



**RCSLT and IDDSI webinar – Making IDDSI work for you
Wednesday, 13th February 2019**

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Good afternoon, everyone. Welcome to today's webinar: Making IDDSI Work for You. My name is Kamini Gadhok and I'm Chief Executive at the Royal College of Speech and Language Therapists. And I'm going to be chairing this afternoon's webinar.

This afternoon, I'm really pleased that we have a number of presenters. We have Dr Ben Hanson, who is Associate Professor at UCL and is also an IDDSI board member. Dr Hannah Crawford, who is Patient Safety Expert Adviser at NHSI and also is a Specialist Adviser for the Royal College of Speech and Language Therapists. Anita Smith, Consultant Professional Lead for Speech and Language Therapy in East Sussex NHS Trust and joining us for the Q&A is Louise Borjes, who's our Project Coordinator at the Royal College of Speech and Language Therapists, supporting work on dysphagia for our members.

Before I go on to the aims and introduce the first speaker, I just want to give you a few housekeeping notes. For those of you who have not been involved in a webinar before, just to let you know that you can send in chat messages at any time by using the chat button. Those will be dealt with by Kaleigh, and so she'll be on hand listening in or watching your issues as they arise and be able to help.

In addition, please do send in any questions that you might have using the Q&A button. It would be helpful if you let us know which of the panellists you would want to answer that question if you can think of who that might be, that is.

It's really important that you do use the chat button, as I said, if you have any difficulties with the webinar software. And if you do want to use Twitter to join the conversation, use the hashtag #RCSLTwebinar.

The webinar is going to be an hour long, with questions at the end. It's going to be recorded and will go online with the slides after the event. Also, we'd like to remind you to fill in the evaluation form that will pop up in a new window once the webinar window closes. This will also be sent out in the post-webinar email.

Finally, just to highlight the learning objectives for the webinar; I'm not going to read that out to you, and hopefully you'll find that this is a useful webinar to respond to some of the issues that you've raised with us previously around IDDSI.

And now I'd like to introduce our first speaker, who is Dr Ben Hanson, Associate Professor at UCL and, as I mentioned earlier, an IDDSI board member.

Dr Ben Hanson, Associate Professor, University College London; and IDDSI Board Member

Thank you very much, Kamini and the RCSLT team for organising this webinar.

Firstly, a reminder of why we're here today. IDDSI is focused on safety and quality of life for all cultures in care settings. And the main reason for changing from the existing UK descriptors is to move from subjective terms to objective. So we've got objective measures for speed limits and even the definition of what's a large glass of wine. So in healthcare, we should use objective measures wherever that's possible. It turns out that measuring and defining texture of food and drinks is not

as easy as measuring things like temperature, for example. But IDDSI have defined a range of measurements and specifications based on the best available science and clinical data. In comparison to the previous UK descriptors, they're quite similar, in particular, for foods. But we've been able to specify some subjective terms using measurements. So soft, for example, we have a fork test to assess that.

And a reminder, as if you needed it, why all this matters. My colleague, Dr Hannah Crawford, is going to cover these patient safety alerts later, but worldwide there was overall a need for greater clarity in diets.

I think you've all heard of IDDSI, but you might not know what it is. And that it is a non-profit voluntary organisation, of multidisciplinary international board of volunteers – all with clinical roles or scientific roles. We followed international best practice on creating guidance and policy documents to come up with the framework, and we do have industry sponsors who support our meetings and administration costs, the website and so on. But they have no position on the board and they have no input to the content of the IDDSI framework. And we published all of those outcomes, and the framework itself open access.

The framework is summarised by this diagram, and it also includes documents describing the physiological rationale and the testing methods that supplement each level. I'll cover the new subcategory, easy to chew, in this presentation later on.

So the first point today is what this webinar is all about. IDDSI is not here to tell you what to do, it's about making IDDSI work for you. IDDSI is a specific language which allows clearer communication, from assessment through all the different care settings, and it should be a tool that you can use in your clinical practice according to your judgement. There were some questions from the delegates about who will enforce IDDSI and how we can monitor whether nursing homes are compliant. There's no government mandate, and there's no law. There is, though, endorsement from the Royal College of Speech and Language Therapists and the British Dietetic Association. We would expect that it would be generally regarded as best practice in the years to come.

The CQC currently has some guidance about IDDSI and it points to the NICE guidelines which require patients to be given foods and drinks in a suitable format. But, at the moment, NICE doesn't specifically mention IDDSI. In practice, the suppliers of foods and drinks are very supportive of IDDSI and are changing products and changing labelling, and they should be good allies going forwards.

So carrying on to look at how IDDSI can work for you. In point 2, we'll talk about some of the examples of how people have exploited the quantitative nature of the IDDSI scale to measure patient outcomes. We'll then look at those texture measurements which define the IDDSI levels and we'll look at if and when they're necessary to be used. And finally, this new subcategory of regular foods, which we're calling 'easy to chew'.

