Policies, Procedures, Guidelines and Protocols

Document Details	
Title	Children and Young People's Community Speech and Language Therapy Dysphagia Policy
Trust Ref No	2555
Local Ref (optional)	
Main points the document covers	Guidance for Children's Dysphagia, eating drinking and swallowing difficulties referral, diagnosis and management in neonates, infants, children and young people by Speech and Language Therapy team in Shropshire Community Health NHS Trust (SCHT)
Who is the document aimed at?	Children and Young People's clinical practitioners, leads and managers.
Authors	Jane Ball, Anna Booth and Dyllis Kilby
Approval process	
Line Manager approval prior to consultation	Dyllis Kilby 14.04.26
Who has been consulted in the development of this policy?	Children's Speech and Language Therapy (CSLT) Dysphagia Team
Approved by (Group/Committee)	Clinical Policy Group Clinical effectiveness Committee – October 2026
Ratified by (Committee/Director)	
Date of Ratification	21/10/2026
Initial Equality Impact Screening	Y
Full Equality Impact Assessment	N
Lead Director	
Category	Clinical
Subcategory (If Applicable)	
Next Review date	31/10/2029
Distribution	
Who the policy will be distributed to	Senior Managers ☒ Line Manager ☐ All ☐
Method	Staff Zone ☐ Public Website ☐ Other ☒ Specify: CSLT Share Point
Keywords	Dysphagia, swallow, Speech, Language, feeding

Document Links		
Required by CQC		
Other		
Amendments History		
No	Date	Amendment (include version)
1	V1 May26	New Policy
2		
3		
4		
5		

1. Contents

Item	Contents	Page
	Title page	1
	Contents	3
1	**Introduction**	6
2	**Purpose**	6
3	**Definitions**	7
	ARFID	7
	Cervical Auscultation	7
	Dysphagia	7
	Enteral Feeding Methods	7
	Gastrostomy	7
	International Dysphagia Diet Standardisation Initiative **(IDDSI)**	7
	Orogastric Tube	8
	Nasogastric Tube	8
	Nasojejunal Tube	8
	Neonate Infant Children Young Person (NICYP)	8
	Non-medical Feeding Difficulties	8
	Oesophageal Dysmotility	8
	Paediatric Feeding Disorder	8
	Pulse Oximetry	8
	Video-Fluoroscopy Swallow Study (VFSS)	8
4	**Duties**	8
4.1	Chief Executive	8
4.2	SLT Managers	8
4.3	Qualified Dysphagia SLTs	8
4.4	Supporting colleagues	8
5	**Referral**	9
5.1	Who can refer?	9
5.2	Means of referral	9
5.3	Who will be accepted?	9
5.4	Who will not be accepted?	9
5.5	The process	10

6	**Responsiveness**	10
6.1	Triage	10
6.2	Prioritisation	10
7	**Consent**	11
8	**Assessment**	11
8.1	Time Scales	12
8.2	Methods of assessment	12
8.3	Location of assessment	12
8.4	Conclusions/Diagnosis	12
9	**Intervention**	12
9.1	Management	13
9.2	Education	13
9.3	Individualised Plan	14
9.4	Frequently used Interventions	14
9.5	Non-Medical Feeding Difficulties	14
9.6	Cognition and Mental Capacity	15
10	**Delegation**	15
10.1	Sharing Information	15
10.2	Supporting People	15
10.3	Supporting colleagues	15
10.4	Disagreement	16
10.5	Eating and drinking with acknowledged risks (EDWAR)	16
10.6	Decision making process	14
10.7	Communication breakdown	14
11	**Record Keeping**	15
12	**Discharge**	15
12.1	Discharge criteria	15
12.2	ICYP discharge with prescribed thickener	17
12.3	Duty of care	15
12.4	Transfer out of area	15
13	**Adverse events**	15
14	**Supervision**	16
15	**Video Fluoroscopy Swallow Studies (VFSS)**	16

16	**Tracheostomy**	16
17	**Nil by Mouth (NBM)**	16
18	**Oral Hygiene**	16
19	**Dysphagia SLT Continuing Professional Development (CPD)**	16
20	**Competency Framework**	17
21	**Consultation**	17
22	**Dissemination and Implementation**	17
23	**Monitoring Compliance**	17
24	**References**	18
25	**Associated Documents**	19
26	**Appendices**	20

1 Introduction

Speech and Language Therapists (SLT) have a unique Health and Care Professions Council (HCPC) recognised and registered role in identifying and managing oropharyngeal dysphagia associated with a broad range of physical, developmental, neurological, head and neck disorders. The key role of the SLT in the assessment, differential diagnosis, and management of dysphagia, eating drinking and swallowing difficulties (EDS) can reduce complications and length of stay in hospital. There is evidence that the appropriate identification and management of dysphagia by SLTs reduces morbidity, mortality and improves quality of life. Improved nutrition and hydration have an impact on physical health, learning potential, social participation, and mental well-being.

