PATIENT MEALTIMES

RED TRAY POLICY
**Policy Title:** POLICY FOR THE USE OF RED TRAYS AT PATIENT MEALTIMES

<table>
<thead>
<tr>
<th>Executive Summary:</th>
<th>To improve the nutritional intake of patients by providing help and/or extra time to eat, by identifying a patient and providing specially coloured meal trays.</th>
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<tbody>
<tr>
<td>Supersedes:</td>
<td>V 2.</td>
</tr>
<tr>
<td>Description of Amendment(s):</td>
<td>N/A</td>
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**This policy will impact on:**
Nurses, Dieticians, SALT, Catering Staff and Ward Staff

**Financial Implications:**
Red Trays already in use on wards therefore nil cost.

<table>
<thead>
<tr>
<th>Policy Area:</th>
<th>Patient Nutrition</th>
<th>Document Reference:</th>
<th>ECT002531</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version Number:</td>
<td>V 3.4</td>
<td>Effective Date:</td>
<td>April 2016</td>
</tr>
<tr>
<td>Issued By:</td>
<td>Director of Nursing Performance &amp; Quality Care Standards</td>
<td>Review Date:</td>
<td>July 2019</td>
</tr>
<tr>
<td>Author:</td>
<td>Facilities Soft FM – Catering Officer</td>
<td>Impact Assessment Date:</td>
<td>On-going</td>
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**APPROVAL RECORD**

<table>
<thead>
<tr>
<th>Committees / Group</th>
<th>Date</th>
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<tr>
<td>Consultation:</td>
<td></td>
</tr>
<tr>
<td>Nutrition Dietetic &amp; SALT Department</td>
<td>May 2015</td>
</tr>
<tr>
<td>Clinical Nutrition Steering Group</td>
<td>April 2016</td>
</tr>
<tr>
<td>Patient Meals Group</td>
<td>March 2016</td>
</tr>
<tr>
<td>Equality &amp; Diversity Lead</td>
<td>June 2015</td>
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<tr>
<td>Safe Guarding Lead</td>
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<tr>
<th>Approval Committee</th>
<th>Date</th>
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<tr>
<td>Quality Strategy Group</td>
<td>April 2016</td>
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<th>Approved by Director</th>
<th>Date</th>
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<tr>
<td>Director of Finance</td>
<td>July 2016</td>
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<tr>
<th>Received for information:</th>
<th>Date</th>
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<tr>
<td>SQS</td>
<td>July 2016</td>
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# EAST CHESHIRE NHS TRUST

## POLICY FOR THE USE OF RED TRAYS AT PATIENT MEALTIMES

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Throughout this document, East Cheshire NHS Trust is referred to as ‘the Trust’.
1.0 POLICY STATEMENT

The aim of the Red Tray Policy is to improve the nutritional intake of patients’ food by providing help, observing and/or extra time to eat, with the use of specially designated coloured meal trays.

BAPEN 2010 highlighted that 38% of individuals were found to be malnourished on admission to hospital or care homes. Malnutrition affects wellbeing; it should be identified and treated using nutrition support. NICE (2006) state that appropriate support should be provided for patients who are able to eat and drink but are unable to feed themselves and for patients who require assistance.

Patients who have increased need for assistance would be at a higher risk of malnutrition if their needs are not met and therefore the red tray is a means of identifying those patients who have increased need for assistance at mealtimes, and who are at a higher risk of malnutrition if their needs are not met.

2.0 ROLES AND RESPONSIBILITIES

2.1 Chief Executive

The Chief Executive has overall responsibility for ensuring that the Trust has appropriate policies and guidelines in place and robust monitoring systems in place. This responsibility may be delegated to a responsible manager.

2.2 Director of Corporate Affairs and Governance

The Director of Corporate Affairs and Governance has the delegated responsibility for ensuring that the appropriate arrangements are in place, to ensure a robust governance of policies/procedures are provided across the Trust. Some of the responsibilities may be delegated to a responsible manager.

2.3 Heads of Service/Executive/ Clinical Directors.

Heads of Service / Clinical Directors are responsible for:

a) Bringing to the attention of staff new publications and documents.
b) Retaining evidence that information relating to newly developed and amended procedures have been cascaded within the teams/ departments and wards.
c) Ensure this document is effectively implemented.

2.4 Line Managers

Responsible for:

a) Assessing the relevant procedural documents as directed by their managers.
b) Informing their staff and where appropriate escalating to management teams failure to receive new policy information, and effectively implement.
c) Ensuring that staff attend all training identified in respect of the policy.

