9 June 2020

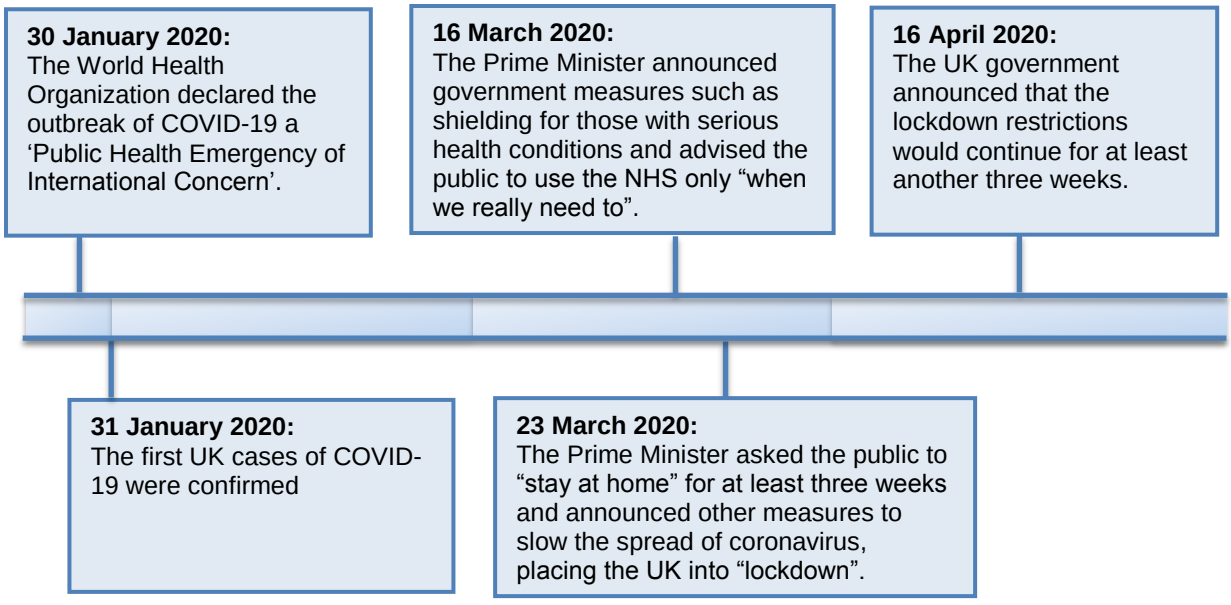
Impact of the COVID-19 pandemic on the speech and language therapy profession

Background

Speech and language therapists (SLTs) across the UK are responding to the COVID-19 outbreak. The events in recent months and the measures to restrict the spread of the virus (Figure 1) have necessitated changes in the way speech and language therapy services are delivered. The need to respond to increased pressure on NHS services caused by the COVID-19 outbreak resulted in the reprioritisation of some health and care services, and new models of service delivery and new ways of working were required to overcome the restrictions on in-person services.

From the outset, there were strong signs that the speech and language therapy profession in the UK was responding quickly and creatively to the changes. The Royal College of Speech and Language Therapists (RCSLT) was aware that a number of speech and language therapy services had begun delivering interventions remotely, where possible, and were introducing telehealth solutions. The RCSLT also became aware that, in some areas, services were ceasing to operate, as SLTs were being redeployed into new roles. To better understand the impact of COVID-19 on the profession, the individuals it serves and provision of services, the RCSLT undertook work to explore and monitor the reality for its membership.

Figure 1: A timeline of key events related to the outbreak of COVID-19 in the UK in the weeks leading up to the launch of the RCSLT survey.



This report summarises the findings of a survey of the RCSLT membership in the early phase of the COVID-19 outbreak in the UK. It is intended that this work will continue over the coming months to assess change over time.

Methodology

The RCSLT established a working group of expert members to develop a survey to explore how the pandemic had, at that time:

- resulted in changes to the role of SLTs;
- had an impact on individual professionals;
- changed the ways in which services are delivered; and
- affected the management of existing speech and language therapy caseloads.

