Royal Cornwall Hospitals
NHS Trust

Speech and Language Therapy Video Fluoroscopy Assessment Standard Operating Procedure

V1.0

September 2025

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Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. The Royal College of Speech and Language Therapists (RCSLT) recommend that any person with feeding or swallowing difficulties (dysphagia) have access to instrumental evaluation of swallowing.

1.2. Video fluoroscopic evaluation of oropharyngeal swallowing disorders (VFS) is a modification of the standard barium swallow X-ray examination. Oropharyngeal swallowing physiology and anatomy is evaluated as the patient eats and drinks a radiopaque substance such as barium sulphate. The radiopaque substance may be mixed with food or drink. The moving images of the oropharyngeal swallow are recorded for interpretation. VFS is used to assess swallowing in all patient populations and across all age groups. It may also be used to examine the competence of the vibratory segment in patients that have undergone a total Laryngectomy.

1.3. The RCSLT Position Paper "Video fluoroscopic Evaluation of Oropharyngeal Swallowing Disorders (VFS); The Role of Speech and Language Therapists" (2013) states that Speech and Language Therapists (SLT) have a key role in delivering this clinical service in a multidisciplinary context. Please refer to this position paper for details regarding SLT contribution to VFS, as a supplement to locally agreed protocols.

1.4. This version supersedes any previous versions of this document.

2. Purpose of this Standard Operating Procedure

2.1. Identify the SLT procedure for the assessment and delivery of video fluoroscopy.

2.2. To create a standardised method of conducting video fluoroscopy assessments in the RCHT trust by SLT team.

2.3. Improve personal care for the patient and reduce the risks associated with a video fluoroscopy.

3. Ownership and Responsibilities

This Standard Operating Procedure (SOP) relates to the following staff groups who may be involved in the assessment and delivery of video fluoroscopy at the Royal Cornwall Hospital

3.1. SLT have a unique role in the assessment and management of oropharyngeal dysphagia and play a key part in delivering VFS services in a multidisciplinary context.

3.2. At all times VFS is subject to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 (and subsequent amendments of 2006 and 2011).

3.3. SLT must have approval, including IR(ME)R entitlement, from their employer to undertake VFS. The SLT's responsibilities in relation to VFS should be stated in their job description.

3.4. SLT conducting the VFS will have undergone relevant in-house IR(ME)R training and E-Learning.

3.5. Clinical competence to undertake VFS must be evidenced by specialist training relevant to the clinical caseload. If an SLT undertakes any extended roles or duties their local clinical governance structures must approve and insure this practice

3.6. Role of Individual Staff

Profession	Role
SLT	1. Selection and referral of patients. 2. Liaison with medical practitioner as required. 3. IR(ME)R trained SLT to complete x-ray referral form. 4. Liaison with administrative staff regarding procedure admin. 5. Preparation of barium and other media required for VFS study. 6. To contribute to decision making re: contrast type, presence of staff required during VFS or who needs to be consulted (e.g. physio post-VFS). • A Patient Group Directive is available for use/administration of Gastromiro and should have been read and signed by any administering SLT staff. 7. To be aware of the rationale for performing VFS, i.e., inform the team of the findings from any clinical swallowing assessment and dysphagia management to date. 8. Clinical responsibility for conducting study. 9. To lead decision making ie: use of compensatory strategies, use of adaptive feeding equipment, delivery of trial boluses (e.g. size, taste, temperature) and decision regarding view of imaging (lateral or AP). 10. Interpretation of findings of VFS study. 11. Joint documentation of findings – images to be saved on PACS with report by Consultant Radiographer. SLT report uploaded to MAXIMS 12. Feedback to patient and/or carer. 13. Offer recommendations based on VFS findings to reduce risk of harm.

