HPFT

Hertfordshire Wellbeing (IAPT) Service

HPFT Operational Policy

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Executive Lead	Chief Operating Officer
Lead Author	Clinical Lead
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Target Audience	All staff working in the Wellbeing Service Any related service which may make referrals to this service Any service which may receive referrals from this service

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Title of document	Wellbeing (IAPT) Service		
Document Type	Operational Policy		
Ratifying Committee	Essex and IAPT SBU Quality and Risk Meeting		
Version	**Issue Date**	**Review Date**	**Lead Author**
6	14th August 2020	14th August 2023	Clinical Lead
Staff need to know about this policy because (complete in 50 words)	This document is intended to ensure a consistent and equitable approach to service delivery across the Wellbeing (IAPT) Service four locality teams in Hertfordshire. It as a reference for staff and those seeking to understand how the service works, how to refer into the service and provides an overview of the clinical interventions provided		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	Ensure staff have a clear understanding of the referral pathway as described in sections 8 and 10 Ensure staff have a clear understanding of the risk assessment and management procedures for the Wellbeing Service (section 17) Ensure staff are aware that there is no longer a need to seek consent from patients to share information with the GP.		
Summary of significant changes from previous version are:	The policy has been reviewed in light of COVID-19 and references that more treatment is now offered online. All reference to seeking consent from the patient to share information with the GP have been removed from this document. This reflects a change to our Information Sharing Statement which sets out how information is processed and shared and subsequent change to our practice.		

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PART 1 – Preliminary Issues:

1. Summary

This is the operational policy for the Improving Access to Psychological Therapies (IAPT) Services in Hertfordshire (otherwise known as the "Wellbeing Team"). This document is intended to ensure a consistent and equitable approach to service delivery across the four locality teams in Hertfordshire and as a reference for staff and those seeking to understand how the service works.

2. Purpose

The Hertfordshire Improving Access to Psychological Therapies (IAPT) Services have been established as part of the national Improving Access to Psychological Therapies programme, which was initiated in 2008 and aimed to expand the provision of evidence based, NICE recommended psychological therapies for the treatment of anxiety and depression (DoH, 2008) through a range of therapy modalities.

The service is commissioned to deliver effective and efficient interventions and to operate according to the procedures and outcomes detailed within the national Improving Access to Psychological Therapies initiative. The service delivers recovery orientated services in line with the principles of Recovery adopted by the Trust (see Appendix 1).

The NICE guidelines for the management of depression, anxiety (panic disorder and generalized anxiety disorder) and obsessive-compulsive disorder (OCD) recommend using a stepped care model. The steps and the interventions required vary across conditions, but the principle is that patients receive the least burdensome effective treatment necessary for their recovery. Within stepped care, the progression of patients from low intensity interventions through to higher intensity interventions is based on a mixture of increased need and past experience of treatment.

The Service purpose is to provide talking therapies to people in the local population experiencing common mental health difficulties. Hertfordshire Wellbeing Services are commissioned to expand in line with the NHS Long Term Plan to achieve increases access each year. For those people entering treatment we are expected to deliver a recovery rate of 50% measured against the IAPT approved minimum data set. The Hertfordshire IAPT Services will also work to meet locally specified and agreed CCG targets regarding activity and performance, and support them in delivering against their commissioning priorities.

The Service offers a range of treatments in accordance with NICE guidelines:

- Cognitive-Behaviour Therapy (CBT) at step 3 (High intensity) and CBT informed interventions at step 2 (Low intensity).

- Evidence based therapeutic models for depression, such as interpersonal therapy (IPT), Brief Dynamic Interpersonal Therapy (DIT) and couples therapy for depression (CTfD).

- Trauma focused CBT as well as EMDR for the treatment of post-traumatic stress disorder

- Step 2 interventions include guided self- help delivered via face to face, online and telephone support, CCBT, workshops and courses offered by psychological wellbeing practitioners,.

The staff delivering these treatments will have a recognised qualification or relevant training.

3. Objectives of the Wellbeing Service

The Wellbeing (IAPT) Service will:

- Provide a directly accessible primary care psychological therapy Service for patients presenting with common mental health disorders.

