

# COVID-19: Maximising the contribution of the speech and language therapy workforce

24 April 2020

## 1. SUMMARY

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The RCSLT supports the redeployment of speech and language therapists (SLTs) to any elements of the wider health and social care system to support the national effort on managing the impact of COVID-19. SLTs have significant skills and expertise to meet the clinical presentation needs of patients with COVID-19 as highlighted in this paper.

At the same time, it is essential that everyone with non-COVID-19 communication and swallowing needs (whether neonates, children and young people or adults) continue to be identified and receive the appropriate level of speech and language therapy required to support them, their families and carers, and the professionals working with them.

It is important, therefore, that decisions around redeployment of SLTs are informed by the need for specific prioritised speech and language therapy services to be maintained both within and beyond a health and social care setting.

This guidance highlights what the RCSLT would expect to see in relation to:

- Maximising the impact of SLTs' skills and expertise – section 3
- SLTs working in critical care – section 4
- SLTs working in community rehabilitation with COVID-19 patients – section 5
- SLTs working in community rehabilitation with non-COVID-19 patients – section 6
  - Community SLTs being redeployed to acute services – section 6.1
  - Learning disability and autism SLTs being redeployed to adult rehabilitation services – section 6.2
- SLTs working in end of life care – section 7

- Neonatal and children and young people SLTs being redeployed to adult speech and language therapy services – section 8
- Final year students – section 9
- SLTs being redeployed to non-SLT roles – section 10
  - in intensive care – section 10.3
  - in non-intensive care – section 10.4
- SLTs who are in a vulnerable category – section 11.

The guidance also includes case studies of how SLTs have been redeployed to date.

## 2. CONTEXT

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At this time of national emergency due to the COVID-19 pandemic, this Royal College of Speech and Language Therapists (RCSLT) profession specific guidance aims to supplement the UK government's redeployment guidance for staff. In addition, the Health and Care Professions Council (HCPC) has issued [guidance on redeployment](#).

SLTs empower people and carers to manage their own health and wellbeing by reducing the risk of harm and the functional impact communication support needs and swallowing difficulties.

The guidance outlines how the speech and language therapy workforce can use those skills and expertise to:

- support the government's main strategies for the pandemic;
- protect the NHS from being overwhelmed in critical care;
- shield the high risk and support the wider risk group.

Whilst not all the devolved governments have issued guidance on priorities, NHS England has published guidance on [COVID-19 Prioritisation within Community Health Services](#).

As a result, the RCSLT expects that:

- the redeployment of SLTs will take account of prioritised services that must continue despite not being COVID-19-related
- sufficient SLTs will remain in their existing roles to sustain prioritised services, where risks of not delivering that service would be high, notwithstanding that the nature and delivery of the service may change
- SLTs can use new pathways to support those shielding who are additionally vulnerable in coping because of communication support needs so that they can be successfully shielded. This includes navigating the advice and information given on COVID-19 by providing general and bespoke support.

- appropriate consultation and wherever possible, agreement with SLTs regarding their proposed redeployment, and a clear explanation of the rationale for the proposal is undertaken.

### **3. MAXIMISING THE SKILLS OF SLTs IN THE CONTEXT OF COVID-19**

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SLTs provide autonomous assessment, differential diagnosis and management for a range of communication, eating, drinking and swallowing difficulties across all age groups and most settings (e.g. NHS, social care, schools, justice). The skills SLTs develop and use depend on the setting and clinical groups they work with.

SLTs are experts in developing care plans which include face-to-face, group work and supportive advice for others and work flexibly both autonomously and by contributing within a broad range of multidisciplinary teams.

SLTs are also skilled in providing education and training to the wider workforce and supporting families and carers in delivering strategies to maximise quality of life and improve outcomes.

It is essential that training and support is given to SLTs asked to undertake new roles.

Where roles include those outside the normal scope of an SLT (see section 10 below), it is important that there is appropriate supervision. The RCSLT has also been aware of examples of a buddy system with a member of the adult team (which could be from any profession).

SLTs should use their expertise and clinical judgement to advise the employer where they believe they are being asked to engage in unsafe or ineffective practice.

The RCSLT is collating training and resources which have been shared with Higher Education England (HEE) and would also ask local SLT adult services to support any upskilling of SLTs as required.

