Leicestershire Partnership NHS Trust

Food and Fluid Refusal Policy in Adults

This is a Trust-wide policy for the care of adult patients whose health is compromised by fluid and/or food refusal. It outlines the approach that healthcare professionals must follow to ensure consistent, compassionate, and effective management of these patients.

Key words: Food Refusal, Fluid Refusal, Refeeding Syndrome

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SUMMARY & AIM

This is a Trust-wide policy for the care of adult patients whose health is compromised by fluid and/or food refusal. It outlines the approach that healthcare professionals must follow to ensure consistent, compassionate, and effective management of these patients.

The policy outlines:

- Potential causes and risks of food and fluid refusal
- Guidance on identifying and monitoring refusal
- Suggested clinical assessments and escalation pathways.
- Consideration of ethical and legal responsibilities in care planning

KEY REQUIREMENTS

Staff must:

- Identify food and/or fluid refusal promptly and assess potential causes using the checklist.
- Report incidents of refusal, deterioration, refeeding syndrome risks, or safeguarding concerns via Ulysses.
- Assess and monitor physical and mental health in accordance with Table 2 (e.g., NEWS2, blood tests, ECG, hydration charts).
- Complete a mental capacity assessment when capacity is uncertain and follow MCA and MHA requirements.
- Consider safeguarding when refusal constitutes self-neglect or there are additional vulnerabilities.
- Convene an MDT meeting when refusal persists, risk escalates, or the situation is complex.
- Develop an individualised care plan, documenting risks, strategies, monitoring frequency, and escalation pathways.
- Communicate effectively with the patient, using interpreters or reasonable adjustments where required, and involve family/advocates with consent.
- Consider risks of refeeding syndrome, involve dietetics, and follow Trust refeeding guidelines.
- Escalate to acute care or specialist services (ED, medical, safeguarding) when clinically indicated.
- Document all assessments, decisions, capacity outcomes, MDT minutes, and plans clearly in the EPR.
- Provide staff support through debriefing when needed due to clinical or emotional complexity.

TARGET AUDIENCE:

Healthcare professionals working with adults in clinical facing roles. This includes anyone involved in the assessment, monitoring, decision-making, or ongoing care of adults who may refuse food and/or fluids across inpatient and community settings.

TRAINING

Staff are required to read the policy**,** understand it with line manager support**,** and update their knowledge.

1.0 Quick look summary

This policy covers food and/or fluid refusal in individuals across inpatient and community settings. It is designed to support staff in recognising food and/or fluid refusal, understanding potential underlying causes, and initiating timely, compassionate intervention.

Food and fluid refusal can lead to serious health consequences, including malnutrition, dehydration, organ dysfunction, and premature mortality. These situations are often complex and require a coordinated, multidisciplinary approach involving medical, nursing, psychological, and allied health professionals.

The policy outlines:

- Potential causes and risks of food and fluid refusal
- Guidance on identifying and monitoring refusal
- Suggested clinical assessments and escalation pathways.
- Consideration of ethical and legal responsibilities in care planning

This policy is not intended for use in:

- people in their last days of life where food/fluid refusal/decline will be a natural expected part of that process.
- acute illness (e.g. acute infection) where oral intake may be temporarily reduced due to symptoms.

1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)
1	7th July 2025	First version of Policy, identified need through learning from incidents

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1.2 Key individuals involved in developing and consulting on the document

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Implementation Lead: Nutrition and Hydration Steering Group
Wider Consultation:

1.3 Governance

Level 2 or 3 approving delivery group – Nutrition and Hydration Steering Group

Level 1 Committee to ratify policy – Quality and Safety Committee

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 (Amendment) Regulations 2023 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

1.5 Due Regard

LPT will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010 (Amendment) Regulations 2023. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.

- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

1.6 Definitions that apply to this policy.

Avoidant/Restrictive Food Intake Disorder (ARFID)	A condition in which an individual persistently avoids certain foods or food groups, restricts overall intake, or both, due to sensory sensitivities, fear-based avoidance (e.g., choking, vomiting), or a lack of interest in eating without concerns relating to body weight or shape. The resulting restriction leads to nutritional deficiency, weight loss, reliance on supplements, or significant interference with psychosocial functioning.
End of Life (EoL)	End of Life (people likely to die within a year)
Food and/or Fluid Refusal	The deliberate or unintentional avoidance or cessation of eating or drinking, including refusal of oral and enteral nutrition, to an extent that poses a risk of dehydration, malnutrition, or clinical deterioration.
LPT	Leicestershire Partnership Trust
Mental Capacity Act 2005 (MCA)	The Mental Capacity Act 2005 (MCA) is a UK legal framework protecting adults (16+) who lack capacity to make decisions about their care, treatment, or finances.
Refeeding Syndrome (RFS)	A potentially fatal shift in fluids and electrolytes that may occur in malnourished people on refeeding.
Self-Neglect	Self-neglect refers to a person's inability or unwillingness to meet their own basic needs, including nutrition and hydration, which places them at risk of significant harm. This may include failure to eat, drink, maintain hygiene, attend to health needs, or avoid hazards.

2.0 Purpose and Introduction/Why we need this policy

The policy does not apply to patients nearing end of life who are likely to have reduced or minimal oral intake. Patients at end of life should have an individualised approach in relation to their care needs and wishes.

This policy excludes medical restrictions, and cases where a temporary reduction in food and/or fluid intake occurs due to acute illness (i.e. short-term vomiting illnesses, such as Norovirus, infections, and post-operative recovery). In these situations, reduced intake is typically a transient symptom rather than a deliberate or persistent refusal. As these cases generally resolve with supportive care and do not require the interventions outlined in this policy, they fall outside its scope.

A patient may refuse food and/or fluids for a variety of reasons, including physical health issues, mental health disorders, acts of protest, or self-harm. The refusal may be a deliberate choice aimed at achieving a specific outcome or may result from underlying conditions such as un undiagnosed physical health condition, psychosis, severe depression, substance-related states, or dementia. Each case requires an individualised assessment to understand the root cause and intent behind the refusal.

The purpose of this policy is to ensure that interventions for patients who refuse food and/or fluid are delivered in a method that is ethical, compassionate, and clinically appropriate. It emphasises the importance of respecting patient dignity, autonomy, and individual circumstances while addressing the underlying causes of refusal. This approach aims to balance patient-centred care with staff responsibility to prevent harm and support recovery, and collaboration between healthcare professionals and patients.

The policy applies to staff working at LPT in the event of food and/or fluid refusal for adult patients within an inpatient setting and community setting.

3.0 Policy Aim and Objectives

Aim:

- To provide staff with a clear process for safely and effectively managing patients who refuse food and/or fluids.

Objectives

- Establish a standardised approach across clinical services and settings.
- Integrate appropriate assessments, monitoring, and interventions for nutrition and hydration.
- Ensure adherence to the Mental Capacity Act 2005 and Mental Health Act 1983.
- Ensure patients are assessed and reviewed holistically.