Profession	Role
	14. To disseminate SLT VFS report to all relevant parties. 15. Competent SLT to provide oral suctioning If required.
Advanced practice Head and Neck SLT (in addition to the above SLT role)	VFSA assessment of patients with a background of head and neck oncology or laryngectomy must only be conducted with a competent member of the Head and Neck SLT service present. 1. Performing self-insufflation assessments / TAUB with total laryngectomy patients – including passing an insufflation catheter. 2. Advanced practice and assessment of Laryngectomy patients' dysphagia and surgical voice restoration. 3. To liaise with Ear, Nose and Throat (ENT) consultants and support Joint management of patients requiring Botox injections. 4. Head and Neck oncology competent SLT to provide stoma suctioning If required 5. A Patient Group Directive is available for use/administration of Lidocaine and should have been read and signed by the administering Head and neck SLT staff.
Competencies in Tracheostomy management in addition to the above base SLT role	1. For any patients with a tracheostomy attending the VFS clinic as an inpatient or outpatient there must be at least one Speech and Language Therapist present who is competent in tracheostomy management.
Administrative staff	1. To liaise with the SLT team to ensure patients are booked for clinic slots inline with the clinical imaging wait times. 2. Arrange inpatient and outpatient VFS bookings and associated tasks 3. Liaise with ward staff/ambulance staff etc.

The VFS SLT involved in this procedure must be aware that the following limitations apply to their role:

- It is not the role of the VFS SLT to make a medical diagnosis.
- VFS should not be carried out without the presence of a SLT with VFS competencies, whose role is to ensure appropriate management and follow up is arranged as required.

- Close liaison with the referring SLT is essential to ensure appropriate management and follow up is arranged.
- The VFS SLT must not undertake the procedure in the absence of the Radiographer who is responsible for monitoring ionizing radiation exposure.
- The procedure will not be carried out in the absence of the Radiographer.

4. Standards and Practice

4.1. Location:

VFSA is carried out at the Royal Cornwall Hospital, Tower Block, X-ray Department, first floor. Patients arriving check in at reception and then are shown to the waiting room until called through to the examination.

4.2. Equipment

The following equipment is readily available:

- Lead coats – various sizes and thicknesses are available.
- Dosimeter badges are worn by the Radiology staff.
- Thyroid shields.
- Appropriate seating/positioning aids for VFS.
- A variety of foam wedges and pads.
- Level two PPE and eye protection as required.
- Suctioning equipment:
    - Patients who are O2 dependent should arrive to the clinic with portable oxygen.

The SLT team is able to provide further items such as dysphagia cups, cutlery, jugs, consistency identification numbers, modified diet leaflets and swallow information leaflets.

4.3. Procedure

4.3.1. Referral

- Patients can be discussed with a VFS competent SLT to ensure a referral for a VFS is appropriate.
- All patients (inpatients or outpatients) need to be seen by a SLT for a clinical bedside assessment prior to the VFS.
- Unless the patient is already known to the SLT service, the referral will not be accepted and will be sent back to referrer.

- The patient should give their preliminary consent for VFS, allowing the referral to be completed.
- The VFS inpatient / community referral forms can be accessed via the SLT county wide shared drive.
- VFS referral forms should be completed and emailed to rch-tr.VFSA@nhs.net
- All patients require a counterpart medical / non-medical referral via Maxims for inpatients or via Integrated Clinical Environment (ICE) system for community patients.
- Specialist services such as Stroke, and Head and Neck oncology are required to send an up-to-date patient summary and rationale via email to rch-tr.VFSA@nhs.net alongside the medical/ non-medical referral.
- Once received, the referral will be triaged and prioritised by a VFS competent SLT.
- Inappropriate referrals will be rejected, and the referrer will be informed.

4.3.2. Booking a VFS

- Standard VFSA clinic slots are on a Tuesday morning with four x 30-minute slots between 9am and 11am.
- The Responsible SLT will use read only access to the clinical radiology imaging system to cross check medical radiology referrals with SLT referrals to the clinic
- The responsible SLT will email clinic bookings through to the clinical imaging booking team in a timely manner.
- The responsible SLT will highlight any infection and prevention control requirements for individual patients.
- Clinical imaging booking administrator to liaise with inpatient wards and arrange outpatient patient letters (Appendix 4) for appointments and if required liaise with the patient to confirm appointment.

4.3.3. Patient and Carer information

The following information about the VFS study is available to patients and carers:

- Appointment letter including radiology department telephone number. Patients should be informed of any changes to the appointment.
- VFS standard information leaflet.

- Written information sheets as required, e.g. information and advice regarding advised modified diet and fluids.

4.3.4. **Consent**

Where a patient has the capacity to consent to a VFS, the referrer must gain and document initial verbal consent for referral to the VFS service.