### **4. CRITICAL CARE SETTINGS**

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In critical care settings, SLTs use their specialist skills to provide interventions and rehabilitation including support for communication, swallowing and airway management.

## 4.1. Intensive care unit (ICU)

Most COVID-19 patients in intensive care units (ICUs) require ventilators, meaning they are sedated. In such a scenario, specific speech and language therapy input would not be required, unless supporting the delivery of mouth care. Please see section 10.3 below about potential redeployment within ICU.

If a patient is awake whilst intubated, SLTs are able to support consent on decisions regarding their care using alternative and augmentative communication (AAC), as well as supporting good mouth care (see government guidance on mouth care [here](#)).

### 4.1.1. Step-down

Step-down beds provide an intermediate level of care for patients who no longer require intensive care, but are too unwell to be transferred to a general ward or discharged.

If a patient is moving from intensive care to step-down, SLTs' specialist skills are essential in supporting communication, swallowing and airway management.

For extubated patients, SLTs will lead on the assessment of needs as a result of intubation and sedation. This includes:

- Swallowing assessment
- Assessment of the impact of laryngeal injury on voice (dysphonia)
- Assessment of other communication impairment.

SLTs can conduct mental capacity assessment related to swallowing and communication issues, e.g. determining a patient's capacity to make decisions around eating and drinking. They can also help to provide communication support to facilitate other members of the MDT to conduct mental capacity assessment regarding other medical issues and decisions, e.g. a patient's ability to make decisions regarding the discharge destination.

As well as facilitating communication to enable decision making and advocacy, SLTs play a critical role in developing communication strategies e.g. through the use of AAC.

Communication assessments conducted by SLTs can also help to inform differential diagnoses, e.g. delirium versus communication impairment.

SLTs are key to MDT management of tracheostomised patients and weaning decision-making (see section 5.3 below)

SLTs are also key to support the delivery of and advocating for mouth care. Good mouth care is particularly important for patients with dysphagia, as they can develop respiratory complications or pneumonia from inhaling food particles and bacteria remaining in their mouths into their lungs. People with dysphagia may also have muscle weakness in their tongues and difficulty using their lips to remove bits of food left in their mouths which are also at risk to be inhaled. For more information, please refer to the government's [guidance on delivering mouth care](#).

## **5. REHABILITATION IN THE COMMUNITY FOR COVID-19 PATIENTS**

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SLTs can add value in supporting the flow in and out of hospital, patient-centred care, planning and triaging for ongoing care in the community.

The input of speech and language therapy in the rehabilitation of swallowing and communication difficulties is critical in managing and supporting patients to facilitate earlier discharge as part of managing patient flow and minimising length of stay. Due to this, acuity in community settings is much higher than it was before. Patients may be discharged whilst still tube fed or ventilated, meaning there is an increased role for SLTs with these patients in the community.

### **5.1. Respiratory issues**

COVID-19 patients who are discharged from critical care may have ongoing respiratory conditions, which can result in increased risk of aspiration pneumonia, poor quality of life and mortality. Dysphagia is common and persistent, but treatable if not overlooked (please see [here](#) and [here](#)). Some of these patients may also have non-invasive ventilation (NIV), which means that they may have long-term respiratory difficulties.

These patients are also at risk of fatigue during meal times and will potentially require assessment and compensatory strategies e.g. a modified diet. Some of these patients may also benefit from expiratory muscle strengthening exercises to improve the swallow function.

They will also have difficulties with communication as a result of respiratory compromise and will require assessment and rehabilitation strategies.

## 5.2. Physical weakness/atrophy/myopathy

Patients admitted to critical care will lose around 20% of muscle mass within the first 10 days of critical illness. This is particularly apparent in those with multi-organ failure, acute respiratory distress syndrome (ARDS) and prolonged lengths of stay. Ongoing muscle atrophy/weakness has been observed within ARDS populations, which remains beyond 1 year post discharge.

Of those patients who have myopathy, [91% have swallowing difficulties](#). Dysphagia assessment, therapy and rehabilitation are needed to ensure safe swallow strategies. These patients may need long term alternative feeding, e.g. a percutaneous endoscopic gastrostomy (PEG).