4.0 Policy Requirements

This policy applies to all staff within LPT and aligns with the following key documents and guidelines:

- Enteral Nutrition Policy, Leicestershire Partnership Trust (2024)
- Managing Malnutrition in Adults in Primary Care, Leicestershire Medicines Strategy Group (2021)
- Managing Medical Emergencies in Eating Disorders (MEED), Royal College of Psychiatrists (CR233, 2022)
- Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, National Institute for Care Excellence, Clinical Guidance 32 (2006)
- Mental Capacity Act (2005)
- Mental Health Act (1983)
- Nutrition and Hydration Policies for Community and Inpatient Settings, Leicestershire Partnership Trust (2023)
- Prevention of Refeeding Syndrome Guidelines, Leicestershire Partnership Trust (2025)
- Regulation 14: Meeting Nutritional and Hydration Needs, Care Quality Commission (2023)
- Safe Administration of Insulin to Adult Patients in a Hospital and Community Setting Policy, Leicestershire Partnership Trust (2023)
- Standard Operations Procedure for Nutrition and Hydration for DMH & FYPC/LDA Adult Hospital Inpatient Use, Leicestershire Partnership Trust (2025)

5.0 Introduction to Food and Fluid Refusal

The refusal to consume food and/or fluids may arise from a wide range of underlying causes. These can result from physical health issues such as gastrointestinal issues (i.e. constipation), mental health disorders such as depression, anxiety, or eating disorders, as well as intentional acts of protest or self-harm.

Each occurrence requires a thorough and individualised assessment to identify the cause and guide the appropriate intervention. For healthcare professionals, understanding the patient's physical, psychological, and social context is essential in addressing the refusal effectively and empathetically, while also considering potential ethical implications, such as patient autonomy and the need for intervention in life-threatening situations.

5.1 Definition of Food and Fluid Refusal

Food and fluid refusal refers to the rejection of consumption of food and fluids (both orally and enteral nutrition). However, a national consensus on the specific calories of food or amount of fluid to define this quantitatively is lacking.

Although specifically for eating disorders, the Medical Emergencies in Eating Disorders (MEED) Guidance on Recognition and Management (2022) stipulates disordered eating

behaviours resulting in high risk and impending risk to life as an estimated calorie intake of <500kcal per day for 2 days or more. These thresholds **are not** intended as minimum intake targets, as they do not meet nutritional and hydration requirements. Instead, they indicate levels warranting immediate escalation and intervention due to the risk of malnutrition and/or dehydration.

5.2 Food and/or Fluid Refusal Risks

Food and/or fluid refusal can lead to significant clinical consequences, including malnutrition, dehydration, organ dysfunction, electrolyte imbalances, and micronutrient deficiencies. These complications may result in severe illness and in some cases, death.

Patients with pre-existing health conditions may be more susceptible to the serious consequences of refusing food and/or fluids, and this risk is not limited to patients who are underweight. Importantly, even patients who are living with overweight or obesity are susceptible to the health risks associated with refusal.

5.3 Cause(s) of Food and/or Fluid Refusal

There are multiple possible causes of food and/or fluid refusal, and the this must be comprehensively assessed to ensure appropriate intervention, avoid the possibility of diagnostic overshadowing. Potential cause(s) can be found in Table.1

Table 1. Potential Causes of Food and Fluid Refusal

Factor	Potential Effect	Examples of Mitigation Strategies
Communication	English may not be their first language, or they require an alternative method of communication. The patient may refuse food/fluid as a method to communicate (e.g., to express dislike, preferences, or an issue).	Consideration food and fluid options offered. Consider alternative ways of communication. Use of interpreter
Cognitive Changes	Skill level changes, forgetting to eat and drink and lack of prompting in these situations can affect intake.	Adult social care, carers, speech and language therapy (SALT), dietetics, occupation therapy support. Team approach.
Cultural or Religious Beliefs	Cultural or religious dietary restrictions may lead to the refusal of certain foods or refusal of foods/fluid during specific times (e.g., Ramadan).	Respect their cultural/religious beliefs and offer food/fluids in alignment to this.
Dietary Preferences	Refusal may be secondary to dislike of the food/fluid offered.	Explore alternatives and care plan preferences.
Dental/Oral Health	Painful dental /oral issues and poor oral hygiene can cause reduced intake.	Dental appointment, oral care, and analgesia
Difficulty with Eating and Drinking (Dysphagia)	Difficulty swallowing can impact on the amount an individual consumes. Additionally, the texture/consistency may be unacceptable to the individual and lead to refusal.	SALT assessment/review if required. Referral for enteral nutrition if indicated.

Eating Disorders	Conditions like anorexia nervosa or bulimia nervosa can result in refusal.	Eating disorder service advice/referral.
Environmental Factors	A change, unfamiliar or an unappealing environment can lead to food refusal.	Consider optimal environment for the individual (e.g., mealtime location)
Independence	Individuals who feel a loss of control or independence may refuse food as a form of asserting autonomy.	Support individual to have as much independence as possible (e.g. cutlery aid, posture, and seating position).
Knowledge	May refuse certain foods or fluids due to a lack of understanding about their nutritional value or importance.	Provide information and discuss importance of nutrition/hydration so an informed decision can be made.
Medication Side Effects	Side effects such as nausea, lack of appetite and drowsiness can affect intake and lead to refusal.	Doctor review of medication/medical review.
Mental Health	Various mental health conditions can impact on food and fluid intake. Examples include: • Symptoms of psychosis such as paranoia, delusional beliefs, or hallucinations may lead to a person refusing food. • People with depression may be experiencing suicidal ideation so the food refusal could be an attempt at self-harm/suicide. • Patients with personality disorders can present with complex behaviours and disordered thinking.	Therapy/medication support. Consider any additional support/advice from specialist services to support the individual.
Physical Health	Pain, illness, nausea, diagnosed and undiagnosed health conditions (e.g., cancer) can cause a lack of appetite. Medication for specific conditions can also affect appetite (e.g., fatigue). Additionally, this may affect the individual's behaviour and lead to refusal.	Medical/medication review.
Previous Negative Experiences	Past negative experiences with food, such as choking incidents.	Support and encouragement. Psychological support
Protest	The refusal of food and/or fluid intentionally as a protest.	Establish underlying cause and if this can be mitigated.
Sensory	A strong aversion to certain foods due to taste, smell, texture, sound, or visual appearance can result in refusal.	Establish 'safe' foods. Consider vitamin/mineral supplement if likely to be deficient. Consider referral for sensory desensitisation.

This table is not exhaustive, and clinicians should additionally use their clinical skills and judgement with the identification of causes.

5.4 Eating Disorders (ED) and Avoidant/Restrictive Food Intake Disorder (ARFID)

Leicestershire Adult Eating Disorder Service (LAEDs) supports adults aged 18 and over who have eating disorders such as anorexia nervosa, bulimia nervosa, binge eating disorder and other diagnosable eating disorders. There is also a Child and Mental Health service (CAMHS) for young people under the age of 18 with an eating disorder.

LAEDs currently is not commissioned to support adults with Avoidant/Restrictive Food Intake Disorder (ARFID). However there is a commissioned offer from First Steps for patients with ARFID who are under 25 years old and meet specific criteria.