The survey questions were developed iteratively by the working group and piloted by SLTs not involved in the working group. The questions were presented on Survey Monkey and RCSLT members[1] were informed of the survey via the RCSLT e-newsletter. Respondents were asked to complete the survey based on their experiences, and not to reflect any anticipated changes. The survey was open between 23 April and 29 April 2020, inclusive.

Annex 1 contains a detailed summary of the questions and responses received. The survey generated quantitative and qualitative data, which were analysed by members of the working group. For the quantitative data, descriptive statistics were produced using Microsoft Excel. For the qualitative data, thematic analysis was used. Members of the working group familiarised themselves with the free-text responses to each of the survey questions, and coded the data according to the themes emerging on this initial iteration. Further rounds of analysis were conducted, in which the codes were adjusted and the responses were recoded, to identify key themes.

Results

A total of 544 responses were received. 84.2% of respondents were from England, 3.5% from Northern Ireland, 9.6% from Scotland, 2.9% from Wales and 0.4% from the Channel Islands and Isle of Man. 1.7% of respondents did not provide their region (Table 1).

[1] The RCSLT membership consists of qualified SLTs, students, speech and language therapy assistants, retired SLTs and others with an interest in the profession.

Table 1: Number and proportion of responses to RCSLT survey by region and the total number and proportion of RCSLT members

Region	Number of members who responded to the survey	Total number of RCSLT members	Response rate
England	458 (84.2%)	14,823	3.1%
Northern Ireland	19 (3.5%)	764	2.5%
Scotland	52 (9.6%)	1246	4.2%
Wales	16 (2.9%)	661	2.4%
Channel Islands and Isle of Man	2 (0.4%)	Data not available	Data not available
No response	9 (1.7%)	N/A	N/A

Figure 2 summarises the level of engagement in the RCSLT survey from across the UK and the cumulative number of confirmed cases of COVID-19 per region at the time of the survey, according to government data sources.

Figure 2: Number of responses to RCSLT survey and cumulative number of confirmed cases of COVID-19 on 29 April 2020, by region.

Scotland
Responses to RCSLT survey: 52
Confirmed cases of COVID-19: 11,034

Northern Ireland
Responses to RCSLT survey: 19
Confirmed cases of COVID-19: 3,463

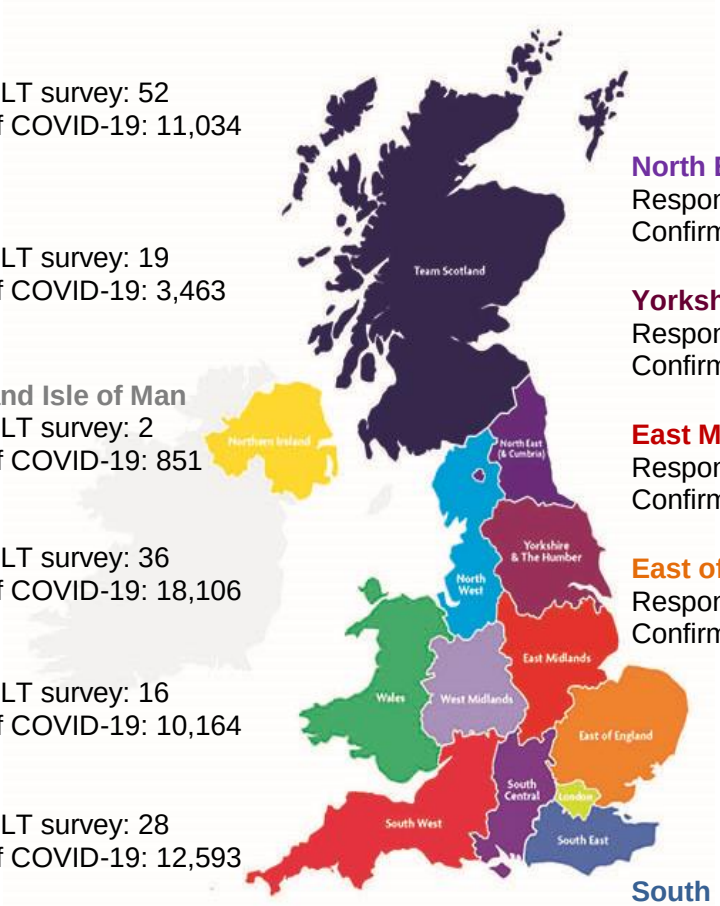
Channel Islands and Isle of Man
Responses to RCSLT survey: 2
Confirmed cases of COVID-19: 851