Firstly, in training and education, a big advantage of the size and international scope of IDDSI is that there's lots of potential to share and adapt existing resources for training and information. Even my local 12-bed hospital can use the same teaching materials and resources that are available worldwide. And it's actually been brilliant to see that the same standards are being used in the very best funded North American hospitals, to some very under-developed areas of rural South Africa.

On the IDDSI resources webpage, there are lots of things to help you out. There are presentations that you can download and deliver yourself. There are videos. There are some posters that you can print out. There's some information and implementation guidelines, month-by-month, for all different sectors, and there are industry guides on product labelling.

We also have translations of the framework into different languages, which you might find useful for some of your staff and patients. And I could ask if you do have some NICE training material or information that you've developed yourself, please do consider emailing that info: office@iddsi.org, and we'd be more than happy to share that.

There's now a section specifically for UK affairs on the IDDSI resources website. Some of the latest additions to the resources are some posters which cover the whole framework and a set of consumer handouts which describe each of the levels. And those have been reviewed for easy readability, and they have some examples of dos and don'ts.

Okay, so let's focus on IDDSI in practice as a communications tool. So as I mentioned, IDDSI can be used as a common language to categorise someone's safe eating ability from assessment through all of their care settings. Looking at the pyramid, the upper and lower limits are the broadest and least restricted levels and the centre is the most restricted, the most modified. So a person's food and drink classifications can be thought of as the upper and lower bounds of their safe eating range. And it's important to highlight that people are not only limited to one level of food and one level of drink. Their meals and their experience will be much more interesting and appealing if they're provided with the full variety of textures that they're capable of. So, for example, if someone's capable that could be a casserole with soft, bite-sized pieces of meat and some smaller pieces of vegetables or rice and pasta, and that could be in a thick gravy – or it could be a custard that goes alongside a pudding.

There's some excellent examples out there, and we'll be demonstrating and featuring some of those on stage at the IDDSI festival on Monday [18 February 2019]. So what we see highlighted on this slide is how you can use a person's range of IDDSI levels as a quantitative measure of their safe eating and drinking capacity. And this tool has been published by Professor Steele, from the University of Toronto, who is using it to track patient progression and rehabilitation.

So now we all have a quantified objective scale, which we can use as we need to. How to use those measurements? Well, we looked at how to classify food and drinks in the food science arena; generally, that uses very expensive lab equipment and when we created the IDDSI framework, we wanted to ensure those measurements were available were open and transparent to all. So we created some simple tools.

The common worry, though, that came out from that was that, do we all need to test everything at the point of service? And I'm happy to say that that's not the case. Manufacturers have all been busy using these tests to reformat their products and standardise all of them against the same international specifications. So in your practice, if you're confident that you are using reliable products and reliable practices then you don't need to test everything each time.

Some of those tests are easier than others. The fork and spoon tests are very convenient and available. We are aware that there has been some problems with syringe availability for the flow test, but we've made sure that the thickener manufacturers have plenty of stock. So if you are struggling, do feel free to ask them for some samples.

IDDSI have also developed a funnel, which is using the same geometry as the syringe. That has no plunger, and so can't be called a syringe, and that would help to avoid some potential confusion with IV syringes. Now, those are being produced out in China at the moment, and we hope to have distribution through 2019.

On to the new subcategory of level 7, easy to chew. Well, since the initial publication of the framework, there've been lots of calls for the definition of the soft but not necessarily bite-sized level. We didn't include this originally, because it was very difficult and there's a very wide range of products and clinical issues around the world. But last year we sent out an international survey and had plenty of feedback from the UK in particular, that showed that this sort of level was very widely used.

We also concluded that easy to chew was the preferred name, rather than 'soft', or 'tender'. And in terms of categorising it, we looked at level 6, which is specifically designed to minimise choking risk through the size limit, so that in the worst case the food particles would not be large enough to totally block the airway. So that means that level 6 is very safe, but it's quite restrictive.

In comparison, the easy to chew doesn't have this risk mitigation built in, and that's why it's a subset of level 7 regular foods, not level 6. That's a failsafe in case of any misunderstanding or mislabelling.

In the meantime, there's been a lot of dialogue between senior UK colleagues and IDDSI board members about our guidelines for using this level. And the specific UK input was to focus on user experience and the quality of life, maintain choice and managing risk through clinical judgement. We did want to make sure that this level was available for some clients with some forms of dysphagia, as long as that's under clinical supervision and guidance.

So we do now have a consensus worldwide and we're updating the framework online to represent that. The first tasks in terms of publicising that have been to create user handouts, so putting this into real peoples' hands. And that includes level 7 easy to chew as you can see here. Level 7 easy to chew is also on the new posters that we've created for paediatrics and adults, which cover the whole framework on one piece of paper.

