The impact of the **COVID-19** pandemic on occupational therapy in the United Kingdom

Survey report

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July 2020
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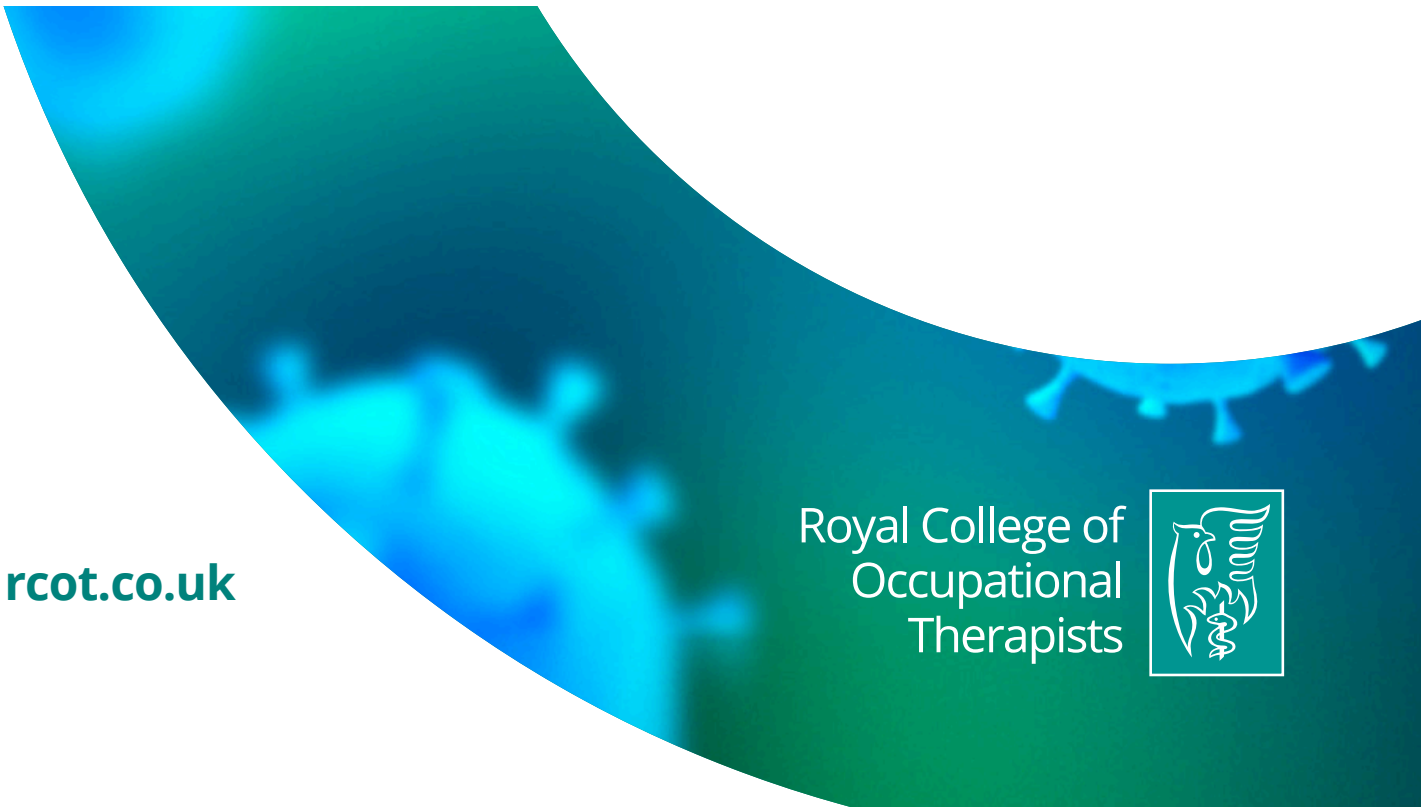
Royal College of Occupational Therapists



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INTRODUCTION

The Royal College of Occupational Therapists (RCOT) is focused on providing members with guidance throughout the evolving COVID-19 pandemic. To understand how the pandemic is affecting occupational therapy and the different ways occupational therapy personnel are responding to it, RCOT distributed a survey exploring the impact of the COVID-19 pandemic on members and the wider profession.

The aim of this survey was to explore how the COVID-19 pandemic has:

- Resulted in changes to the delivery of occupational therapy practice, pre- and post-registration education and research in the UK.
- Had an impact on individuals' existing occupational therapy caseloads/workloads.
- Had an impact on individuals.

METHODOLOGY

The survey

A descriptive cross-sectional survey collecting quantitative and qualitative data was designed using JISC (Joint Information Services Committee) Online Surveys. JISC Online Surveys is compliant with UK data protection law and the General Data Protection Regulations. The survey was broadly separated into sections. The first part asked demographic questions to obtain insight into who was responding. Then the nature of the impact the pandemic was having on roles was explored, participants were asked to describe what the changes meant for them, with space provided for personal responses. Suggestions for areas of further RCOT support to help with adapting work and/or study after the initial acute phase of the pandemic has passed were gathered. No personal data such as age, gender or ethnicity were collected for this survey. The survey was piloted with 11 members of RCOT staff, prior to distribution.

The survey took place in June and July 2020 and was distributed to RCOT members via communications including OTNews, Highlight and the R&D Bulletin, and more broadly to the wider profession via social media channels including Twitter.

Ethical approval

The project was reviewed and approved through the RCOT project governance process prior to survey dissemination (Reference number PE53-2020). The survey 'landing page' provided participant information about the purpose of the survey and how findings would be used. Participants were asked to provide explicit consent to take part in the survey before being able to proceed to the survey questions.

Risks of participating in the survey were identified as minimal as it was voluntary and anonymous. However, the project lead was sensitive to the fact that the COVID-19 pandemic may have affected participants in different ways, and their responses to thinking about how the pandemic has affected their practice, education or research activities may cause feelings of distress or upset. To mitigate for this as much as possible, a survey debrief signposted participants to the RCOT website and provided links to other sources of support.

The participants

The survey set out to obtain as many views and perspectives as possible from a wide range of occupational therapy personnel including; practitioners, educators/academics, manager/directors, researchers, support workers, pre/post-registration students and apprentices, unemployed and retired workers. The survey was primarily aimed at RCOT members in all four UK nations, though participants did not have to be an RCOT member in order to take part in the survey.

Data analysis

Quantitative data were analysed using descriptive statistics. Thematic content analysis of qualitative data obtained from open questions was carried out. All qualitative responses were exported into Microsoft Excel, these were reviewed by the research assistant (KC) and coded into themes. When no new themes emerged, the coding and themes were reviewed by the project lead (GW) to confirm the analysis. Discussion took place for further clarification and to agree the final themes.

RESULTS

Who responded and demographics

In the UK there are 37,145 occupational therapists registered with the HCPC as of August 2020, and 5,974 students registered on occupational therapy courses for 2019-20.

Out of this population 1,505 potential participants accessed the survey; 5 people declined to take part in the survey, giving a total response of 1,500.

Figure 1 shows that most participants (67%, n=1,005) worked in statutory healthcare. Accordingly, most described themselves as practitioners (74.2%, n=1,212) as shown in figure 2.

Figure 1 Which of the following options best describes your situation?