- Provide early access and appropriate interventions adopting a stepped care approach as per NICE guidelines

- Provide a “whole person” approach that takes account of an individual’s health comorbidities and lifestyle

- Develop areas of specialist interventions for individuals experiencing mental health problems in such contexts as long term physical problems, medically unexplained symptoms and peri-natal

- Keep people in work and/or assist their return to work

- Promote self-referral and access to Services from all sectors of the community, including traditionally underserved/socially excluded groups such as older adults, BME groups, younger adults (16-24 years), individuals with long term health conditions and mild learning disabilities.

- Work with partners to optimise provision

- Signpost individuals and carers when identified needs indicate other services are required.

- Provide all interventions and interfaces with professionals, Service users and carers in accordance with wider Trust Values.

- Work with, and refer appropriately, to HPFT Secondary Care community services and CAMHS, according to agreed protocols and referral criteria

- Seek advice via the team psychiatrist to facilitate one off assessments with Consultants for working age adults, the older person, CAMHS Specialists or Perinatal Specialist.

- Ensure that when carers' needs are identified they are offered an assessment of their own needs and provided with access to appropriate support

- Offer fair access to care (FAC) assessments and appropriate social care packages for service users whilst in the service.

- Build and develop consistent links and relationships within primary care services by providing primary care mental health support, advice and education to primary care staff.

- Be flexible and adaptable with the ability to evolve and change according to need of the individual, carers, the primary care team and HPFT secondary services.

- Audit the effectiveness of the service and identify gaps in provision in order to inform the future commissioning of services.

- Maintain a minimum of 50% recovery rate across all teams

4. Definitions

Key words / phrases in this document include:

IAPT	Improving Access to Psychological Therapies
NICE	National Institute for Health and Care Excellence
CBT	Cognitive Behaviour Therapy
IPT	Interpersonal Therapy
DIT	Dynamic Interpersonal Therapy
EMDR	Eye Movement Desensitisation and Reprocessing Therapy
CCBT	Computerised CBT programmes
PWPs	Psychological Wellbeing Practitioners
HIWs/HITs	High Intensity Workers, typically CBT Therapists, Clinical or Counselling Psychologists providing step 3 interventions
SPA	Single Point of Access

Stepped care model: A model of delivering and monitoring care where the most effective yet least resource intensive treatment is delivered first; only "stepping up" to intensive / specialist Services as required clinically.

Step 2 interventions: Self-help; guided self-help; CCBT; courses / workshops / groups designed to target mild common mental health problems; expert advice; short-term brief interventions; signposting to/mobilising resources of Step 1, watchful waiting'…with further assessment.

Step 3 interventions: Brief psychological treatments / standard talking therapies for mild to moderate and severe anxiety disorders and depression including CBT, EMDR, DIT, Counselling for Depression, Couple Therapy for Depression, IPT.

5. Team Locations and Opening Hours

The core operating hours for the Service are between 9:00am and 5:00pm Monday to Friday. Where possible, the Service aims to provide sessions between 8:00am and 8:00pm Monday to Friday and at weekends according to patient need.

Wellbeing (IAPT) Services are based in:

South West Herts Wellbeing Team bases:-

Prospect House
Peace Drive
Watford
WD17 3XE

Hertsmere
Civic Offices
Borehamwood,
WD6 1 WA

North West Herts Wellbeing Team bases

St Pauls
Slippers Hill,
Hemel Hempstead
HP2 5XT

99 Waverley Road
St Albans
AL3 5TL

East Herts Wellbeing Team bases:-

Rosanne House,
Welwyn Garden City
AL8 6HG

59 New Road,
Ware
SG12 7BU

North Herts Wellbeing Team base

Saffron Ground,
Ditchmore Lane
Stevenage
SG1 3LJ

6. Service User Profile and Eligibility

The Wellbeing Service provides IAPT for:

- People aged 16 and over, including older adults and people with mild learning disabilities who have mild to moderately severe levels of common mental health problems, in particular depression and anxiety

- People who are registered with a Hertfordshire GP. If people are not registered they will be given help to do so.

- People referred by other statutory services provided the person is registered with a Hertfordshire GP. The GP will be informed a referral has been received.

- Younger people aged 16 and 17 will be accepted into the service if they present with mild to moderately severe levels of depression and anxiety and can be seen individually without the need for family work or inter-agency working (liaising and meeting with Children's Social Care, Educational Support, Youth Offending Team etc.).
  If the above conditions are not met, the individual will be referred on to the local Child and Adolescent Mental Health Service (CAMHS).