2.5 Ward Managers, Sisters in Charge, Housekeepers

a) Must ensure that all staff handling patient’s food on the wards have completed the necessary Food Safety Training course and instruction about red trays.
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b) Need to ensure that there is ample staff on the wards during the mealtime to assist with the red tray patients.

2.6 Nursing staff
Ensuring that staff serve the meal as quickly as possible. Assisting all patients that have been identified as requiring a Red Tray, by feeding where required, or just to help the patient by cutting food or opening packets. Usually these patients will be on food charts and require recording at the end of the meal.

2.7 Volunteers and Patient Carer
a) Volunteers- recruited to assist with feeding should have training on feeding techniques, therapeutic diets and food safety, arranged by the Volunteer Lead, Facilities Soft FM Speech & Language Therapist, and the Wards involved.
b) Patient Carer- should be encouraged and assisted with instruction on the provision of the meals service, as the patients’ needs can change especially with swallowing problems. The carer should be kept well informed via the Ward Sister of how they can best assist with their care.

2.8 The Nutrition & Dietetics Department/ Speech & Language Therapist (SALT)
Offer support for the Protected Mealtime and the Red Tray Initiative when monitoring the therapeutic diets. Dietitians and Speech and Language Therapists may recommend the need for a Red Tray during their assessment of the patient, and they find he/she meets the criteria. Also the nursing staff can place a patient on a red tray if they are at all concerned.

2.9 Catering Department
The catering department will be responsible for collating the menus from the patients and separating of the red tray patients to be checked by the dietitian and/or diet chef. For those patients on the PMOS (Patient Meal Ordering System) will already have been highlighted on the menu print out for checking. The catering department will ensure that the choice and quality of the food, chosen by the patients who are on red trays, is correct and make the necessary changes requested by the dietitians, before placing on a red tray to be delivered in a timely manner to the ward.

2.10 Quality and Performance Monitoring
The Quality and Performance Monitor will be responsible for ensuring that the Red Tray Policy is adhered to by the wards and the catering department. This procedure will be monitored during routine patient meals catering audits, but will formerly be audited every six months to ensure compliance with the Red Tray Policy.

3.0 IMPLEMENTATION

3.1 Scope
a) This policy provides a framework for best practice at mealtimes
b) Patients are allocated red trays at meal times when they have been identified by the nursing staff during MUST or assessed by the dietitians or SALT team to require either help to cut up food, to be fed, or have swallowing difficulties requiring supervision or just additional time to eat their meal.
c) Red trays are not to be used to identify patients on special/modified or supplemented meals, though such meals may be on a red tray for the purpose identified above.
POLICY FOR THE USE OF RED TRAYS AT PATIENT MEALTIMES

Meals on red trays for named patients must not be offered to any other patient.

3.2 During Protected Mealtimes the staff will have more time during this quieter period to help the patients on Red Trays.

3.3 Must ensure that all staff handling patients’ food on the wards complete the Food Safety course online via e-learning within 3-6 months of joining the Trust. This ensures that the Trust is compliant with the Food Safety Laws. Training needs to be updated every 3 years.

• Volunteers recruited to assist with feeding should have training on feeding techniques, therapeutic diets and food safety, arranged by the Volunteer Lead, Facilities Soft FM and the Wards involved.

• Patient Carer should be encouraged and assisted with instruction on the provision of the meals service, and as the patients’ needs change especially with swallowing problems, should be kept well informed via the Ward Sister of how they can best assist with their care.

3.4 Must ensure that sufficient staff are available to assist identified patients as needing a red tray and help. Inability to comply with this should be reported via the Datix reporting system.

3.5 Where a relative, carer or partner is assisting a patient there must be sufficient support by staff to encourage and oversee the help being given to the patient.

3.6 Where help is offered to encourage and agree to relatives/carers/volunteers providing assistance with feeding after instruction, this must not be the case when a yellow sign is above the patient’s bed. The sign indicates that the patient has a bad swallowing problem and only the SALT team can feed the patient, for Health & Safety reasons.