Qualified dysphagia SLTs [hereafter referred to as SLTs] are integral members of services and multidisciplinary teams (MDT) supporting neonates, infants, children, and young people (NICYP) with dysphagia and their carers. SLTs are involved in MDT decision making for this client group, informing the broader clinical management.

NICYP with dysphagia may present in different ways and have varying symptoms and profiles of abilities. Services should be child-centred and provide a range of interventions which are culturally appropriate. There is evidence that interventions, behavioural and other, used by SLTs in the treatment of dysphagia are effective (Royal College of Speech and Language Therapists (RCSLT 2025).

The SLT has a key role in assisting carers of NICYP to make informed decisions and in educating others in the management of dysphagia. The views, wants and feelings of NICYP will be sought and fully considered. This is as outlined in the Shropshire Community Health NHS Trust (SCHT) i-Thrive model which details the level of support or treatment the NICYP may need to develop their eating, drinking and swallow skills. The i-Thrive model has four components which are: Prevention and Promotion (Skilling up staff, parents, carers, children and young people), Getting Advice (Universal Support), Getting Help (Targeted Support) Getting More Help (Specialist Support) and Getting Risk Support (Risk management and crisis support), for further information see Appendix 1 – SCHT SLT EDS iThrive model.

2 Purpose of this Policy

- To introduce and provide information on dysphagia and its impact on NICYP's physical and mental well-being.
- To state the role and responsibilities of SLTs in relation to dysphagia and/or EDS difficulties.
- To identify the principles of service delivery to NICYP within the area of dysphagia.
- To outline National Guidelines for dysphagia and feeding management as stated by the Royal College of Speech and Language Therapists (RCSLT) including their Dysphagia Competency Framework (2025).
- To ensure that SLTs undertaking dysphagia assessments and interventions are trained to standards in accordance with RCSLT Dysphagia Competency Framework (2025) and Trust service guidelines.
- To provide links to local service guidelines, competencies, and care pathways for related areas (e.g., neonates, eating and drinking with acknowledged risks).

3 Definitions

3.1	ARFID, Avoidant and Restricted Food Intake Disorder	This is a psychiatric disorder describing sensory and behavioural feeding difficulties where a self-restricted diet impacts upon nutritional status, health, and wellbeing, ARFID Awareness UK 2023.
3.2	Cervical Auscultation	Cervical (neck) auscultation (to listen) can be regarded as a tool for the assessment of Dysphagia (Balasubramanium, Bhatt 2012). Cervical auscultation is defined as: ○ 'the recording of sounds and vibrations caused by the human body from the throat during swallowing' (Dudik et al 2015). ○ 'the use of a listening device, typically a stethoscope in clinical practice, to assess the sound of swallowing' (Leslie et al. 2007). ○ SLTs require specific post graduate training to use cervical auscultation.
3.3	Dysphagia	The term used to describe an eating, drinking, swallowing disorder or difficulty usually resulting from a neurological or physical impairment of the oral, pharyngeal, or oesophageal mechanisms. The normal swallow has 4 phases: 1. Anticipatory [anticipatory is also known as pre-oral] 2. Oral [food/drink/saliva managed within the mouth] 3. Oropharyngeal [the movement of food/drink/saliva from the mouth into the pharynx] 4. Oesophageal [the movement of food/drink//saliva through the oesophagus]
3.4	Enteral feeding methods	Non-oral methods of gaining nutrition. Orogastric tube, Naso-gastric tube, Naso-jejunal tube or gastrostomy.
3.5	Gastrostomy	Used where oral intake is not safe, tolerated, or sufficient. A tube is inserted directly into the stomach through the skin and fixed in place. Nutrition in liquid form is passed through the tube.
3.6	IDDSI	International Dysphagia Diet Standardisation Initiative developed April 2019 to describe all food textures and drink thickness modifications. www.iddsi.org IDDSI was adopted in April 2019.
3.7	Orogastric Tube	A tube is passed from the mouth into the stomach and fixed in place. Nutrition in liquid form is passed down the tube. Training is required to provide nutrition using this method by other medical professionals.
3.8	Nasogastric tube	A tube that is passed down one nostril into the stomach and fixed in place. Nutrition in liquid form is passed down the tube. Training is required to provide nutrition using this method by other medical professionals.