A VFS can be completed if the patient is deemed not to have capacity and is unable to give consent, if the VFS is deemed to be in the patient's best interest. Where a patient does not demonstrate capacity, the medical referrer should complete a Mental Capacity Act (MCA) form in line with RCHT /CFT MCA policy, demonstrating the VFS is in the patient's best interest, and ensure this documentation is uploaded/stored in the appropriate place for their local system.

Note:

- Please note additional support for those who may need BSL or where English is not the first language can be found in the RCHT Interpreting and Translation Services Policy.

- In some circumstances, a carer may be present during the procedure to improve patients experience and compliance. This will be under the instruction of the radiographer who will complete a consent form if needed.

4.4. VFS study protocol

As outlined in the RCSLT's VFS Position Paper, there is significant variability in the literature and in published protocols for VFS. VFS should always follow a systematic and a structured framework as possible to allow for comparison within and between patients. However, VFS is a dynamic assessment and should be flexible to allow changes to protocol or framework dependent on the patient's presentation or their response to the evaluation.

The following is therefore a useful guideline for protocol but will be dependent upon patient's presentation or their response to evaluation, and is not exhaustive:

4.4.1. **Consultant Radiographer / Radiographer specialised in VFSA role:** (Positioning, imaging timing and reporting)

- All those present in the room who are not contributing to the procedure will be there at the discretion of the radiographer and are permitted to stand behind the screen during when screening is occurring.

- The Radiographer will ask the patient to confirm their identity with date of birth and address.

- The Radiographer will check if the patient has any allergies or intolerances.

- The Radiographer will ask female patients of child-bearing age to confirm they are not, to the best of their knowledge, pregnant and sign the appropriate consent form.

- The Radiographer will jointly analyse the images with the SLT and upload the final report to the clinical imaging reporting system.

4.4.5. **Patient positioning arrangements:**

- Standing, if needed, where patient fitness safely permits.

- Use of standard chair for improved patient stability where transfers can be safely undertaken.

- Otherwise, use of patient's own chair, portering chair, VFS chair, or trolley/bed (note: A-P view cannot be undertaken with trolley and may not be possible with a portering chair due to its dimensions)

- Use of appropriate support in the form of pillows, foam pads, etc. to achieve optimal position.

4.4.6. **Use and preparation of radio-opaque materials:**

- Refer to the recipe tables for diet and fluids See Appendix 3.

- Radio-opaque materials used in VFS may include: EZ-HD, EZ-Paque and Gastromiro.

- Use of materials used may change depending on factors such as stock availability, best before dates, clinical or patient preference.

- EZ-HD and EZ-Paque are a pharmacy only product, therefore, does not need a PGD or prescription for use.

- Staff should be aware of the current Summary of Produce Characteristics (SPC) for EZ-HD to ensure the patient does not have any of the exclusion criteria https://www.medicines.org.uk/emc/product/6667/smpc#gref

- Staff should be aware of the current Summary of Produce Characteristics (SPC) for E-Z-Paque to ensure the patient does not have any of the exclusion criteria E-Z-Paque 96 % w/w powder for oral suspension - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)

- A Patient Group Directive is available for use/administration of Gastromiro and should have been read and signed by any administering SLT staff. Staff should be aware of the current Summary of Produce Characteristics (SPC) Gastromiro - Summary of Product Characteristics (SmPC) - (emc)

4.5. **Images collected:**

4.5.7. **Lateral plane:**

- Preliminary screen: check patient optimally positioned and examine anatomical features for evidence of abnormality, prostheses, previous surgical intervention and location of insufflation catheter (if applicable).
- If the patient's mouth is dry or the patient is on oxygen: either water can be applied to mouth by means of oral hygiene sponge or given a small sip of water (if felt safe to do so).
- Self-administered bolus, where considered safe is encouraged.
- Fluids trials as per VFS SLT/clinically indicated, e.g. single sips and sequential sips, fluid modification.
- Diet of varying consistencies to be trialled as per VFS SLT/clinically indicated.
- Repetition of any of the above trials where clinically indicated.
- Trial of compensatory techniques if clinically indicated.

