



Restoring services and keeping everyone safe: Framework to support decision making

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This framework has been put together by the Royal College of Speech and Language Therapists (RCSLT) to support members in restoring their services within the context of the COVID-19 pandemic. It is intended as a decision-making guide to be used when planning service delivery. It is relevant to members across the UK, working in both adult and children's services.

This document and related RCSLT guidance are being updated regularly to reflect the current situation. Please check the [RCSLT website](#) for the latest information.

Background information: COVID-19 and routes of transmission

The World Health Organization (WHO) recently concluded that, based on the current evidence, transmission of COVID-19 is primarily through respiratory droplets and contact routes (or fomites).¹ COVID-19 is a novel virus, distinct in several ways from other viral respiratory infections such as Severe Acute Respiratory Syndrome (SARS) or Middle East Respiratory Syndrome (MERS).² A high viral load has been detected in the saliva of patients with COVID-19 with viral shedding observed in one study up to 11 days after hospitalisation³ and in another study for up to 25 days after symptom onset.⁴ Viral shedding from throat swabs has been reported for as long as 37 days post-symptom onset.⁵ Research suggests that patients with severe COVID-19 such as those who are critically ill, have a significantly higher viral load and shed the virus for longer.⁶ Respiratory droplet emissions when coughing or sneezing have been widely acknowledged as important routes of COVID-19 transmission.^{4,7} Aerosols generated by speech are also proposed to be a potential source for transmission.^{8,9}

COVID-19 transmission and aerosols

International and national COVID-19 policy and practice recommendations consistently highlight the emission of aerosols (very small droplets) from COVID-19 positive patients as increasing the risk of the airborne transmission.^{17,26,30} Aerosols may remain suspended in the air for a period of time, travel over a distance and may cause infection if inhaled.¹⁰

Aerosol emissions and coughing

The dichotomous definition of aerosols and droplets is an arbitrary one, based on droplet size rather than a formal measure of infection risk or transmission rate.^{11,12} The boundary of distinction varies across the literature.¹³ In realistic contexts emissions from a cough or sneeze form a complex cluster of droplets across a range of sizes and from different levels of the respiratory system, within a turbulent gas cloud, under forward momentum.¹⁴ In contrast to laboratory-based investigations of isolated droplets, the distance travelled by droplets emitted on a cough varies depending on a range of contextual factors; the patient's physiology, air flow currents, humidity, temperature.^{14,15} Other droplets may evaporate and remain suspended in the air for hours.¹⁴ Coughing is a widely acknowledged source of aerosol droplet emissions^{7,10,13,16,17} and saliva droplets emitted during coughing have been highlighted as an important route for virus transmission.¹⁵ The infective potential of aerosols depends on the anatomical origin of the fluids, the viral load, and the force of aerosol generation.

For references and further information please see: [Aerosol generating procedures, dysphagia assessment and COVID-19](#)

COVID-19 and children

Current evidence suggests that COVID-19 infection generally causes a mild disease in children, with serious illness seen infrequently. The exact rates of infectivity and transmission are not fully known, but UK data suggests that children are as likely as adults to become infected by the virus. There is limited evidence about transmission from children; some data suggests that they may be less likely to transmit the virus, but the evidence is inconclusive. For further information check the RCSLT website.

Framework for decision making:

Understanding the impact of COVID-19 and implications for service delivery

CONTEXT

1. What is the current situation for the service you would normally provide? You may wish to consider the elements that have impacted on:

a. **Current caseloads** (known need)

- Open caseloads
- Closed caseloads
- On hold/deferred

b. **Potential caseloads** (unknown need)

- Cases that have been missed due to COVID-19
 - patients/service users not attending hospitals/clinics/schools – implications, eg for stroke
 - lack of access for screening and review, eg by health visitors or social workers
 - patients/service users not contacting speech and language therapist (SLT)/general practitioner (GP)/other professionals to report issues or concerns as they do not wish to be a ‘burden’ on NHS in current situation; they think services are not operating at present or services are more difficult to access by telephone rather than face-to-face
 - patients/service users not attending other routine medical appointments (eg neurology) where screening questions would be asked regarding speech/swallow, triggering referral to SLT
- Normal referrals and backlog of referrals, suspended clinics re-opening with referrals to SLT resuming
- Patients/service users may be discharged from hospital more rapidly than usual in an effort to maintain bed capacity. As a result they may be going home having had more limited acute/rehab SLT input than usual in relation to dysphagia and/or communication needs, and either need urgent follow up, have more acute or critical presentations which community resources do not routinely deal with, or have to wait on A waiting list
- New referrals directly and indirectly due to COVID-19 (eg new clinical needs, mental health needs, trauma)

c. **Staffing/workforce** (eg redeployment, expertise needed)