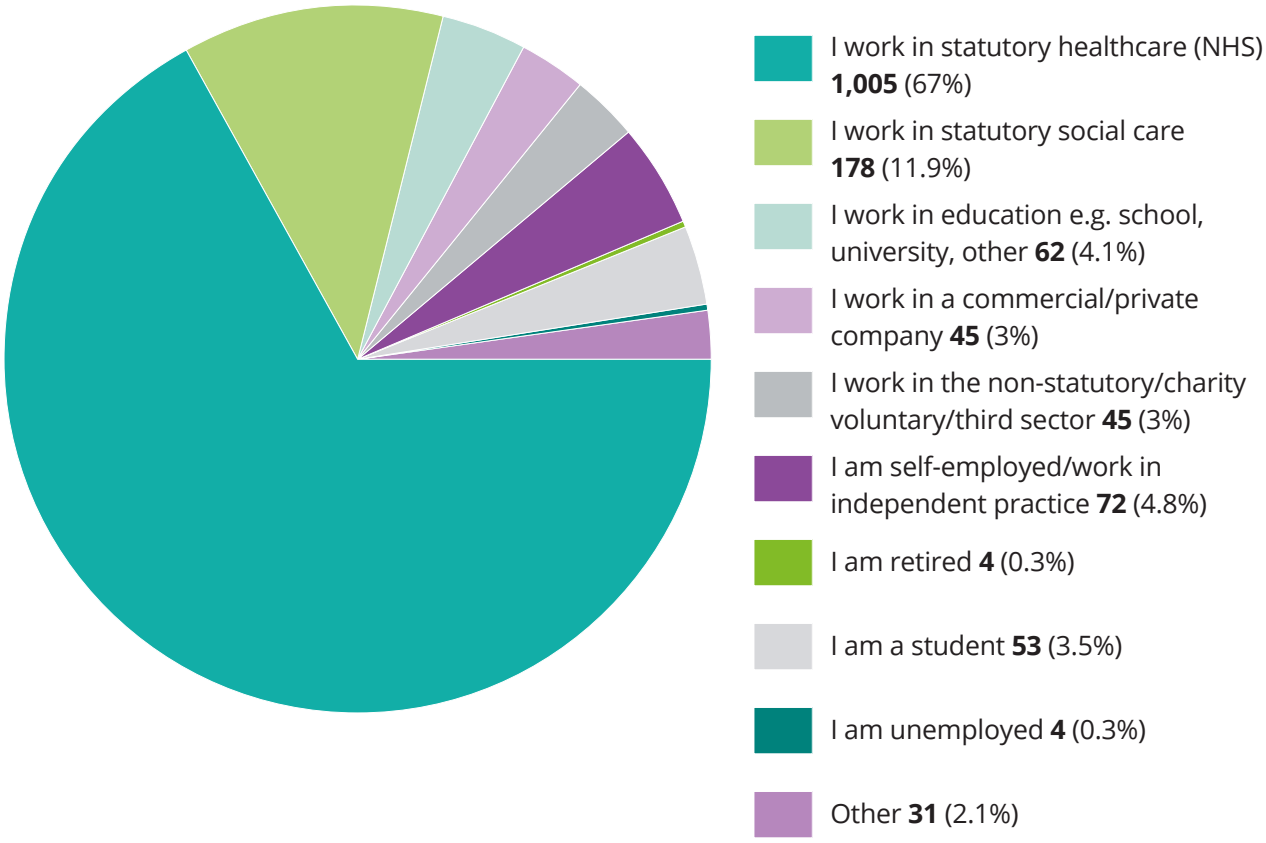
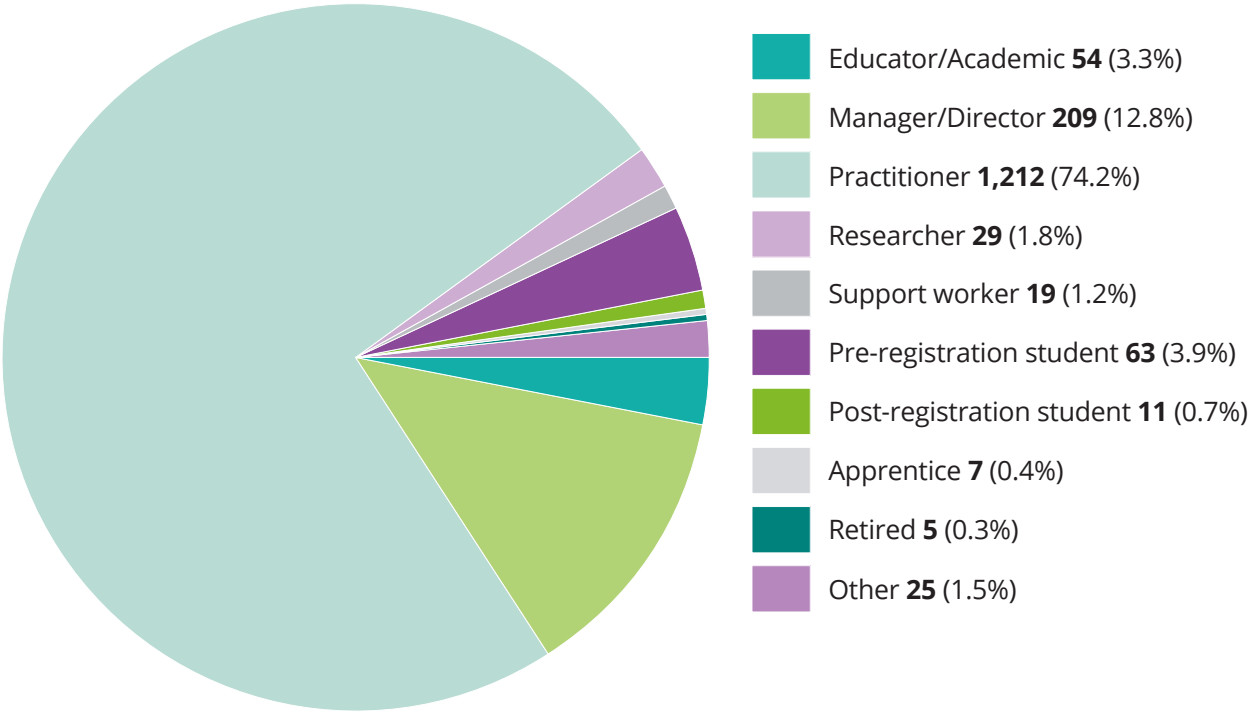


Figure 2 Which of the following best describes your role? Please select all that apply



Participants responded from all four nations in the United Kingdom as shown in Figure 3. The response is in alignment with the proportion of RCOT members in each nation *(England 79%, Scotland 10%, Wales 6%, N Ireland 4%, Overseas 1% - figures correct June 2020).*

Figure 3 Which UK nation do you work or study within? Please select one option

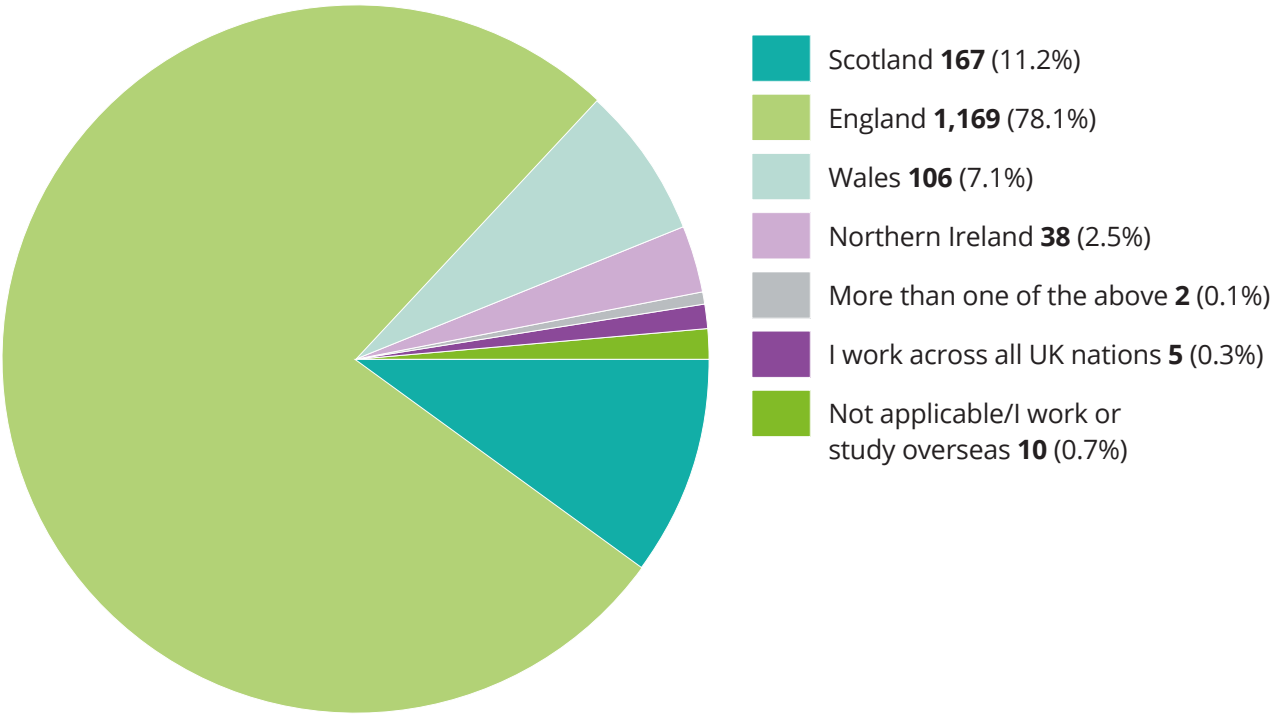
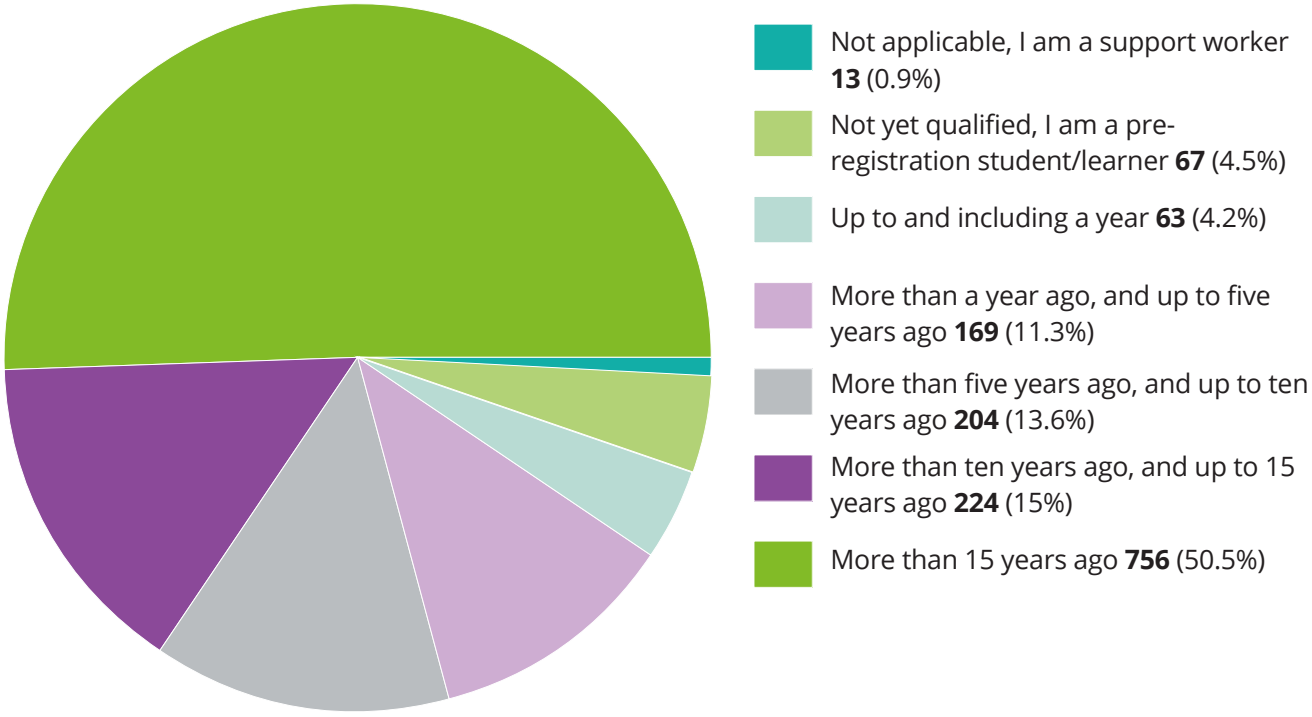