- People newly diagnosed with dementia, where anxiety and/or depression are present and where the individual is not already receiving services from within a secondary care setting, will receive support and advice and will be supported to access additional services as appropriate.

- The Wellbeing (IAPT) Service teams will provide therapeutic interventions to people with mild – moderate anger problems providing these problems occur within the context of a mild to moderate mental health condition. Where, during the course of an assessment it emerges that an anger management issue is the predominant one, the CCGs have agreed an Individual Funding Request be made for specific targeted interventions i.e. Domestic Violence.

- The service will also provide interventions for individuals referred with mild eating difficulties related to psychological issues.

- People with comorbid long term physical health conditions and where a short term IAPT intervention would be appropriate

The service will also work with people who self-refer.

Where the person does not meet the eligibility criteria but needs more intensive interventions a referral will be made to another service within HPFT. Such internal referrals should follow the agreed pathway (see section 17) and the person's GP should be kept informed of all such decisions in writing. The patient's case remains open on PC MIS until the referral is accepted. (see guidance in section 17 with regard to the process for stepping care up to secondary care services).

7. Access to healthcare for people with a learning disability

RULE

People with a learning disability will access appropriate services and receive the best treatment available in line with good practice and legal frameworks. Therefore all services will ensure that

- Reasonable adjustments are made to ensure that each person has the opportunity for health, whether they have a learning disability or not. (Equality Act 2010)
- Assume that each person has capacity. If assessment shows they do not, a decision must be made in their best interest. (Mental Capacity Act 2005)
- Everyone has a right to expect and receive appropriate healthcare (Human Rights Act 1998)

Adjustments will include:

- Spending time with the individual to gain an understanding of their preferences for treatment
- Asking them where they would prefer to be treated,
- Providing additional support to assist with communication, this support will be available via accessible information and/or audio equipment. Accessible information will include appointment letters and leaflets, available on the Performance page on the intranet.
- If someone has difficulty understanding their treatment it is the responsibility of the staff to refer them to a specialist learning disability service for additional support
- People with a learning disability may have a Health Action Plan or Purple Folder and all HPFT staff will ask for permission to see these and contribute to the plan when appropriate
- Valuing and welcome the contribution of the relative/carer/advocate

8. Referrals

The Wellbeing Service aims to provide patients access to psychological therapies. The functions and roles of the team assist in supporting the patient journey from referral to end of treatment.

Patients can access the Wellbeing Service by referring themselves or by being referred by another professional currently involved in their care.

The Wellbeing (IAPT) Services teams will accept referrals from GPs and other health care professionals, from secondary care services, or from individuals in the form of a self-referral.

External referrals and role of the Single point of access (SPA)

External referrals will be accepted in written form, by letter or secure email, directly to the Single Point of Access. Self-referrals will be accepted by telephone, letter, self-referral portal (web link) or by secure email where such facilities are available.

All Wellbeing (IAPT) Service referrals received by the SPA will be uploaded onto PC-MIS by a SPA referral advisor. At this point SPA will enter the "complete referral" date on to PC-MIS, corresponding to the date the referral was received, The expectation is that SPA then contact the service user either via telephone or letter (copied to the service user's GP unless permission withheld) within 72 hours of receipt of referral. The date of this contact is entered onto PCMIS as "date of first contact". If the referral is considered urgent the referral will be passed to the urgent clinical advisor working in SPA for a telephone screening assessment to be made, as a priority.

If a service user self-refers via telephone, the SPA referral advisor will enter the relevant information onto the online portal as part of the call unless it is immediately evident that the individual needs urgent care. They will record demographic details (full name, date of birth, gender, ethnicity, address, phone number and GP).

SPA will review all referrals for risk. If a referral is clearly appropriate for the Wellbeing (IAPT) Service and there are no risk concerns, the referral will be allocated straight to the appropriate Wellbeing (IAPT) Team on PC-MIS. Where risk is identified a SPA clinician will complete a triage by telephone to check risk factors, suitability and make a clinical decision with regard to the appropriate service for the person referred. Based on Wellbeing service criteria SPA will make a decision about step allocation with the majority of referrals being allocated for a step 2 assessment. Referrals considered appropriate for step 3 or where there is a query re suitability not resolved by the abovementioned risk call, will be allocated to the team "admin account" for screening by a Wellbeing Team Senior Clinician.