North West
Responses to RCSLT survey: 36
Confirmed cases of COVID-19: 18,106

Wales
Responses to RCSLT survey: 16
Confirmed cases of COVID-19: 10,164

West Midlands
Responses to RCSLT survey: 28
Confirmed cases of COVID-19: 12,593

South West
Responses to RCSLT survey: 45
Confirmed cases of COVID-19: 6,056



North East & Cumbria
Responses to RCSLT survey: 28
Confirmed cases of COVID-19: 7,224

Yorkshire & The Humber
Responses to RCSLT survey: 54
Confirmed cases of COVID-19: 9,665

East Midlands
Responses to RCSLT survey: 30
Confirmed cases of COVID-19: 6,530

East of England
Responses to RCSLT survey: 38
Confirmed cases of COVID-19: 10,478

London
Responses to RCSLT survey: 99
Confirmed cases of COVID-19: 24,090

South East and South Central
Responses to RCSLT survey:
27 (South Central) 73 (South East)
Confirmed cases of COVID-19: 16,116

Impact on speech and language therapists' professional roles, responsibilities and duties

95.6% of respondents said that the pandemic was having an impact on their **professional roles, responsibilities and duties**

The survey sought to explore the nature of the changes being experienced by the 520/544 respondents who reported that the COVID-19 pandemic was having an impact on their professional roles, responsibilities and duties (Table 2).

Table 2: Six most commonly reported changes experienced by SLTs. Full results are presented in Table 10. (Please note: respondents were asked to select from a list of options, with a free text box at the end, and could select any that applied to them. Therefore, the percentages do not total 100.)

Changes reported	n	Percentage of all respondents
Altered method of service delivery (e.g. remote delivery)	343	63.1%
Reduction in routine clinical caseload	340	62.5%
Reduction in referrals for patient/client groups on routine clinical caseload	278	51.1%
No longer seeing patients/clients directly	266	48.9%
Restriction to the location of service delivery caused by closure of usual place of work (e.g. school, clinic)	240	44.1%
Increased non-clinical tasks and/or projects	228	41.9%

Respondents were also asked to report on what these changes meant for them as an SLT (Table 3).

Table 3: Six most common reflections on changes to practice. Full results are presented in Table 11. (Please note: respondents were asked to select from a list of options, with a free text box at the end, and could select any that applied to them. Therefore, the percentages do not total 100.)

Reflections on changes	n	Percentage of all respondents
Opportunities to work in new and innovative ways	333	61.2%
Learning new skills	296	54.4%
Development of new care pathways	184	33.8%
Lack of clarity of new role	170	31.3%
Concern regarding how to help	133	24.4%
Lacking confidence in current role	113	20.8%

Impact on delivery of speech and language therapy services

92.8% respondents said that the pandemic was having an impact on **service delivery**

A total of 505/544 respondents reported that the pandemic was having an impact on service delivery. Almost three-quarters (74.5%) of respondents reported that there were patients/clients on their caseload who were no longer receiving intervention but would usually do so, and provided the reasons for this (Table 4).

Table 4: Six most commonly reported reasons that patients/clients were not receiving intervention. Full results are presented in Table 15. (Please note: respondents were asked to select from a list of options, with a free text box at the end, and could select any that applied to them. Therefore, the percentages do not total 100.)