## 5.3. Tracheostomy

The number of COVID-19 patients requiring a tracheostomy is unclear with different views on timing, indications and outcome. Only those patients requiring greater than 14 days mechanical ventilation may require a tracheostomy, and of those the ongoing in hospital mortality is unclear. Discharging patients with tracheostomies into the community is historically challenging and will become even more so with more stretched demand on services.

One of the tracheostomy patient presentations for COVID-19 is laryngeal injury which can result in vocal cord palsy. Another presentation is laryngotracheal stenosis.

Patients may have ongoing swallowing difficulties, which includes secretion management and risk of aspiration. In terms of their communication requirements, they will need alternative communication strategies or management of one-way speaking valves, as well as communication therapy as they may improve over time. In addition, [tracheostomy weaning plans will be needed](#).

Patients will require support with airway management: evaluation of voice and swallowing, including the use of fiberoptic endoscopic evaluation of swallowing (FEES), as well as advice before, during and after reconstructive surgery (for example, see [here](#) and [here](#)).

## 5.4. Social aspects

The ability to communicate and eat and drink safely is essential for patients' health and wellbeing, quality of life and participation in daily life.

SLTs are able to lead the development of holistic approaches to rehabilitation and care planning. SLTs develop and deliver strategies to meet ongoing communication, swallowing and tracheostomy needs in the community; this includes supporting patients with communication problems to access rehabilitation provided by other members of the MDT. SLTs have skills in the training and development of the wider MDT (including volunteers) to support the delivery of key interventions.

Patients and their families may need counselling and support with respect to longer term decisions around eating, drinking and swallowing, voice disorders and communication. This includes supporting strategies to enable patients to return to work.

## **5.5. Delirium and cognition**

The prevalence of delirium in hospitalised patients with pneumonia is hard to establish, but there appears to be an [all age risk for 'confusion' of about 15%](#). As delirium is a risk factor for the severity of pneumonia it is likely this would apply to COVID-19. Delirium may also develop in 60-80% of patients in the intensive care setting. While the presence of severe delirium may delay discharge, fluctuating symptoms may persist for many weeks and hence some patients may be expected to be discharged home or to community beds with symptoms.

Mild cognitive impairment is very common on discharge from hospital after ARDS and may persist at one year in about a quarter of patients and a major risk factor is the duration of delirium (see [here](#) and [here](#)). It is unclear how many patients have persisting severe cognitive impairment.

Communication assessments conducted by SLTs can also help to inform differential diagnoses, e.g. delirium vs communication difficulty.

As stated in section 4.1.1 above, SLTs can conduct mental capacity assessment related to swallowing and communication issues e.g. determining a patient's capacity to make decisions around eating and drinking. They can also help to provide communication support to facilitate other members of the MDT to conduct mental capacity assessment regarding other medical issues and decisions.

## **6. THE ROLE OF SLTs IN SUPPORTING REHABILITATION IN THE COMMUNITY FOR NON-COVID-19 PATIENTS**

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### **6.1. Redeploying SLTs who work with adults in community settings to support acute SLT services**

To prevent secondary/acute care being overwhelmed, it will be vital to adopt a whole pathway approach for the redeployment of staff. SLTs will be pivotal in creating additional capacity within our acute hospitals by rapidly identifying, moving, and managing patients into step down and community settings, by supporting the community management of patients previously managed within hospital pathways and by increasing the capacity of admission avoidance services. SLT adaptability within professional boundaries will facilitate rapid and safe patient discharges and will include providing flexible access to equipment provision.

Given the establishment of field hospitals around the UK, as well as an increase in COVID-19 cohorted wards in hospitals, it is assumed that workforce modelling will reflect the skills and capacity required from the SLT profession to support rehabilitation of COVID-19 patients as well as patients with other needs e.g. stroke and head and neck cancer.

SLTs currently working within adult community settings can support the wider MDT in the prioritisation of non-COVID-19 caseloads and the triaging of patients.

In addition, these SLTs may be required to work flexibly across different patient cohorts and sites (across acute and community). However, see section 5 above for the increase in demand for SLT input for COVID-19 patients discharged into the community. It is vital that SLTs expertise is fully utilised to manage these patients.