So I think that's all I'd like to say about this. We've had a few more questions, which we'll cover at the end and just for now I'll pass on to Dr Hannah Crawford.

Dr Hannah Crawford, Patient Safety Expert Advisor, NHSI

Thank you, Ben, and thank you to RCSLT for hosting this webinar and for inviting me to join you.

As Kamini said, as well as being a consultant speech and language therapist, I am a Patient Safety Expert Advisor at NHS Improvement, and I'm here representing NHS Improvement at this webinar.

So where NHS Improvement came into this was via an alert that was brought to our attention from a mental health trust who had reviewed its own incidents and felt that a misunderstanding of the term 'soft diet' had contributed to the incidents in their setting. As a result of that, we looked at the National Reporting and Learning System and reviewed a slice of data over a two-year period.

In that data, we were able to identify that the term, or the use of the term 'soft diet' had contributed to incidents reported to the NRLS and within that slice of data, seven of those reports had resulted in significant harm; with two of those reports the patients died.

So you've seen the alert briefly in Ben's slides, but this is what we produced at NHSI and this was released at the end of June 2018. Within the NHS, the patient safety team should have seen and disseminated this alert, and it has also gone out to pharmacists and GPs. This alert primarily urges us to not use the term 'soft diet' because it is imprecise and it can lead to misunderstanding. And a result of that, we advised that, while we don't use the term 'soft diet', we do start to use the IDDSI terminology. We were aware IDDSI was being released internationally and as a member of the Royal College of Speech and Language Therapists, I was aware that RCSLT were encouraging members to begin implementing IDDSI with full uptake in April 2019.

IDDSI is a clear and systematic way of describing food and fluid modification and will hopefully reduce the misunderstandings in relation to food and fluid modification.

One of the things we feel very strongly about at NHS Improvement is that we have one system for describing food and fluid modification, regardless of the reason why the individual needs their food or fluid modified. So that covers people with dysphagia, and people who we may not traditionally have classed as having dysphagia, but need their food modified. So regardless of the reason you need your food modified, the end result is the same: food is modified in the same way. And the reason we are recommending we have one system is that having more than one system can lead to confusion, errors and a risk to patient safety. And where people at the front end of food delivery, such as domestics and catering assistants may be the ones providing food to patients, we cannot expect them to make decisions about which system would be used to describe the modification for that individual patient.

The important thing to say from my perspective is that you should always use your clinical judgement first and foremost when making recommendations for texture modification or fluid modification for your patient. That is the thing that should be overriding. However, we recommend that you do use IDDSI as the starting point for this description. You may then want to make individualised, person-centred recommendations around IDDSI as a tethering point, so we would recommend that you always refer to IDDSI descriptors in case notes, reports and clinical documentation and in any professional correspondence. But it's really important to make sure that the description and the recommendation for food modification is right for that individual and not driven by IDDSI.

So, as Ben said, IDDSI is not a law; IDDSI is a language that we would recommend you communicate with in a person-centred way for your patients. And that is the starting point and a tethering point.

Another important point to make is that patients themselves may use different terminology and that's fine. It must be meaningful to patients and their families, but, as I say, in those professional correspondence, case notes and clinical documentation, make reference to IDDSI so that in transfers of patients and in multidisciplinary input everyone understands the recommendations that have been made.

The other thing that I would endorse that Ben has touched on already is that, where we make a recommendation for a specific texture for individuals, an unforeseen consequence of that can be a fairly restrictive approach to provision of food and fluid. And I think it's very important that we look at the upper and lower limits of what service users or patients can manage and make sure we give them the least restrictive options and as interesting and varied diet as we can.

In order to do this, I'm going to speak to you briefly about a case presentation. So John lives in a small group home. He has moderate learning disabilities and cerebral palsy. He's had his food modified for several years. He can't eat a normal consistency diet. He needs his meat to be pureed with gravy added and he needs vegetables to be well cooked and chopped, but he can eat crisps like Skips and Wotsits and he loves chocolate buttons and foods which melt in his mouth. He can eat sandwiches if the bread is very soft and the crusts are cut off and the sandwiches chopped into 1.5cm squared pieces and the fillings are moist, such as egg, or tuna mayonnaise. The speech and language therapy recommendations previously have indicated a texture 'E' diet: fork-mashable with pureed meat and they've specified the size that the food should be chopped to.

However, John knows his food should be prepared, and he tells people that he eats 'choppy' food. Recently, the group home manager has contacted the speech and language therapist because she's worried that John needs re-assessing because they've heard about the IDDSI texture descriptors. The speech and language therapist reassures the manager that the way John's food needs to be prepared has not changed, just the way we describe it has changed. John's food would now be described as IDDSI level 6, soft and bite-sized, with meat at IDDSI level 4 pureed. John can also manage some transitional foods. She advises the manager that John can eat any food that falls between IDDSI level 3 and IDDSI level 6, but that he would not be safe eating IDDSI level 7, normal or easy to chew.