Reasons given	n	Percentage of all respondents
As a result of changes to service delivery based on national guidance or local policy	203	37.3%
Closure of usual place of work (e.g. school, clinic) or service	181	33.3%
Patients/clients not wishing to continue with intervention at the current time	160	29.4%
Patients/clients not having access to teletherapy	115	21.1%
Risks associated with aerosol generating procedures (AGP)[a]	87	16.0%
Closure of caseloads	84	15.4%

[a] *For more information about aerosol generating procedures, please refer to the RCSLT report on "Aerosol generating procedures, dysphagia assessment and COVID-19"*

Respondents were asked to report on the action that has been taken with the patients/clients on their caseload who were no longer receiving intervention (Table 5).

Table 5: Action taken with patients/clients no longer receiving intervention. Full results are presented in Table 17. (Please note: respondents were asked to select from a list of options, with a free text box at the end, and could select any that applied to them. Therefore, the percentages do not total 100.)

Action taken	n	Percentage of all respondents
Given advice	307	56.4%
Placed on review	199	36.6%
Discharged	67	12.3%
None	36	6.6%
Provided therapy in other location/by another service	15	2.8%
Don't know	12	2.2%

The survey sought to explore how provision had changed for patients/clients on routine caseloads who were continuing to receive intervention (Table 6).

Table 6: Six most commonly reported changes in service provision for patients/clients on routine caseloads who were continuing to receive intervention. Full results are presented in Table 13. (Please note: respondents were asked to select from a list of options, with a free text box at the end, and could select any that applied to them. Therefore, the percentages do not total 100.)

Change in provision	n	Percentage of all respondents
More remote provision of therapy – via telephone consultations	330	60.7%
Patients/clients seen less frequently	242	44.5%
More remote provision of therapy – via video consultations	237	43.6%
More advice provided to others	224	41.2%
Care being delivered in a different way due to considerations about PPE	208	38.2%
Providing information via leaflets	154	28.3%

Positive changes associated with the pandemic

70.7% of respondents said that, as a result of the pandemic, there have been **changes that are of benefit to their clinical practice, patients/clients and/or service, which they would like to see continue into the future.**

The 385/544 SLTs who reported that there were positive changes as a result of the pandemic were invited to provide details of the changes that they would like to see continue in the future. The key themes emerging from the responses were ranked according to the number of responses per theme (Table 7).

Table 7: Five most commonly reported changes respondents would like to see continue in the future

Rank	Theme
1	Increased choice of methods to provide services (e.g. via telehealth)
2	Online meetings using technology improving engagement to broader range of team members
3	More flexible working arrangements
4	Improved collaboration between MDT members in supporting patients
5	Increased involvement of family members (particularly parents)

Discussion

This survey provides insight into the experiences of SLTs in an early phase of the COVID-19 outbreak in the UK. The findings indicate that there have been changes to the role of SLTs and the ways in which services are delivered, resulting in an impact on SLTs and individuals on existing speech and language therapy caseloads.

Unsurprisingly, in light of social distancing measures, adaptations have had to be made to the ways in which services are delivered, and a high proportion of SLTs (48.9%) are no longer seeing patients/clients directly (Table 2). There has been an increase in the provision of services remotely, by telephone (60.7%) and video (43.6%) (Table 6). This indicates that the profession has responded quickly to provide services in different ways and adapt to new ways of working. More than half (61.2%) of respondents reported that the pandemic has provided opportunities to work in new and innovative ways (Table 3), and throughout the survey, respondents commented on the "*quick pace of change to implement new practices*" compared with their experiences prior to the pandemic. The survey responses indicate that many SLTs are embracing the use of technology to conduct virtual meetings with colleagues and that they would like to see more flexibility in working arrangements continue into the future (Table 7). Additionally, offering a choice of methods to provide services, particularly through the use of telehealth, was the most commonly reported change that respondents would like to see continue in the future (Table 7).