### **6.2. SLTs working with people with learning disabilities and autism and potential re-deployment within adult SLT rehabilitation services**

SLTs working in learning disability and/or autism are experts in facilitating communication for individuals who have communication difficulties. These skills will be invaluable with respect to ensuring accessible communication for those with cognitive and communication difficulties at all pathway stages. This is essential for consent, advanced care planning and shared decision-making.

Many people with learning disabilities have hidden difficulties with both understanding information and expressing themselves which require support and reasonable adjustments to maximise their involvement and engagement with information about COVID-19 and what social isolation and social distancing actually mean.



Speech and language therapy services for this population group should continue to be provided with staff only being re-deployed once priorities are identified and met. If appropriate, SLTs working with this population can support communication and dysphagia management as part of rehabilitation the community for adults with other clinical needs.

## **7. THE ROLE OF SPEECH AND LANGUAGE THERAPY IN END-OF-LIFE CARE**

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SLTs play a key role in delivering end-of-life care as experts in communication and dysphagia management, which are essential components in providing high-quality end-of-life care to people and their families. Good communication between the person who is dying, their family and their health and social care teams can reduce anxiety and distress, and manage emotional and physical needs.

High-quality end-of-life care means person-centred care, involving

- good communication
- ongoing assessment and coordination between services
- family-focused support that is tailored to any set of circumstances – cultural, social, psychological, and spiritual.

Both child and adult end-of-life care services advocate the same principles in planning and management:

- Use of a holistic approach
- Information sharing
- Advance care planning
- Coordinated care.

Management of eating/drinking and use of communication strategies will notably change over the time of receiving end-of-life care. As mentioned in section 4.1.1. above, SLTs can conduct mental capacity assessment related to swallowing and communication issues and can help to provide communication support to facilitate other members of the MDT to conduct mental capacity assessment regarding other medical issues and decisions. SLTs can also support advance care planning and the delivery of mouth care (for government guidance on mouth care, please see [here](#)).

### **7.1. Considerations for COVID-19 patients**

Although the goals of care for COVID-19 patients are to preserve and prolong life as most people with COVID-19 will survive and recover, not everyone will.

For those who are not recovering from COVID-19, or choose not to have active or invasive treatments to prolong life, it is equally important that these people receive high-quality and compassionate care at the end of their lives.

However, decisions about further escalation of treatment or shifting the focus to end-of-life care will take place more quickly than perhaps in a non-COVID-19 patient. The government's [clinical guide for the management of palliative care in hospital during the coronavirus pandemic](#) states that:

*“It may not be possible to have joint discussions involving the patient, those close to them and the clinicians because:*

- *the patient may have become ill and deteriorated very quickly, so they may not be able to fully participate in the decision-making.*
- *the patient’s family and those closest to them may not be able to be present because of hospital infection control procedures, or they may be in self-isolation or looking after family members who are ill.”*

In light of the guidance above, SLTs have a key role in facilitating communication remotely, between the patient and families. Use of AAC and technology will enhance this work.

## **8. SPEECH AND LANGUAGE THERAPISTS WORKING WITH NEONATES, CHILDREN AND YOUNG PEOPLE AND POTENTIAL RE-DEPLOYMENT WITHIN ADULT SLT SERVICES**

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### **8.1. Neonates**

SLTs have a vital role on the neonatal unit across all levels of care, both as autonomous practitioners and as part of the MDT. They work with families through use of various mediums, e.g. vCreate, to support safe feeding, prevent persistent early feeding difficulties, enhance and support developmental outcomes and promote earlier and safe discharge home.

Please see [Speech and language therapy: role and intervention in neonatal care](#) for a more detailed description of the role of speech and language therapy and neonatal care during the COVID-19 pandemic.

## 8.2. Children and young people

SLTs working with children and young people are skilled at working with children and young people (CYP) with developmental difficulties, special educational needs, additional support/learning needs, and complex disability.

They work closely with families and carers and provide education and training to a range of professionals in the MDT to support communication strategies. SLTs working with CYP are also skilled in the assessment and management of eating, drinking and swallowing difficulties both in hospital and community settings.

Many children are very vulnerable and SLTs should be working as part of the MDT to prioritise contact and support for them.