Internal referrals

Internal referrals from other HPFT Teams may be submitted via email to the relevant Wellbeing quadrant email account. This account is monitored by each quadrant's administration team, who act by entering the referral as a new case on PCMIS. Subsequently these referrals are allocated to the Team's "admin account" for screening. The person who screens the referral will respond via email to the referrer, copying in the relevant Duty email address and names of the managers of their team.

All such referrals are to be screened by team managers for IAPT suitability within 72 hours of receipt of referral. The timeframe for assessment in Wellbeing for internal referrals is 28 days from receipt of referral.

9. Exclusion Criteria

General:

The Wellbeing Service offers a formal psychological intervention, i.e. a short-term goal focused and structured intervention requiring the individual to take an active role in the change process, rather than support for individuals in crisis. It is not appropriate or beneficial for service users to start treatment with the Wellbeing Team if they are not in a position to engage with such an approach.

Exclusion criteria: People presenting with risk to self

People who present with significant risk to self or others are not appropriate for the Wellbeing Service (IAPT) teams, and should be referred to secondary care services or other appropriate/commissioned services. The relevant GP must be informed.

These include:

- Individuals who have recently attempted suicide and where (a) the triggers for the risk are still current, and/or (b) the individual feels no regret of having attempted suicide and/or (c) regrets the attempt not being successful.

- Individuals who are regularly seriously self-harming – deep cutting, burning, scalding, or drinking bleach or have a history of repeated self-injury requiring medical intervention.

Any such referrals should be considered on a case by case basis where the risk episode is formulated before being rejected. This will (for instance) enable clinicians to establish whether the triggers that led to the risk behaviour are still current, in which case alternative sources of support should be sought.

If not clear from the referral information and/or consultation with the referring professional, this may involve the Wellbeing Team carrying out an assessment with the individual. If evident following assessment or during treatment that the above conditions are unable to be met, the individual will be stepped up to secondary care services with immediate effect. The Wellbeing Team will not provide a “holding” function for individuals waiting to be seen in secondary care.

If there is a history of self-harming as a way of managing emotional difficulties the Wellbeing Team does not provide DBT type interventions, or interventions specifically aimed at targeting the self-harm (also please see criteria specific to young people below).

Exclusion criteria: People presenting with risk to others

- Individuals identified as experiencing severe anger management problems as identified by a history of agitation or threatening manner causing fear in others. This includes physical aggression to people or animals and destruction of property.

- Individuals who have been charged and/or convicted of violence related issues in the last 12 months or for whom there is a significant history of interpersonal aggression.

- Individuals identified as experiencing anger management problems in the absence of a mental health problem may submit an Individual Funding Request for specific targeted interventions. Under such circumstances the Wellbeing Service will not refer on to specific services but may direct individuals to the BABCP/BACP websites where they can access accredited therapists in their locality.

Exclusion criteria: Substance abuse

- Individuals with substance or alcohol misuse, which would interfere with the patient's ability to engage in interventions offered, should be referred to relevant drug and alcohol services (CGL). The Wellbeing (IAPT) Team may work with individuals concurrently engaged with specialist drug and alcohol services, provided that they have progressed to a stage where they are able to engage in a highly structured, goal orientated, short-term type of therapy, focused on helping them address anxiety and / or depression, rather than focused on the drug and alcohol problem, and where the substance misuse does not interfere with this intervention.

Exclusion criteria: Serious mental illness

- Individuals open to on-going care from secondary care mental health services, except where this is only for medication review/monitoring.

- Individuals with a current, recent or provisional diagnosis of a severe and enduring mental health problem, should be referred to secondary care services (Steps 4 and 5). However if an individual presents with a historical diagnosis of a severe and enduring mental health problem and (a) has been considered stable for a substantial period of time and (b) is currently managed in primary care with no input needed from secondary care services, the Wellbeing Team may assess to establish whether their current presenting difficulties are amenable to the short term focussed interventions offered by the Wellbeing Team.

- Individuals with a current diagnosis of personality disorder - although as explained in the previous point any such referral where the diagnosis is historical should be considered on a case by case basis before being rejected. Also please see previous comments on DBT informed interventions.

Exclusion criteria: Eating disorders

- Individuals presenting with anorexia nervosa;
- Individuals with severe bulimia.
- Individuals presenting with a history of anorexia, who may now present with atypical anorexia or bulimia,
- Individuals with moderate/ severe binge eating disorder (i.e. episodes of binge eating occurring more than 4 times per week) and where medical complications are evident as a consequence of the binge eating;
- Individuals where the function of the eating disorder is that of emotion regulation in the context of self harm.