While telehealth offers a means of continuing to provide services where in-person therapy is not an option, respondents also commented that there could be longer term benefits. SLTs reported that it offers greater choice for individuals accessing speech and language therapy services and potentially could have benefits for access to services, such as for those "*who cannot attend specialist outpatient clinics due to problems with physical access and/or long distances to travel to clinic*". Furthermore, respondents suggested telehealth could also offer a means of providing a more efficient and cost-effective service, as it "*reduces waiting times and results in less car travel, costs, time and emissions*". However, some respondents commented that it would not be a long-term solution for providing services to some client groups. Examples of comments received on this issue include:

> *"We have large cohorts of children who cannot be treated via video consultation and where telephone consultation can only provide an interim level of support"*
>
> *"Telehealth where feasible for review appointments (but thoroughly against using them for initial appointments for swallow/ voice)"*
>
> *"The nature of the clients I work with (children with ASD and/or LD) may have the technological access to teletherapy but do not have the attention span/cognition"*

Further exploration of SLTs' perspectives on the use of telehealth with different client groups is required.

Concerns were also raised about the barriers to access telehealth, including *"clients not having access to technology to support with delivery of video consultations/therapy"* and *"parent/carer unable to be at home and have time to be with them and access the teletherapy"*. While we do not have data about the number of patients/clients affected, 21% of those responding to the survey reported that some patients/clients did not have access to teletherapy and, as a result, were not receiving any intervention (Table 4). On a positive note, respondents commented on the role of telehealth in facilitating increased involvement of and contact with families and carers, particularly parents (Table 7). Examples of comments received on this topic include:

> *"Increased contact with parents (rather than work being carried out through teaching assistants)"*
>
> *"More involvement with parents/carers by telephone and some practice of activities at home (usually seen in school with limited engagement from some families.)*
>
> *"Opportunity to work closely with parents/ carers"*

The survey responses raised concerns about unmet need. Of those responding to the survey, 74.5% reported that there were patients/clients on their caseload who were no longer receiving intervention but would usually do so. More than a third of respondents (37.3%) reported that this was due to changes to service delivery as a result of national guidance or local policy, such as the NHS England guidance on COVID-19 Prioritisation within Community Health Services (Table 4). The second most commonly reported reason was closure of place of work/service (33.3%), followed by patients/clients not wishing to continue with intervention at the current time (29.4%) (Table 4). Possible reasons for this latter choice include having other priorities at the time (e.g. care-giving responsibilities), and/or that many individuals on speech and language therapy caseloads are in the vulnerable category and are not able to, or choose not to, access in-person services (e.g. being fearful of attending hospital appointments). Further data is required to confirm this.

Another area of concern regarding unmet need is that 51.1% of respondents reported that they had experienced a reduction in referrals for patient/client groups on routine clinical caseloads (Table 2). This could potentially be because of the reasons discussed above – for example, changes to the ways that services are being delivered, the prioritisation and reduction of services being offered and patient/client choice. It would be beneficial to conduct a more detailed analysis of the data to determine whether any particular client groups and/or settings were being particularly affected.

In relation to the speech and language therapy workforce, it is concerning that SLTs are reporting high levels of uncertainty about their role at the time of the survey being conducted. Of

those responding to the survey, 31.3% reported a lack of clarity about their role, 24.4% reported uncertainty of how to help and 20.8% reported that they were lacking in confidence in their role (Table 3). The RCSLT conducted another survey to explore issues related to the wellbeing of the workforce[2], and so it was deemed not to be in scope for the current survey, but it would be useful to explore this in more depth. However, as this survey was undertaken at a time when a number of services were still adapting to new ways of working and there was a high degree of ambiguity about the pandemic across the country, it is, perhaps, to be expected that these issues were reported.