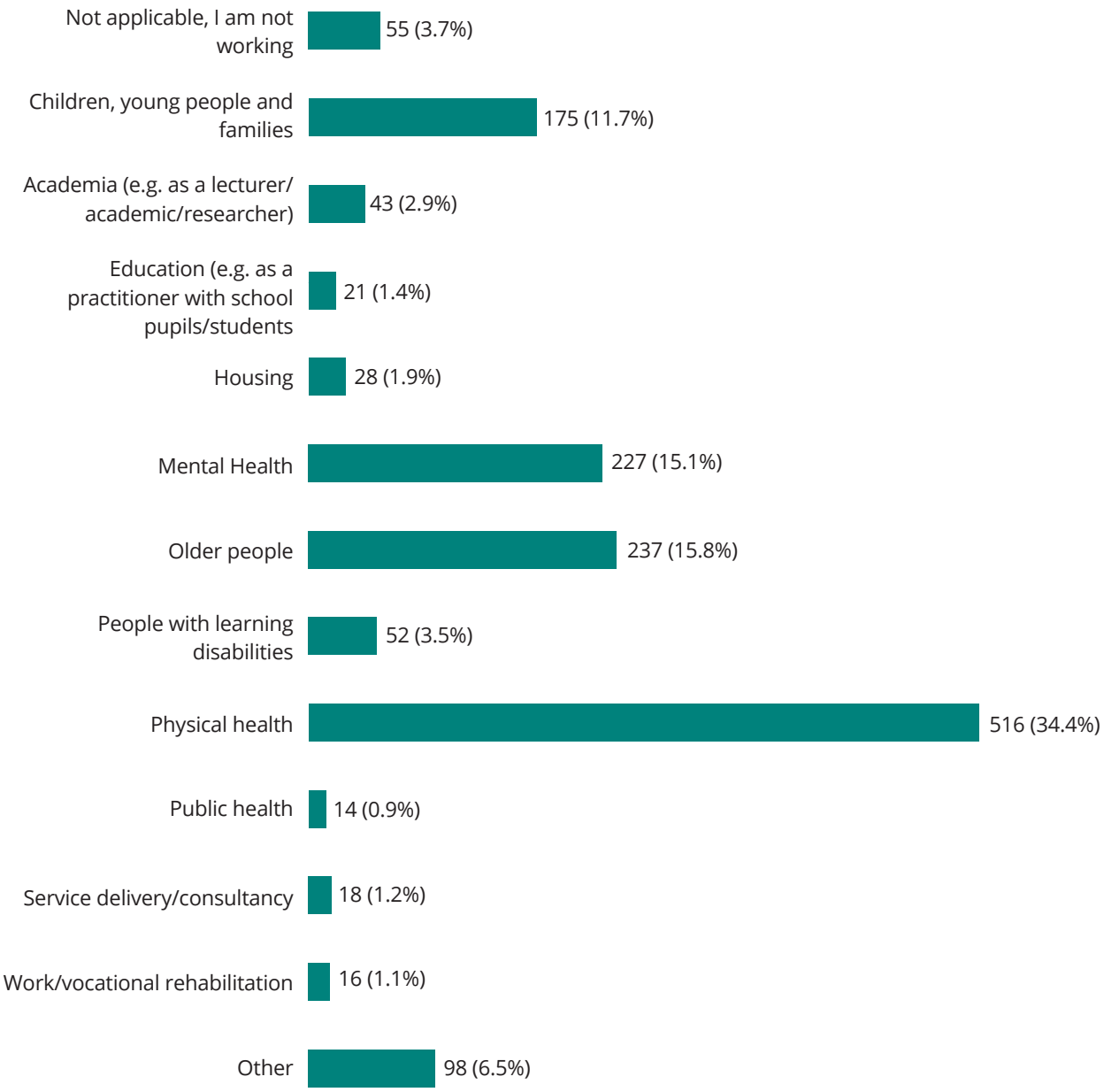
Figure 4 shows that the majority of participants could be described as experienced, having qualified more than 15 years ago (50.5% n=756)

Figure 4 If you are an occupational therapist, how long ago did you qualify? Please select one option



Participants worked across a broad range of areas within occupational therapy, the majority worked in physical health (34%, n=526), followed by older people (15.8%, n=237), mental health (15.1%, n=227) and children, young people and families (11.7%, n=175) as shown in figure 5 below.

Figure 5 Which of the following best describes the area of occupational therapy in which you work? Please select one option



Impact of the pandemic on role, responsibilities and duties

Almost all participants (97.6%, n=1,464) said that the COVID-19 pandemic had had an impact on their role, responsibilities and duties. Appendix 1 provides a full breakdown of the nature of the impact.

Changes to the occupational therapy workforce

Redeployment to another team (including non-occupational therapy teams) had occurred (32.5%, n=476), and of those a small number of participants had been redeployed to support the multidisciplinary team in ICU (1.6%, n=8).

A few participants had rejoined the workforce following retirement (0.5%, n=8), and a small number had joined the workforce as a Band 3 support worker (0.6%, n=9) or had been placed on the HCPC temporary register and were working as a Band 5 occupational therapist (1.2%, n= 17).

For some participants the impact of the pandemic had led to an increased time in practice either through returning to work or an increase in the hours worked (10.8%, n=158).

A small number of participants were unable to work due to ill health (1%, n=14).

Changes to work/study location

Most participants (59.5%, n=870) were providing an alternative method of service delivery (e.g. remote service delivery) and have had to learn new skills (i.e. IT skills) in order to keep working (32.3%, n=472). Some participants were working/studying fully from home 26.9% (n=388) and closure of their usual place of work (e.g. school, clinic, higher education institute) had impacted on others (22.2%, n=325). Others were unable to attend their usual place of work/study due to caring commitments, or themselves or someone they live with being in a higher risk group (shielding/isolation) (9.7%, n=142).

Changes to people seen at work

A reduction in routine caseloads (39.5%, n=577) and a reduction in new referrals (30.4%, n= 444) had an impact for some participants. A quarter of participants were working with different groups of people compared to normal caseloads (24.9%, n=364) and others were no longer seeing people who access services directly (22.9%, n=335).

Changes to role and duties

The role of some participants (19.6%, n= 286) had expanded due to a reduction in staff availability and others were taking on new leadership and management responsibilities

(18.3%, n=268). Non-practice-focused tasks and projects had increased for some (26.1%, n=381), whilst for others current projects were put on hold (26.9%, n=394). Others were providing counselling for staff (12.4%, n=181) and people accessing services, their families/carers (11.7%, n=171).

Impacts on education and research

Participants felt that there was a lack of CPD to support their work during this time (17.8%, n=260).

Teaching had been cancelled (5.5%, n=80) or moved online (7.4%, n=108) and placements had been cancelled or postponed (2.7%, n=39). Communication had been affected with some students (4%, n=58) having less contact with their university tutor and student colleagues while a small number had more contact than before (0.5%, n=8). Graduation had been delayed for some participants (2.1%, n=31). Research funding has also been affected with 20 (1.4%) reporting that their research funding had been paused or withdrawn.

New opportunities

In addition to the new skills and expanded role opportunities outlined above, other opportunities had occurred with new projects beginning (26.5%, n=388) and new CPD opportunities had been created to support work in some areas (20%, n=295).

Qualitative responses

Participants further described the impact of the pandemic on role, responsibilities and duties in their qualitative responses within the following themes: impact of redeployment, financial impacts, changes to location/base, changes to working hours and patterns, altered service demands, changes to role/service provided, loss of role/service and postponement of education and development as described below.

Redeployment had occurred to both occupational therapy and non-occupational therapy teams, and there was a sense of loss of professional identity and frustration about time being wasted as redeployed staff were not fully utilised:

> *"Redeployed to COVID Ward as part of D2A [discharge to assess] team".*

> *"I have been deployed into a more generic role as part of the organisational response, less focused on my professional background".*

> *"Significant time training redeployed staff that were not required".*

Financial impacts were felt by many respondents particularly those who were self-employed, furloughed or indeed made redundant:

"I was on furlough and have been made redundant".

"Lost my business".

"My 20 month fixed term contract has ended with very limited work options currently available".

"I have two roles of work, one I am working from home with [service] then the other is furloughed, so having to take on Universal Credit to make ends meet".

Changes to location/base – many participants were now working from home and adapting to this, whilst others had been relocated and were finding the location challenging to deliver their work from:

"Adapting to working virtually & at home to enable social distancing".

"Services delivered in an alternative location (ward instead of resource centre)".

"Working out of temporary base, not fit for purpose which has a knock on effect on morale, increased stress and reduction in staff availability means working far more hours than normal (I normally work full-time)".

Changes to working hours and shift patterns were described by several participants with a move to seven-day working commonly cited and increased workloads were frequent for many:

"Working shifts 7 day service which now runs 8-8 without sufficient staff".

"Working different shifts (evenings to 10pm)".

"Longer hours, new shift patterns, covering weekends, 7 day service".

"Increased workload in team as client group has changed".

"Increased workload in Higher Education due to the pandemic".

Altered service demands – some participants had seen an increase in demand in referrals to their service whilst others had seen referral patterns alter dependent on need:

"Increase in urgent referrals to facilitate hospital discharge- discharge to assess model (previously not used)".

"Fewer routine urgency referrals, as these are placed on a waiting list until restrictions lifted; increase in Amber urgency referrals and same day post discharge visits, for people with complex needs".

Changes to normal role/services provided caused significant disruption for many participants and was the strongest theme to emerge from the qualitative responses in this area. Disruption was experienced across all areas of work, but appeared most significant for those working in hospitals:

"Working in acute stroke and stroke inpatient rehabilitation. The Trust is implementing a 'no rehab' policy therefore our role has significantly altered to focus in early discharge planning".

"My ward purpose has been changed - we were Older Adult Mental Health, but had to create COVID-19 recovery beds & therefore had our Mental Health beds reduced. The main communal areas of the ward were no longer accessible to patients & new admissions are quarantined".

"Leading an MDT through extreme and rapid change to adapt and react to the needs of patients".

"I am locuming in a service that has been completely reconfigured into a discharge to assess service, working from home except when visiting patients".

"Changes and restrictions to community services making discharges more complex. Different discharge pathways. Managing more staff, as staff redeployed to my area".

"We do not have individual caseloads, we have clinicians from other teams to help us, we are now continuously training the new staff".

Other impacts included a loss of role/service:

"Service is being closed".

"Colleagues leaving roles are not being replaced, not enough charity funding to fund their replacements".

The postponement of education and development was evident as resources were focused on dealing with the pandemic:

"My first input as a newly graduate band 5 occupational therapist. Where I work it's busy, no time to do my preceptorship. My supervisor has been changed three times and can be difficult to do supervision".

"All training cancelled, student placements on hold".

"I wanted to do further study and courses are now on hold".