Referrals for patients who have/are suspected of having an eating disorder can be completed by their general practitioner (GP), or by clinicians within the Trust. Information for how this is completed is on the LAEDs website.

After a referral has been completed, this will be reviewed at triage and the patient will hen either be given an assessment or rejected at this time. Waiting times for assessment are individual for the patient's needs. Whilst awaiting assessment monitoring of physical health should continue by the referring team/GP.

Once a patient has had an assessment and has been accepted by LAEDs they will follow their local Standard Operating Procedures for monitoring and managing food refusal in line with the patients' individual needs.

MEED (medical emergencies in eating disorders) provides guidance for professionals on recognition and management of patients with eating disorders. MEED guidance is used in both the inpatient and outpatient services within LAEDs. This includes information on physical health monitoring of patients and support for patients at risk of refeeding.

6.0 Safeguarding

Food and/or fluid refusal is a form of self-neglect and patients with additional vulnerabilities may fall under the safeguarding adult's framework as defined in the Care Act 2014.

Self-neglect encompasses a range of behaviour's that can lead to serious harm or death, including failure to meet basic nutritional and hydration needs. In such cases, safeguarding measures are crucial to protecting vulnerable patients. If there is any uncertainty, it is essential to consult the Safeguarding Team for advice.

The identification of safeguarding concerns requires a thorough assessment to determine whether the refusal of intake is influenced by underlying vulnerabilities such as mental illness, dementia, or learning disabilities. It is equally important to evaluate whether external factors, such as neglect, abuse, or coercion, are contributing to the behaviour. For all cases, the patient's capacity to make decisions should be assessed in accordance with the Mental Capacity Act (MCA) 2005.

When safeguarding concerns are identified, the Trust's Safeguarding Adults Team must be notified. The patient's care plan should incorporate safeguarding considerations, including strategies to mitigate risks and referrals to relevant services. All safeguarding concerns must be meticulously documented in the electronic patient record (EPR), ensuring that assessments, discussions with the patient and their family (if appropriate), and interventions are clearly recorded.

Collaborative working is a vital component of safeguarding. The multidisciplinary team (MDT) along with the patient's general practitioner (GP), community services, and safeguarding leads, must work together to ensure a coordinated approach to care. When necessary, referrals should be made to specialist services such as adult social care, eating disorder services, or mental health services.

Additionally, staff involved in patient care should be appropriately trained in safeguarding processes and in recognising the signs of self-neglect. Providing education and support to patients and their families is equally important, such as offering guidance on the risks of reduced intake and connecting them with relevant resources.

7.0 Communication

Effective communication with the patient is essential in evaluating and addressing the underlying reasons for food refusal. A comprehensive approach should be taken to understand any barriers that may impact the patient's ability or willingness to engage.

Key considerations include:

- **Language proficiency**: Determine whether English is the patient's first language and assess their ability to engage in discussions around complex health matters. If necessary, arrange for an interpreter.
- **Cognitive and learning needs**: Identify any learning disabilities or cognitive impairments that may affect comprehension. Consider whether information should be provided in alternative formats to support understanding.
- **Sensory impairments**: Ascertain whether the patient has any hearing or visual impairments that could affect communication.
- **Mental and physical health status**: Evaluate whether current mental health conditions or physical illness are affecting the patient's capacity to communicate effectively (see Table.2).

Collaborative communication should be maintained across the multidisciplinary team:

- Liaise with healthcare colleagues, and external partners to develop a comprehensive understanding of the patient's circumstances.
- With the patient's informed consent, involve family members or appointed advocates in discussions.
- Raise awareness of the issue during site safety huddles to ensure coordinated support and oversight.
- Seek guidance from the Safeguarding Team where there are concerns regarding the patient's welfare.
- Record concerns and actions taken by submitting an incident report via Ulysses.

Where applicable, ensure the **Reasonable Adjustments Digital Flag** is reviewed and updated to reflect any identified communication, sensory, or cognitive support needs. This ensures that appropriate adjustments are recognised and consistently implemented across services in line with legal and clinical obligations.

8.0 Incident Reporting

Food and/or fluid refusal must be reported as an incident using Ulysses in the following cases:

- Cases where refusal results in clinical deterioration (e.g., dehydration, malnutrition, electrolyte imbalances).
- Instances of refeeding syndrome (RFS).
- Failures in care delivery, such as missed monitoring or inadequate documentation.
- Any safeguarding concerns identified during care.

Incidents should be reported by the member who identified the refusal, or a nominated member of staff. The Trust Incident Reporting Policy can be referred to for further guidance on the incident reported process.

9.0 Consent and Mental Capacity

Clinical staff must ensure consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. A patient can also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed, and the patient consenting must have the mental capacity to make the decision.

If there are concerns regarding the patient's mental capacity, a prompt mental capacity assessment must be completed as per the MCA 2005. There must be additional consideration of other legal frameworks such as the Mental Health Act 1983 (MHA 1983) if required.

The MCA 2005 principles are:

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- understand the information relevant to the decision,
- retain that information,
- use or weigh that information as part of the process of making the decision, or
- communicate their decision (whether by talking, using sign language or any other means).

In the event that the patient's mental capacity is in doubt, staff must ensure that a mental capacity assessment is completed using the LPT MCA Template. This must be on the EPR and clearly documented.

During this process, the staff member should consider the patient's preferred methods of communication and seek guidance from the Speech and Language Therapy (SALT) team if required to ensure all methods have been taken to ensure effective communication.

Decisions regarding mental capacity are time-specific, meaning that a patient's mental capacity can change over time (e.g. during an infection). Therefore, it is important to consider whether their mental capacity is likely to change. All meetings and discussions related to this process must be thoroughly documented in the EPR.

9.1 Mental Health

In some cases, a patient's mental health condition may affect their decision-making ability in relation to food and/or fluids. It is important to differentiate between decisional capacity (the ability to express a decision) and executive capacity (the ability to act on that decision).

As an example, a patient may verbally express they understand the need for nutrition but may not follow through due to the impact of an underlying mental health issue, such as depression, psychosis, bipolar and personality disorders, or an addiction that compromises their decision-making ability.

When there is reason to believe that mental health symptoms or substance misuse are influencing actions or decisions, the patient's mental capacity must be questioned.

9.2 Best Interest Meeting

When it is determined that a patient lacks the capacity to make a specific decision, and this incapacity places them at risk, a Best Interests (BI) meeting must be convened. The BI meeting provides a structured framework to thoroughly assess risks, evaluate options, and create an actionable plan. Decisions made during the meeting are shared responsibilities among all participants.

The Best Interests Meeting must:

1. Utilise a patient centred approach. The individual must remain central to the decision-making process. This must include any cultural values, beliefs and wishes.
2. Use an MDT approach.
3. Involve family and friends where appropriate. Family members or close friends should be consulted and invited to participate. In cases where no family or suitable representative is available, a referral to the Independent Mental Capacity Advocate (IMCA) Service must be made.

The IMCA acts as a legal safeguard for individuals who lack the capacity to make specific decisions, such as accepting medical treatment.