Another key theme running throughout the survey is the role of the SLT within the multi-disciplinary team (MDT), and working relationships with colleagues from other professions. Respondents commented that they would like to continue to see increased collaboration between members of the MDT to deliver care to patient/clients (Table 7). Specifically, respondents commented on the "*better recognition of our role and expertise especially with trache weaning*" and "*more MDT working".* We could speculate about the reasons for the respondents having experienced closer working relationships within the MDT, including that the reorganisation of services has broken up established teams, resulting in the removal of barriers to better MDT working and increased willingness of staff to collaborate. Nevertheless, some SLTs did comment that the pandemic had resulted in "*strained MDT relationships"* caused by changes such as "*navigating new ways of working"*.

In summary, the survey responses indicate that there have been both positive and negative changes to practice (Table 3). During this early phase of the pandemic, a high proportion of SLTs (70.7%) reported that there have been changes associated with the pandemic that have been of benefit to their clinical practice, patients/clients, and/or service, that they would like to see continue into the future. It will be important to examine whether these changes are maintained over time. It will also be of interest to monitor whether specific issues become more or less significant when this survey is repeated. For example, at the time of responding some SLTs commented that telehealth services were in the process of being set up. It would be interesting to see whether the proportion of those using telephone and video consultation increases over the course of the pandemic. As services begin to re-open, the uptake of telehealth as a means of providing services is more likely to stabilise as it becomes more embedded and its strengths and limitations are better understood. Additionally, the issue of insufficient PPE supplies was a particular issue at the point at which this survey was conducted, so it will be important to observe whether this continues to be a reason given for patients/clients not accessing intervention (Table 6).

[2] The findings of this survey will be made available in due course.

Limitations

As with all surveys, there are limitations that should be considered when interpreting the results. We must be cautious in our assumption that these respondents are representative of the experiences of the RCSLT membership as a whole.

The geographical spread of survey respondents is broadly representative of the geographical spread of the RCSLT membership (Table 1), however, there may be regional differences that should be explored in more detail.

Additionally, we cannot be certain that the clinical areas in which the respondents work is representative of the profession as a whole. It may be the case that a disproportionate number of respondents are working in services that have been closed, undertaking less clinical work and/or working from home and therefore have more time to complete this survey compared with those in an acute setting. Further exploration of the data would be required to determine this.

Conclusions

The findings of the survey provide a snapshot in time of the profession's response during the early phase to the COVID-19 pandemic. The findings indicate that the pandemic has had a substantial impact on the profession, services and those accessing these services. This aligns with informal intelligence gathered from other sources to provide an overall picture of the impact of COVID-19 on the profession.

SLTs report both positive and negative changes associated with the COVID-19 pandemic. While there are concerning issues that have emerged from this survey, including the levels of uncertainty experienced by SLTs and significant concerns about levels of unmet need, it appears that there is a strong consensus (70.7%) that there are positive changes that should be maintained post-COVID. It is clear that digital technology and collaboration has had a key role to play in the response of the profession to the pandemic, and it is likely to continue to do so throughout the coming months, and further into the future.

Potential future directions

Further inspection of the data to look at trends by region and clinical area for certain questions would be of benefit. For example, Figure 2 illustrates that there are 'hotspots' for COVID-19, in that some regions have been more significantly impacted by the number of cases of COVID-19 than others, according to government data sources. It would useful to explore whether the experiences of those in regions less affected by the disease were different from those in regions more affected by the disease.

It may also be beneficial to conduct interviews and/or focus groups with those who responded to the survey to explore certain topics in more detail.

To examine potential changes over the course of the pandemic, it would also be beneficial to repeat this survey later in the summer.

Annex 1: Survey questions and results

Which RCSLT Hub region(s) do you work in?