- Lack of capacity with SLT, admin and clinical support, including SLT assistants and interpreters/advocate staff, being re-deployed, unwell or shielding (and impact, eg outpatients discharged)
- Services embedded within multidisciplinary team (MDT) settings that are interdependent to function
- Reduced overall capacity in acute setting due to increased time required for donning/doffing personal protective equipment (PPE) with COVID-19 patients/service users

- Available capacity reduced by increased time required for new ways of working, eg setting up/supporting telehealth with patients/service users; reading up/learning/developing new approaches to adopt
- Deployment of students, trainees and volunteers
- Risk assessments for all staff within 'at risk' groups and particularly Black, Asian and minority ethnic (BAME) staff, and impact on alternative work arrangements and contribution to restoration of wider services
- Impact of working patterns – 7 day working, staggered start/end times

d. **Location**

- Location of service not open, eg school, adult day centres, nursing homes
- Inability to see patients/service users face-to-face
- Limited rooms to offer therapy/services due to social distancing measures
- Limited access to hardware, stable software or wifi bandwidth to support virtual interventions
- Risk issues – limited scope for joint visits with patients/service users identified as high risk to lone workers due to other services limiting contact and community settings, such as probation offices being closed

e. **Patient/service user preferences** (eg anxiety of contracting the virus)

- Reduction in access as a result of concerns re viral transmission
- Reduction in access due to beliefs around/access to technology
- Clinically vulnerable patients/service users and shielding
- Patients/service users declining even remote input due to feeling overwhelmed by the pandemic and not feeling able to participate in therapy

NATIONAL LEVEL

2. In order to inform the re-establishment of a service, what have governments (UK-wide) set out re policy/guidance?

Set out below are the latest documents relating to the following areas (be aware that these are being continually updated):

a. **Essential and key workers prioritised for testing**

- The priority list for COVID-19 testing in England is available [here](#)
- The priority list for COVID-19 testing in Scotland is available [here](#)
- The priority list for COVID-19 testing in Wales is available [here](#)
- The priority list for COVID-19 testing in Northern Ireland is available [here](#)

b. **Social distancing measures**

- Guidance for England is available [here](#)
- Guidance for Scotland is available [here](#)
- Guidance for Wales is available [here](#)
- Guidance for Northern Ireland is available [here](#)

- c. **Shielding for patients/service users and/or staff who are vulnerable**
- Guidance for England is available [here](#)
 - Guidance for Scotland is available [here](#)
 - Guidance for Wales is available [here](#)
 - Guidance for Northern Ireland is available [here](#)
- d. **Personal protective equipment (PPE)**
- The UK-wide PPE hub is accessible [here](#)
- e. **Re-opening of locations (eg schools)**
- Guidance on the wider opening of schools in England from 1 June is available [here](#)
 - Guidance on safe working in education, childcare and children's social care settings in England is available [here](#).
 - The strategic framework for reopening schools, early learning and childcare in Scotland is available [here](#); see also [guidance for education authorities and schools](#) on reopening of schools
 - The decision framework for the next phase of education and childcare in Wales is available [here](#)
 - The coronavirus recovery plan in Northern Ireland, including steps towards recovery in multiple sectors including education, is available [here](#); see also a Ministerial statement on the outline plan for restarting the education system in Northern Ireland available [here](#)
- f. **Restarting of services**
- The UK-wide coronavirus recovery strategy, including the roadmap to lifting restrictions, is available [here](#)
 - Guidance on closures in England is available [here](#); see also [NHS England guidance](#) on COVID-19 prioritisation within community health services and [NHS England letter](#) on the second phase of NHS response to COVID-19
 - Scotland's recovery route map, including the phased approach to lifting restrictions, is available [here](#); see also [Scottish Government guidance](#) for community health staff
 - Guidance on closures in Wales is available [here](#)
 - Guidance on closures in Northern Ireland is available [here](#); see also the Northern Ireland Executive coronavirus recovery plan [here](#)
- g. **Using telehealth where appropriate (audio and/or video)**
- HCPC principles for good practice in remote consultations and prescribing are available [here](#)