- If a BI meeting must occur before an IMCA can participate, the referral should still be made, and this must be documented in the individual's health records.
- Family views should also be included wherever possible.

9.3 Court of Protection

In situations where a final decision cannot be agreed upon or where the decision carries significant legal implications, it may be necessary to apply to the Court of Protection. The court can appoint a Judge to make the final decision on actions deemed in the patient's best interests.

This process ensures that decisions are carefully considered, collaborative, and legally robust, safeguarding the individual's welfare and rights.

9.4 Patients Deemed to have Mental Capacity

For patients who are deemed to have mental capacity, they have the legal right to refuse food and/or fluids. This can be challenging for staff when it is intertwined with their duty of care.

In these cases, it is crucial to ask the patient the reason for their refusal (e.g., related to their physical health or personal choice). An MDT meeting must be arranged to discuss and ensure all appropriate actions and considerations have been implemented.

The identification of food and/or fluid refusal must be reported on Ulysses and discussed with the Safeguarding Team. If the reason for refusal is accepted, support should be offered based on their rationale.

The patient must be informed of the risks involved in their decision both verbally and in writing, through an information sheet. This ensures they have the knowledge to make an informed decision. If food refusal continues, the consequences of this refusal must be explained to the patient in the presence of another registered clinical practitioner, and a full record must be made in the EPR.

If food and/or fluid refusal persists, it will lead to a deterioration in the patient's health, potentially causing them to lose mental capacity. They may wish to create an advanced plan to refuse treatment, as their physical decline may prevent them from being able to express their wishes at the end of their life.

If the patient had expressed their desire to refuse food and fluids until death, it is crucial to recognise that they cannot be forcibly fed or given artificial nutrition (i.e. nasogastric tube feeding) without their consent. The refusal to consent remains binding under these circumstances.

It is important to note that artificial nutrition and hydration are considered medical treatments. Therefore, the same legal principles that apply to other medical treatments also apply to the use of artificial nutrition and hydration. Courts have determined that food and fluid refusal is not considered an attempt at suicide unless accompanied by a diagnosed mental illness or disorder.

10.0 Physical and Mental Health Assessments and Monitoring

The level of physical health and mental health monitoring is dependent on the setting. Table. 2 outlines the frequency and assessments required in inpatient settings. The observations, tests, and assessments must be carried out by a training and competent member of staff. Additional monitoring and testing may be required based on the patient's clinical needs. The requesting clinician must document the assessment and monitoring completed on the patients EPR.

Specific services (i.e. ED) may require additional or alternative monitoring based on clinical needs and this will be outlined in their Standard Operating Procedure.

In community settings, it may not be feasible to conduct all recommended tests and assessments. General practitioners (GPs) or appropriately trained clinicians should lead and organise assessments and monitoring in line with the patient risk and needs.

The responsibility of reviewing blood test results lies with the attending GP, who will determine whether secondary care admission is necessary. For example, admission may be indicated in cases of acute kidney injury (AKI) or significant electrolyte imbalances that cannot be managed within the community setting.

Healthcare professionals must document the reasons for any limitations to health assessments and monitoring clearly in the EPR and outline alternative strategies or monitoring plans (e.g. has mental capacity to decline). Communication with the MDT is essential to ensure that all potential risks are identified and mitigated where possible.

Table.2. Physical and Mental Health Observations and Frequency for Inpatient Settings **(excludes eating disorders settings)**

Test or Observation	**Upon identification**	**Daily**	**Weekly**	**Fortnightly**
Medical Assessment*	✓	✓		
Mental State	✓	✓		
National Early Warning Score (NEWS 2)	✓	Four Times Daily or more if indication on Track and Trigger		
Electrocardiogram (ECG)	✓		✓	
Weight, BMI and MUST Score	✓		✓	
Food & Fluid Charts	✓	✓		
Bowel & Urine Chart	✓	✓		
Urea, Creatinine and Electrolytes	✓	✓		
Full Blood Count (FBC)	✓			✓
Liver Function Tests (LFT)	✓			✓
Lipids	✓			✓
C- Reactive Protein (CRP)	✓		✓	
Blood Glucose (Capillary)	Twice daily (or more frequent if clinically indicated)	Twice daily (or more frequent if clinically indicated)		
Phosphate	✓	✓		
Calcium & Adjusted Calcium	✓	✓		
Magnesium	✓	✓		
Ketones (Capillary)	✓	Twice daily or more frequent if clinically indicated.		
Venous Thromboembolism (VTE)	✓		✓	
Waterlow/aSSKINg	✓		✓	

*The medical assessment should include:

- Physical health (e.g. underlying cause, presentation, review of results/investigations, and risks)
- A medication review, including antihyperglycemic agents, angiotensin-converting enzyme (ACE) inhibitors, diuretics, and antihypertensives. These should be re-evaluated once oral intake improves.
- Evaluate oral health, ensuring the oral mucosa and tongue are moist and pink.
- Assess tissue turgor and monitor for pressure ulcers.

- Monitor for signs of oedema.
- Onward referrals to specialist (e.g. dietetics)

10.1 Blood Glucose

Hypoglycemia, defined as a blood glucose level below 4.0 mmol/L, can occur as a result of food refusal, particularly in patients with low glycogen and fat stores or those on medications such as antihyperglycemic agents.

Patients with diabetes who are refusing food require additional consideration due to their heightened risk. An urgent medical review is necessary to determine whether dosage adjustments are required. In the event of hypoglycemia in inpatients with diabetes, the hypoglycemia pathway must be followed and can be found in the Safe Administration of Insulin to Adult Patients in a Hospital and Community Setting Policy (see Appendix 3 and 4).

10.2 Ketone Bodies

Starvation ketoacidosis, a rare condition caused by the production of ketone bodies in response to carbohydrate depletion, can occur even when blood glucose levels are normal. This makes monitoring for ketones essential in patients with prolonged food refusal. A capillary ketone level of 0.6 mmol/L or higher requires escalation to a specialist for review.

Symptoms of ketoacidosis include fatigue, nausea, abdominal pain, and confusion. If elevated ketone levels are identified, staff must seek specialist advice, and a structured assessment and monitoring plan should be implemented as outlined in Table.2.

10.3 Refeeding Syndrome

Refeeding Syndrome is a condition which can occur in a malnourished or starved individuals following the reintroduction of nutrition. The condition presents with biochemical shifts leading to abnormalities and clinical symptoms. The dietetics team regarding appropriate management (see Table.3. for risks). Staff can refer to the ‘Refeeding Guidelines (February 2025) accessible on StaffNet.

For ED patients, the MEED guidance states the risk of refeeding syndrome should be considered if the patient has had little or no nutrition for 5 days or more, have features of malnutrition such as low BMI or history of weight loss, has low levels of potassium, phosphate, or magnesium before feeding, low white blood cell count or a history of alcohol or drug misuse.

Table 3: High Risk of Refeeding Syndrome (NICE 2006)

High Risk:

Patient has one or more of the following:

- BMI less than 16 kg/m^2
- Unintentional weight loss greater than 15% within the last 3–6 months
- Little or no nutritional intake for more than 10 days
- Low levels of potassium, phosphate, or magnesium prior to feeding.