Exclusion criteria: other

- Where the primary difficulty is related to childhood sexual abuse these individuals should be referred on to local specialist services.
- Patients presenting with multiple event trauma
- Individuals with a moderate to severe learning disability whose clinical needs can best be met within specialist learning disability services.
- Individuals who are seeking a formal diagnosis, for instance of an Autistic Spectrum Disorder or dementia.
- Individuals unwilling to be registered with a Hertfordshire GP
- Individuals presenting with hoarding and who as a consequence of their hoarding are not able to use rooms in the home for their intended purpose. The Wellbeing Team are unable to work with people presenting with this condition if due to the severity of hoarding there is a risk of infestation, fire safety, blocked access routes, items collapsing, and a risk of falls to patient or other persons living or visiting the property.

Exclusion criteria specific to young people (under the age of 18)

- Individuals under the age of 16.
- The Wellbeing team are unable to offer interventions where the aim is that of reducing self-harm. Therefore we are unable to see individuals aged 16 and 17 who have a history of repeated self-harming and impulsive overdosing and who are currently self-harming. Young people who self-harm should have access to the full range of treatments and services recommended in NICE

guidance CG133 within child and adolescent mental health services (CAMHS).

- Individuals aged under 18 who present with anorexia or bulimia nervosa

10. Assessment Process

The Wellbeing service aim to provide the minimum intervention necessary tailored to the needs of each individual patient. Mild to moderate mental health problems will usually be treated using brief guided self-help interventions at Step 2, whereas moderately severe mental health problems will usually indicate formal psychological therapy at Step 3.

Step Allocation

Step	Service	Severity	Functioning	Risk	Clinical intervention
1	**GP**	Mild	Good	None	Identification/ watchful waiting
2	Wellbeing Service (IAPT) **low intensity**	Mild – moderate	Relatively unaffected	No current intent	Guided self-help based on CBT & signposting
3	Wellbeing Service (IAPT) **high intensity**	Moderate – moderately severe	Definitely impeded	Low - no intent	CBT or other evidence based psychological therapy
4/5	**Secondary care**	Severe	Poor	High	Multidisciplinary approach/ longer term therapy

The IAPT minimum data set tools provides an index of the severity of symptoms of depression and anxiety, however decision making around step allocation is not based solely on scores on these measures:

The PHQ measures depression:
0 – 4 None
5 – 9 Mild
10 – 14 Moderate
15 – 19 Moderately Severe
20 – 27 Severe
The GAD measures anxiety:
0 – 4 None
5 - 10 Mild
11 – 15 Moderate
15 - 21 Severe

10.1 Referral screening

All referrals will be screened for one of the following outcomes (for external referrals this is carried out by SPA, for internal referrals this is carried out by a member of the Senior Team):

- Initial assessment at Step 2
- Initial assessment at Step 3
- Signposting to alternative service (including return to GP)

Post screening, the Single Point of Access (SPA) will make a recommendation about the step of care required. Any referrals considered appropriate by SPA for Step 2 will be passed directly to the relevant team. The team's booking clerk will contact the individual to book an assessment with a Step 2 (PWP) Worker. Referrals not allocated to Step 2 by the SPA will be passed to the team (the PCMIS "admin account") for the Wellbeing (IAPT) Senior Clinicians to review and allocate to an appropriate step for assessment.

If, following a reasonable number of contact attempts, it is not possible to arrange an Initial Assessment, the case will be closed and the referrer notified.

Where the outcome is signposting to another service, a letter will be sent to the patient indicating the outcome and a copy sent to the referrer. Signposting should not be based on paper/referral information only, but should only occur after discussion with the service user.

10.2 Confidentiality and consent

Patients will have been provided with a copy of the Protection and Use of Service User Information (PUPI) form via the SPA. At the initial assessment all service users will be explained the terms and limits of confidentiality. This conversation will be recorded as a summary note on PCMIS. The following statement will be used on e-referral sites and in discussion with patients:

This is an NHS service provided in partnership with our local GPs and other health care providers, to ensure a joined up approach to your care. Information is therefore shared with your GP to support continuity of care. Your information will be held securely and confidentially in electronic and paper format in accordance with the principles of the Data Protection Act 2018. To find out how your information is processed and shared please refer to our 'Fair Processing Notice' and sharing information page

Patients will be asked for the following consent information

- Consent to contact via email
- Consent to contact via home/mobile/work phone
- Consent to service leaving voicemails on home/mobile/work phone
- Consent to contact via SMS

10.2.1 Confidentiality issues specific to young people

Young people, aged 16-18 are presumed competent to give consent to treatment. It is advisable to obtain parental contact details and record whether the young person consents to their parent(s) being contacted if considered necessary by the treating clinician.

