etc.) took up more than half the time allocated. Parents also have many concerns about things other than their child's speech and language development. During the visits we observed, parents asked about the introduction of solid food, moving on to cow's milk and standing up and walking; none asked about speech and language. The health visitors we spoke to noted that parents were rarely concerned about speech and language development at the 9-12 month check (perhaps because no-one expects babies to be talking by this age). Health visitors said speech and language is more of a parent priority at the 24-30 month check.

- **Timing**. Different staff complete the ASQ at different times. For example, some staff did the ASQ at the beginning of the 9-12 month window so that if any delays were identified they could return a few months later to reassess the child. Other professionals did the screening at the upper age limit to allow the child as long as possible to develop the various skills measured.

- **Signposting**. The ASQ covers speech and language but health visitors don't have consistent, good quality resources to give parents to help them support their children's communication.

- **Parental anxiety**. Health visitors mentioned that the colours and scoring system of the ASQ can be anxiety-inducing for some parents. Having your child marked as 'in the black' or being 30 points from the top score can feel extreme. Health visitors also mentioned that it is hard for parents not to think of the ASQ as a pass or a fail exam, which can cause them to be less honest in their answers. During home visits, we observed how parents and grandparents felt uncomfortable about children being 'scored' at such a young age.

- **Self-assessment**. Parents are asked to complete the ASQ themselves before the ASQ appointment. Health visitors mentioned that they came across both over and under-reporting, and quite often observed evidence contrary to what parents had written down. They also mentioned that the distinction between 'yes' and 'sometimes' was not clear for many parents but could impact the overall score

- **Language and interpretation**. Professionals highlighted that the tool itself had a fairly high reading age and that it was sometimes hard for parents to understand what the questions were asking. For example, one question asks if children can say three words, and from our observations, parents interpret this quite broadly. There were also some concerns that the tasks and language used were quite American, making it harder for some parents to understand what was being asked.

- **Age-appropriateness**. Several of the professionals we spoke to felt that some of the questions on the ASQ were not age-appropriate. In particular, health visitors mentioned the gross motor section of the ASQ at the 9-12 month check was quite advanced. One speech therapist we spoke to said that for speech and language the 9-12 month questions were too advanced while for the 24-30 month check they were too easy. The fact that many children score 'white' for communications, despite the questions being too advanced, suggests that the ASQ may not be suitable for measuring speech and language skills in as much detail as we would like.

5.2 WellComm screening

If a child scores 'grey' or 'black' on the ASQ, they will be offered a WellComm screening. Parents do not have to agree to the WellComm screening being carried out.

5.2.1 How it works

The WellComm screening is designed to provide a more granular and nuanced understanding of speech and language development for children who have received a 'grey' or 'black' score on their ASQ. Some areas of GM, such as Manchester, are also attempting to roll out the WellComm screening to cover a wider group of children, for instance all children eligible for extended early education entitlement (i.e. two-year-old funding).

The WellComm screening is performed by a trained assessor who asks the child questions, observes the child's behaviour and discusses with the parent. There are ten questions/tasks that the assessor evaluates, giving a binary Yes/No score for each.

Figure 3: WellComm screening - 6-11 months

	What the child understands	Yes/No (✓/✗)
1	Does the child turn towards you when his/her name is called?	
2	Does the child relate two objects together in play?	
3	Does the child look at or point at an object and then look at you?	
4	Does the child follow an adult's gaze?	
5	Can the child follow simple instructions with non-verbal cues?	

	What the child uses	Yes/No (✓/✗)
6	Does the child hold up his/her arms to show he/she wants to be picked up?	
7	Can the child copy an action/gesture?	
8	Can the child point to ask for something?	
9	Does the child babble?	
10	Does the child shout to get an adult's attention?	

Children are scored based on the binary outcomes of the WellComm screen, according to a traffic light scale that can trigger a referral to a speech and language specialist service:

- Green (8-10 Yes): on track for speech and language development
- Amber (6-7 Yes): mild to moderate delays in speech and language development
- Red (0-5 Yes): automatic referral to speech and language specialist

Following the WellComm screening, the family is given a handout from the Big Book of Ideas (a product from the same company that makes the WellComm screening tool) that includes activities that you can do with your child to help address the specific areas where they scored the lowest. In some areas of GM, an Amber screening also leads to a specific pathway for mild to moderately delayed children.

5.2.2 Potential difficulties in using ASQ to measure GM wide programme

As with the ASQ, there are a number of reasons why WellComm might not be a good way to measure the impact of any GM wide approach to improving speech and language skills. We have set them out below:

- **Need for trained assessors**. The professionals we spoke to who weren't speech and language specialists had only carried out the WellComm screening a handful of times. All of them said they didn't feel particularly confident completing it. This seemed to be because of a lack of experience and also the limited training in WellComm they had received.
- **Assessing children who don't speak English as their first language**. Because the WellComm screening needs to be carried out by an assessor, there are sometimes issues with children and parents with English as an additional language. Different parts of GM handle this differently, with some using interpreters and others relying on parental self-reporting.
- **Parental anxiety.** Several professionals had encountered parents who refused the WellComm screening. Professionals felt there were a variety of reasons for refusing a WellComm referral:
    - **Social norms**. A number of professionals said that, in some cases, parents refused a WellComm screening because they had an older child who had scored grey or black on the ASQ and did not have any subsequent communication problems.
    - **Outside influence**. Several professionals mentioned that views of grandparents or extended family could mean a referral was rejected ('All children develop at different rates').

06 / Conclusion

Our fieldwork has provided us with a richer understanding of existing parent and professional behaviour in GM.

6.1 Key findings

The key findings from our fieldwork are that:

- Most parents know what to do e.g. reading, singing, playing games but real life gets in the way.
- There are still some key gaps in knowledge, including the role that parents can have in supporting their child's language skills. In particular we think parents underestimate the importance of incidental communication and 'serve and return' interactions from a very young age.
- The wider environment matters and in areas with low levels of speech and language skills both parents and professionals may not realise when a child is behind.

6.2 Measurement

The ASQ is not suitable for measuring the impact of a GM wide approach. WellComm may be a better approach but it is not currently delivered universally. We suggest investigating the following possible approaches:

- Identify existing areas/groups of children where WellComm is already used for all children and using these areas as pilot areas.
- Use an existing standard speech and language tool for all children in the pilot area. The assessment could be carried out by speech and language students who are already trained in administering the tool.

07 / Endnotes

[1] Kaushanskaya, M., Gross, M., & Buac, M. (2013). Gender differences in child word learning. *Learning and Individual Differences*, 27, 82–89. https://doi.org/10.1016/j.lindif.2013.07.002

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