Patient has two or more of the following: • BMI less than 18.5 kg/m^2 • Unintentional weight loss greater than 10% within the last 3–6 months • Little or no nutritional intake for more than 5 days • A history of alcohol abuse or drugs including insulin, chemotherapy, antacids, or diuretics
Very High Risk: • BMI < 14kg/m2 • Negligible intake for >15 days or more

11.0 Multidisciplinary Team (MDT) Response to Food and Fluid Refusal

Food and fluid refusal may occasionally be resolved through simple, immediate interventions such as offering an alternative meal aligned with the patient's preferences or adjusting their physical positioning. However, in many cases, refusal is multifactorial and requires a coordinated response from an MDT to ensure appropriate assessment, support, and intervention.

MDT meetings are essential for collaborative decision-making, shared responsibility, and escalation of complex cases. They bring together professionals from diverse disciplines to ensure comprehensive, patient-centred care planning and provide a mechanism for risk management and governance oversight.

An MDT meeting must be convened under any of the following circumstances:

- The patient has refused food and/or fluids as defined by clinical criteria.
- The patient presents with complex physical or mental health needs and is refusing nutrition.
- The patient is at significant clinical risk due to refusal, regardless of mental capacity.
- The patient is at risk of developing refeeding syndrome.
- The patient is refusing both physical observations and nutrition.

11.1 MDT Composition

The MDT should be organised by the staff member who identified the refusal. Membership may vary depending on the patient's needs and healthcare professionals/services involved. The MDT may include:

- GP, psychiatrist, nurses, occupational therapist, dietitian, speech and language therapist, physiotherapist
- Mental health professionals, where applicable

- Safeguarding Team representative, if required
- Care provider
- The patient
- Family/advocacy

The patient's voice, wishes, and feelings must be central to MDT discussions. This may be achieved through direct participation or representation via a family member, advocate, or other appointed individual.

MDT meetings must be held regularly in inpatient settings, in addition to daily 'safety huddle' meetings. In community settings, the MDT frequency will depend on the risk and frequency agreed during the MDT.

11.2 MDT Meeting Governance

- A designated staff member must chair each MDT meeting.
- A separate individual must be assigned to record minutes and support the Chair.
- Minutes must be uploaded to the patient's Electronic Patient Record (EPR) and include:
    1. Names and roles of all attendees
    2. Key discussion points
    3. Challenges or concerns raised.
    4. A detailed action plan with assigned responsibilities and timelines
    5. Information regarding any planned follow-up meetings

11.3 MDT Meeting Discussion Checks

During each MDT meeting, the following areas must be reviewed and documented:

- Reasons for food and/or fluid refusal, including any new developments.
- Physical and mental health status (checks as per Table 2, any abnormalities, refeeding syndrome risks and actions).
- Mental capacity assessment status and any changes.
- Effectiveness of previously trialled interventions
- Patient engagement and communication needs
- Escalation requirements or transfer planning (e.g., to acute care)
- Family or advocate involvement and feedback
- Updates to the care plan

12.0 Care Planning and Documentation

All patient records must comply with Trust policies and professional body standards. Documentation must be accurate, comprehensive, and timely to ensure continuity of care and legal accountability.

12.1 Individualised Care Plan Requirements

Each patient must have a personalised care plan developed collaboratively by the MDT using a patient-centred approach. The care plan must include:

- Assessment and Risk Review
    - Thorough assessment of identified concerns and associated risks
    - Documentation of mental capacity status and rationale
    - Summary of patient engagement and support strategies
- Patient Preferences
    - The patient's expressed wishes, values, and communication needs
    - Interventions to be avoided (if applicable)
- Clinical Monitoring and Interventions
    - Planned interventions and frequency of monitoring.
    - Signs and symptoms to observe.
    - Required tests and physical observations (refer to Table 2)
    - Escalation protocols
    - Key support contacts
- Results and Findings
    - Documentation of regular physical assessments and actions needed (e.g., vital signs, weight)
    - Recording of test results and clinical findings

12.2 Care Plan Review and Update Protocol

- Care plans must be reviewed during every MDT meeting or in response to any change in the patient's condition.
- Updates must be documented in the EPR, including any changes to interventions, risks, or escalation plans.
- The care plan may be discontinued once the patient resumes adequate intake of food and fluids, and associated risks are resolved.

13.0 Disagreements with Actions/Outcome

Professional disagreement can occur; however, this provides an opportunity to listen to different viewpoints and ensuring all factors are being considered. It can also help identify alternative interventions or solutions to provide the best patient care and outcome.

On occasion, the disagreement may affect progress, and therefore it is essential to ensure steps are implemented to resolve the concern. Staff can seek guidance from senior colleagues and also contact the Safeguarding Team to address the concerns. All staff must remain professional, regardless of the differences in perspective.

14.0 Staff Debrief and Support

Food and fluid refusal can be a complex and emotionally challenging issue for the staff involved in the patient's care. It is crucial that staff have access to appropriate support and are given the opportunity for a debrief.

Line managers and senior staff members involved in the patient's care should ensure that staff have an opportunity for reflection following the MDT meetings, as well as additional debriefing sessions if needed.

Staff can also be signposted to the LPT Wellbeing Service for additional support, providing them with resources to manage the emotional and mental health challenges that can arise from managing complex cases such as food and fluid refusal.

15.0 Duties within the Organisation

Managers
Managers are to ensure practices/processes are in place to manage and monitor patients who are refusing food and/or fluids.
Managers should guide their employees to actions.

All Employees
All staff are responsible for ensuring that they are familiar with this procedure.
All staff should understand what is expected of them in terms of caring for a patient who is refusing food and/or fluids and access training according to their role.

Dietitians
Dietitians play a key role in the diagnosis and management of dietary insufficiency and are key in the management and treatment of patients with food and/or fluid refusal.

Medical Responsibility
The doctor in charge of the patient's care is responsible for - coordinating the response to the patient food and/or fluid refusal. This includes assessment of the reasons behind and refusal, treatment for the underlying cause, ensuring that it is clear who will undertake the monitoring outlined in the procedure and that it is reviewed, ensuring that patients are escalated to specialist emergency department (ED) services or secondary care as needed.