The RCSLT has submitted evidence to the Education Select Committee about the impact of COVID-19 on children and young people with speech, language and communication needs (SLCN) and dysphagia, highlighting the impact of any reductions in provision and the need for investment in children's SLT services when 'normality' returns.

In response to a request from NHS England, the RCSLT has published an [overview of the current impact of COVID-19 on services for vulnerable children and young people in England](#), including those with special educational needs.

The RCSLT is also working with the other devolved nations to consider the impact of COVID-19 and how the needs of CYP can continue to be met.

If required, **and only once essential priorities for meeting the needs of CYP are identified and met**, SLTs could be optimally redeployed to working on providing interventions for adults with communication needs. In addition, they could be skilled up to support the management of dysphagia. Dysphagia-trained SLTs, particularly those working with children over the age of 10, will have many transferrable skills to assess and manage dysphagia in adults. Intervention could be through the use of telehealth where access and/or concerns about risks to infection may be an issue.

## 9. FINAL YEAR STUDENT SLTs

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Any student on a UK programme in their final year of study who has completed all their clinical practice placements is eligible to join the [COVID-19 temporary register](#). The HCPC advice for students and useful FAQs can be found [here](#).

Students and universities will work together to identify and arrange a suitable work role. Regardless of the role the final year student SLT will undertake, it is essential

that adequate training on the use of equipment and supervision appropriate to the role being undertaken is received.

The RCSLT has published guidance for students wishing to work, which can be found [here](#).

## **10. CONSIDERATIONS FOR WORKFORCE REDEPLOYMENT INTO NON-SPEECH AND LANGUAGE THERAPY ROLES**

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Given the scale of the immediate response required and the need to boost local capacity to meet patient demand, it may be necessary for some SLTs to be redeployed to settings outside their usual scope of practice and to work with different client groups and interventions with appropriate supervision and training.

In addition, within the constraints of the current situation, appropriate consultation and, wherever possible, agreement with SLTs regarding their proposed redeployment and a clear explanation of the rationale for the proposal should be made.

As highlighted in above, the RCSLT expects that the redeployment of SLTs into non-speech and language therapy roles will take account of the following:

- a) maximising the skills and contributions of SLTs for COVID-19 patients**
- b) prioritisation of services that need to continue for non-COVID-19 patients.**

### **10.1. Leadership**

Leadership is critical at this time and senior SLTs may be required to help establish new teams and ways of working. Senior SLTs can also add value in offering their leadership skills across the organisation.

### **10.2. Redeployment terms and conditions**

Before redeployment, the RCSLT strongly recommends that SLTs check the terms and conditions for any changes to their contract as this can be different from the normal speech and language therapy working pattern.

### **10.3. Redeploying SLTs to support the wider MDT in ICUs**

There are a number of tasks that an SLT can undertake with appropriate training and supervision to support the wider MDT in ICUs if the patient is sedated.

Most COVID-19 patients in ICUs require ventilators which result in the patient being sedated. If the patient is sedated, SLTs may be redeployed, with appropriate training and supervision, to support the wider MDT with these patients. The list below which outlines potential tasks has been taken from the government's [Adult critical care novel coronavirus \(COVID-19\) staffing framework](#):

- a) Proning and turning patients
- b) Repositioning, moving patients safely with lines
- c) Ventilator monitoring
- d) Emergency airway scenario
- e) Physiotherapy management
- f) Care of the deceased patient
- g) Suctioning
- h) Passing nasogastric tubes (NGTs) (ideally for SLTs who have nasendoscopy skills)
- i) NGT management
- j) Basic observations, bedside safety checks
- k) Blood gases
- l) Tracheostomy care (in an ICU the cuff will not be let down)
- m) Specimen collection
- n) PPE running and buddying
- o) Health care assistant tasks
- p) Counselling/debriefing staff.

In addition, SLTs can support with providing and advocating mouth care for ventilated patients. The government has published UK-wide guidance on [mouth care for patients with COVID-19 or suspected COVID-19](#).