The speech and language therapist also reassures the manager that they should still use John's chosen term, 'choppy' foods, when they are talking about food with John, but that in any reports or clinical documentation IDDSI terminology should be used so that everybody supporting John is using a clear and common language, with a clear supporting description.

The final thing I would like to say is that IDDSI is a systematic approach to the description of food and fluid modification. However, it is not research into the efficacy or effectiveness of texture of fluid modification. So as practitioners, we should really critically evaluate the most up-to-date evidence about texture and fluid modification and make person-centred, flexible recommendations, based on the evidence, the wishes of the patient and family or carers, and your own clinical experience.

It's also really important to say that, where patients lack capacity, recommendation should be made in their best interests and represent the least restrictive option, taking into account health, wellbeing and quality of life. What IDDSI will do is provide us this systematic and consistent predictable approach to the description of food and fluid modification. So we look forward to the development of more robust research findings because we can now consistently describe the food and fluid textures.

I'd now like to hand you over to Anita, who is going to talk us through implementation in East Sussex.

Anita Smith, Consultant/Professional Lead SLT, East Sussex Dysphagia Lead, East Sussex Healthcare NHS Trust

Thank you, Hannah, and thank you to the Royal College for inviting me to describe my journey in East Sussex through implementing IDDSI.

East Sussex Healthcare Trust is an integrated acute and community trust. We have two acute hospitals, a community hospital, 243 care homes and 30 speech and language therapists, roughly. So it's quite a large patch to cover.

We started thinking about how we were going to implement IDDSI and we started looking at the college website, and there was a really good model on there that we could use. And it had three phases to it: aware, prepare and adopt. So that's what we decided to use.

So I first became aware of IDDSI by attending ESSD and hearing the board talk about it. And I think that would be a really good model to approach; I wonder when that's coming in. Well, I didn't have to wait too long, because I had six weeks' notice from East Sussex that we would be implementing IDDSI with a go-live date in May 2018, so I had to think about it really quite quickly.

So I started to think about who my stakeholders were. It's really important to do a stakeholder analysis to look at who needs to be involved, what level they need to be involved and to start those discussions early in order to get buy-in from your key stakeholders.

So this is an example of the stakeholder analysis that I did. So you can see that there are people in the different boxes for who we need to engage with and what level of engagement. So people who have maybe had low interest and low influence, high interest, high influence. So you can see there's an orange arrow, which shows that we had two key stakeholders that were going to be crucial to the implementation of IDDSI, and they were our care homes and our GPs. They may at this stage in the process have had low interest, but really high influence on whether we were going to be successful or not. So they were key people that we'd got engage with really early in the process.

Okay, going back to this. The third stage under aware was raising awareness. So we discuss IDDSI in all our local team meetings. We developed two working groups: a strategic group, which identified what tasks needed to be done, who could do them, what the timescales were. And we also developed an operational group that would put into place the actions that the strategic group came up with. We developed our project plan with our timescales and the communication strategy, and we met with our communication team to identify what was required and also what support was available.

As I mentioned, we had six weeks in order to implement within East Sussex. So I saw this very much as not the speech and language therapists' show, but very much about how the teams – the whole teams – could pull together in order to implement this new programme.

On to the second stage of the model is prepare. And for us, this started in April 2018 and the three areas that I look at under this model are resources, joint planning and training. So under resources, we looked at what external resources were available to help us implement IDDSI and Ben's already gone into all the details that are available through the IDDSI.org website, which are amazing and I'd

really strongly recommend that you look at those, but also the College has a lot of information on there also that's available for you.

I also wanted to look at what was internal to my organisation. As I said, there's lots of things there – lots of people there – that can help, if only you ask for that help. So I informed the local Improvement Office to get their support. I worked with my Communications Team to develop a communication strategy. We looked at how we could use newsletters, screensavers, email communications, and I also worked with my learning and development department who were really instrumental in helping us pull together advertising sessions and also an elearning module.

Now, in East Sussex, we had an added complication, in that our industry partner was changing the scoop size of their product. So looking at this, we looked at, well, what was our stage 1; they were going to move to level 2 and there was 0.5g difference. I wasn't sure that I would be happy and that that would be a clinically acceptable difference. So I decided that I needed to do a bit of assurance testing on that. I looked at my stage 2 that we were going to move to level 3, which was the greatest change in scoop size of the product and thought, I need to reassess those. Luckily, they were very small in numbers. And I looked at stage 3 to level 4; there was minimal change in the scoop size, and I thought, we can map those ones over.

So just to give you a very brief outline of what our assurance project involved. We looked at our stage 1 to level 2. We co-opted 24 patients to take part in that, and these were patients that we'd assessed at being safe, with no clinical, overt signs of penetration on stage 1. We used a standardised protocol to assess them on level 2 and we looked for clinical indicators, or changes that might lead us to think that there was a safety concern.