17.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision
- Remember that information
- Use the information to make the decision
- Communicate the decision

18.0 Monitoring Compliance and Effectiveness

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring
Page 13	Review of incidents and complaints	Directorate highlight reports	Quality Forum	Nutrition and Hydration Steering Group. Twice a year

19.0 References and Bibliography

Enteral Nutrition Policy, Leicestershire Partnership Trust (2024)

Managing Malnutrition in Adults in Primary Care, Leicestershire Medicines Strategy Group (2021)

Managing Medical Emergencies in Eating Disorders (MEED), Royal College of Psychiatrists (CR233, 2022)

Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, National Institute for Care Excellence, Clinical Guidance 32 (2006)

Nutrition and Hydration Policies for Community and Inpatient Settings, Leicestershire Partnership Trust (2023)

Prevention of Refeeding Syndrome Guidelines, Leicestershire Partnership Trust (2025)

Regulation 14: Meeting Nutritional and Hydration Needs, Care Quality Commission (2023)

Safe Administration of Insulin to Adult Patients in a Hospital and Community Setting Policy, Leicestershire Partnership Trust (2023)

Standard Operations Procedure for Nutrition and Hydration for DMH & FYPC/LDA Adult Hospital Inpatient Use, Leicestershire Partnership Trust (2025)

20.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

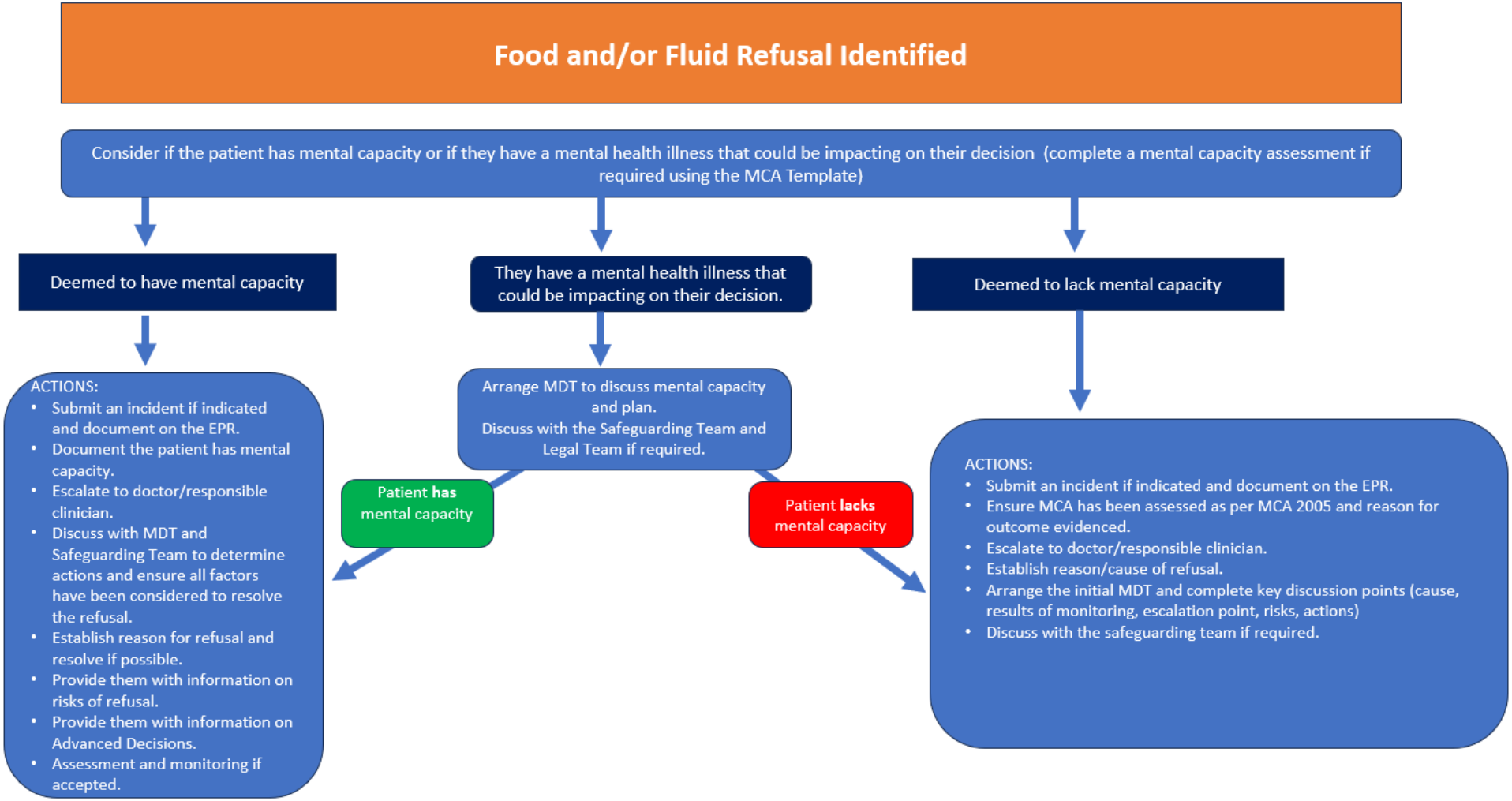
Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendix - Flowchart(s)

Flow charts show the step-by-step process for the key aspects of the policy and are a very good visual aid for staff. Consider filling x1 page with a process chart - as it could also be used as a poster or leaflet at meetings – flowcharts are not accessibility friendly so please consider other ways of providing this information or follow the guidance for making word documents accessible. If you need to use a flowchart, please provide a description of what the flow chart says for those who use a screen reader.

Appendix 1. Process Flowchart Following Identification of Food and/or Fluid Refusal



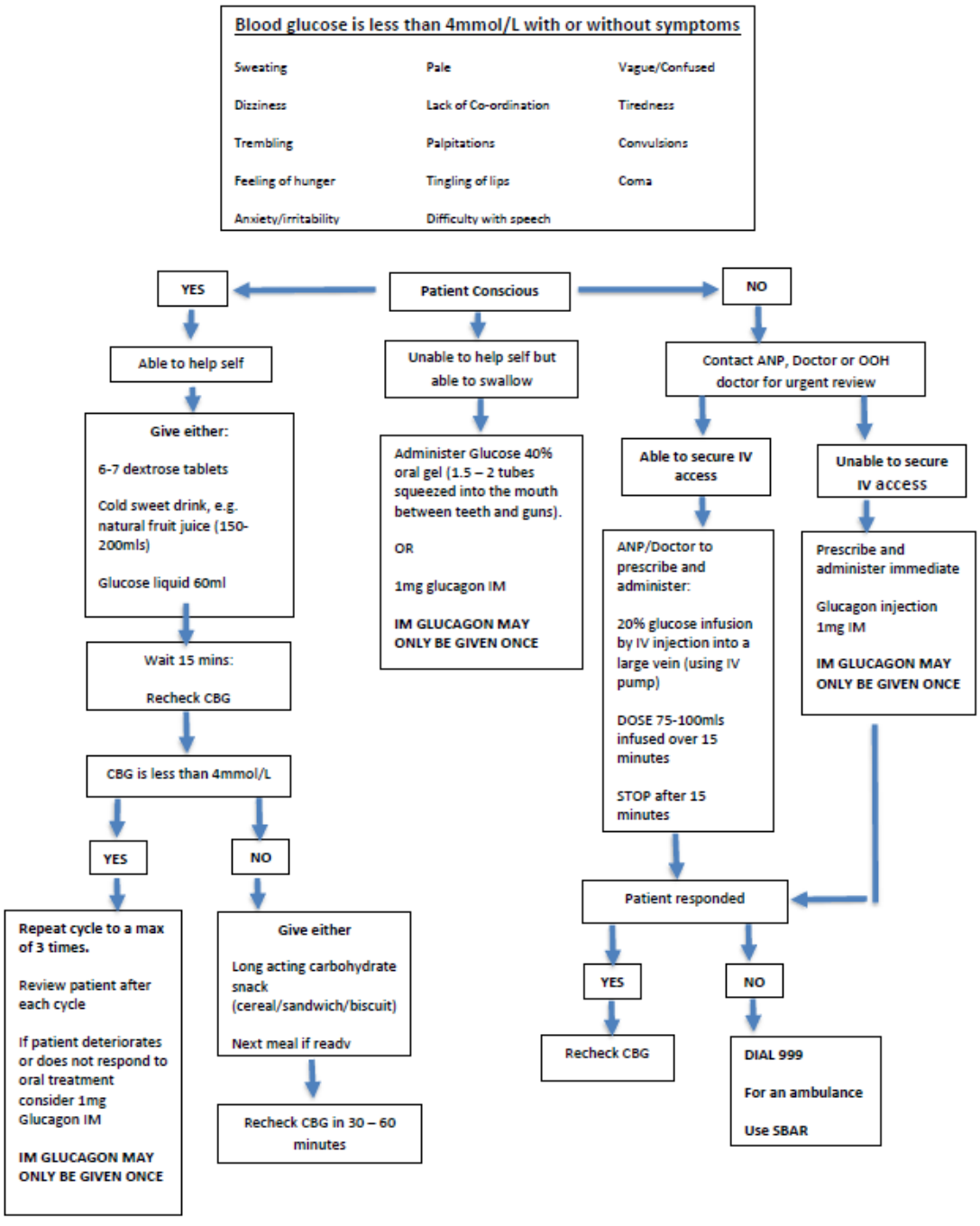
Appendix: 2 Food and/or Fluid Refusal Checklist