4.5.8. **Antero-posterior (A-P) plane – if indicated:**

- Preliminary screen: check patient optimally positioned and examine anatomical features for evidence of abnormality, prostheses, previous surgical intervention.
- Repetition of any of the above when clinically indicated.

4.5.9. **Lateral-oblique plane (Laryngectomy):**

- Initial swallow of EZ-HD contrast to highlight anatomical structures.
- Assessment of vibratory segment using sustained phonation following direct verbal prompts from SLT.
- Head and Neck oncology competent SLT may use insufflation/ self-insufflation to assess. the competence of the vibratory segment.
- Repetition of any of the above when clinically indicated.

4.5.10. **Further to the above, the following will be incorporated as clinically indicated:**

- Instruction to cough post-silent penetration or aspiration.
- Instruction to swallow if follow-up swallow is not triggered spontaneously in response to significant pharyngeal residue.

- Postures/manoeuvres trialled to assess the impact on the clinical findings for management, rehabilitation or risk reduction.

- Trial of other texture on an individual basis, e.g. .g. patients with long term brain injury, spinal injury, learning disability etc may wish to bring their own preferred food.

- Variation to standard views, for instance, oblique.

4.6. **Image recording:**

- All imaging for VFS will be performed by the radiographer in accordance to departmental protocol for VFS. Standard IR(ME)R procedures will be applied.

- The study will be recorded to PACS for permanent storage. Where available, still images may be printed for inclusion with the report or in the patient's medical or SLT notes.

4.7. **Termination of the procedure:**

- While a study should aim to be comprehensive, it is envisaged that it may have to be terminated at any stage of the procedure. The circumstances determining this could include, for example, large-volume aspiration, withdrawal of consent, patient distress, patient non-compliance, and concerns for fitness for continue such as breathing difficulties, paroxysmal coughing etc. This is not an exhaustive list.

4.8. **VFS Interpretation**

The following procedures are in place to ensure best reliability and inter reliability of interpretation of images:

- Presence of one Radiographer and at least one appropriately trained and experienced VFS Level three or four competent SLT.

- It is best practice to have two trained and experienced VFS competent SLT available for the VFS.

- Use principles from MBSIMP(Modified Barium Swallow Impairment Profile) framework as a standardized tool to interpret the VFS study.

- Use of penetration / aspiration scale (Rosenbek JC, et al. A penetration-aspiration scale. Dysphagia 1996; 11:2,93-98).

- Use of the Dynamic Imaging Grade of Swallowing Toxicity (Hutcheson KA, Barrow MP, Barringer DA, et al. Dynamic Imaging Grade of Swallowing Toxicity (DIGEST): scale development and validation. Cancer. 2017; 123: 62-70).

- The use of any evidence based SLT specialty specific outcome measures or rating tools relevant to the specific patient demographic for example the head and neck oncology patient population.

- Joint SLT and Radiographer interpretation and reporting where able.
- Use of RCHT VFS competencies to inform training and requirements of SLT based on previous RCLST VFS competencies stored on in the documents library under Competency Assessment for Speech and Language Therapists: Videofluoroscopy.

4.9. **VFS Reporting**

- VFS reporting is subject to professional standards, as outlined in the RCSLT VFS Position Paper.
- The report will be completed by the SLT/s conducting the VFS in a timely manner following the assessment. This can be done jointly with the Consultant / specialised radiographer.
- Unexpected findings, including unsuspected medical conditions, must be included in any report, and highlighted to the patient's GP or medical in-patient team.
- The report should be circulated in an appropriately timely fashion to the patient and/or carers, and medical or other health professionals involved in the patients care as appropriate.
- A copy of the SLT VFS report will be uploaded to the relevant electronic patient systems such as Maxims / RIO/ Insight web.

4.10. **The SLT report contains the following information:**

- Patient identification information.
- Diagnosis and relevant medical history.
- Current nutrition.
- Clinical question (purpose of the VFS study).
- Clinicians undertaking the examination.
- Views undertaken (negative statement made if AP view not obtained, e.g. due to positioning issues).
- Contrast agents used.
- Structural and physiological abnormalities e.g. post-surgical anatomy, cricopharyngeal bar or abnormal cervical osteophytic outgrowth (if identified by Radiologist).
- IDDSI Consistencies evaluated.
- Oral stage function.
- Pharyngeal stage function.

- Upper oesophageal sphincter function.
- Results of interventions attempted i.e. manoeuvres and postures.
- Observed penetration and/or aspiration or perceived risk thereof.
- Severity of impaired features will be indicated by the impressionistic terms, mild, moderate and severe.
- Overall impression of swallow function.
- Recommendations, including any suggested therapy (negative statement to be included if therapy not indicated) and plan for review.
- Follow up plan.

4.11. **Further to the above, please note:**

- In the case of in-patients who have undergone a VFS, a note should be made in the inpatient medical notes including a summary and/or immediate guidance for the ward immediately following the study. A formal report is still written, and a copy placed in the electronic notes once completed and paper notes where appropriate.
- Reporting will be completed in a descriptive manner highlighting impairment of swallow efficiency, safety by consistency, highlighting salient features and making summary statements. Where appropriate tonicity and alaryngeal voice will be commented on for those with a laryngectomy.
- The effectiveness of any compensatory strategies e.g. follow-up swallows (spontaneous or instructed) will be detailed.
- Functional implications will be commented on, e.g. it is unlikely that oral feeding can sustain an adequate level of nutrition.
- Hypotheses regarding the aetiology of the swallow impairment will be made, e.g. the above observations are consistent with a neurological cause.

4.12. **Recommendations may include the following:**

- Recommendations for nutrition/hydration, e.g. oral intake, nil by mouth, enteral feeding only, modified oral feeding, a combination of enteral and modified oral feeding.
- Recommendations for optimising oral intake can be advised where indicated.
- Management strategies, e.g. compensatory strategies, manoeuvres, therapeutic intervention.
- Therapeutic management if appropriate such as specific swallowing exercises.
- The appropriacy of patients for surgical voice restoration and botox.

- Indications for ongoing management.
- Other investigations or onward referral to be considered.

4.13. Health and safety: general procedures

COSHH: No substances hazardous to health and coming within the remit of this legislation are currently in use.

4.14. Infection control:

- SLT observe the local protocols for handling patients with known or suspected infection requiring special measures. In-patients in this category should be at the end of the x-ray attendance list where able.
- PPE should be worn as per the Trust policy at the time.
- Cleaning of patient seating and x-ray equipment is the responsibility of the radiographer.

4.15. Equipment:

- Where possible re-usable utensils such as spoons will be used.
- Utensils such as teaspoons and specially adapted dysphagia cups will be cleaned in accordance with recommendations laid down by the Infection Control service. The specifications include the use of bactericidal detergent.
- Single use insufflation kits will be used for Laryngectomy patients and disposed of inline with the trusts waste management policy.
- Diet and fluid portions are allocated to each patient and disposed of between patients in line with x-ray departmental protocol.

4.16. Contrast materials:

- Refer to the recipe tables for diet and fluids in Appendix 3.
- Patients are made aware that barium products will be used for the VFS study and will be given the opportunity to advise the SLT and radiographer of any previous suspected or known adverse reaction.
- In the case of patients who have recently undergone reconstructive surgery to the aero digestive tract (e.g. post head and neck surgery, oesophagectomy, etc.), senior medical staff will be consulted prior to undertaking the VFS study to determine patient safety for exposure to the proposed use of contrast materials.
- Unused contrast materials are disposed of in line with x-ray departmental protocol.

4.17. Resuscitation/Adverse Reactions:

- SLT are subject to resuscitation and anaphylaxis training, as provided locally.
- In the event of an adverse incident (significant respiratory distress, cardiac arrest, etc.), there is ready access to suitably trained personnel.
- There is access to local resuscitation team on site (2222).

4.18. Clinical incident reporting

Reporting of clinical incidents in the main X-ray department will be undertaken by local radiography and/or nursing or medical staff according to the recognised procedure with the option of a separate SLT report on Datix.

4.19. References

Royal Cornwall Hospital NHS Trust (20203). *Oropharyngeal Dysphagia Assessment and Management in Adults Clinical Guideline V8.0*. [online] RCHT Documents Library. Available at:http://doclibrary-rchtintranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/SpeechAndLanguage/OropharyngealDysphagiaAssessmentAndManagementInAdultsClinicalGuideline.pdf [Accessed 7 Nov. 2023].

Document Control Title Videofluoroscopy Procedure for Speech and Language Therapists and Radiographers Standard Operating Procedure. (n.d.). Available at: https://www.northdevonhealth.nhs.uk/wp-content/uploads/2019/07/Videofluoroscopy-SOP-V2.0.pdf [Accessed 7 Nov. 2023].

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Smithard, D.G., O'neill, P.A., Park, C.L., Morris, J., Wyatt, R., England, R. and Martin, D.F. (1996) **Complications and outcome after acute stroke: does dysphagia matter?** *Stroke*. 27(7), 1200-1204

Tibbling, L. and Gustafsson, B. (1991) **Dysphagia and its consequences in the elderly**. *Dysphagia*. 6(4), 200-202.

RCSLT. (n.d.). *Dysphagia - learning*. [online] Available at: https://www.rcslt.org/members/clinical-guidance/dysphagia/dysphagia-learning/#section-5 [Accessed 7 Nov. 2023].

IDDSI. (2019). *IDDSI*. [online] Available at: https://iddsi.org/.

Royal Cornwall Hospital NHS Trust (2023). *Ionising Radiation Safety Policy V3.2* [online] RCHT Documents Library. Available at: http://doclibrary-rcht intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/MedicalPhysics/IonisingRadiationSafetyPolicy.pdf [Accessed 7 Nov. 2023]

Benefits and Risks of Radiation Fluoroscopy poster (cornwall.nhs.uk)

Royal Cornwall Hospital Trust (2024) Referral, Justification and Reporting of Radiological Procedures Policy. Available at Referral, Justification and Reporting of Radiological Procedures Policy

Royal Cornwall Hospital NHS Trust (2023) Speech and Language Therapy Management of Adults with Head and Neck Cancer Clinical Guideline. Available at Speech and Language Therapy Management of Adults with Head and Neck Cancer Clinical Guideline

Royal Cornwall hospital Trust Insertion of insufflation catheter competencies InsertionOfInsufflationCatheterCompetencyAssessmentRecord.pdf

The Sunderland voice scale An investigation of reliability of the Sunderland Tracheosophageal Voice Perceptual Scale.pdf

RCHT VFSA competencies available on the RCHT documents library under Competency Assessment for Speech and Language Therapists: Videofluoroscopy, Levels 1- 4

5. Dissemination and Implementation

5.1. This document will be made available on the Royal Cornwall Hospital Trust intranet. It will also be ratified and disseminated through the Nutrition Steering Group and Therapies Senior Management Team.

5.2. This document will be highlighted to all SLT staff undergoing VFSA competencies or who have completed them at Royal Cornwall hospital Trust.

6. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	1. SLT VFSA competencies. 2. SLT insufflation catheter insertion competencies. 3. VFSA clinic wait list and wait times. 4. SLT PGD Compliance.
Lead	SLT VFSA clinic Leads / Dysphagia Lead post holder.
Tool	**Creation of an SLT competency and PGD sign off database.**
Frequency	Yearly / As new VFSA competencies completed.
Reporting arrangements	SLT Dysphagia Lead / VFSA Clinic Leads. SLT professional Lead.
Acting on recommendations and Lead(s)	1. Stroke Clinical lead for SLT. 2. SLT dysphagia lead. 3. Head and Neck oncology SLT leads. 4. Critical Care ITU SLT Leads.
Change in practice and lessons to be shared	No specific change in practice required. Dissemination of information to be shared via below. SLT CPD, Team meetings, County wide SLT service meetings and service specific MDTs.

7. Updating and Review

This document will be reviewed on a 3 yearly basis by the Dysphagia lead / VFSA clinic lead post holder in conjunction with any other key stake holders.

8. Equality and Diversity

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

8.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Speech and Language Therapy Video Fluoroscopy Assessment Standard Operating Procedure V1.0
This document replaces (exact title of previous version):	New Document
Date Issued / Approved:	23 December 2024
Date Valid From:	September 2025
Date Valid To:	September 2028
Author / Owner:	Alexander Bond, Acute SLT team Lead and Dysphagia lead. Claire Higgins, Head and Neck Oncology SLT Joint Lead and Joint VFSA Clinic Lead.
Contact details:	01872 252470
Brief summary of contents:	Identify the SLT procedure for the assessment and delivery of video fluoroscopy. To create a standardised method of conducting video fluoroscopy assessments in the RCHT trust by SLT team.
Suggested Keywords:	Speech and Language Therapy, Video Fluoroscopy Assessment.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Dual Chief Nursing Officer
Approval route for consultation and ratification:	Nutrition Steering group (December 2024). Therapies Senior Management team. Clinical Support Care Group Governance.
Manager confirming approval processes:	Clare Rotman
Name of Governance Lead confirming consultation and ratification:	Becky Osborne

Information Category	Detailed Information
Links to key external standards:	RCSLT position paper.
Related Documents:	The RCHT Management of Oropharyngeal dysphagia in adults' guidelines.
Training Need Identified:	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Speech and Language Therapy

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
August 2025	V1.0	Initial issue	Alexander Bond, Acute SLT team Lead and Dysphagia lead. Claire Higgins, Head and Neck Oncology SLT Joint Lead and Joint VFSA Clinic Lead.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Speech and Language Therapy Video Fluoroscopy Assessment Standard Operating Procedure V1.0
Department and Service Area:	Clinical support/ Therapies
Is this a new or existing document?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Alexander Bond, Acute SLT team Lead and Dysphagia lead. Claire Higgins, Head and Neck Oncology SLT Joint Lead and Joint VFSA Clinic Lead.
Contact details:	01872 252470

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	SLT staff involved in the delivery and procedures of Video Fluoroscopy assessment of swallowing.
2. Policy Objectives	Identify the SLT procedure for the assessment and delivery of video fluoroscopy. To create a standardised method of conducting video fluoroscopy assessments in the RCHT Trust by SLT team.
3. Policy Intended Outcomes	Increase patient safety through clarified roles and responsibilities for SLT's Delivering VFSA clinics.
4. How will you measure each outcome?	Incident monitoring, Competency completion.
5. Who is intended to benefit from the policy?	SLT staff delivering VFSA Clinics.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Therapies Senior Management Team. Care Group Governance. Imaging.
6c. What was the outcome of the consultation?	Content agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Alexander Bond, Acute SLT team Lead and Dysphagia lead and Claire Higgins, Head and Neck Oncology SLT Joint Lead and Joint VFSA Clinic Lead.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. VFSA E-Z-Paque Recipe sheet

IDDSI Diet Consistency / amount	**Barium Solution** **1x E-Z-Paque bottle diluted with 60ml of water.**	**Portioning**
Level 4 Puree: 1 pot of level 4 puree custard. (use custard as ambient and can be out on side with no food hygiene risk).	Add 10 ml of Ez Paque solution above. Stir well.	1 pot splits between two patients.
Level 5 Minced and Moist diet: 1 pot of level 5 minced and moist rice pudding. (use rice pudding as ambient and can be out on side with no food hygiene risk).	Add 10 ml of Ez Paque solution above. Stir well.	1 pot splits between two patients.
Level 6 soft and bite sized diet: ½ banana chopped to level 6 consistency.	Add 10 ml of Ez Paque solution above. Mix well.	Aim for ¼ banana per patient.
Level 7 regular: Biscuit.	Iced to the edge of the biscuit using the Ez paque solution above.	1 biscuit per patient.

IDDSI Level Fluids	**Barium solution:** 1x Pot of E-Z-Paque. Diluted to 600ml.	**Thickener:** Thick and Easy Clear.	**Number of Thickener scoops per 200ml of E-Z-Paque solution**
Level 0 Thin Fluids			None
Level 1Slighlty thick Fluid			1x Scoop per 200ml
Level 2 mildly thick Fluid			2x Scoop per 200ml
Level 3 Moderately Thick Fluid			3x Scoop per 200ml

Appendix 4. VFSA Patient Information Leaflet

RCHT patient information leaflet 1829 – Video Swallow.

Accessible on the RCHT intranet.

Covering the patient information below:

- What is a video swallow?
- Why do I need it?
- Are there any alternatives?
- How do I prepare for it?
- What does it involve?
- Will I have any pain or discomfort?
- Who will be involved?
- How long does the examination take?
- Are there any risks?
- What happens afterwards?
- When will I get my results?
- About your consent.
- Further Information and contact details.