3.9	Nasojejunal tube	A tube that is passed down one nostril through the stomach into the small intestine and fixed in place. Nutrition in liquid form is passed down the tube. Training is required to provide nutrition using this method by other medical professionals.
3.10	NICYP	For the purposes of this document the words neonate, infant, child and young person (NICYP) will be used to refer to the individual/s with the eating, drinking or swallowing difficulty. Neonate refers to a preterm baby under 37 weeks of gestational age. Infant refers to a baby between 37 weeks gestational age and 12 months. We use the term 'child/ren' to refer to pre-teen children (1-12 years). We use the term 'young people' to refer to teenagers (13-19 years)
3.11	Non-medical Feeding Difficulties	Feeding difficulties in which the aetiology does not have an anatomical and/or physiological basis. This may include Avoidant Restrictive Food Intake Disorder (ARFID)/self-restricted feeding patterns which is a sensory/behavioural feeding issue.
3.12	Oesophageal dysmotility	Oesophageal dysmotility occurs when contractions in the oesophagus become irregular, unsynchronised, or absent. This means food is not moved smoothly through the oesophagus (NHS England).
3.13	PFD, Paediatric Feeding Disorder	Paediatric Feeding Disorder is impaired oral intake that is not age-appropriate and is associated with medical, nutritional, feeding skill, and/or psychosocial dysfunction.
3.14	Pulse Oximetry	Pulse oximetry is a non-invasive monitor that measures the oxygen saturation in the blood by shining light at specific wavelengths through tissue (Torp, Modi & Simon 2022). It can be used as part of dysphagia assessment to identify aspiration.
3.15	Video-fluoroscopy swallow study (VFSS)	This is a dynamic X-ray procedure which allows inspection of the anatomy and physiology of swallowing and helps to identify the presence and/or cause of aspiration and the response to it.

4 Duties

4.1 Group Chief Executive in Common

The Chief Executive in Common of SCHT should ensure that all clinical staff working with NICYP have access to this guideline, should ensure that appropriate training and updates are provided to all relevant staff groups and should ensure that staff have access to appropriate equipment that complies with safety and maintenance requirements.

4.2 SLT Managers

Managers should ensure that staff are aware of and have access to policy guidelines. Staff training needs should be identified and addressed. Appropriate education, supervision and support mechanisms are in place to ensure good practice.

4.3 Qualified dysphagia SLTs

SLTs should familiarise themselves with this guidance, the National Institute for Health, and Care Excellence (NICE) and RCSLT guidance on the diagnosis and management of paediatric dysphagia. They should keep their knowledge and skills in dysphagia diagnosis and management up to date.

4.4 Supporting colleagues

Non-dysphagia trained SLTs working within their level of competence and following written guidance (see SCHT SLT EDS Screening Tool Appendix 2) should discuss eating drinking and swallowing issues and offer basic advice at initial contact with the CYP and carer.

5 Referrals

5.1 Who can refer?

In case of concerns about a NICYP's eating/drinking/swallowing, the following professionals can refer the child to the SLT: General Practitioner (GP) and Paediatricians. Referrals may also be accepted from the following professional groups but only after agreement has been obtained from a doctor and documented in the NICYP's electronic patient records. Health Visitor (HV), Speech and Language Therapist (SLT), Occupational Therapist (OT), Physiotherapist (PT), Community Children's Nurse (CCN), Dietician, Educational staff within special schools only.

Referrals made directly from parent/carers are not accepted.

If a parent telephones the children's SLT service to make a referral for EDS support, they are asked to contact their GP or the NICYP's Consultant to request this referral is made. Where the GP does not feel a referral is needed the triaging SLT will:

- contact the GP directly via telephone/email
- contact the Consultant if the child is known to one
- inform SLT service manager

5.2 Means of referral

The process for referring NICYP who are not in hospital to children's community Speech and Language Therapy is via the SCHT SLT referral form (see Appendix 3). This is available on our website. The referral is accepted when the form has been fully completed.