3.7 Managers must ensure that staff are aware that when patients miss a meal or arrive at a ward out of hours, there is a 24 hour provision for hot or cold meals for the patient via the Help Desk on ext. 1999

4.0 Measuring Performance

4.1 Key performance indicators relating to this policy:

a) Ward staff who serve the meals should be complete the appropriate Food Safety training with regards to patients meals service, safety and nutrition.

b) Adherence to the Red Tray Policy

c) Adequate staff available to serve patients with red trays.

d) Adhering to any other internal or external audit requirements:

   PLACE – Yearly audit (Patient Led – Assessment of Care Environment)

   CQC – Quality Care Commission
5.0 AUDIT

The following performance indicators will be monitored and adhered to for the management of the Red Tray Policy. This policy requirement will be monitored during routine patient meals checks /catering audits, but will formerly be audited as stated below to ensure compliance:

<table>
<thead>
<tr>
<th>KPI’s</th>
<th>Monitored by:</th>
<th>Monitoring frequency</th>
<th>Reporting to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wards following the Red Tray Initiative</td>
<td>Responsible person from the Patients Meals Group</td>
<td>Twice per year</td>
<td>Patients Meals Group Clinical Nutrition Steering Group Quality Forum</td>
</tr>
<tr>
<td>Key areas in the audit: Staff helping, what type of help, was the meal correct on delivery, did the patient have to wait for help, what happened when the meal was not eaten, was the patients food chart filled in.</td>
<td>Quality Performance Monitor/ Patient Meals Group</td>
<td>Twice per year</td>
<td>Patient Meals Group Clinical Nutrition Steering Group Risk Management</td>
</tr>
<tr>
<td>Have the staff completed Food Safety Training</td>
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6.0 RISK MANAGEMENT

6.1 Under no circumstances should meals on red trays for named patients be offered to any other patient.

6.2 When identified by the SALT team as a high risk patient with swallowing problems, the patient should be closely observed, due to the risk of choking. These patients should be identified with a yellow sign above the patients bed.

6.3 Non-compliance with these guidelines should be reported via the incident reporting System Datix.

7.0 REVIEW

7.1 This policy will be reviewed every three years by both the Patients Meals Group and the Clinical Nutrition Steering Group, or when necessary due to the publication of new guidance.

7.2 Reviews will be coordinated by a responsible person from within the Patients Meals Group and issues identified during an audit and performance review.

7.3 The performance review may identify changes that are urgently required and would be presented to both the Patients Meals Group the Clinical Nutrition Steering Group and the Quality Forum to be sanctioned.
8.0 REFERENCES

- *Hospital food as treatment*. British Association for Parental and Enteral Nutrition (BAPEN) and British Dietetic Association, 1999. (BAPEN 2006 & 2010)

- BDA The Association of UK Dietitians – The Nutrition & Hydration Digest: Improving Outcome Through Food & Beverage Service


- Still Hungry to be Heard - Age Concern, August 2009

- Better Hospital Food Programme. Department of Health 2002

- Campaign for Protected Mealtime, Hospital Caterers Association 2004

- The Matrons Charter – Department of Health, 2004

- Nutrition and Hydration Toolkit 2006

- Trust Food & Hydration Strategy 2016
Appendix 1: **USE OF THE RED TRAY**

- Nurse / Dietitian or Speech Therapist must assess the patient as requiring a red tray using the following criteria:
  - All patients identified by SALT as needing supervision for swallowing difficulties.
  - All patients who require feeding.
  - All patients who require more time to eat their meal independently.
  - All patients who require physical help or need encouragement to eat.

- When the meal arrives on the ward the nurse supervising the meal service should ensure there is adequate staff/carer/relatives available to serve all patients on Red Trays. Red Tray meals are issued as indicated on the menu and consistent with any special dietary, food textures and fluid requirements are all checked for the correct consistencies. Therapeutic diets should only be given to the named patient. If items are not as specified on the menu the catering department should be contacted as soon as possible to obtain the correct meal.

- Before the meal tray is removed the nursing staff must check what the patient has eaten /drunk and this must be documented on the Food Record Chart (FRC), fluid balance chart and any other record as appropriate.

- Snacks are available at ward level and non-prescribable supplements such as Meritene are (available at ward level) and should be offered if less than ½ the meal is eaten. Additional snacks or supplements taken by the patient must be recorded so that a comprehensive record is maintained.

- The Trust has a 24hour service for Hot and Cold meals via the Help Desk ext.1999

Appendix 2 **Hydration Identified by RED MUGS**

- Patients’, who have been identified as requiring extra and regular assistance with their meals may also require monitoring of their fluid intake, hot beverages or cold drinks can be given in a Red Mug. The patient may not be able to take the drink in one go so the red mug also signifies to nursing staff that this patient needs to be aided with/given frequent sips. Any nurse passing the bed of such a patient should stop and help the patient to take a sip/drink from their beaker.