Factor	Question	Yes	No	Strategies / Key Information
Communication	*Could food refusal be a way of communicating discomfort, or dislike? Are there any language barriers, i.e. English is not their first language?*	☐	☐	*Use interpreter services. Consider communication methods, i.e. pictorial menus, and communication boards. Observe non-verbal cues.*
Cognitive Changes	*Is the individual experiencing memory or skill changes affecting intake (e.g., forgetting to eat/drink, or not recognising food)?*	☐	☐	*Prompting may be needed. Use reminders, clocks, and visual cues. MDT approach: e.g. involve SALT, RD, OT, carers, Adult Social Care.*
Cultural or Religious Beliefs	*Is the refusal related to culture/religion (e.g., Ramadan)?*	☐	☐	*Respect religious/cultural needs. Schedule meals around fasting. Document in care plan.*
Dietary Preferences	*Is refusal linked to food/fluid dislikes or a specific dietary requirement (e.g. vegetarian)?*	☐	☐	*Explore and document food preferences. Offer suitable alternatives. Involve the person in food choices. Update care plan regularly.*
Dental/Oral Health	*Are dental pain, poor oral hygiene, or oral infections contributing to reduced intake?*	☐	☐	*Refer to dentist. GP/pharmacy review to consider analgesia. Ensure oral care support and care plan. Softer options if unable to eat with pain and high energy/protein fluids. Monitor regularly.*
Dysphagia (Swallowing Difficulties)	*Is there difficulty swallowing or issues with food consistency/fluid thickness leading to refusal?*	☐	☐	*SALT assessment. Consider cause. Modified textures and fluids documented in care plan. Consider referral to the nutrition and dietetics service if appropriate.*
Eating Disorders	*Are there signs of an ED, i.e. anorexia nervosa, bulimia, or avoidant/restrictive food intake?*	☐	☐	*Contact/refer to specialist eating disorder services for advice/referral. Monitor mental and physical health.*

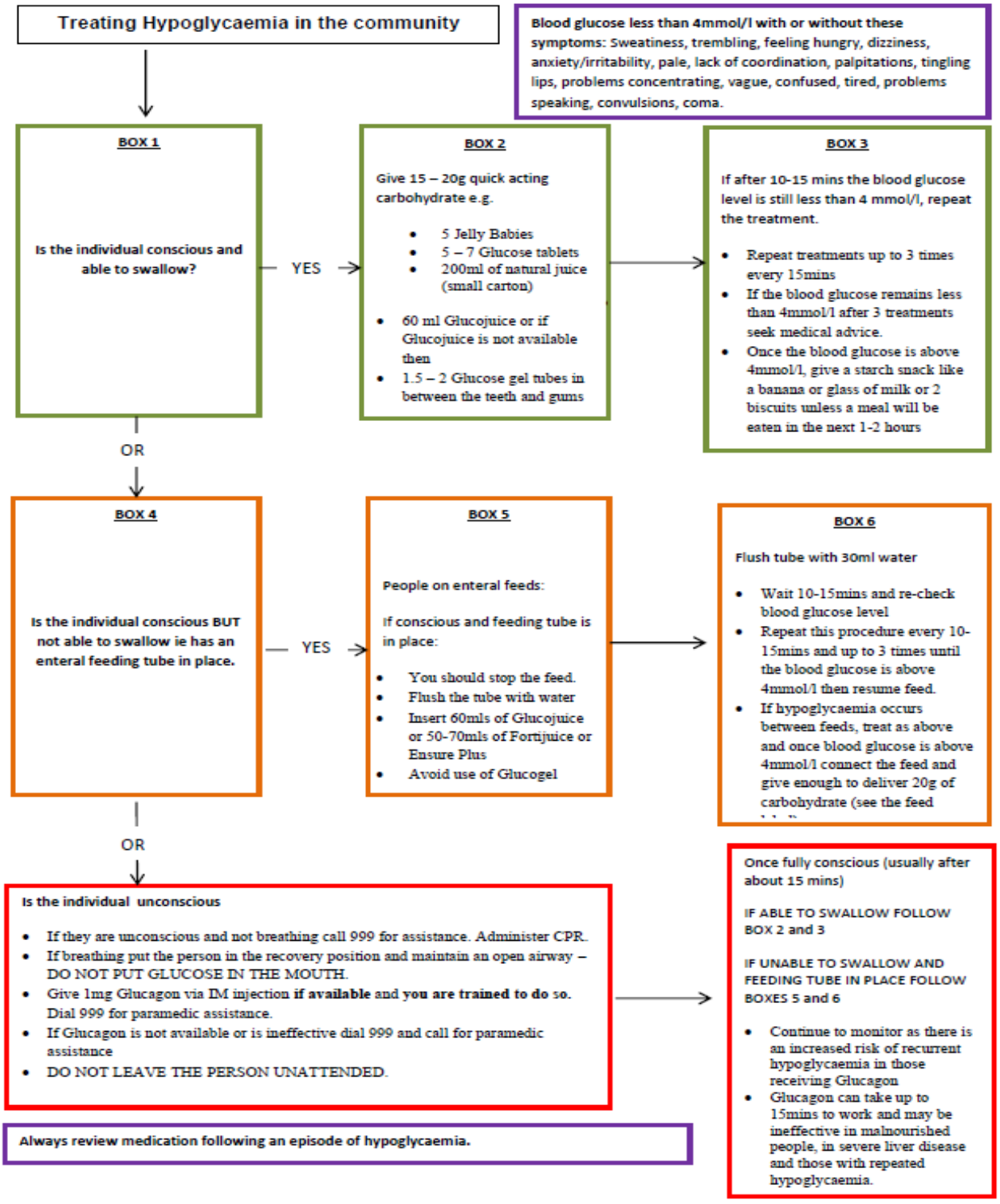
Environmental Factors	*Is the mealtime setting unfamiliar, overstimulating, or unpleasant? Have possible environmental triggers (e.g., noise, lighting, seating) been considered?*	☐	☐	*Create a calm, familiar environment. Consider noise, lighting, and mealtime preferences. Allow choice of eating location if possible.*
Independence	*Is refusal related to a perceived loss of control or autonomy?*	☐	☐	*Maximise independence (e.g., adapted cutlery, posture support). Encourage involvement in food choices and preparation if possible.*
Knowledge	*Does the individual understand the nutritional importance of food and fluids?*	☐	☐	*Provide education in line with their communication needs. Support informed decision-making.*
Medication Side Effects	*Are side effects such as nausea, reduced appetite, or drowsiness contributing to refusal? Have recent medication changes been reviewed?*	☐	☐	*Review medications with GP/pharmacist (e.g. to adjust timing/dose). Manage side effects (e.g., antiemetics). Monitor closely.*
Mental Health	*Is refusal linked to mental health conditions (e.g., psychosis, depression, personality disorder)?*	☐	☐	*Consider symptoms like paranoia, delusions, or suicidal ideation. Refer to/advice from mental health services.*
Physical Health	*Is a **known** physical health condition(s) (e.g., cancer or reflux) contributing to refusal?*	☐	☐	*Comprehensive medical assessment/review required. Rule out/identify the cause(s). Manage symptoms (e.g., pain relief). Consider nutrition support if required.*
	*Have **undiagnosed underlying** causes such as constipation, diarrhoea, abdominal pain, infection, or reflux been considered?*	☐	☐	
Previous Negative Experiences	*Has the individual had past trauma linked to food (e.g., choking)?*	☐	☐	*Offer reassurance. Do they have any 'safe' food/drinks they feel they can eat/drink? Build positive mealtime experiences. Gradual desensitisation. Consider psychological input if needed.*