### **10.4. Redeploying SLTs into other roles**

SLTs can use their high level communication and education and training skills as follows:

- a. advice on achieving effective communication where barriers to understanding and challenges exist
- b. basic advice on feeding
- c. support in imparting information/communicating with relatives
- d. support/counselling for patients/carers
- e. counselling/debriefing staff, supporting well-being

- f. dealing with an initial response to service level concerns/complaints
- g. NHS 111 and its devolved nations equivalents – with training
- h. fit testing for PPE
- i. working alongside public health and organisations' communication teams on communicating information
- j. supporting other health care staff, such as allied health professions' teams and services.

## 11. SLTs FALLING INTO THE VULNERABLE CATEGORY

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The RCSLT recognises that some SLTs across the UK will fall into the [vulnerable category](#) and will be working from home. These staff should be supported to utilise their clinical expertise from home and minimise the impact of redeployment on SLT services. Suggested home working tasks include:

- a. providing clinical telephone support
- b. delivering training
- c. delivering telehealth
- d. delivering triage.

## **ANNEX 1: CASE STUDIES OF REDEPLOYMENT**

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Speech and language therapy services have provided a number of case studies of how their staff have been re-deployed in response to COVID-19:

### **Case study 1: Children and young people speech and language therapy services**

SLTs have been redeployed to:

- a. Working alongside adult dysphagia as a healthcare assistant
- b. Healthcare assistant on surge wards
- c. Healthcare assistant in the community supporting discharged parents with district nursing teams
- d. Supporting dietitians with early discharge pathway work
- e. Redeployed to mental health hub/mental health A&E
- f. Supporting inpatient mental health wards (children and adult)
- g. Admin (e.g. call handling) particularly for those self-isolating or shielding

### **Case study 2: Adults and children and young people speech and language therapy services**

#### **Workforce**

- a. SLTs working with adults have been upskilled in critical care work
- b. SLTs working with children and young people are receiving intensive training/upskilling to be redeployed
  - i. into adult services
  - ii. on to the rapid discharge MDT/stroke team
  - iii. on to the Trust's FFP3 fit mask fitting team
- c. Speech and language therapy admin team are supporting the COVID-19 testing pod
- d. SLTs are working with the public health consultant to develop signposting info for families as many families are struggling to cope
- e. SLTs are running a child care facility in the speech and language therapy department for Trust staff who are not able to get childcare in their local schools
- f. A fourth year student has joined the team as an assistant
- g. The service is looking to get extra support from retired/ex-staff through NHS Professionals

#### **Service redesign and prioritisation**

- a. The most urgent patients (both children and adults) across inpatient and outpatient and community settings are still seen
- b. Daily triage and phone clinics take place across all areas

- c. Telehealth is being piloted,
- d. Advice packs on self-management and emergency equipment have been sent out to 100 laryngectomy patients
- e. Head and neck cancer pathway is being maintained, albeit differently
- f. The services' speech and language therapy dysphagia flag on the Trust's electronic medical record to identify vulnerable people in the area to inform them regarding shielding

#### **Other work undertaken using speech and language therapy expertise**

- a. Made large supply of communication boards that are available to all wards 24/7 from the medical equipment library
- b. Sent electronic copies of communication boards to all departments
- c. Emailed packs of communication aids and dysphagia information to all nursing homes

#### **Case study 3: Adults and children and young people speech and language therapy services**

This service is 'definitely not doing routine work', with the focus being more on preventing the children and young people (CYP) service reaching a crisis and providing universal and targeted resources. This service has had a lot of focus on sourcing/creating resources and self-management.

They have also:

- a. retained all their adult and adults with learning disabilities (ALD) services, all CYP staff with dysphagia and complex needs skills, as well as most of their leads and clinic co-ordinators
- b. identified who needed to run the critical part of the service to stop other people becoming infected
- c. redeployed staff into
  - i. practice development and staff care and wellbeing
  - ii. healthcare support workers
- d. CYP staff remote team able to offer advice and signposting
- e. child and adolescent mental health services (CAMHs) staff and third sector autism organisations have set up helplines
- f. staff who need shielding are working remotely from home.

#### **Case study 4: Children and young people speech and language therapy services**

This service's CYP practitioners have been given training around mealtime support and enhanced manual handling to support ward level staff and ensure patients'



nutrition is optimised for recovery. The CYP practitioners have also produced resources to support communication for those wearing personal protective equipment (PPE) and visuals/social stories for medical interventions in relation to COVID-19, to maximise patients' understanding in times of extreme stress.