"I am in a rotational post, the next stage of rotations were postponed".

Meaning of changes to roles, responsibilities and duties

The meaning of these changes had both positive and negative impacts on the participants – Appendix 2 provides a full breakdown of the results.

Positive changes

The positive changes caused by the COVID-19 pandemic that were reported most often by participants included: opportunities to work in new and innovative ways (64.2%, n= 932) and learning new skills (51.3%, n=744). New care pathways and guidelines were also being developed (35.4%, n=514). The benefits of home working and other positive changes were explored further in the qualitative data.

Negative changes

However negative impacts were reported in terms of the impact on personal health and wellbeing (46.3%, n=672) with almost half of the participants finding it harder to maintain a work-life balance (49.6%, n=719) and time management was more difficult for some (31.1%, n=451). Constraints on approaches to working were experienced (48.7%, n=706); a lack of clarity about their role was reported (32.3%, n=468); and access to support/ supervision or mentorship was reduced for some (32.9%, n=477).

Communication

Communication was impacted both positively with 24% (n=248) being part of a new team and negatively with 41.1% (n=597) saying they felt isolated from a team. Poorer communication with people they normally work with was reported by 32% (n=464) whilst 22.4% (n=325) said communication had improved. Specifically, multidisciplinary team communication was thought to be poorer (24.8%, n=360) whilst 18.8% (n=273) thought it had actually improved.

Education and career development

A small number of participants responded that new career pathways/options had emerged (5.7%, n=83) and opportunities to take responsibility for medication management had emerged for a few (2.5%, n=37).

For those studying, more participants reported a lack of a clear roadmap outlining the progression through their programme of study (3.9%, n=49) than those with a clear roadmap (0.6%, n=8). Confidence in progressing into their chosen career as an occupational therapist was mixed with 7.5% (n=109) lacking confidence compared with 6.1% (n=88) who were growing in confidence.

Qualitative responses

The qualitative data provided further insight into what these changes in role, responsibilities and duties meant to participants and brought to light a variety of both positive and negative experiences. Themes arising from analysis of the qualitative data were: feelings of uncertainty in a new role; new opportunities as a result of change; feelings of isolation; an altered work life balance; financial worries; and deterioration of mental and physical health.

Those working on the frontline in hospitals and those redeployed to work with patients with COVID-19 appear to have experienced the greatest amount of disruption and experienced big challenges with the structural reorganisation of acute services, particularly the rapid development of 'discharge to assess' pathways.

This example highlights the difficulties experienced from a managerial perspective:

> *"I have felt "frustrated, undermined, voiceless and side-lined" as an OT service manager in an acute hospital. I would absolutely agree that bruised relationships and damage to collaborative processes have brought tensions to the surface in a heightened and often emotional way. For me this was in relation to the rapid implementation of the Discharge to Assess model to meet the requirement for the HM Government COVID-19 Hospital Discharge Service Requirements.....Our patient-flow and case-management team were responsible for the hospital response for the D2A process – and this involved the exclusion and side-lining of physiotherapy and occupational therapy recommendations to assist with the selection of the correct discharge pathway. This resulted in the hospital teams feeling devalued and asking "why are they here" if they are not being listened to."*

The impact of being undervalued as a consequence of role changes in acute services was expressed by other participants:

> *"Considering leaving the acute sector as occupational therapists have been taken off the wards and redeployed into 'discharge lounges', with extremely little patient contact, not conducting assessments and only completing paperwork for discharges based off other professional input, i.e., nursing, physio, medics, social workers etc. It's depressing and strips our profession of our unique input to patients and their families. Occupational therapy is seen as a non-essential role on acute wards and we have been reduced to expensive discharge facilitators by typing out electronic forms of patients we have not been allowed to assess. I spend up to 90% of my time now in an administration role. PLEASE HELP!"*

Others also experienced challenges of being relocated and redeployed that they had to overcome in this period:

"Having to relocate a service to a different hospital was very challenging. I had also just rotated onto the paeds team and my supervisor has had to work from home due to being pregnant. It's been difficult to overcome and learn new skills being the sole OT for the service".

"I am currently working in respiratory medicine and with ICU step downs. It has been a challenging time but one I feel has been special to be a part of. I have been working closely with the ICU team to promote the role of OT and have data to support the role of an OT within the unit. As a service we have networked with our community colleagues and developed a COVID rehab pathway. I have learnt a lot and it is an experience I will never forget".

Many participants had their roles, responsibilities and duties altered to become more home-based with reduced caseloads as a consequence of not being able to carry out face-to-face consultations. This led to role changes with work becoming more administration and desk-focused. Varying impacts were experienced as some embraced the opportunity to carry out overdue administration or found opportunities for CPD that they previously haven't had time to do:

"As I am having to shield, my role has become more non clinical, I am completing many more audits and evaluations than I normally would if I was completing clinical facing role".

"Working from home full time means opportunities to work on CPD and service development, giving me opportunities to work on projects I haven't previously found the time to do".

"The reduced F2F work meant I had more time to catch up on CPD, admin, work/life balance & have a 'new normal party' as soon as 6 were allowed to meet etc".

Some participants also reflected on how this new way of working could help in the future with work-life balance with some being able to carry out desk-based work more efficiently in a home environment and benefitting from reduced travel time:

"Enjoy working from home - less distractions, less tired from travelling time. Feel confident to manage my own time".

"I also have better occupational balance now as no commute time means I am working out more. But I really miss being in work, around my team and working with patients".

However, this was not the case for all, as many who have been forced to work from home due to shielding or not being able to carry out face-to-face interactions, reported feelings of isolation and increased difficulties in working in their home environment had significant impacts for some:

"Having my own children at home has made working life a very difficult juggling act".

"Being at home, isolated with no supervision or support. Dealing with highly distressed service users that I am not confident in knowing how to support psychologically. Consequently, left my position. Wondering if I want to be in this profession at all".

"Feeling very isolated within my role and hating working from home and constant screen time. Getting many migraine headaches".

Deteriorating mental and physical health associated with these alterations to their role, responsibilities and duties were also reported:

"No let up, stress everyday constant pressures to get patients out of hospital".

"It means being stressed".

"Moved to new team with limited support, felt anxious and has had a negative impact on my confidence and self-esteem. Felt isolated from previous support of colleagues from my old team and no supervision over the last 3 months- no time in current role supervision on hold".

"There have been days where I have had low mood and felt disorientated, lacking motivation, others from old team and family have helped me with this and supported me during those times".

In some situations, loss of independent practice or reduction in caseloads due to not being able to carry out face-to-face consultations have led to some being financially much worse off:

"No work and potential bankruptcy".

"The company would not furlough me, my income has dropped by 75%".

"I have lost all my paid work, but overwhelmed with opportunities within the charitable and voluntary sector - not ideal".

"I've been successfully self-employed for 4 years but my income disappeared over night with lockdown and hasn't returned".

Impact on occupational therapy service delivery

Participants were asked if the pandemic was having an impact on their usual occupational therapy service delivery, 85.1% (n=1,275) said yes it was, 3.3% (n=49) said no, and 11.6% (n=174) said they were not involved in service delivery.

Participants who responded, yes their usual service delivery was impacted, were asked how intervention had changed for people on their routine caseload and responses are shown in Figure 6.

The majority of responses (69.4%, n=884) indicated that the service was being delivered in a different way due to considerations about practitioner safety and cross-contamination. Almost half of those responding to this question (46.6%, n=593) said that services were being delivered differently due to considerations about Personal Protective Equipment (PPE).

Some people on routine caseloads were being seen less frequently (37.4%, n=476) and more than half were receiving remote provision of therapy via telephone consultations (57.8%, n=736) and online/video consultations (44.3%, n=564).

More advice was being provided (32.5%, n=414) with information via online resources (29.6%, n=377) and leaflets (25.4%, n=323).

Very few participants reported there had been no change to intervention received by people on their routine caseload (3.3%, n=42).

Qualitative responses

The qualitative data give several examples of the changes to routine intervention where services were being delivered differently:

> *"Service is being delivered in a different way due to changes in the discharge process, not getting usual reablement customers".*
>
> *"Previously I was working on a frailty unit, this service stopped at the beginning of the pandemic. It is due to reopen next week but with fewer patients attending".*
>
> *"Significant time limits being put on neurorehab and vocational rehab, patients not receiving enough rehab to meet their needs".*
>
> *"More one to one work due to restrictions on groups. Unable to get outside teachers, musicians etc. onto ward meaning more work for OTs and need to find new ways of working".*

Some interventions were being diverted to another service for delivery, particularly community services to support quicker hospital discharges:

"More reliant on the enablement and community therapy service to deliver rehab and allow for quicker discharge".

"Having to rely on community teams to complete home visits, discharge home visits and provide complex equipment".

Some participants described an increased demand for their service:

"Service provision has been increased greatly, 2 fold, and at a much more rapid pace".

"Case load has got bigger. More demand on occupational therapy has been needed more than ever. More contact with my clients. Working in children's home with school for children who have experienced complex trauma. The children have been really struggling with not being able to access meaningful leisure occupations".

Others gave examples of where remote contact was supporting delivery:

"Video assessments where possible".

"All social care services are delivered by video and phone apart from very few visits. It's concerning how we can't discharge our responsibilities under the mental capacity act and manage risk e.g. self neglect cases".

"Contact with carers is one thing that has radically changed - more telephone and email use, rather than face to face. Not really appreciated how often we talk to carers as they are present at the bedside".

"Ad-hoc and telephone advice only".

However, for others, services had stopped altogether:

"Service is suspended only vulnerable patients have telephone contact".

"Our normal service has been discontinued during the pandemic".

"On-going cases have predominantly stopped as work (Major adaptations) is carried out by external agencies, housing allocations are not happening at the moment in the main and new visits are not allowed unless urgent".

"We have had to stop the group programme we run twice a year, just when we were thinking of expansion. It's an OT group, it's practical and relies heavily upon group interaction, we have to rethink this one and present options which management will accept. This is a bit of a challenge".

Participants were asked if there was anyone on their caseload who was no longer receiving intervention that would usually do so. More than half said yes (54.7%, n=695, Total response =1,270). The reasons for the lack of intervention are shown in Figure 7.