Table 8: Number of responses to RCSLT survey and cumulative number of confirmed cases of COVID-19 on 29 April 2020, by region

RCSLT Hub Region	Responses to RCSLT survey	Number of confirmed cases of COVID-19 on 29 April 2020
Channel Islands and Isle of Man	2	851[1]
East Midlands	30	6,530[2]
East of England	38	10,478[2]
London	99	24,090[2]
North East & Cumbria	28	7,224[2]
North West	36	18,106[2]
Northern Ireland	19	3,463[3]
Scotland	52	11,034[5]
South Central	27	16,116[2]
South East	73	
South West	45	6,056[2]
Wales	16	10,164[5]
West Midlands	28	12,593[2]
Yorkshire & the Humber	54	9,665[2]
No response	9	N/A
Total	**544**	**-**

[1] Sources: https://www.gov.je/Health/Coronavirus/Pages/CoronavirusCases.aspx; https://covid19.gov.gg/test-results; https://covid19.gov.im/open-data-downloads/
[2] Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882452/COVID19_Weekly_Report_29_April.pdf
[3] Source: https://www.health-ni.gov.uk/news/daily-covid-19-figures-29-april-2020
[4] Source: https://www.opendata.nhs.scot/dataset/covid-19-in-scotland/resource/287fc645-4352-4477-9c8c-55bc054b7e76
[5] Source: https://public.tableau.com/profile/public.health.wales.health.protection#!/vizhome/RapidCOVID-19virology-Public/Headlinesummary

Is the pandemic having an impact on your professional roles, responsibilities and duties?

Table 9: Number and percentage of responses received

	n	Percentage of all respondents
Yes	520	95.6%
No	10	1.8%
No response	14	2.6%

What is the nature of the impact on your role, responsibilities and duties? (Please select all that apply)

Table 10: Number and percentage of responses received. (Please note: respondents could select more than one option, therefore the percentages do not total 100)

	n	Percentage of all respondents
Expanded role due to reduction in staff availability	111	20.4%
Reduction in routine clinical caseload	340	62.5%
Reduction in referrals for patient/client groups on routine clinical caseload	278	51.1%
Working with different patient/client groups from routine clinical caseload	110	20.2%
Restriction to the location of service delivery caused by closure of usual place of work (e.g. school, clinic)	240	44.1%
Redeployment	107	19.7%
Providing support/counselling for patients/clients and their families/carers	102	18.8%
Altered method of service delivery (e.g. remote delivery)	343	63.1%
Change in duties due to being unable to attend usual place of work (e.g. due to caring commitments, myself or someone I live with being in a higher risk group (shielding/isolation)	56	10.3%
No longer seeing patients/clients directly	266	48.9%
Increased non-clinical tasks and/or projects	228	41.9%
Increased clinical time (e.g. returning to clinical practice)	15	2.6%
My research is on hold	21	3.9%
I am unable to work	7	1.3%
Other (please specify)[6]	77	14.2%
No response	38	7.0%

[6]The most common response by those who chose 'Other' was: change in leadership/managerial duties and responsibilities (n=11). A number of individuals also reported that they were awaiting redeployment (n=7).

What do these changes mean for you as a professional? (Please select all that apply)

Table 11: Number and percentage of responses received. (Please note: respondents could select more than one option, therefore the percentages do not total 100)

	n	Percentage of all respondents
Being a part of a new team	111	20.4%
Reduced access to support /supervision/mentorship	98	18.0%
Opportunities to work in new and innovative ways	333	61.2%
Lack of clarity about role	170	31.3%
Lacking confidence in current role	113	20.8%
Lacking competence in current role	59	10.8%
Learning new skills	296	54.4%
Concern regarding how to help	133	24.4%
Development of new care pathways	184	33.8%
Absence of clinical guidelines	87	16.0%

Improved MDT relationships	101	18.6%
Other (please specify)[7]	84	15.4%
No response	49	9.0%

[7]The most common response by those who chose 'Other' was: high levels of uncertainty, anxiety and stress (n=10).

Is the pandemic having an impact on your service delivery?

Table 12: Number and percentage of responses received.

	n	Percentage of all respondents
Yes	505	92.8%
No	7	1.3%
No response	32	5.9%

If patients/clients on your routine caseload are continuing to receive intervention, how has this changed? (Please select the three most frequent).