- Patients will be offered seven drinks during the day. Should the patient require further drinks this should be provided from the beverage trolleys.

- The domestic will not be allowed to clear the mug like the red tray, so that the fluid intake can be logged on the patients chart.
Appendix 3                Equality and Human Rights Impact Assessment

Equality Analysis (Impact assessment)

Please START this assessment BEFORE writing your policy, procedure, proposal, and strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services.
Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

    Red Tray Guidelines

Details of person responsible for completing the assessment:

- Name: Sue Thomson
- Position: Facilities Soft FM – Catering Monitor
- Team/service: Facilities Soft FM

State main purpose or aim of the guidelines, policy, procedure, proposal, strategy or service:
(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

The aim of the Guidelines for the Red Trays is to improve the nutritional intake of patients by providing help and / or extra time to eat by the use of a specially designated meal tray that is red in colour. Encouraging carers, staff and volunteers to be trained in Food Safety or feeding procedures. All groups of patients, both young and old with disability or without, and from ethnic or religious backgrounds may be affected and may be identified as at Risk by the MUST scoring. Identifying medical condition or concerns for their health by not eating.

2. Consideration of Data and Research
To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document
Cheshire East (CE) covers East Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

Age: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).
Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

Gender: In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at 18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% in 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- Jewish: 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
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- Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- None: 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- Not stated: 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

Carers: In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)
There has been no evidence of complaints or concerns on the grounds of discrimination.

2.3 Does the information gathered from 2.1 – 2.2 indicate any negative impact as a result of this document?
There have been no negative impacts but encouraging positive comments made during audits by staff because this keeps the staff focused on checking the patients that are highlighted by the red trays.

3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently? Yes □ No √
Explain your response: No – These guidelines are there to protect the interests of all groups and do not disadvantage any group. All patients will be treated according to their taste, religion, race, beliefs eg vegetarian, disability and age. Menus are tailored for all types of dietetic requirement eg. Reduced salt, fat, gluten free, diabetic, celiac hala, kosher etc. Menus are planned with catering team, Patients Meals Group, Dietitians, SALT Team, Facilities Soft FM and a cross section of ward staff, Sisters, Housekeepers, N/As from across the Trust who have special interest in the patients meals. Should the guidelines be required in a different format it would be possible for translation / interpreter services to be made available if required.

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently? Yes □ No √
Explain your response: No – These guidelines reflect the need for red trays for ANYONE identified.

DISABILITY
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently? Yes □ No √
Explain your response: Patients with a disability would be treated the same as everyone else when being identified as requiring a red tray. The assistance offered would be tailored to the patients requirement.

AGE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, age groups differently? Yes □ No √
Explain your response: No – these guidelines do not disadvantage any age groups. The meal requirement will depend on their taste and preference but will be selected from a menu that will best suit them, from solid normal food to softer options of prepared dysphagic meals. Wards have identified special cutlery if it is not already on the wards, from the Occupational Therapy Department. For patients with partial or no sight this would highlight the nurse to either feed or by placing the meal in such a way like a clock on the plate and explain to the patient what food is at what time, so they can build up a picture.

LESBIAN, GAY, BISEXUAL: From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently? Yes o No √
Explain your response: No adverse impacts identified

RELIGION/BELIEF: From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently? Yes o No √
Explain your response: No adverse impacts identified.

CARERS: From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently? Yes o No √
Explain your response: No adverse impacts identified. Any carers helping a relative etc. would be given instruction on how best to help the patient concerned.

OTHER: EG Pregnant women, people in civil partnerships, human rights issues. From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? Yes o No √
Explain your response: No further adverse impacts identified.

4. Safeguarding Assessment - CHILDREN
a. Is there a direct or indirect impact upon children? Yes o No √
b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:
c. If no please describe why there is considered to be no impact / significant impact on children
All patients including children are treated the same and the diet chefs will always speak to patients about their menu’s and Taylor them to the child’s palette

5. Relevant consultation
Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organizations etc?
There is no requirement to consult with stakeholders or key groups. The guidelines are to enable staff to comply with legislation and best practice.
6. Date completed: June 2015 Review Date: June 2018

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
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<tbody>
<tr>
<td>Continually update and maintain information on legislation and new procedures introduced. Assistance at any time by the Dietitians and SALT team for changing diets.</td>
<td>S.Thomson</td>
<td>On going</td>
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<td></td>
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<td>On going</td>
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8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead: lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead:

Date: 30.6.15