LOCAL LEVEL (including ICSs/STPs in England)

3. How are the services that will be reopened being prioritised at a local level? You may wish to consider the following:

- a. Is a needs-led approach being used to decide the order in which services are reopened?
- b. Is the approach being led by medical professions, eg GPs, surgeons?
- c. Is a risk-based approach being used? eg impact on outcomes – cancer, stroke, public health and prevention (early years, people with learning disabilities, autism, mental health), vulnerable groups, public safety (eg status of criminal procedures)
- d. Is there cohesion across the total care pathway or are there risks, and if so where are these?
- e. Is there segregation of COVID-19 and non COVID-19 patients/service users and staff by site?

4. How can these priorities be influenced?

We're aware that services may need to make their case locally and the following resources may be useful:

RCSLT resources to members

- In addition to the resources produced in response to COVID-19 and referenced elsewhere, members may find it helpful to look at [RCSLT's Local Influencing Pack](#) which was designed to support members to influence their decision-makers, stakeholders and budget holders.
 - Key things to consider are:
 - If your decision-makers, stakeholders and budget holders have agreed or published aims, can you demonstrate how your proposal to continue, restart or vary your service will help them to fulfil those aims?
 - Are there legal requirements to provide a service? (Noting that some provisions have been temporarily relaxed using emergency COVID-19 legislation – eg education, health and care (EHC) plans in England)
 - Are there policies or statements published by your government to which your trust or board needs to respond, even if they do not have the force of law?
 - Will failure to provide a service lead to risk for the organisation: risk to patient or staff safety most of all, but also to quality of service, reputation and outcome? Consider using the risk register where appropriate.
 - Can you demonstrate demand for the service with the voices and stories of service users and local service user organisations, along with any community, political or media allies you have made?
- a. In England, it will be essential to check how your local Integrated Care System (ICS), working with its local delivery partners, is prioritising the recovery of services.

In England, ICSs are developing plans to restart non COVID-19 services. Focus areas include:

- *Increasing critical care capacity*
- *Separate urgent and elective work*
- *Services to be virtual by default*

- *Restarting services for people with urgent needs*
- *Strict segregation of the health and care system between COVID-19 and non COVID-19*
- *Development of new community-based approaches to managing long term conditions/shielded patients/service users linked to the self-care and self-management agenda.*

- b. As well as service user organisations, it is important to work alongside other professions and their professional bodies where helpful.

DATA

5. What is the data on demographics and patients/service users that is needed to help inform the restarting and delivery of services to reduce health inequalities?

- a. Consider the ongoing impact of COVID-19 on specific population groups who may be more vulnerable, eg frail and elderly, people with learning disabilities, those with underlying health conditions, mental health, progressive neurological conditions, palliative conditions etc.
- b. Consider additional groups who may not easily access reformed services, eg the orthodox Jewish community who do not access resources required for telehealth, or contexts where access to health/education trained interpreters is not possible.
- c. Greater impact of COVID-19 in deprived areas, with disproportionately higher infection rates and disproportionate long-term impact in survivors.
- d. Reduced agency in some communities to follow guidance because of financial, housing or social pressures.
- e. Indirect impact of COVID-19 including increased racism and worsening mental health; worsening child health due to school closures and increase in risk for children known to social services or vulnerable to loss of school support and educational disadvantage in children.

NB. The RCSLT is supporting members to collect data (see section 10).

SETTING

6. Is the usual setting where you would deliver your service open and safe?

We're aware that services may have previously been provided in a variety of settings, such as:

- Schools
- Community/day centres
- People's own homes
- Criminal settings (police stations, courts, probation, youth offending offices)
- Outpatient clinics (NB. some clinic buildings are being used for COVID-19 centres)
- Nursing/residential homes

If your setting is open you will need to ensure this is in line with guidance around hygiene, infection control, social distancing, and security. See section 9 for further information.