The main reason for the lack of intervention was due to changes based on national guidance or local policy in response to the COVID-19 pandemic (60.1%, n=422). This was followed by people who access services not wishing to continue with their intervention at the time (48.6%, n=341) and carers (24.4%, n=171) not wishing to continue.

Closure of workplaces (i.e. schools, clinics) or services was cited as a reason for people no longer receiving intervention (29.6%, n=208) as was closure of caseloads (17.4%, n=122).

Concerns were evident about practitioner safety and cross-contamination (29.9%, n=210) but few participants reported people no longer receiving services due to limited access to PPE (4.7%, n=33).

A lack of access to digital devices and services was another reason for people not receiving services with people lacking access to equipment/resources (26.7%, n=184) or services being unable to support remote service delivery (15%, n=105).

The qualitative data supported information about the reasons for people no longer receiving intervention:

> *"Lots of issues. Government guidance about essential input only. Lots of our patients are shielding or extremely vulnerable and have decided to not have intervention at this time or are anxious to do so".*
>
> *"Suspected cases of COVID and patients shielding".*
>
> *"Closure of supported living and residential homes, day services etc."*
>
> *"Risk of infection to patient is greater than risk of not doing the planned intervention e.g. developing cooking skills is not urgent or essential. Patient work is closed so intervention on hold".*

The impact of a lack of intervention and concern for the welfare of people who would normally access services was expressed many participants:

"Some children are not coping with remote work while in their own home".

"Incorrectly asked to reduce service delivery to those who needed OT more at this challenging time, made us feel less essential".

"Not able to take patients out in the community as much as is needed. Once a patient is on home leave they do not tend to come back".

"Assessment cannot be competently and fully be completed virtually, therefore partially completed for less urgent patients. Internet connection being poor or breakdown of NHS video software leading to patient declining further attempt and awaiting face to face".

For others remote service delivery was not thought to be appropriate for people who normally access their services:

"Cognitive ability of client and type of intervention reduces effectiveness of online delivery".

"Direct sensory integration treatment that currently unable to complete".

"Driving assessments need to take place face to face".

"Many of my clients with brain injury would not benefit from online therapy, as they need face to face".

Figure 6 If people on your routine caseload are continuing to receive intervention, has this changed? Please select all that apply

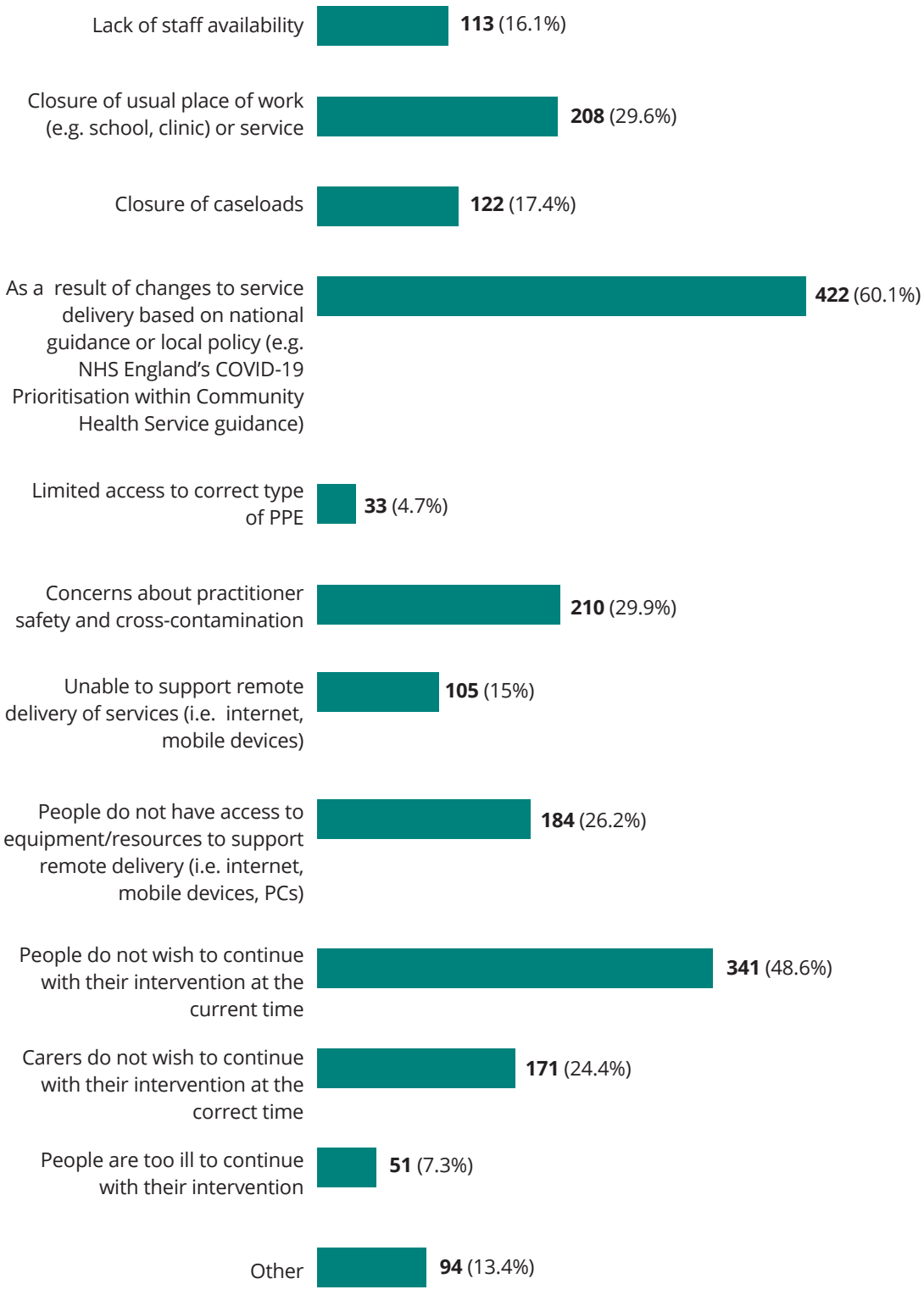
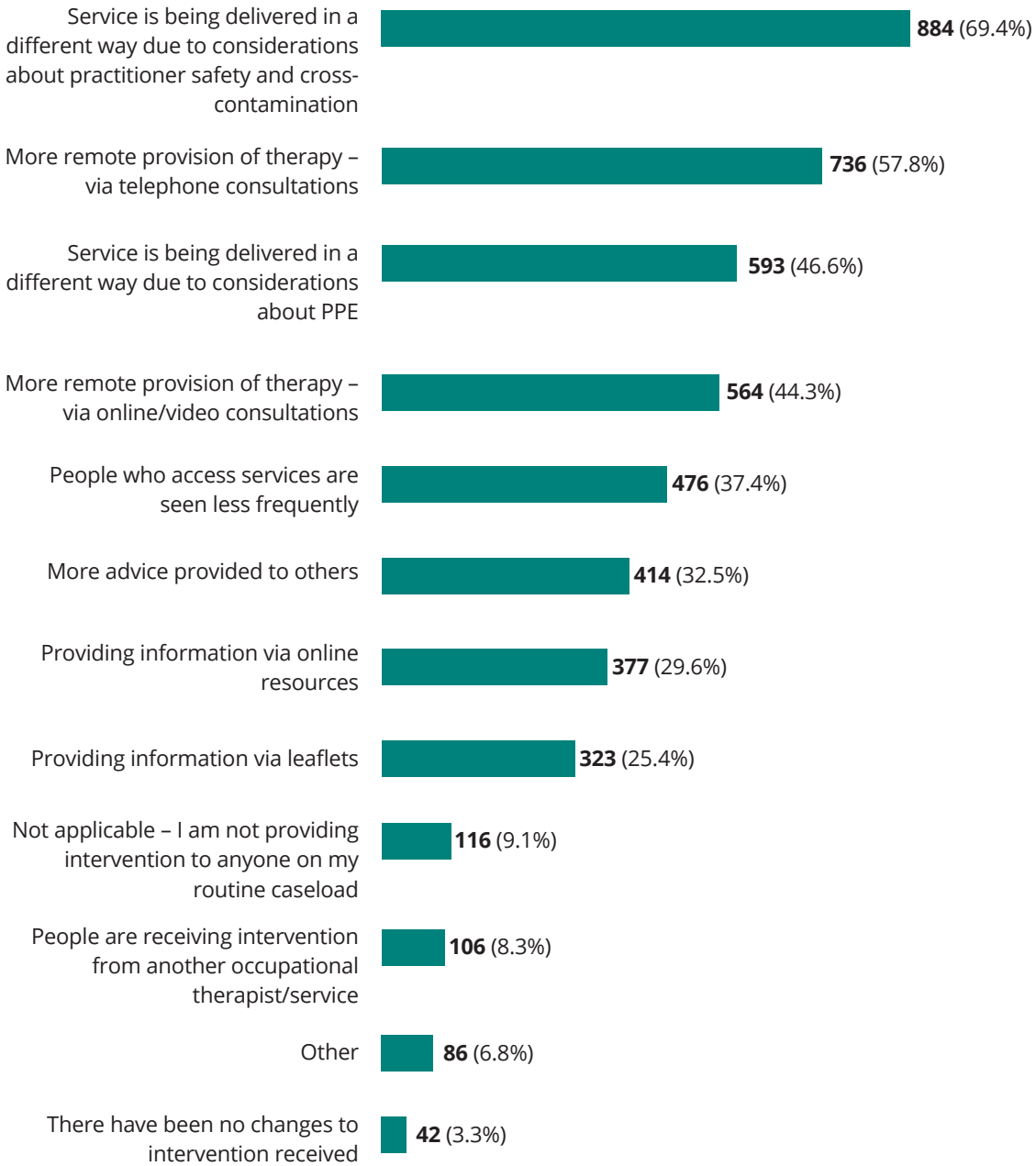


Figure 7 Why are people on your caseload no longer receiving intervention? Please select all that apply

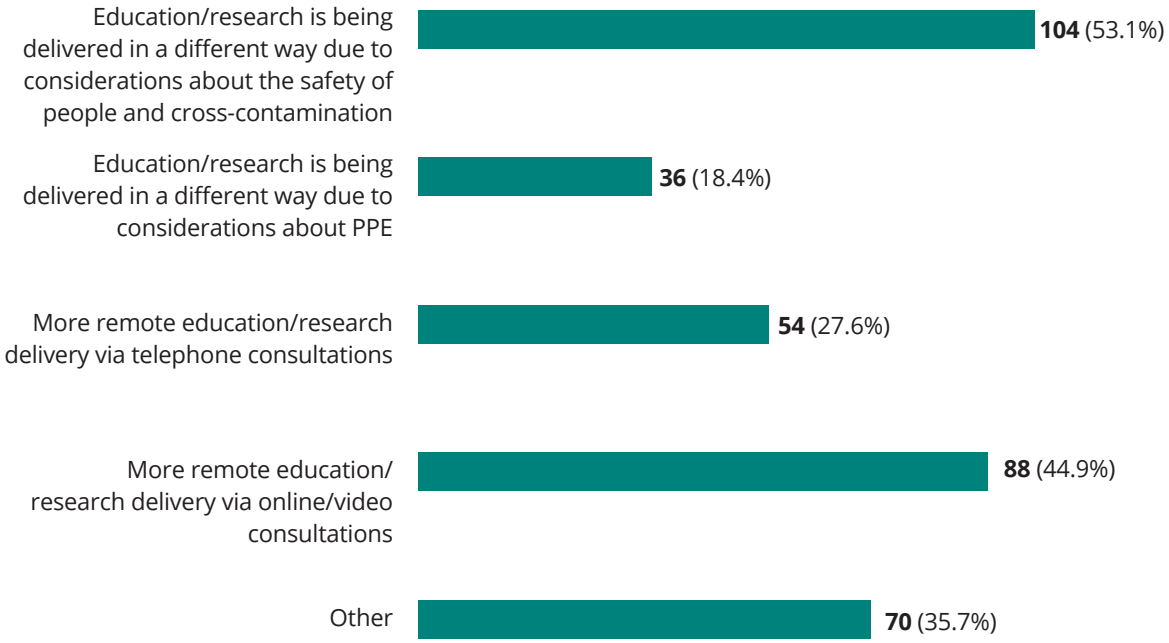


Impact on academic and researcher roles

Impacts of the pandemic on academic, educator and researcher roles were experienced by 13.6% (n=204) of the participants. The main affects are shown in figure 8 below.

More than half of participants responding to this question reported that education/ research was being delivered differently due to concerns about safety and cross-contamination (53.1%, n=104) and 45% (n=88) stated that remote education/research was being delivered online or via video.

Figure 8 How is your academic/research role being affected? Please select all that apply



Qualitative responses

Three additional themes emerged from the qualitative data related to academic and researcher roles: impact on student placements; impact on CPD; and impact on research execution.

Occupational therapy student placements have been badly affected by the pandemic with cancelled placements and uncertainty regarding future opportunities:

> "*I regularly take 3-4 student placements per year but have had to cease doing so because of pandemic restrictions".*

> *"As a team we usually offer for students at each block of clinical practice, we are not able to offer student placements currently or in the foreseeable future as continuing to work remotely and from home for the most part".*

"We have had to cease student placements currently and on re-opening opportunities we cannot take as many students due to reduced space and have split teams".

"Cancelled student placement as role has changed to working from home and reduced opportunities for joint working and MDT. Lost opportunities for OT students to have a valuable placement. Risk of having students left on their own with limited support and guidance".

Opportunities for educator training have also been affected:

"Educator training course was postponed so I am unable to have a student at current time".

The impact on post-registration CPD and researcher development was also highlighted:

"No training at present while online training is created".

"A few training programmes I had been booked to deliver have been postponed or cancelled due to COVID".

"Due to increased work load less time to study [name] OT MSc".

"NIHR internship application postponed due to COVID".

"I am a part time PhD student. I have applied for extenuating circumstances to pause while redeployed full time to front line. I haven't got the energy to do both".

Other impacts on research were described including funding and lost data:

"Research has been paused however due to start again using remote consultations".

"Research project on hold due to pandemic and social distancing impacting on interviewing".

"Loss of data for research due to earlier discharges".

"Research trial suspended (I am PI for our site). Awaiting amendment but I am unlikely to be able to continue with this due to our current circumstances".

"The funding for my research role was cancelled, it won't go ahead".

Benefits of the COVID-19 pandemic on practice, education or research roles that participants would like to see continue in the future

The pandemic has also brought about changes that participants said they would like to see continue into the future with almost two-thirds saying yes, they would like to see some of the changes that had occurred continue (62.9%, n=935).

Qualitative responses

One of the most significant changes that occurred as a consequence of the pandemic is the speed with which adapting to online working has taken place with reduced face-to-face contact and to replace workplace meetings due to workplace closures or requirements of social distancing. Many participants gave examples where they had embraced this move towards greater incorporation of technology in their working life, and recognised it as a change that needed to happen:

> *"It has presented many opportunities for the service to embrace new ways of working. It has helped us move on more quickly joint working with partners around the preventative agenda, has dispelled myths about using technology to undertake assessment and has provide us with the opportunity to massively reduce waiting list through creative solutions".*

> *"I've seen that it is possible to do more work on the phone and not always essential to immediately make domiciliary visit the first step".*

> *"Exploring online platforms to provide resources for example RECAP. Microsoft teams has been really useful and would be good to continue after pandemic has ended. Communication within the team has changed with remote working".*

> *"A thorough initial assessment is carried out per telephone at point of triage for every referral. Meaning that advice can be given immediately, prioritisation is more reliable and no one sits on a waiting list without any contact at all".*

> *"Use of Near Me technology has enhanced some service delivery but cannot replace face to face interventions indefinitely".*

The increased use of technology enabled working has opened up avenues for more home-based working. Although many reflected on the need for balance in the use of technology in their work. While it was felt that it cannot completely replace much valued face-to-face interaction, many wanted to incorporate more home/remote working into their future work. Notable benefits included reduced travel time and costs for both those who access services and occupational therapists, as many working in the community cover a large geographical area with large caseloads:

"Working from home has been proved successful in terms of workload management we were in trial phase when lockdown commenced".

"We can provide a more equitable service as patients do not need to travel to us. Thus, remote working should continue in some form".

"Video consultations and follow up appointments saves patients time & parking coming into the hospital and can be done at more convenient times for the patients".

"The use of technology for both staff and patients which can be used in conjunction (not instead of!) with traditional ways of working. Some will be cost saving, others will allow services to be more accessible in more remote areas (as long as the internet works!)".

"MDT meetings by video have been more frequent due to removal of travel time".

Some contemplated in their open responses how working from home had brought about greater personal work-life balance with less time spent commuting to and from the workplace, enabling them to spend more time with family, and reducing the stresses of commuting:

"The concept of flexible working (one day every 2 or 4 weeks) OT's in the NHS could work from home. This could provide a relief from stress of commuting to work, pressure on parking in the hospital, and provide some quiet time to complete CPD in own environment".

"Working from home one day a week, has allowed me to maintain some mental health and increase productivity".

"Remote working in some cases is more time efficient and cost efficient for myself and clients. This also frees up time for better MDT liaison as while others are also working more remotely it's easier to diarise input. It's meant I can be home more for my kids etc. too!"

Some participants who had been redeployed or had their role redefined reflected on the learning experience of these new ways of working with upskilling and new-found knowledge:

"Due to redeployment I have formed closer relationships with care staff and a much better understanding of their day to day roles within sheltered housing. This has helped me to gain a realistic view of how advice and input from occupational therapy translates in care workers practice and will improve my skills in delivering handling plans and instructions that staff feel like they can work with".

"I was redeployed to work with the rehabilitation team (OT & physio) from another hospital at one of the field hospitals built in our area. It was more of a step-down facility so these patients did not require a high level of medical support by the time they reached us. It was a

great opportunity to meet other people and be back in a hospital environment as I typically work with children in a community setting. Although redeployment came with its own set of challenges, on the whole it was a wonderful opportunity, good learning experience and it felt good to be doing something for our country".

With occupational therapists being redeployed to assist in ICUs and work in new MDTs, a step forward for the profession and the utility of the occupational therapists' role was seen to have positive impacts:

"Becoming an OT on the COVID ICU completing early rehab has shown the benefits of having OTs in the ICU, and has led to a business case being put forward to have OT positions funded on all ICUs in the hospital".

"Development of ITU service".

"Easier discharge pathways. Quicker availability of discharge pathways".

"Back to basics of washing & dressing assessments & home visits. More emphasis has been on discharge planning & efficient assessment of complex patients. Feel OT role is more valued now as effective discharge planners, including mental health & nursing needs. We are excellent communicators".

Many saw this as an opportunity for promotion of the work of occupational therapists:

"I work in ICU and have seen an increased awareness /understanding from OT colleagues (and the wider MDT) about what I do. Also a better understanding of the rehab needs for patients post ICU i.e. on the step-down wards and in the community. How to promote occupational therapy within an acute hospital setting, during a pandemic".

"More representation at key policy decision making groups regarding rehab and the role of OT and wellbeing and the role of OT in community people have been occupationally deprived with/without symptoms".

"To promote the value of OT to acute hospital trusts. Promote the role of OT in rehab from COVID. Promote the role of OT as frontline workers. Promote OT taking on leadership roles in all settings, especially rehab in the community".

Structural changes to service delivery were also seen as an advantage to some as services have been made more efficient with hospital discharges, with fewer processes to go through, which ultimately made it better for people accessing services:

"Services streamlined, changes implemented more quickly".

"In our setting, smaller MDT groups for goal setting, less time wasted and more time spent discussing each case as there are less to discuss".

"Just given the therapy service a shake up, which has opened up service development ideas looking at efficiency and use of technology".

Improved communication and team working have also been a positive outcome, some reported greater integration and support:

"In our hospital the whole physiotherapy and OT team was joined together. Therefore, I now have a closer relationship with colleagues. This has been a great support network and has brought a great sense of team spirit and positivity in a dark time".

"Stronger MDT working and presence on wards".

"Working better within MDT communication had to improve we worked as a team where as before things felt quite segregated".

"I have been able to meet new OTs and build rapport and understanding of roles".

Finally, with reduced caseloads and working from home, some have found more time for personal development:

"I have enjoyed the opportunity to engage in CPD activities remotely, which I may not have had otherwise".

"Have made more use of different kinds of CPD training (rather than physically attend study/conferences), webinars, papers on line. Much more time efficient and from the comfort of my own home".

There has also been more time for developing aspects of services which participants had not previously had time for:

> *"Access to remote system from home (working from home due to pregnancy) has meant I have been able to complete lots of project work which would have usually been impossible due to time constraints".*

> *"It has allowed for time to update service resources and patient leaflets, some of which had not been updated for years".*

> *"Opportunity to take part in developing and delivering a new service which would otherwise not have been offered".*

As participants' work moved online there was a greater need to develop online resources due to an increased reliance on them to deliver services:

> *"More use of online resources and social media being recognised as a useful platform for therapists, children and parents".*

> *"Increased provision of educational resources for families prior to accessing service. More access for the public to advice and guidance from a clinician".*

> *"Completion of on line resources and materials which will be useful in future training and sessions".*

Development of resources

RCOT has produced many resources to support its members during the COVID-19 pandemic that are available on the website. Participants were asked what other areas they would like support with from RCOT to help with adapting their work and/or study after the initial acute phase of the pandemic has passed. Themes were developed from 723 qualitative responses and these included: guidance on safely returning to the workplace; advice on remote working; rehabilitation guidance; mental health support; promotion of occupational therapy; sharing of occupational therapists experiences throughout the pandemic; and there were general expressions of gratitude to RCOT for the current resources and support.

Qualitative responses

As social distancing restrictions ease with the reduction of COVID-19 cases, participants requested RCOT guidance and support with how to safely return to respective areas of practice due to the continuing ongoing risk of COVID-19:

> *"How we can return to routine community rehab patients as currently only supported to attend urgent patients".*

"Straight forward guidelines for when we are allowed to see clients face to face - I work from home".

"Details and clinical examples of how services are adapting and embedding the discharge to assess model long term and what is the future role of hospital OT".

"More information about the longer term impact of COVID-19 on OT services".

"Implications for students, including delayed graduation if placements can't go ahead in 2020".

As remote working becomes normalised for many, participants expressed the need for guidance on new ways of working, not only on good practice with accessing technology-enabled services but also guidance on personal good remote working practices:

"Further guidance on use of remote virtual technology for assessment".

"Sharing best practice from the new virtual world. Sharing tips on facilitating groups via video link. Safety and ethical considerations for virtual practice".

"Additional guidance on maintaining and achieving occupational balance when working/ studying from home".

Participants recognised that rehabilitation is going to be a key focus area for people recovering from COVID-19 and are looking for continued support and learning resources here:

"Continued support and guidance regarding COVID patients' rehab and recovery".

"Continued work on fatigue management and post COVID advice for patient support".

"Ongoing advice re COVID rehab as more research is carried out".

Mental health support and an understanding of the impact of the pandemic on mental health on both the occupational therapy workforce and people accessing occupational therapy services was a clear area of interest for further advice and resources:

"Traumatic stress and emotional overload in relation to front line therapists".

"Mental health - the long term implications and suggestions for supporting recovery".

"Mental Health specific guidance - information seems to be COVID-19 specific but there's nothing with regards to mental health if the client has not had COVID but ongoing mental health problems struggling as a result of the current situation".

Some highlighted the need to further promote their role and the value of occupational therapy and require support to retain their professional identity:

"Information on redeployment and how to put forward a case/evidence for people who are no longer receiving a service, but need one".

"How to retain your profession when working in a more multidisciplinary role".

"Occupational identity after changing your way of working".

"Supporting the importance of our role in acute hospitals as some trusts have used this pandemic to move OT staff permanently in the community with no hospital OT staff".

Participants expressed their desire to connect more with other occupational therapists and share and gain insight into others' experiences throughout the pandemic:

"To hear of experiences other OTs have had. To share changes that have occurred within services as a result of the pandemic. To share other thoughts and feelings of OTs experiences during the pandemic both professionally and personally. To develop a guideline or framework for OT practice during a pandemic".

"More opportunity to link with other clinicians. Reflect and debrief opportunity to improve resilience and well-being".

"Details and clinical examples of how services are adapting and embedding the discharge to assess model long term and what is the future role of hospital OT".

"I would like more information about how staff coped and what tips they can share for working differently. I would like to continue to hear from RCOT as I have heard more from them during the pandemic than I did before".

Others communicated their gratitude for the output of resources and advice from RCOT that already been provided and expressed need for the continuation of this support:

"The resources so far have been excellent. Thank you".

"Thank you for all the resources that are available!!"

"Just knowing you're there".

DISCUSSION

The COVID-19 pandemic has brought about significant disruption to occupational therapy in the UK with clear impacts on roles, responsibilities and duties. The results of this survey show that all areas including practice, education and research have been affected. In addition, significant personal impacts have been experienced in terms of health and wellbeing and financial hardship.

In practice, redeployment of occupational therapists was shown to have had substantial impacts on participants. This disruption meant many were working in unfamiliar settings and in areas outside of their usual practice. Participants were working with different groups of people compared to normal caseloads, and feelings of uncertainty and a lack of clarity about their role and concerns about reduced access to support/supervision were expressed by participants.

Normal services had also been disrupted and the impact of a lack of intervention and concern for the welfare of people who would normally access services, but were not receiving occupational therapy, was expressed by many participants. However, disruption had also brought about opportunities for change. Some participants reported rapid efficiencies and service improvements through quicker and better processes, improved team working and integration which ultimately should have longer lasting benefits for people accessing services.

Understandably there were concerns about the professional implications of some of these changes. The survey data highlights the importance for RCOT to continue providing reassurance and advice regarding the scope of occupational therapy practice, and support members to continue to use their professional judgement to assess risk and make sure people receive safe care, informed by the values and principles in the HCPC Standards of Conduct, Performance and Ethics (HCPC 2020)[1], as well as the RCOT Code of Ethics and Professional Conduct for Occupational Therapists and Professional Standards for Occupational Therapy Practice (2015 *NB currently under review*)[2].

Further, these changes had caused considerable impacts on personal health and wellbeing, as participants described the impacts of stress, loss of income, lack of support, dislike towards or difficulty in working from home and managing their own family, longer hours and difficulty in maintaining their own work life balance. Conversely, others noted the benefits of more flexible working and reduced commuting time.

[1]https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/
[2]https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/rcot-standards-and-ethics

One of the most notable changes that occurred as a consequence of the pandemic is the speed with which adapting to online and home-based working has taken place. Many participants reported that they embraced this move towards greater incorporation of technology into their working life, and that the pandemic has accelerated a change that needed to happen in many services dispelling myths about using technology and affording creative solutions. The move to digital service delivery was embraced by most, and many cited the benefits of this type of approach in terms of the benefits to both people who access services, and those delivering services through reduced travel time and costs. Whilst for others remote service delivery was not thought to be appropriate for people who normally access their services. Some had struggled to support online delivery, either due to their own IT abilities, a lack of adequate technology being provided by employers, or the fact that those who accessed services did not have access to technology themselves.

The situations that the pandemic has forced upon participants suggests that there is no better time for them to be thinking about improving their digital service delivery and upskilling themselves or their teams to be able to respond to the challenge of delivering services differently. The data suggests a desire for continued support and development of skills in digital and remote working through the generation of new RCOT resources and advice in this area.

With our lives turning increasingly digital, COVID-19 may have accelerated a revolution. However, it is important no-one gets left behind as digital exclusion is a reality for 22% of the UK's population (UK Consumer Digital Index 2019)[3] who lacked basic digital skills and access since long before the COVID-19 outbreak. Therefore, RCOT could highlight the digital divide to governments and policymakers and support national initiatives to address digital exclusion.

For those working and studying in higher education or carrying out research, again the biggest impact was due to activities being delivered differently due to considerations about the safety of people and the move to remote delivery of education and research. The effects of remote and online learning were felt by both those delivering and those engaged with education. Loss of peer support and contact with educators was reported by learners. Longer term impacts on research as funding was withdrawn or research was delayed and the impact on researcher development will not be known for some time, but the short-term impact on research and researchers was clear from this survey.

[3]https://www.lloydsbank.com/assets/media/pdfs/banking_with_us/whats-happening/lb-consumer-digital-index-2019-report.pdf

Many participants cited the cancellation or withdrawal of student placements as being of significant impact. Not just on themselves, but also on the lost opportunities and effect on learners and ultimately the progression of new graduates into the workforce. RCOT's recent call to all practitioners, service managers and departmental leads to work creatively and collaboratively with local universities delivering pre-registration occupational therapy programmes to explore access to placements is vital to ensure that pre-registration students are supported to complete their programmes of study. In addition, RCOT should continue to provide advice and guidance, in conjunction with other professional and statutory bodies, to enable learners to progress in a way that is most appropriate in these rapidly changing, highly complex circumstances and continue to take a pragmatic and proportionate approach to the application of the RCOT Learning and Development Standards for Pre-registration Education (2019).

Occupational therapy personnel are resourceful and adapting to changes in research, education and health and care services is not new. For some this period of extraordinary change brought about by the pandemic offered opportunities and time to undertake CPD and to reflect on the learning experiences from these changes with upskilling and new-found knowledge; even alternative career options. Further RCOT support and resources were welcomed, especially those that could be accessed remotely such as webinars and online learning.

Areas that participants highlighted specifically as welcoming further support from RCOT on included: guidance on safely returning to the workplace; advice on remote working and technology enabled services; rehabilitation guidance; mental health support; promotion of occupational therapy; and opportunities for sharing of experiences throughout the pandemic.

KEY MESSAGES

The impact of the COVID-19 pandemic on the occupational therapy profession has been profound and varied as reflected in both the quantitative and qualitative responses to this survey:

- Almost all participants (97.6%) said that the COVID-19 pandemic had had an impact on their role, responsibilities and duties. These included changes to location/base, changes to working hours and patterns, altered demands, changes to role or services provided and loss of role or service.
- Redeployment to another team (including non-occupational therapy teams) had occurred for a third of participants.
- The pandemic has also changed occupational therapists' roles in acute services, with some feeling undervalued, but also highlighted ways in which occupational therapists' skills can be better utilised in this area in future as they are vital to the rehabilitation process.
- COVID-19 has forced many to work from home with greater dependency on digital technologies. This has driven innovation and brought service benefits and more efficient ways of working for some, however support is required to enable this technological shift for others.
- The financial impact of the pandemic was felt by many through furlough, redundancy and loss of business.
- The pandemic has also brought about changes that almost two-thirds of participants said they would like to see continue into the future including: use of technology; home-working and more flexible working; structural changes that brought about more streamlined services; improved communication; and better team working.
- The development of new skills and expanded roles and other opportunities have occurred for some. New projects have begun and new CPD opportunities had been created to support work in some areas.
- The recent call to all practitioners, service managers and departmental leads to work creatively and collaboratively with local universities delivering pre-registration occupational therapy programmes to explore access to placements is crucial to ensure that pre-registration students are supported to complete their programmes of study, and the workforce supply pipeline is optimised.
- The pandemic has and will continue to impact on health and wellbeing, not just of those accessing occupational therapy services, but all those in the profession who have experienced changes in their professional lives or undergone COVID-19 related personal trauma and the demand for mental health support cannot be underestimated.

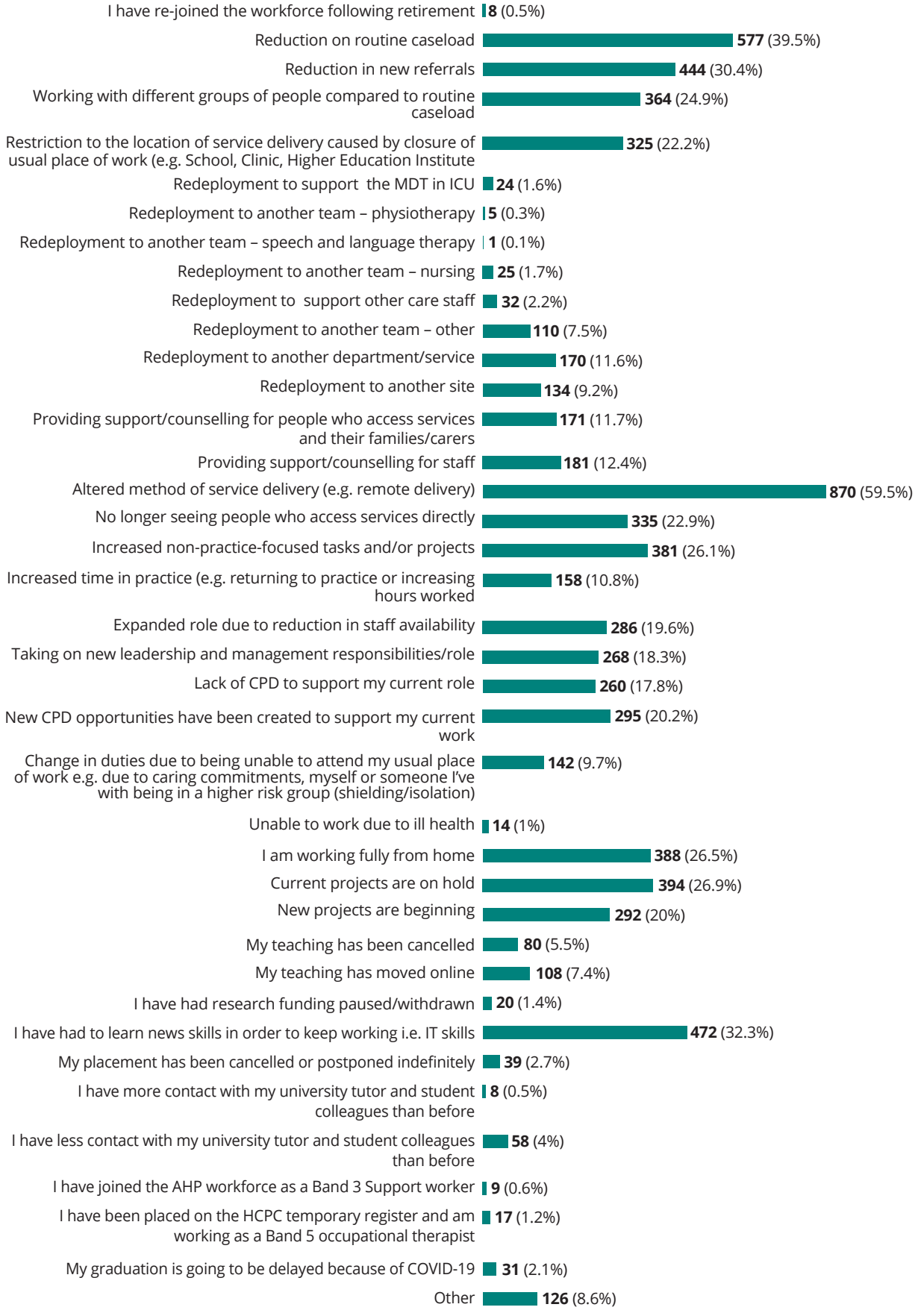
RECOMMENDATIONS

As we move through and beyond the COVID-19 pandemic, the participants in this survey have illustrated the challenges and opportunities that the occupational therapy profession within health, care and academic landscapes have been presented within the UK.

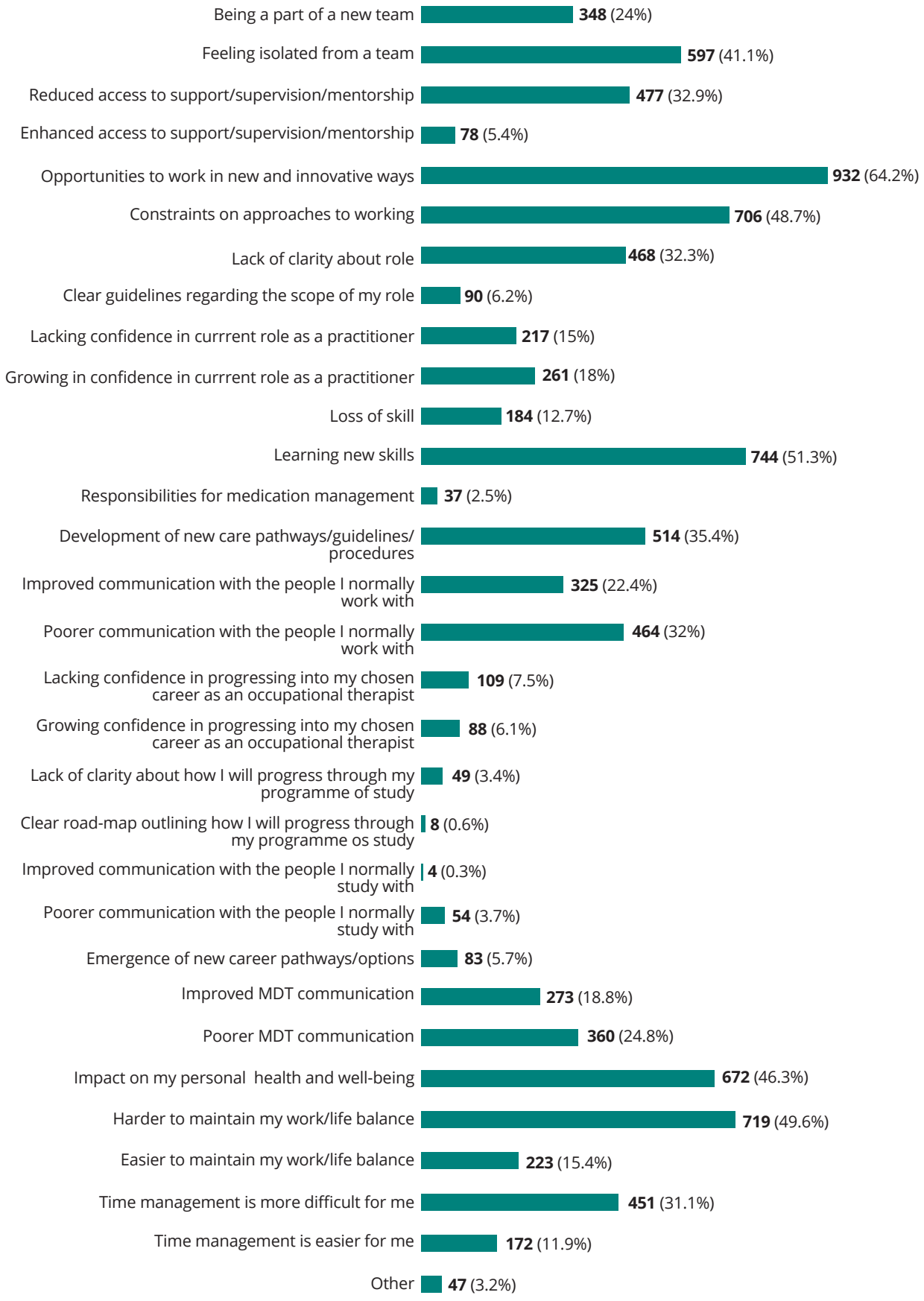
To enable members to maintain their response to the pandemic and develop their skills in this time of unprecedented change, it is recommended that RCOT:

- continues to support its members to use their professional judgement to assess risk and to make sure people receive safe care, informed by the values and principles in the HCPC Standards of Conduct, Performance and Ethics (HCPC 2020) and the RCOT Standards for Occupational Therapy Practice (RCOT 2017), and continues to provide reassurance and advice regarding the scope of occupational therapy practice.
- continues to support and encourage practitioners, service managers and departmental leads to work creatively and collaboratively with local universities delivering pre-registration occupational therapy programmes to explore access to placements for pre-registration students.
- continues to support the development of skills in digital and remote working through the development of advice and new resources.
- highlights the digital divide to governments and policymakers and support national initiatives to address digital exclusion.
- continues to highlight CPD opportunities, especially those delivered online/remotely.
- continues to highlight research funding opportunities, (both COVID-19 and non-COVID-19 related).
- considers development of further advice and resources (especially those that can be accessed remotely) to support members in: guidance on safely returning to the workplace; remote working and technology enabled services; post COVID-19 rehabilitation guidance; mental health support; promotion of occupational therapy; and create opportunities for the sharing of experiences throughout the pandemic for members to learn with and from each other.

Appendix 1: Results – Impact of COVID-19 pandemic on roles, responsibilities and duties



Appendix 2: Results – Meaning of change on role and responsibilities



The impact of the **COVID-19** pandemic on occupational therapy in the United Kingdom

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