Protest	*Is refusal being used as a method of protest or to assert control?*	☐	☐	*Explore underlying issue/reason for protest. Discuss concerns respectfully. Can the reason for refusal be safely resolved?*
Sensory	*Is refusal due to aversion to texture, smell, appearance, temperature, or sound of food? Interoception – e.g. do they recognise hunger or thirst?*	☐	☐	*Identify 'safe' foods. Modify sensory characteristics (e.g., texture, temperature). Consider sensory desensitisation. Routine/prompts if there are issues with hunger/thirst recognition. Consider dietetics referral if the referral criterion is met.*
Please note this checklist is not exhaustive, and professional clinical experience and judgement should be used.				

Appendix: 3 Treatment of Hypoglycaemia (Inpatients)



Appendix: 4 Treatment of Hypoglycaemia (Community)



Please note, suitable alternatives to Ensure of Fortijuce nutritional supplements/feeds may be used depending on the supplement/feed prescribed and contractual changes.

Food and/or Fluid Refusal Assessment and Review Form

This form outlines assessment findings, clinical risks, strategies, and responsibilities related to the refusal of food and/or fluids.

Patient Details

Name: _____

Date of Birth: _____

NHS Number: _____

Location: _____

Attendee List

Name	Job Role

Assessment Overview

Assessment Area	Key Findings
Nutritional Status (Please also record on MUST Template on S1)	Weight: Height: BMI: _____ kg/m² Recent Weight Change (kg and as a percentage): MUST Score: _____
Type of Refusal	☐ Food ☐ Fluid ☐ Fluid and Food

Start Date of Refusal and Current Duration:	
Food Intake	
Fluid Intake	
Mental Capacity to Refuse (Ensure MCA template on S1 complete if assessed).	☐ Has mental capacity ☐ Lacks capacity
Physical Health Concerns	
Cause(s) of Refusal	
Refeeding Syndrome Risk	☐ Yes ☐ No
Mental Health	
Safeguarding	☐ No concerns ☐ Referral made – Reason: _____

Risk Summary & Concerns

Risk Area	Details
Dehydration	
Refeeding Syndrome	
Physical Health and Deterioration	
Mental Capacity	
Mental Health	
Neglect / Safeguarding	

Plan of Care & Interventions

Domain	Actions / Interventions	Person/Team Responsible	Timescale / Frequency
Nutrition Support			
Fluid Monitoring			
Medical Monitoring (incusing escalation plans)			
Refeeding Plan			
Mental Capacity & Consent			
Mental Health			
Safeguarding			
Family / Advocacy Involvement			

Sign-Off & Review

Primary Clinician: _____

Date Plan Initiated: _____

Next Review Date: _____

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Appendix: 6 Training Requirements

Training Needs Analysis

Training required:	No
Training topic:	Food and/or Fluid Refusal
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ Role specific ☑ Personal development
Directorate to which the training is applicable:	☑ Mental Health ☑Community Health Services ☐ Enabling Services ☑ Families Young People Children / Learning Disability Services ☐ Hosted Services
Staff groups who require the training:	Healthcare professionals in clinical roles
Regularity of Update requirement:	N/A
Who is responsible for delivery of this training?	N/A
Have resources been identified?	Policy to read. Staff can refer to the nutrition and hydration on Ulearn.
Has a training plan been agreed?	N/A
Where will completion of this training be recorded?	☐ ULearn ☑ Other (please specify)
How is this training going to be monitored?	N/A

Appendix: 7 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers	☑
Respond to different needs of different sectors of the population	☑
Work continuously to improve quality services and to minimise errors	☑
Support and value its staff	☑
Work together with others to ensure a seamless service for patients	☑
Help keep people healthy and work to reduce health inequalities	☑

Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☑

Appendix: 8 Due Regard Screening Template

Section 1	
Name of activity/proposal	Policy
Date Screening commenced	February 2026
Directorate / Service carrying out the assessment	FYPC
Name and role of person undertaking this Due Regard (Equality Analysis)	Noor Al-Refae
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: To update and review the Food and Refusal policy and complete an equality analysis.	
OBJECTIVES: Due regard and quality analysis.	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	No impact
Disability	No impact
Gender reassignment	No impact
Marriage & Civil Partnership	No impact
Pregnancy & Maternity	No impact
Race	No impact
Religion and Belief	No impact
Sex	No impact
Sexual Orientation	No impact
Other equality groups?	None identified

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	No
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4. √

Section 4
If this proposal is low risk please give evidence or justification for how you reached this decision:
The policy does not put any person at risk of unfair treatment because of the characteristics reviewed.

Signed by reviewer/assessor	Noor Al-Refae	Date	26th February 2026
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Jane Martin	Date	26th February 2026

Appendix: 9 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	Food and/or Fluid Refusal	
Completed by:	Noor Al-Refae	
Job title	Senior Strategic Learning Disabilities Dietitian	Date 24th February 2026

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	Information may be shared with the patients consent between healthcare professionals this is documented in Systmone.
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.	
Data Privacy approval name:	
Date of approval	

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust