1. **Introduction**

Sunderland Psychological Wellbeing Service provide access to assessment and a range of psychological treatment interventions to those people with common mental health problems who have a low to moderate level of need.

1.1 The Department of Health (DOH) guidance in relation to Care Programme Approach (CPA) as revised through Refocusing the Care Programme Approach: Policy and Positive Practice Guidance (2008) clearly sets out an underpinning statement of values and principles that all in secondary mental health services should aim for.

Whilst it is clear that this guidance does not apply to the Trust’s Sunderland Psychological Wellbeing Service, the service meets the standards and principles in their practice as outlined in this practice guidance note (PGN).

Sunderland Psychological Wellbeing Service from 1st May 2014 use the IAPTus...
system as their principle electronic health care record. This PGN sets out the
associated recording requirements and the links to Cumbria Northumberland,
Tyne and Wear NHS Foundation Trust (the Trust/CNTW) electronic health
care record RiO which is the principle health care record used by all other
services of the Trust.

2 Referral

2.1 When a referral is received a check is undertaken by team administrator to
ascertain if the person referred has any existing health care records using
CNTW Patient index facility and patient document tracking facility both of which
are part of RiO. Where previous paper records are identified these should be
requested via the Trusts records department at St Nicholas hospital. This is to
ensure all relevant information is available to the clinician to inform clinical
decision making.

2.2 If the person referred has an existing registration on the Trust electronic care
record RiO, the administrator will check if the information held is current with
that provided on the referral and if needed update demographics.

2.3 If the person referred does not have an existing registration on the Trust
electronic care record RiO, the administrator will register them on RiO using
the demographic information provided on the referral.

2.4 If the person referred has an existing registration on IAPTus, the administrator
will check if the information held is current with that provided on the referral
and if needed update demographics.

2.5 If the person referred does not have an existing registration on IAPTus, the
administrator will register them using the demographic information provided on
the referral, using the RIO number as the local identifying number and creates
referral.

2.6 If the person referred does not have any previous record of care on RIO then the
person is offered an appointment by the administrator for a triage assessment.
For anyone with an existing health care record the referral is administratively
triaged by a Health Care Professional to determine if the referral is appropriate
i.e. a decision is made on the basis of the information received.

2.7 In the event the referral is not appropriate the Health Care Professional will
administratively triage the service user to another service, update care
pathway within IAPTus, record the referral as not accepted (documenting
rationale for none acceptance in referral notes)

2.8 Where the outcome of this administrative triage is that the referral is not
appropriate this will be communicated to the GP/referrer and the person
referred by contacting them by telephone or sending an
inappropriate referral letter including signposting to relevant service where
appropriate. If the relevant service is an CNTW service then the Health Care
Professional would facilitate this referral.
2.9 Where the outcome of the administrative triage is that the referral is appropriate the person referred will be contacted and offered an assessment appointment.

3 Assessment

3.1 Sunderland Psychological Wellbeing Service have a staged approach to the assessment of an individual’s needs.

3.2 Initially assessment involves a triage appointment via telephone or face to face based on the preference of the service user.

3.3 The triage assessment with the service user requires that consideration must be given to the following:

- Reasons for referral
- Current difficulties
- Personal Circumstances; e.g. Family, Social, Economic, Housing, Carer responsibilities
- Are there any children living in the household (name, DOB, relationship)
- Personal History
- Mental Health History
- Forensic History
- Drug/ Alcohol (recorded in units)/ Substance History
- Current and Previous Psychological Therapies/Treatments
- Current and Previous Medication

and a record made in the assessment section of the IAPTus electronic health care record in relation to each area including where there is no information e.g. Mental Health History - None: Medication would be recorded in the problem/medication section of the IAPTus electronic healthcare record.

3.4 Also the following questions should be discussed with the service user and the responses recorded in patient expectation section of the IAPTus electronic health care record

- What does the patient expect from the service?
- What are the patient’s expectations of therapy?
- Do they have any specific goals?
- Based on the assessment and discussions with the patient, what is the recommended treatment?

3.5 The triage assessment will also involve the assessment of risk using the narrative risk assessment approach that requires consideration of

- Current Clinical Risk factors/Hazards
- Known Static Risk Factors/Historical Risk
- Examination of Mental State/Clinical Presentation
• Mediating Protective factors

3.6 The associated information will be on the Risk assessment section of the IAPTus electronic health care record and the Impression / formulation (outcome) will inform the risk management / contingency plan. The setting of the risk rating button using the following guidance.

**No risk**  No apparent risk i.e. No history or warning signs indicative of risk

**Low**  No current behavior indicative of risk but history and/or warning signs indicate possible risk. No special risk prevention measures or plan required

**Medium**  History and/or current circumstances indicate significant risk and plan to manage risk is required

**High**  History and current circumstances indicate serious and imminent risk. Highest priority to be given to risk prevention

3.7 If the outcome of the triage appointment is that the service user requires further intervention then they move into treatment.

3.8 Where the triage appointment establishes that the service user requires no further intervention, this will be shared with the service user both verbally and in writing by sending them their summary assessment letter. This will include, where appropriate relevant self-help information leaflets.

3.9 A copy of the summary assessment letter will also be sent to the service user’s GP

4  **Consent to share information**

4.1 Consent to seek and Share Information, whether the service user would like to receive copies of letters and would like to be reminded of any future appointments should be discussed and initially agreed with the individual as part of the Triage assessment.

4.2 The outcome of this discussion should be recorded in the electronic care record (IAPTus) using the consent form, accessible via the assessment section. If the outcome of the triage is that the person requires treatment by the service, at the first treatment appointment the person is given a copy of the consent to seek and share information document to review and sign. This document is then scanned into IAPTus and stored in the documents section. The electronic version would also be updated.

4.3 As a provider of NHS-commissioned IAPT services CNTW are required to submit a monthly data set return to the Health and Social Care Information Centre (HSCIC).
4.4 The IAPT service stores all information safely and securely and sends data set
information safely to a secure central data storage area. All data collected is
subject to the strict rules of confidentiality, laid down by Acts of Parliament,
including the Data Protection Act 2018 and the Health and Social Care Act
2001 and the NHS Care Record Guarantee.

4.5 No information that could reveal a patient’s identity is used in national reports.
These reports only show summary numbers of, for instance, patients receiving
different types of treatments and it is impossible to identify any person seen by
any IAPT service from them.

4.6 However, if a service user does not want their information included in national
analyses, they can opt out by informing their treating clinician who will make
sure the information is not used by selecting the Refused Consent for the Consent for Data to Flow to DoH setting on IAPTus under the
demographic screen.

4.7 Service users will be informed of the use of their information in the data set
returns and their right to opt out though the provision of an information sheet.

5 Care planning / Treatment

5.1 The assessment and discussions with the patient, will inform the
recommended treatment.

5.2 The allocated clinician will discuss the recommend intervention / treatment
with the service user. This will include agreeing with the service user the
anticipated contact frequency, venue, if appropriate, and the goals of
treatment and constitute the service users care plan for the period of treatment
with the Sunderland Psychological Wellbeing Service.

5.3 The goals of treatment should be recorded in patient expectation section of the
IAPTus electronic health care record

5.4 Throughout the period of treatment the collaborative approach is supported by
good clinical record keeping and feedback from service users including
through patient experience questionnaires.

5.5 Throughout the period of treatment the allocated clinician will enter all clinical
contacts into the service user’s electronic health care record (IAPTus)
including contemporaneous notes.

5.6 Risk assessment is a dynamic and ongoing process and is an integral part of
any contact with service users. Where this ongoing process alerts the
allocated clinician to a change in assessed risk they will record their new
assessment in the risk assessment section of the IAPTus electronic health
care record. Any alerts should be recorded on both the IAPTus record and the
RIO record.

5.7 The outcome of the new risk assessment will inform the implementation and
recording of any changes required to the management plan or the setting of
the risk rating button.

6 Transitions / Discharge

6.1 It may be identified during treatment with the Sunderland Psychological Wellbeing Service that the service user requires intervention / treatment from another CNTW service. The arrangements for either transition to the new service or joint working will be agreed between the services with the involvement of the service user.

6.2 Where there is a period of joint working appropriate records will be kept on IAPTus and Rio with the lead professional ensuring that arrangements for prompt information sharing are in place. A copy of the joint care plan should be offered to the service user and provided to their GP.

6.3 Where transition to another CNTW service results in discharge from Sunderland Psychological Wellbeing Service the allocated clinician will update the record on IAPTus through updating the care pathway, discharging the referral and informing the service user’s GP of the discharge.

6.4 For most service users they will be discharged from IAPT services when their period of treatment is completed. This transition out of service will be supported by clear communication via a Treatment discharge letter to the service user and their GP.

7 Information sharing within CNTW

7.1 Throughout a service user’s care pathway with Sunderland Psychological Wellbeing Service it is essential that other CNTW services who do not have access to the clinical record via IAPTus are able to access key clinical information should the service user present to their service.

7.2 The electronic care record used by other CNTW services (Rio) enables access to the IAPTus viewer which will hold information related to an episode of care being delivered by Sunderland Psychological Wellbeing Service. It should be noted that this information is updated every 24hrs and therefore will not always represent real time entries. The information held in the IAPTus viewer will include the following clinical information:

- Demographics and Alerts (all alerts) – this is the default/ home page for the viewer
- Latest Referral
- Latest Appointment
- Latest Assessment
- Latest Medication
- Latest Allergy
7.3 RIO users will continue to have access to historical information pertaining to service users that have accessed Psychological Therapy Services in the past and had their clinical information stored in RiO.

8 Record keeping standards

8.1 The record keeping standards set out in the Trust’s CNTW(O)09 – Records Management Policy, practice guidance note MR-PGN-02, Record Keeping Standard, Section 2, continues to be required in the use of the IAPT electronic care record IAPTus. The IAPTus system is the principle patient record for Psychological Therapy Services (Primary Care mental Health and IAPT).

8.2 However unlike The Trust’s other electronic patient record (Rio) IAPTus does not have the facility to "cross out" an incorrect entry, nor will the IT helpdesk be the contact point in relation to any misfiling on the record. Users of the IAPTus system will only be able to delete

- future appointments
- Care pathway steps
- Draft versions of letters (these are not visible to other users including IAPTus system super-users, and are not part of the clinical record but sit on a functionality akin to a note pad attached to IAPTus)
- Future planned supervision

8.3 Errors made in completing diary availability

8.3.1 The process below sets out what to do if a clinician or administrator misfiles a document on the patient record on IAPTus or make an incorrect entry or think there is another reason why the record should be amended.

NB an incorrect entry is one that contains factually inaccurate information

- Complete standardised deletion proforma
- Email proforma to IAPTus Superuser
- Request the removal of a document that has been filed in the wrong patient record
  - Request is logged, system support check that the person making the request has put the document on the correct record
  - Misfiled Document deleted
- Request is to delete an incorrect entry
• System support check that the person making the request is the clinician who made the entry. If not then advise that the clinician needs to make the request
• Entry made on the wrong patient record?
• If yes the request is logged and entry deleted

• Request is to delete an incorrect entry made on the patient’s record.
• If corrected information has been entered onto the patient record then the request is logged and entry deleted
• If corrected information has not been entered onto the patient record the clinician is advised to make the correct entry and advise IAPTus superuser once this is done
• The Request is logged and entry deleted

• Deletion request does not relate to misfiling or incorrect clinical entry onto a record - Caldicott approval needed
• Advise person making the request to call Caldicott Support for approval/advice.
• Caldicott decide whether entry (however made e.g. notes / form / letter) should be removed and inform IAPTus Superuser who will log the request and take action advised
• If entry to remain, person making the request follows Caldicott Support advice

8.4 It is strictly forbidden to access an individual's health record on IAPTus unless doing so for a legitimate reason i.e. provision of healthcare and treatment.

8.5 Individuals must not look at any information relating to themselves (if they have a record), their own family, friends, colleagues, acquaintances or if they recognise a name.

8.6 Access to records is monitored and inappropriate access may result in prosecution under UK law and / or disciplinary action.

9 Associated documentation

CNTW(C)06 Non Attendance (Did Not Attend-DNA) Policy
CNTW(C)07 Promoting Engagement with SU (Policy on non-compliance)
CNTW(O)09 Records Management Policy, practice guidance note
MR-PGN-02 – Record Keeping Standards