Because we had to do this in a very short space of time, we worked with Hull and East Yorkshire NHS Trust to get 24 patients together, and we had a 92% success rate that both stage 1 and level 2 were both clinically safe for that patient group. So we decided that risk was acceptable and therefore we mapped across our stage 1 to level 2, which did make things slightly easier because that was the majority of the people that were on modified fluids at that time.

The second stage of the prepare part of the model is looking at joint planning. We worked with all these different stakeholders to enable us to develop a programme of implementation that would be successful and would deliver what we needed to do within time. Medicines Management supported us in writing and distributing information to primary care. Pharmacy and acute and community monitored the stock levels to enable us to successfully manage that transition date. Our catering department liaised with suppliers of the modified diets, ensuring that they were IDDSI compliant, that we tested them and we agreed a transition date with dual labelling.

We worked very closely with our dietetic department anyway, but they just happened to be running some primary care training, so we were able to add some slides onto that training so that they could raise the awareness of IDDSI within primary care. And at the time when we went live in May, we didn't have pre-thickened ONS – so the Oral Nutritional Supplements. So we did work with them and did a small-scale study on our first-line ONS and flow testing those, so we could transition our patients who needed that extra support.

We looked very much at our communication team to help us develop collateral that we could share. We looked at all the meetings that were available, and we used something that's called the Apple Model, to drip feed information using the IDDSI #iddsiaware on all of our collateral. We went to every meeting that we possibly could – not just speech and language therapists, the whole team pulled together in this.

We developed leaflets that were accessible for other healthcare providers, for patients using a thickening product who weren't known to speech and language therapy anymore, so they knew what was expected and what was going to happen. And also patient information leaflets for those patients already on our caseload and known to us. And we developed collateral in terms of posters that we could place in all clinical areas.

Our speech and language therapy team utilised Swallowing Awareness Day to raise awareness, and we did lots of team training. And the operations group, as I mentioned earlier, put into practice what the strategic group felt was required.

The third stage of the prepare model was looking at training. We were lucky that Nutricia had just developed their elearning module and it was a very accessible, very user-friendly elearning module that we really did promote and was very well received. In an acute service, it's very difficult to release staff from the ward, so we did a trolley. We dressed up a trolley and we took it round the wards and went across two hospitals in four days; we trained over 600 members of staff.

We developed bookable sessions. So 45-minute drop-in sessions. We had 27 bookable sessions and we had those in two different community services areas and we had very poor uptake, which was very disappointing. I'll talk a little bit about my learning from that in a slide later on.

We did in-house training. This is what they really like. They like you to go along and see the staff in their own areas, but it's very labour-intensive. So what we did is we prioritised where we did that through triangulating care homes where we felt we had poorer compliance and where maybe they had a large room that they could host a session for other neighbouring care homes to try and pull people in and utilise the time to the most effect.

We did group sessions with physios, OTs, dietetics, stroke services, etc. We provided stands in key areas, and we worked with our housekeepers and provided training to our housekeepers. And, as I mentioned, our dieticians supported us through training in primary care.

That's just our trolley, so you can see what that looked like.

I mentioned that we did the bookable sessions and they weren't very successful. Well, we ended up... we did a telephone survey to try and work out why weren't they successful? Why did we have such poor attendance? So we phoned our care home managers – most of the 243 that we had that we could talk to. 20% reported they didn't even receive the information, which was strange, because we'd posted it and we'd emailed it.

Through discussion, we found out that post is not the most efficient mode of cascading this type of information. They advised us that, actually, if we spent the time phoning them, explaining what it was all about and backing it up with an email with all the information in, we would have much more successful attendance.

They also said that we need to make sure that the information is clear and concise and that will help them to identify who to cascade that information to.

Through doing this training programme, one size doesn't fit all. You need to have access to lots of different tools in your toolkit. One thing which surprised me was that the care home manager said that 98% had access to the internet and that, actually, 69% would have loved to have the opportunity to complete an elearning module. But all areas said they would really appreciate some additional training.

The third element of our model was the adoption phase, and this consisted of the actual IDDSI Day, making sure that we covered all of our bases – large and small – and embedding and monitoring and making it business as usual. So looking at IDDSI Day itself, we reassessed our stage 2 to stage 3. As I mentioned, they weren't huge numbers, so actually it didn't cause us too many problems.

We developed our new bed signs – which you can now see up in front of you – and our new diet sheets. We made sure that we had tins of the new product, with the new scoops, and we had new sachets, because also the size of those had changed.

We made sure that we had our menus available with the new terminology on there, but it was dual labelled initially, to make sure that that eased the transition.

In order to cover all bases large and small, one of the things that we thought we really need to get this right... and we have community hospitals that get their prescriptions and their drugs from the main hospital site. So we needed to make sure there was a supply that was available for them to draw on.