7. If the usual setting is not open:

- a. **Are there reasonable alternatives to location?**
 - Are there appropriate travel options (consider implications re public transport)?
 - Would these locations and facilities comply with infection control requirements?
- b. **Are there different service delivery offers?**
 - Have you discussed this with commissioners?
 - Would it be possible to spread delivery of care across a 7-day week?

SERVICE DELIVERY

8. What type of service are you trying to deliver? For example, if your service is defined using the following:

- a. Universal
- b. Targeted
- c. Specialist

9. Considerations for the delivery of services:

The following points should be taken into account when planning your service delivery approach:

- a. Where services are being restored, **consider a staged approach** with constant monitoring against government guidance as well as mechanisms for stepping services back down again if needed.
- b. **Location/practical working arrangements**
 - Location and practice should follow appropriate local infection control guidance
 - Busy/populated locations may need to limit visitors or stagger access/working times
 - Reduce unnecessary footfall and working across different sites risking further contamination
 - Arrangements for food and break times
 - Risks around shared equipment and shared facilities
 - Shielding and working arrangements for staff who are vulnerable
- c. **Before providing a service to individual patients/service users**
 - Consent for treatment
 - COVID status of patient/service user and parents/carers, and appropriate stratification (where possible)
 - Shielding for patients/service users who are vulnerable
- d. **Face-to-face contact and appropriate measures**
 - Social distancing (where possible)
 - Requirements for access to PPE and a uniform that can be washed/cleaned for decontamination – see [RCSLT website](#) for latest guidance and information on PPE (to consider: is PPE a barrier to communication work?)
 - Decontamination between service visits – consider impact on time, number of patients/service users that can be seen (where possible)
 - use of public transport or independent means (for staff and patients/service users)

- Individual programmes of work instead of groups
 - Restrictions with numbers of people to see at any given time
 - Checking patients/service users or parents/carers want a face-to-face consultation – they may choose to self-isolate
- e. **Use of telehealth (audio and/or video)** (see RCSLT [guidance](#))
- Acceptability and comfort by the patient/service user and/or wider workforce
 - Appropriateness for the activity to be undertaken
 - Easy access to telehealth (low and high tech), eg access to mobile phones by patient/service user
 - Patient/service user preference – texts, phone calls or video mode
 - Communication platforms, eg Zoom, Facebook
 - Use of technology, eg webinars, online resources, e-learning
 - Access to admin and IT support to sustain service delivery and meet standards around data protection and clinical care
 - Access to clinical notes
- f. **Mixed approach of telehealth and face-to-face delivery**
- Consider using social distancing measures to deliver intervention through another member of the workforce or parent/carer
- g. **Monitored self-management – working with patients/service users to self-manage as appropriate**

NB. You will need to take account of accessibility and capacity of patients/service users and carers/parents in relation to these service delivery models; eg levels of literacy, visual or hearing issues, physical disability. This is not a 'one size fits all' approach, and may need case by case consideration for digitally excluded patients/service users.

EVALUATION

10. Consider how to evaluate new service delivery models (eg outcomes, audits, patient/service user engagement)

The following ideas are some examples of approaches which could be used:

- a. Review effectiveness and engagement – meetings, online learning
- b. Measure trends in service usage by deprivation quintile, age, gender, by BAME status and other protected characteristics
- c. Review uptake of remote consultation
- d. Review use of online learning and education opportunities
- e. Review digital exclusion patterns, did not attend (DNAs) (face to face and telehealth)
- f. Patient/service user feedback
- g. Wider determinants such as safeguarding (adults and children) trends

NB. The [RCSLT Online Outcome Tool \(ROOT\)](#) enables services to collect outcomes data for all pathways, and can be used to capture new ways of working (eg remote delivery of intervention).

The [RCSLT COVID-19 Data Collection Tool](#) supports services with capturing data specifically on the management of patients/service users with confirmed and suspected COVID-19.

STAFF WELLBEING

11. Consider staff wellbeing in the context of new service delivery models

- a. Staff health and wellbeing initiatives – including appropriate supervision, training, continuing professional development (CPD), debriefs, breaks and flexibility in job plans
- b. Engagement – opinion on what has/hasn't worked well
- c. Teams need a sense of belonging and identity – how is this best facilitated?