The process for referring Children's ward inpatients to the children's community Speech and Language Therapy is via phone call to the referral team in therapy admin or send an email to the referral team in therapy admin
shropcom.childtherapyreferrals@nhs.net

The process for referring Neonatal ward inpatients to the children's community Speech and Language Therapy is via phone call to the referral team in therapy admin or send an email to the referral team in therapy admin or direct discussion with the neonatal SLT.

5.3 Who will be accepted?

Referrals will be accepted for NICYP with eating and/or drinking difficulties at the oral, pharyngeal, and oesophageal phase of swallowing and those for whom the aetiology is unknown.

Consideration will be given to provide advice and signposting to CYP presenting with EDS difficulties not related to physiological and anatomical problems. Parents/carers of CYP with self-restricted feeding patterns will be signposted to the SCHT SLT website (EDS section) for a universally available video and handouts providing strategies and information.

5.4 Who will not be accepted?

- NICYP in the community not registered with a Shropshire, Telford, and Wrekin GP (General Practitioner Doctor).
- In-patients of private hospitals which receive funding for SLT.
- In-patients of hospices unless charging arrangements are in place.
- Child or young person presents with feeding difficulties associated with attachment disorder, anorexia, or bulimia unless they have identified physical EDS needs which meet the criteria.
- Nutrition or hydration deficits without dysphagia difficulties
- Isolated dribbling issues
- Isolated oesophageal dysfunction
- Isolated difficulties with use of utensils and fine motor skills affecting eating and/or drinking independently.

5.5 The Process

See SCHT SLT EDS service pathway (Appendix 4)

5.5.1 Inpatient referrals:

The therapy admin staff member taking an inpatient referral over the phone will complete a SCHT SLT EDS inpatient phone referral form (see Appendix 5).

The therapy admin staff member will email the written referral received (by email or taken by phone) to the dysphagia team email address and if urgent will also make telephone contact with the dysphagia SLT on duty, to ensure the information has been received. The dysphagia SLT on duty will triage and action the referral.

5.5.2 Outpatient referrals:

The therapy admin staff receiving an SLT referral (SCHT SLT referral form Appendix 3) will send an email to the dysphagia team email address. If referral is urgent the therapy admin staff will also make telephone contact with the dysphagia SLT on duty The dysphagia SLT on duty will triage the referral.

6 Responsiveness

6.1 Triage

All new dysphagia referrals are triaged by the SLT on duty using the SCHT SLT EDS triage form (see Appendix 6). Triage involves a dysphagia risk analysis which is completed by an appropriately trained SLT within 3 working days of receipt of referral. SLTs will follow current relevant guidance from the RCSLT and/or commissioners in relation to timeframes for responding to new referrals. A contemporaneous record of triage and an outline of the proposed management will be documented in the client's record.

6.2 Prioritisation

Dysphagia referrals will be considered for high priority action if:

- NICYP is having chest infections &/or showing signs of aspiration as reported by referrer.
- NICYP's poor weight gain is a significant concern in association with oral, pharyngeal, or oesophageal swallowing concerns.
- A decision on an important aspect of feeding is reliant upon the SLT assessing the NICYP.
- There are other significant EDS concerns.
- The NICYP shows signs of severe oral motor dysfunction.

7 Consent

It is necessary to follow guidelines relating to consent as set out in the Trust's Consent Policy and Mental Capacity Act, (2005).

8 Assessment

8.1 Time scales

- Inpatient referrals are actioned within 3 working days of receipt of referral. Efforts are made to make telephone contact with the referrer on the day of the referral.
- High priority outpatient referrals are contacted within 2 weeks of the referral and an appointment arranged as appropriate.
- Low priority outpatient referrals are seen within 18 weeks of the referral.

8.2 Methods of assessment

Selected and used at the SLT's discretion when clinically appropriate.

- SLTs will gain information from the referrer through:
  - Information supplied to the SLT before the appointment through the SCHT SLT EDS parent and carer questionnaire (Appendix 7) sent with their appointment invite.
  - Discussion with carers and CYP
  - A SCHT SLT EDS case history to be completed at initial appointment (Appendix 8)
- Conduct clinical assessments SLTs will select appropriate assessments based on clinical reasoning and evidence-based practice.
- SLTs are predominantly involved in the first three phases of swallowing though have knowledge about the diagnosis of oesophageal dysfunction. Problems during the oesophageal phase are managed by the GP or gastroenterologist.
- SLTs may refer for a specialist VFSS at Birmingham Women's and Children's Hospital (BWCH) to visualise some or all of the swallow stages if clinically indicated (see Appendix 9). Local SLT will aim to accompany NICYP to their VFSS appointment at BWCH. A VFSS can assist in diagnosis and help identify strategies to improve swallow efficiency and provide a benchmark for outcomes. These

investigations allow SLTs working in an MDT to determine the safety and efficacy of adapted eating/drinking regimes and can also provide reassurance and education to NICYP and their carers. SLTs require specific post graduate training to take an active role in VFSS and analysis of results.

- SLT to request named Consultant to refer NICYP for VFSS if referred to another tertiary hospital.
- Prior to investigations a full explanation as to the rationale and expected outcome of the investigation is given to the carer of a neonate/ infant and directly to the child/ young person and their carer.
- Cervical auscultation can be used as an adjunct to the clinical assessment for dysphagia.
- Pulse oximetry may be used to identify aspiration events in acute hospital settings by a member of nursing/medical staff.

8.3 Location of assessment

The NICYP will be seen in the location which best meets the needs of both the NICYP, their parent carers and the service.

SLTs will adhere to the SCHT lone working policy where applicable.

8.4 Conclusions/Diagnosis

Through the process of assessment, the SLT will

- describe the NICYP's difficulties.
- attempt to reach a hypothesis regarding aetiology.
- based on these findings, recommendations will be made.
- these conclusions and recommendations will be communicated to the carer of the neonate /infant, the child/ young person, their carer, and referral agent through written documentation and where possible through verbal report.
- onward referrals will be made as required.
- feedback and where appropriate discussion with MDT regarding future management.

9 Intervention

9.1 Management

Management of dysphagia must be least restrictive of all options available. It may include environmental modifications, safe swallowing advice, appropriate utensil advice, appropriate drink thickness and food texture modification, posture in liaison with appropriate Allied Health Professional (AHP) colleagues and the application of swallowing strategies to improve the efficiency of swallow function and minimise the risk of aspiration.

9.2 Education

SLTs provide education and training in the form of the Risk of Aspiration and IDDSI training package for those involved (family, carers, professionals, and relevant others) in dysphagia support and/or NICYP specific training and will maintain links with the MDT to inform them of advice provided. A Universal training offer is available on the SLT trust website regarding 'self-restricted eating', aimed at parents and carers of CYP with self-restricted diets.

9.3 Individualised Plan

SLTs create an individualised feeding plan, which is also referred to as eating and drinking guidance (EDG) (Appendix 10 SCHT SLT Neonatal feeding plan), (Appendix 11 SCHT SLT EDS EDG). Handouts may be provided for supporting the management of a range of EDS difficulties considering the understanding, knowledge and skills of the NICYP and their carers and the demands of the environment.

9.4 Frequently used interventions:

- Modification of the texture of food and/or thickness of liquid as per International Dysphagia Diet Standardisation Initiative (IDDSI) guidelines
- Physical adaptations i.e. position, jaw stabilisation
- Utensil adaptations
- Pacing
- Environmental adaptations

9.4.1 Modification of the thickness of fluids as per IDDSI guidelines. SLTs to adhere to RCSLT guidance regarding thickener use. Parent/carer to be involved in the MDT decision making for the use of thickener as noted in the thickener agreement (Appendix 12 – SCHT SLT EDS Thickener Agreement)

9.4.2 Feeding strategies/techniques SLT's follow the SOFFI infant pacing pathway. SOFFI – Support of Oral Feeding for Fragile Infants (Ross 2011).

9.4.3 Modifying the flow rate SLT's follow the SOFFI infant pacing pathway.

- Compensatory strategies such as purposeful swallow, chin tuck
- Modify posture
- Strategies for developing/improving oral motor skills

Appropriate management of enteral feeding. This includes working within the MDT team to support families to wean their NICYP off enteral feeds if appropriate and putting in place an individualised desensitisation programme as per the needs of NICYP. See SCHT SLT EDS enteral weaning pathway, Appendix 13.

9.5 Non-medical Feeding Difficulties

For those NICYP identified with a non-medical feeding problem, (e.g. ARFID, self-restricted feeding patterns without oral-motor difficulties) the emphasis for SLT intervention is on education and reassurance. This client group has a sensory / behavioural feeding difficulty rather than an oral motor eating drinking and swallowing difficulty. CYP presenting with ARFID will require a MDT approach including psychiatry, nutrition specialist / dietitians and sensory specialists / Occupational Therapists.

9.5.1 The SLT will give general management advice and signpost the parents/carers to relevant sources of further information and support (e.g. www.arfidawarenessuk and a universal training video for Parent/carers and handouts developed by this service which can be found on the Trust website – https://www.shropscommunityhealth.nhs.uk/chslt-eating-drinking-swallowing-needs Onward referrals will be made by SLTs as appropriate if they become aware that the CYP's limited food intake is resulting in significant risk to the child's health or the parents/carer's level of anxiety will impede their ability to follow advice given.

9.6 Cognition and Mental Capacity

Many NICYP with dysphagia (particularly those with cognitive needs) may be unaware that they have a swallowing problem. For NICYP who have not reached 'Gillick Competence', parents/carers must take responsibility to make decisions in the best interest of their NICYP. Assessment and treatment in NICYP with cognitive impairments are made in the NICYP's best interests following the guidelines of the Mental Capacity Act, 2005. Educating parents/carers involved in the care of people with dysphagia is essential in ensuring compliance with safety recommendations made by the SLT. Parents/carers need to understand what the SLT recommendations are, it's purpose and why it is being proposed. They also need to understand the potential benefits, risks, and alternatives to ensure informed decisions are made.

10 Delegation

10.1 Sharing Information

Any recommendation or advice should be recorded in the NICYP's electronic patient records (EPR) and information shared with MDT. People acting under the SLT's advice must be given appropriate written information including food texture and drink thickness recommendations, how to identify deterioration of the function and what to do if difficulties arise. SLT to inform parents/carers it is their responsibility to provide respite settings with the most recent copy of their child/young person's EDG.

10.2 Supporting people

Parents/carers and placement staff supporting NICYP with dysphagia are offered the 'risk of aspiration and IDDSI' training provided by the SLT EDS service.

10.3 Supporting colleagues

Non-dysphagia trained SLTs working within their level of competence and following written guidance (see SCHT SLT EDS Screening Tool Appendix 2) can discuss eating drinking and swallowing issues and offer basic advice at initial contact with the CYP and parent/carer.

SLT assistants, Nursery Nurses, Portage, Healthy Child Practitioners under the advice of a dysphagia trained SLT and working within their level of competence may support NICYP with dysphagia needs. Risk of Aspiration and IDDSI training is available from this service.

10.4 Disagreement

Where disagreement exists between the child, young person, parent/carer and the SLT every effort will be made to resolve it through discussion. However, if agreement cannot be reached and the child, young person or parents/carers refuse to consent to the plan of intervention this will be documented in their EPR and shared with the MDT and where appropriate the local safeguarding policy will be followed.

10.5 Eating and drinking with acknowledged risks (EDAR)

Where there is identified and acknowledged risk with oral feeding and parents/carers make an educated decision through discussion with the MDT to continue oral feeding this will be documented on the EDAR awareness form and shared with the MDT and uploaded to their EPR (see Appendix 14 – SCHT SLT EDS Eating and drinking at acknowledged risk form)

10.6 Decision-making process

Full discussion of eating, drinking and swallowing assessment findings and recommendations are made with CYP and carers with joint decision making for management planning.

10.7 Communication Breakdown

In circumstances when designated feeders change and the SLT is not informed, responsibility for the feeding situation reverts to the parent/carer, educational placement and/or respite setting.

11 Record-keeping

SLTs will adhere to RCSLT and Trust guidelines on record-keeping and information governance.

12 Discharge

Discharge Process - discharge from the SLT service will be at the discretion of the SLT after consultation and agreement with the parent/carer of the NICYP. If appropriate, a discharge report/email will be completed and sent to parent/carers, MDT, and educational placement as relevant and documented in the EPR. Discharge will be recorded in the acute hospital medical notes only if the child is an in-patient.

12.1 Discharge criteria:

- Assessment indicates that therapy and further assessment is not appropriate.
- When the NICYP is no longer progressing, has reached full resolution of their difficulty or they have reached their maximum potential.
- NICYP/parent/carer is noncompliant with SLT recommendations.
- NICYP is no longer registered with a GP practice within Shropshire.
- The carer of the neonate, infant or child, the young person or their carer discharges themselves or service is refused.
- The NICYP may be discharged if no concerns have been raised by the parent/carer within the last 6 months.

12.2 NICYP discharge with prescribed thickener:

When a NICYP is discharged but continues to require the prescribed thickener, parents/carers are responsible for informing the SLT EDS service when changes to their drinking skills occur and a review is required by this service for the safe and appropriate continued use of thickener.

12.3 Duty of care

A duty of care is opened when the referral has been accepted and the NICYP has received initial contact from a SLT in the EDS service. This maybe via telephone, virtual or face to face contact. Duty of care to the NICYP is terminated through completion of the discharge process as cited above.

12.4 Transfer out of area

In the case of a NICYP being transferred to out of area SLT service, the duty of care will rest with the new service provider once the transfer has been completed.

13 Adverse Events

SLT's must ensure that they understand how to document adverse events and safeguarding concerns in accordance with the SCHT's incident management policy and safeguarding policy. Respiratory arrest, choking, clinically suspected aspiration and other adverse events must be recorded in detail immediately following the event in the client's record and the MDT informed.

All SLTs employed by SCHT must follow their policies and have up to date mandatory training for safeguarding, infection control and Paediatric cardio-pulmonary resuscitation (CPR) including choking training and anaphylaxis.

14 Supervision

Dysphagia SLTs will access clinical supervision for their dysphagia caseload and will follow the SCHT's supervision policy.

15 Video Fluoroscopy Swallow Studies (VFSS)

There is no local VFSS service available for NICYP in Shropshire. Therefore, local SLTs will seek support and guidance from SLT colleagues in tertiary centres.

16 Tracheostomy

Due to the small numbers of NICYP with tracheostomy in Shropshire, it is not appropriate to expect local SLTs to be competent to work in this area independently. Therefore, local SLTs will seek support and guidance from community nursing colleagues and SLT colleagues in tertiary centres.

17 Nil by mouth (NBM)

The final decision to place a client nil by mouth lies with the medical team. The SLT can make their recommendations to the medical team. The decision is usually made as part of a MDT discussion and where possible should include the parent/carer of NICYP and the child/ young person.

18 Oral Hygiene

There is evidence to suggest that poor oral hygiene increases the risk of aspiration pneumonia (Remijn et al 2022) SLTs should promote the Office for Health Improvement and Disparities publication (2022) on maintaining good, safe oral health when required in liaison with the MDT.

19 Dysphagia SLT Continuing Professional Development (CPD)

All SLTs working in the field of dysphagia must undertake a post registration dysphagia course which should be a quality assured or RCSLT registered dysphagia course. They should maintain their knowledge and skills in the field of dysphagia and demonstrate reflective practices.

20 Competency Framework

All SLTs working in the field of dysphagia must:

1. Provide evidence of their competencies using the RCSLT Dysphagia competencies framework for eating drinking and swallowing (2025) (see **www.rcslt.org**) and RCSLT Neonatal Dysphagia Competencies Framework see **www.rcslt.org** (RCSLT 2018).
5 Demonstrate continuing professional development in the field of dysphagia at a level commensurate with their clinical level of expertise following RCSLT and HCPC guidelines.

21 Consultation

This policy has been discussed with, Clinical Services Manager (targeted children's services and Children's AHP Lead) Alison Parkinson, Children's SLT Team and the Children's SLT eating, drinking and swallowing service therapists.

22 Dissemination and Implementation

This policy will be distributed to relevant staff groups by managers and published on the Trust website.

23 Monitoring Compliance

Compliance will be monitored by:

- Review of any concerns raised about the service by staff, other professionals, the parent/carer of the neonate or infant, the child/ young person.
- A Review of guidelines will be carried out in 2030.

24 References

ARFID Awareness UK 2023, www.arfidawarenessuk.org

Balasubramanium, R. & Bhat, J. Cervical Auscultation: A Systematic Review. Advances in Life Sciences and Technology. ISSN 2224-7178 (paper) 2225-062X (online), Vol 6.)

Dudik J.M, Coyle J.L and Sejdic E (2015) Dysphagia Screening: Contributions of Cervical Auscultation Signals and Modern Signal-Processing Techniques. IEEE Trans Hum Mach Syst. 2015 Aug; 45(4): 465 - 477. http://ieeexplore.ieee.org/stamp/stamp.jsp?tp=&arnumber=7064736

Groher, M.E. & Crary, M.A. (2016) Dysphagia: Clinical Management in Adults and NICYP. 2nd Edition, Pub: Elsevier

ICAN: Infants, Child and Adolescent Nutrition, Vol 3 Number 6.

The International Dysphagia Diet Standardisation Initiative (2016) https//iddsi.org/framework/

Leslie, P., Drinnan, M., Zammit-Maempel, I., Coyle, J., Ford, G., and Wilson, J. 2007. Cervical Auscultation synchronized with images from endoscopy swallow evaluations. *Dysphagia*, **22** (4): 290-298.

Mental Capacity Act**,** Mental Capacity Act 2005 (legislation.gov.uk)

Milleer, C.K (2011) Aspiration and Swallowing Dysfunction in Pediatric Patients.

National Guidelines for dysphagia and feeding management as stated by the Royal College of Speech and Language Therapists (RCSLT), Communicating Quality Live, (2016)

National Institute of Clinical Effectiveness. Oral health: local authorities and partners. NICE guidelines [PH55] Published date: October 2014

NHS England, NHS England

Office for Health Improvement and Disparities 2022, www.gov.uk/government/publications/child-oral-health-applying-all-our-health/child-oral-health-applying-all-our-health

Remijn. L, Snachez. F, Heijnen. B, Windsor. C & Speyer. R (2022) Effects of Oral Health Interventions in People with Oropharyngeal Dysphagia: A Systematic Review. Journal of Clinical Medicine, 2022 Jun; 11(12): 3521.

Rosenvinge, S. and Starke, I. 2005. Improving care for patients with dysphagia. *Age and Ageing*, **34** (6):587-593.

Royal College of SLT. 2025. Dysphagia competencies RCSLT: London. https://www.rcslt.org/members/clinical_areas/dysphagia/dysphagia_training_competency_framework www.RCSLT.org

Royal College of SLT. 2025. Dysphagia competencies RCSLT: London. https://www.rcslt.org/members/publications/publications2/videofluoroscopic_position_paper2025 www.RCSLT.org

Royal College of Speech and Language Therapists (RCSLT) 2021 Eating and drinking with acknowledged risks: Multidisciplinary team for the shared decision-making process (adults). www.RCSLT.org

Torp, Modi & Simon (2022) Pulse Oximetry. Treasure Island (FL): StatPearls Publishing; 2023 Jan.

25 Associated Documents

SCHT policies which are related or have relevance to implementing this policy:

- Lone working
- Consent
- Record keeping
- Incident management
- Supervision
- Mandatory training
- Information governance
- Infection, prevention and Control
- Safeguarding

26 Appendices

No.	Appendices	Page(s)
1	SCHT SLT EDS i-Thrive model Appendix 1 SCHT SLT EDS i-Thrive model.pptx	5
2	SCHT SLT EDS Screening Tool Appendix 2 SCHT SLT EDS screening tool.doc	8, 16
3	SCHT SLT referral form Appendix 3 SCHT SLT referral form.docx	10
4	SCHT SLT EDS service pathway Appendix 4 SCHT SLT EDS service pathway.docx	11
5	SCHT SLT EDS inpatient phone referral form Appendix 5 SCHT EDS inpatient phone referral form.docx	11
6	SCHT SLT EDS triage form Appendix 6 SCHT SLT EDS triage form.doc	12
7	SCHT SLT EDS parent and carer questionnaire Appendix 7 SCHT SLT EDS parent and carer questionnaire.docx	12
8	SCHT SLT EDS Case history Appendix 8 SCHT SLT EDS case history.docx	12
9	Birmingham Women's and Children's Hospital VFSS referral form Appendix 9 BWCH VFSS referral form.docx	13
10	SCHT SLT Neonatal feeding plan Appendix 10 SCHT SLT Neonatal feeding plan.docx	14
11	SCHT SLT EDS EDG Appendix 11 SCHT SLT EDS EDG.docx	14
12	SCHT SLT EDS Thickener Agreement Appendix 12 SCHT SLT EDS Thickener agreement.docx	14
13	SCHT SLT EDS Enteral weaning pathway Appendix 13 SCHT SLT EDS enteral weaning pathway.doc	14
14	SCHT SLT EDS Eating and drinking with acknowledged risk form Appendix 14 Eating and drinking with acknowledged risk form.docx	16