When we went live in May, it was very early on, and Nutritia weren't quite ready, I don't think, for the implementation as quickly as we did. But there was problems with getting the scoops available. So we had to make sure we had enough for assessing all of our patients. And also we had patients who already had tins of thickener. Well, we didn't want to waste those, so we needed to have some extra scoops that we could swap the scoops around and then give them information on how to mix the new dosage. And we also needed to make sure that we had the new sachets available.

Something just to note is we have lots of satellite clinics like videofluoroscopy clinics and swallow disorder clinic, FEES clinics, etc., which all have folders in – I'm sure you all have these as well. And we needed to make sure all of our templates, all of our folders, all of our electronic systems had all the new terminology already on there so that we were ready to go. We wanted to embed and monitor. This is about making it business as usual. Our operation group has continued to meet, because there'll always be issues that have arisen that we need to deal with, so example the easy chew level 7 regular is now coming out, so the operational group will be looking at how we can implement that.

One of the things that we did do was a Survey Monkey for all of my speech and language therapy staff, and it really drew it home to me that you can't underestimate the amount of time that is required to ensure that your team feel really confident and competent in introducing a new system. So spend the time on that extra training, on practising, on working together.

We're continuing to do care home training. We now have a rolling programme every month where care homes can book on to those sessions – and we're building it in to all the existing training programmes that we already have and that we already do. So that's our healthcare assistant training, our housekeeper training, our FY1 and 2 training. Every training element that we do, we now have the IDDSI slides on there.

We're also using our networks to ensure that we're keeping everybody abreast of all the information in IDDSI. And just to mention that, next month, on 13 March, will be Swallowing Awareness Day. And on this day we will be using the opportunity to update people on IDDSI – particularly around the level 7 easy to chew.

So just to finish off then, what were my challenges and surprises as I went through this journey with my team on implementing IDDSI? Well, industry equipment not being available was an issue at the time, but now we're so many months forward, I'm sure those of you that haven't implemented won't have an issue with that.

We only had six weeks to implement, and we're a very large Trust. If you pull your team together – and don't look just to speech therapy as that team, but look very broadly – it is doable and it is achievable.

I was surprised with the poor level of uptake from the care homes and also some of the information that they gave us. And we've been able to use that information to structure our training for the future, which has been very, very helpful. Ben's already mentioned the syringe availability and the new funnels coming on board. And now we're in a different place with ONS as well, because there are some ONS that have now been tested by industry that are IDDSI compliant.

To my surprises, we've had minimal number of patient queries. We've had no safety alerts and incidents. I think because we really did engage with our stakeholders very early on, we've had an

excellent buy-in, and staff really have believed that it was the right thing to do. I think as a profession, we're very good at sharing. And, as Ben mentioned, there's a forum there on the IDDSI website where you can send in your resources – do that. Let's share and let's save everybody else having to do the work – let's make sure we're sharing it.

And because I went live in May, I wasn't worried when the NHS I alert landed on my desk with a demand for an action plan to make sure we're compliant; we were already compliant, because IDDSI enabled us to be so.

Okay, so that's the end of my presentation. I'd like to hand back to Kamini for the question and answer session.

Kamini Gadhok MBE, CEO, RCSLT

Thank you so much to all our presenters this afternoon. We've had a number of questions come in as the presenters have been speaking, and we also had a number of questions that were submitted prior to the webinar.

So I'm going to go to some of the questions that were submitted as you were all speaking. So the first one to Hannah is: in the case example given in recommending no foods at level 7, how does this fit with his reported ability to manage crisps and Wotsits?

Dr Hannah Crawford, Patient Safety Expert Advisor, NHSI

Yeah, I didn't mean all types of crisps. What I was talking about was Skips and Wotsits, which are the melt in the mouth type of foods, which are bite and dissolve foods, which we would class as transitional foods. So hopefully that would clear that query up.

Kamini Gadhok MBE, CEO, RCSLT

And the next question I think may be for Ben: why does the adult level 7 easy to chew patient information leaflet say that it's not suitable for those with swallowing problems? The person who has asked the question said that their understanding was that it would be made clear that it would be suitable if under the direct instruction of a clinician.

Dr Ben Hanson, Associate Professor, University College London; and IDDSI Board Member

Yeah, that's right. It is suitable under the direct supervision of a clinician. But what the wording is, is that this level is not intended for people where there's an identified increased risk of choking. So it really does just relate to that particle size.

What we don't say in that guidance is that it's not suitable for people with swallowing disorders, because it's well recognised that there may be people with swallowing disorders that just relate to thin liquids, for example, but would have no problems with this level, or even with level 7 regular foods.

So we do want to highlight that it is about the choking risk. And I think there was another question also about if you're able to have level 7 easy to chew and then chew it up, do you not arrive at level 6 with bite-sized pieces and yes, you do – absolutely. The idea is that level 6 has that particle size restriction built in already, so it's inherently at that safe size. The idea is to avoid the risk of some people with cognitive impairments or unsafe eating behaviours forcing food down too quickly, or not chewing correctly. And even if normally they'd be okay with this, giving them the restricted particle size is a safety net. If they've been assessed that they're safe and able to chew reliably, then yes they'd be able to move up to the derestricted particle size.

Kamini Gadhok MBE, CEO, RCSLT

And then another one for Hannah. Level 7 easy to chew patient information leaflet says, your clinician might recommend this level if teaching advanced chewing skills. And the questioner is asking what's meant by this? They were saying that advanced chewing may not be the issue, but general clinical assessment and judgement is.

Dr Hannah Crawford, Patient Safety Expert Advisor, NHSI

I think that brings us back to the point in my presentation that I made that the most overriding driver should be clinical judgement, and IDDSI should be used as the language that you convey that judgement with. So if you feel as a practitioner that level 7 easy to chew is appropriate for your client, then that is what you recommend and it would almost be like an off-prescription in the way that sometimes medication is recommended to be crushed when that isn't necessarily in the formulation guidance, but the clinician, knowing the patient and the clinical case, will make an off-prescription recommendation. Then the most important thing and the primary driver should be your clinical judgement.

Kamini Gadhok MBE, CEO, RCSLT

Thank you very much, Hannah.

So I'm going to move to some of the questions that were submitted prior to the webinar. One of these was: how can we train and support care agency staff who spend very little time in people's homes, but are responsible for ensuring safe and enjoyable oral intake for people with dysphagia?

Anita, would you like to take that one?

Anita Smith, Consultant/Professional Lead SLT, East Sussex Dysphagia Lead, East Sussex Healthcare NHS Trust

I think that is a challenge, and also is a challenging group of staff that we work with because it's rapid turnover usually as well.

What we've done in East Sussex which has proved quite helpful is we've kept the rolling programme of monthly sessions available. They're free of charge to any healthcare provider, to register and attend. Originally it was 45 minutes; we've extended it slightly now to include a few other things. But I think we had training available already and it's just making that training available to people, and including the IDDSI in that training now, whereas we would have had UK descriptors maybe before

Kamini Gadhok MBE, CEO, RCSLT

Thank you so much, Anita.

So one of the other questions that came in was about where IDDSI descriptors are going to be used, and if they were going to be utilised in other acute medical settings, e.g. gastro, maxillofacial, in order to reduce confusion.

So I wonder if you can help with that, Hannah?

Dr Hannah Crawford, Patient Safety Expert Advisor, NHSI

Yes, from the NHS Improvement point of view, the alert is recommending that the descriptor guidance, the IDDSI, is used across all settings, so that would mean that the questioner who asked that question, yes. The NHS Improvement alert released in June 2018 recommends that, yes, they are used in all settings for all patients who need food modified for whatever reason.

Kamini Gadhok MBE, CEO, RCSLT

Thank you very much. And the next question I think I'm going to ask Ben to respond to. Thickener recommendations for infants under 12 months is Carobel, but this is found to be too unstable.

Thank you so much for that question. This has been an issue that's been raised to the RCSLT, to myself and Louise by a number of our members and, as a result, we've actually been in touch with Ben. And, Ben, do you want to just tell the audience what we're doing around supporting this piece of work?

Dr Ben Hanson, Associate Professor, University College London; and IDDSI Board Member

Yes, I'm very happy to be involved in this and working with Louise Bax at Great Ormond Street. We've managed to get the agreement of Nutricia, who produce Carobel, to fund some research into using it as a thickener with a variety of different formulas, whether they're ready to use or powdered, to provide those IDDSI guidelines. It can be a challenging product to use, but we're getting there, and we hope to report back to Nutricia with some guidance and then the expectation is they'll be able to issue that to all their customers.

Kamini Gadhok MBE, CEO, RCSLT

Thank you very much.

So moving on to one of the other questions we had prior to the webinar, was about advice regarding how to implement staff awareness of level 7 regular/easy to chew, if people have already provided training. What can you say about that, Ben? Back to you.

Dr Ben Hanson, Associate Professor, University College London; and IDDSI Board Member

I'd say that we do have those patient handouts, the consumer handouts, that are available. And there isn't an enormous amount of extra learning to be done there. The main issue is that it's soft, but not necessarily bite-sized. So we have the description of soft. And it's wonderful that staff have been trained already and I think it needs to be used where appropriate. So as it's being used under clinical supervision, that will form part of the instructions and part of the documentation that goes along with that.

Kamini Gadhok MBE, CEO, RCSLT

Okay. We've had a few more questions come in online. I don't know, Ben, if you want to answer this after the webinar, but it's: would it be possible for the consumer handouts to be put onto electronic record-keeping systems, e.g. SystemOne, at a national level – well, that probably isn't for you, actually! – so that everyone can keep up to date? I mean, that's an interesting request and actually that would probably be something for NHS Digital to ask them that question. So we can go to them on that one.