Table 13: Number and percentage of responses received. (Please note: respondents could select more than one option, therefore the percentages do not total 100)

	n	Percentage of all respondents
Patients/clients are seen less frequently	242	44.5%
Care is being delivered in a different way due to considerations about PPE	208	38.2%
More remote provision of therapy – via telephone consultations	330	60.7%
More remote provision of therapy – via video consultations	237	43.6%
More advice provided to others	224	41.2%
Providing information via leaflets	154	28.3%
Patients/clients are receiving intervention from another speech and language therapist/service	27	5.0%
Not applicable - I am not providing intervention to any of my patients/clients on my routine caseload	78	14.3%
Other (please specify)[8]	68	12.5%
No response	46	8.5%

[8]The most common response by those who chose 'Other' was: developing and providing resources (n=10).

Are there patients/clients on your caseload who are no longer receiving intervention but would usually do so?

Table 14: Number and percentage of responses received.

	n	Percentage of all respondents
Yes	406	74.6%
No	97	17.8%
No response	41	7.5%

Why are patients/clients on your caseload no longer receiving intervention? (Select all that apply)

Table 15: Number and percentage of responses received. (Please note: respondents could select more than one option, therefore the percentages do not total 100)

	n	Percentage of all respondents
Staff availability	51	9.4%
Closure of usual place of work (e.g. school, clinic) or service	181	33.3%
Closure of caseloads	84	15.4%
As a result of changes to service delivery based on national guidance or local policy (e.g. NHS England's COVID-19 Prioritisation within Community Health Services guidance)	203	37.3%
Limited access to correct type of PPE	30	5.5%
Risks associated with aerosol generating procedures (AGP)	87	16.0%
Our service does not have access to teletherapy	42	7.7%
Patients/clients do not have access to teletherapy	115	21.1%
Patients/clients do not wish to continue with intervention at the current time	160	29.4%
Patients/clients on my caseload have been discharged with advice to re-refer if required	64	11.8%
Other (please specify)[9]	79	14.5%
No response	144	26.5%

[9] The most common response by those who chose 'Other' was: local prioritisation criteria (n=16).

Were patients/clients on your caseload informed that they are no longer receiving intervention?

Table 16: Number and percentage of responses received.

	n	Percentage of all respondents
Yes	308	56.6%
No	39	7.2%
Don't know	48	8.8%
No response	149	27.4%

Thinking about the patients/clients on your caseload who are no longer receiving intervention, what action has been taken? (Please select all that apply)

Table 17: Number and percentage of responses received. (Please note: respondents could select more than one option, therefore the percentages do not total 100)

	n	Percentage of all respondents
None	36	6.6%
Discharged	67	12.3%
Placed on review	199	36.6%
Given advice	307	56.4%
Provided therapy in other location/by another service	15	2.8%
Don't know	12	2.2%
Other (please specify)[10]	83	15.3%
No response	148	27.2%

[10] The most common response by those who chose 'Other' was: placed on hold until therapy resumes (in-person or via telehealth) (n=20).

To date, have there been any changes as a result of the pandemic that are of benefit to:

- **your clinical practice;**
- **your patients/clients; and/or**
- **your service**

that you would like to see continue in the future?

Table 18: Number and percentage of responses received.

	n	Percentage of all respondents
Yes	385	70.7%
No	114	21.0%
No response	45	8.3%

If 'yes' please provide details of the changes that you would like to see continue in the future:

Changes related to service provision

- increased choice of methods to provide services
- increased involvement of family members (particularly parents)
- increased flexibility in conducting assessments - using technology, support of others remotely, increased discussion with other team members
- increased regularity of client support and contact
- improved collaboration between MDT members in supporting patients

Changes related to professional practice

- access to CPD (online training) to improve specialist/extended skills
- online meetings using technology improving engagement to broader range of team members
- online support (given and received)
- reduced travel
- more flexible working arrangements improved skill sharing
- improved understanding of the roles of different members in MDT
- re-evaluation of role/redeployment
- easier to get permission for new ways of working
- improved speed in rolling out initiatives previously trialed but not adopted