Someone's also asked about level 6 soft and bite-sized diet includes crumbly cakes and biscuit bits and, as a department, we feel that the guidelines on this point are not clear. Could anybody help to clarify this element of level 6? Ben?

Dr Ben Hanson, Associate Professor, University College London; and IDDSI Board Member

I can, and I'm afraid this is a cultural issue that biscuits in other parts of the world tends to mean something that's a bit more like a scone. Yes, it is extremely confusing. We have had this a few times, and I've asked... or I've raised it at the IDDSI Board that there is a potential source of confusion. And it's not the only one, and it points to that issue that IDDSI is not based around template or ideal foods, because it's just impossible to say, okay, this person's going to be safe on a banana, or a potato, or on rice, because there's no such thing as standards.

So we have included, by popular demand, some examples of textures and example products. But they are always going to be non-standard around the world. And this one in particular is a rather horrible example of where biscuits in the UK means something utterly different to biscuits in North America for example.

Kamini Gadhok MBE, CEO, RCSLT

Thank you. And I think that partly answers the question that's come in about projects that have implemented the IDDSI framework for different cultures and ethnic groups. And, as you say, IDDSI is international. Is there any way of sharing any of that learning in this country?

Dr Ben Hanson, Associate Professor, University College London; and IDDSI Board Member

So we discussed lots of different cultural issues when we were coming up with the framework in the first place. And there's lots of things that have been reflected in the pyramids. Even the fact of the colours being suitable for those with colour blindness. And we're avoiding red because of potential

confusion with different diets, standards in different countries as well and it being a lucky or unlucky colour in different cultures.

I, I guess, being a scientist, I've relied back on the numbers as being the least open to interpretation, so level 1, level 2, level 3, etc., and the flow test giving a numeric output.

In terms of different cultures, I'd say if you want to explore that, we do have the translations into different languages on the website. And that's been relatively non-standard as well, because translating it you have to go through a process of forwards translating and backwards translating and then having that approved by several different native speakers of that language.

So, yeah, we've suffered through that – if that's the right word! – of trying to translate these standards. I think the common language that I would encourage people to refer to is the numeric aspects in terms of numbers and also the video and pictorial implementations of IDDSI. So if you can show something on a YouTube clip, or if you can download the app which has some of those example pictures, you can use that app in places that you don't have internet access. So I'd recommend using pictures and the numeric tools, try to avoid language where possible.

Kamini Gadhok MBE, CEO, RCSLT

Thanks very much, Ben.

We've had quite a lot more questions coming in, so I'll try and see how many we can get through in the time we have left. One is about if it's possible to adapt the resources to make them easier to understand for people with learning disability.

Hannah, do you want to take that?

Dr Hannah Crawford, Patient Safety Expert Advisor, NHSI

Yes, I would say that things like the framework, it would be very important to stick to the colours and the numbers. But if you are developing resources to support what exists for IDDSI, to make them accessible for people with learning disabilities and for individual patients, yes, definitely produce resources and then, as Anita said, share them. Send them to the email address at IDDSI so we can share them and we can use those resources together to learn and to develop services for our patients and service users.

Kamini Gadhok MBE, CEO, RCSLT

Another one is about if someone is at a high risk of choking, but has a sufficient chew, would bite-sized but not soft be appropriate? That's quite... is that very specific? Hannah?

Dr Hannah Crawford, Patient Safety Expert Advisor, NHSI

I think, again, that's got to be down to individual clinical judgement. I think this is an example of where we can't use IDDSI to drive our recommendations, we must make our recommendations and then use IDDSI to help support that.

So IDDSI isn't going to tell you what's right for your service user; you make a clinical judgement about what is right for your service user and then look at which descriptor of IDDSI matches what you want. And it may, in this case, be more about supervision than the IDDSI language that you're using. So, yes, your service user might be fine to use a level 7 easy to chew with supervision, and level 6 without it, but that's down to your clinical judgement and your clinical recommendations.

Kamini Gadhok MBE, CEO, RCSLT

Okay, thank you so much everybody. We've had nearly 180 participants joining the call – some of whom are outside of the UK, so thanks to all of you for listening in, and to all of your questions.

For those questions that we've not managed to answer, either through the presentation... I think a number of questions that were submitted prior to the webinar we hoped actually were already

covered through the presentation. For those that have been submitted since, we will obviously be reviewing those and posting the answers after this event.

So I just want to thank all of you again and remind you to fill in the evaluation form – that's really helpful for us for planning the next webinar. And that's going to be on putting children, young people and their parents/carers at the centre of decision making. It's going to be held on 20 March and will be over a lunch period. And just for those of you who might be working with children or have colleagues who do, please do listen in to that one.

So a big thank you again from me to all our presenters and to all our participants. Thank you very much. Goodbye.