Consent needs to be regularly reviewed, in light of new information that might arise in working with a young person. For example, if a young person discloses sensitive material or material that might pose a risk to the young person or others, the clinician needs to reconsider what is in the young person's best interest and act accordingly, with the help of clinical supervisors and in accordance with Trust Policies and Guidelines.

Sharing or obtaining information about a young person from other agencies or professionals should be carried out with the consent of the young person. If this is not in the best interest of the young person, for example in cases where abuse of the young person is suspected, the clinician can override consent, however a clear rationale of this must be recorded in the case notes as well as any efforts made to obtain consent.

Clinical notes should specify who has provided formal consent, and the limits of what has been agreed. For example, a young person might give consent for a parent to be informed of the length of treatment, but refuse consent for the parent to be informed regarding the content of sessions. Or a young person might consent to their parent being informed about their suicidal thoughts but refuse consent for a parent to be informed of their use of contraception. If a young person requests that confidentiality be maintained, this should be respected unless the clinician considers that failing to disclose information would result in significant harm to the young person.

10.3 Initial appointment

An initial appointment should take place within 28 calendar days of the referral being received by the service.

This will consist of the minimum assessment necessary to gather all pertinent information necessary to plan an appropriate intervention. This will include a focus on risk and the individual's needs, in order to discuss an appropriate intervention. Standardised risk questions are mandatory on the PCMIS data system at initial assessment, and the clinician must ensure that they have adequate information to answer the standardised questions.

A standard initial assessment will be carried out at Step 2 and Step 3. During the assessment an agreement will be reached confirming the appropriate step for treatment and the planned intervention. At this stage the individual may decline the service. Within a stepped care model, the majority of patients entering the service will be assessed and treated within Step 2 (Approx 70%).

A letter will be sent to the individual indicating the outcome of the assessment and a copy sent to the patient's GP unless permission has been withheld.

If the outcome of the assessment identifies a Step up from Step 2 to Step 3, this should be given priority within the team, to ensure continuity of treatment for patients and management of risk issues.

10.4 Treatments offered

Each patient should always be enabled to make an informed choice in respect to the range of possible appropriate interventions.

10.4.1 Low intensity interventions

Contacts for low intensity assessment will usually be telephone, or online, unless face to face contact is required, for example due to communication difficulties . Interventions available are but not limited to:

- Psycho-educational workshops
- Computerised CBT
- One to one interventions either on the telephone or face to face

10.4.2 High Intensity interventions

High intensity treatment will take place in individual or group therapy formats.

10.4.3 Signposting/referral to another service

In specific cases one-off information or signposting will be all that is necessary. In other cases another service will be more appropriate for the patient. Step 2 workers in particular have an important role in facilitating s to access help from appropriate organisations. Following the completion of the assessment a post-assessment Patient Experience Questionnaire (PEQ) will be provided for the patient, to be completed without the therapist being present unless specifically requested by the patient.

11. Discharge

The worker will inform the GP in writing of progress after (a) the initial assessment and (b) at end of treatment when the individual is discharged from the Wellbeing (IAPT) Service.

Patients who fail to attend assessment appointments will be discharged, as it must be assumed that they have decided not to pursue treatment at this time. Once treatment has started, patients will be discharged automatically if they do not attend two sessions during treatment. Cases may be reviewed on an individual basis dependent on circumstances.

If a person fails to contact the service or does not attend an agreed appointment, the worker will review any risk issues in line with the services DNA policy. In most instances, a letter will be sent inviting the person to make contact to arrange another

time to be seen. If they fail to contact the service within 7 working days or they make contact but fail to attend the subsequent appointment, the worker will discuss the circumstances with the supervisor and a decision will be made and recorded with regard to discharging the patient, unless it is agreed with the supervisor that this course of action is clinically not in the person's best interests. The patient and referrer will be notified accordingly.

At discharge a letter must be sent to the patient's GP and/ or referrer (i.e. Diabetes Specialist Nurse, perinatal team). Good practice would stipulate that all correspondence should be cc'd to the patient unless they prefer not to have a copy. At the point of discharge all patients should be asked to complete a Patient Experience Questionnaire. This questionnaire should not be completed in the presence of the clinician unless specifically requested.

12. Staffing

The Wellbeing Services comprises Clinical, Administrative and Management roles:

- Service Line Lead and Clinical Lead
- Service Managers and Team Leaders
- Deputy Clinical Leads
- Senior Clinicians/CBT Therapists
- High Intensity Workers (HIWs): CBT Therapists, Clinical and Counselling Psychologists
- Senior Psychological Wellbeing Practitioners (SPWPs)
- Psychological Wellbeing Practitioners (PWPs)
- Long Term Conditions Leads
- Assistant Psychologists
- Administrative Team
- Consultant Psychiatrists
- Social Workers
- Support workers
- Access Lead

Service Line Lead and Clinical Lead

The Wellbeing Team Service Line Lead provides operational leadership and oversight of the Services and the Clinical Lead provides senior clinical leadership and oversight for the Services. Their roles include promoting and maintaining adaptive working relationships with the CCG commissioners and other stakeholders, including but not limited to sub-contractors and partner organisations, GPs and other NHS providers.

Service Manager

Service Managers have responsibility for overseeing the operational functioning of their allocated teams. They are accountable for the allocation, deployment, prioritisation and delivery of Psychological Therapies, for implementing and reviewing systems, policies, standards and procedures that ensure the provision of

high quality services. They are responsible for the line management of staff with the Service, although this may be delegated to other members of the team as appropriate.

Deputy Clinical Lead

Deputy Clinical Leads provide senior clinical leadership with the teams to ensure the systematic provision of a high quality specialist Primary Care Psychological Therapy Service. Their role is to assist the Clinical Lead and utilise delegated responsibility in ensuring the effective high quality clinical functioning of the services. They supervise and support the psychological assessment and therapy provided by psychological therapists and other clinical members of the team who provide psychologically based care and treatment. They take a strategic role working across the whole County, enhancing clinical effectiveness and safety, and supporting the implementation of developments and changes in practice.

Senior Clinicians

Senior Clinicians provide additional leadership to support the clinical operation of the teams. They will hold a clinical caseload of relatively more complex service users within the moderately severe range. They will be involved in monitoring the service provision, service development, research and evaluation. The Senior Clinicians will provide clinical and caseload management supervision and oversee the supervision of clinical team members. The Senior Clinician will hold responsibility for the screening of referrals into their team.

High Intensity Workers / Therapists (HIW/HIT)

High Intensity Workers provide evidence-based psychological therapies to service users presenting with mild, moderate to severe depression and anxiety disorders in accordance with NICE guidance. It is a service expectation that qualified HITs achieve formal accreditation with the BABCP.

A completed high intensity treatment will involve up to 12 clinical contacts, one of which will be for the purpose of initial assessment. If more than 12 sessions are required, this must be discussed and agreed in advance with the clinical supervisor. On occasion a maximum of 20 sessions may be required.

High Intensity Therapists will hold a caseload of a minimum of 23 service users, providing twenty hours of attended clinical contact time each week (per WTE). They will treat a minimum of 78 service users annually. Case allocations will be completed by clinical supervisors in liaison with the Service Manager, who has overall responsibility for ensuring that service users receive assessment and treatment within the time-frames set.

As part of their role they are required to maintain effective communication with GPs and attend GP practice meetings as required.

High Intensity Therapists may provide supervision for colleagues/Trainees if they have completed the relevant Supervision training.

Trainee High Intensity Therapists

Trainee HITs provide high intensity, evidence based psychological interventions whilst undertaking a programme of training for this role. The training will equip the Trainee High Intensity Therapist to provide cognitive behavioural therapy (CBT) to service users presenting with a range of complex problems for which CBT is demonstrated to be clinically effective. They will complete a one-year post graduate certificate training programme, involving two days a week at University and three days a week providing supervised practice.

A completed high intensity treatment will involve up to 12 clinical contacts, one of which will be for the purpose of initial assessment. If more than 12 sessions are required, this must be discussed and agreed in advance with the clinical supervisor. On occasion a maximum of 20 sessions may be required.

Trainee High Intensity Therapists will hold a caseload of a minimum of 12 service users, providing twelve hours of completed clinical contact time each week. Case allocations will be completed by clinical supervisors in liaison with the Service Manager, who has overall responsibility for ensuring that service users receive assessment and treatment within the time-frames set.

Senior Psychological Wellbeing Practitioners

Senior PWPs have a lead role in the development and support of innovative practice within the teams, and provide clinical and caseload management supervision for the PWPs and Trainee PWPs in their Teams. They are responsible for case allocations, in liaison with the Service Manager, who has overall responsibility for ensuring that Service users receive assessment and treatment within the time-frames set. In addition, they typically carry a small caseload. They have lead responsibility for the ongoing development and delivery of group programmes at Step 2.

Psychological Wellbeing Practitioners (PWPs)

PWPs work at step 2 to provide high volume, low intensity interventions to people presenting with mild to moderate depression and anxiety disorders

A completed low intensity treatment will involve up to 7 telephone, online or face-to-face clinical contacts, with the first of these contacts for assessment and the initiation of guided self-help interventions. If more than 7 clinical contacts are to be given this must be discussed and agreed in advance with a clinical supervisor. On occasion a maximum of 10 contacts may be required.

Psychological Wellbeing Practitioners will hold caseloads of a minimum of 50 people, providing twenty hours of completed clinical contact time each week (per WTE). They will treat a minimum of 250 people annually. Case allocations will be completed by clinical supervisors in liaison with the Service Manager, who has overall responsibility for ensuring that service users receive assessment and treatment within the time-frames set.

PWPs play a key role in delivery of group programmes and workshops and the delivery of CCBT packages.

Assessments at step 2 will take up to 45 minutes, with follow up treatment sessions (telephone, online, face to face or email) lasting up to 35 minutes.

Trainee Psychological Wellbeing Practitioners

Trainee PWPs provide high volume, low intensity evidence based, psychological interventions whilst undertaking a programme of training for this role. They will attend a one-year post graduate certificate training programme, involving one day a week at University, one day a week protected study leave, and three days a week providing supervised practice. Trainees also play a role in delivering group programmes and may be involved with CCBT.

As their training progresses and they are deemed competent to carry out assessments and then treatment by the Senior PWP in their Team, Trainee Psychological Wellbeing Practitioners will typically hold a caseload of a minimum of 30 service users, providing twelve hours of completed clinical contact time each week. Case allocations will be completed by clinical supervisors in liaison with the Service Manager, who has overall responsibility for ensuring that service users receive assessment and treatment within the time-frames set.

Long Term Conditions Leads

LTC lead clinicians develop and maintain the provision of psychological interventions and support for adults living with long term conditions and also young people newly diagnosed with long term conditions. They will develop and maintain long term condition-focused pathways to support service users and also supervise the development of the Wellbeing Teams to promote these.

Assistant Psychologists

Assistant Psychologists will work closely with the Clinical Lead to undertake research and auditing of identified areas, to support service development and innovation. They will support the Teams by generating reports aimed at improving service delivery and clinical effectiveness. They will provide teams with support around the IAPT EPR (PCMIS) including setting up accounts for new staff members and providing training around PCMIS.

In addition Assistant Psychologists will hold a small clinical caseload. Under close supervision of either a Clinical Psychologist or Senior Clinician they will deliver interventions appropriate to their level of experience, and developmental needs. The range of clinical interventions they can be expected to be involved in includes high volume, low intensity interventions (step 2), group facilitated cognitive behavioural therapy (CBT) based, self-management interventions as well as high intensity interventions (step 3) to service users who present with mild to moderate depression and anxiety disorders. These may be face to face or over the telephone.

Administrative Staff

Administrative staff are responsible for the efficient running of administrative functions within the Wellbeing Teams. Responsibilities include, but are not limited to, the documentation of referrals into the services, their progression and deactivation. They will be required to co-ordinate the appointment booking system and manage telephone call into the team which includes taking messages for workers. They will be required to input data and scan documents and attach them onto the EPR.

Booking Clerks

Booking clerks are responsible for the efficient and timely booking of assessment appointments. Responsibilities include, but are not limited to, telephone contact to patients to book their appointments, confirmation letters sent via post or email, SMS confirmation when agreed, 'unable to contact' letters and discharges. They will be required to coordinate the assessments booking system and work with the team to ensure there are enough appointments provided. They will be required to input data and liaise with referrers when needed.

Consultant Psychiatrists

The role of the Psychiatrist in the Wellbeing Service is to provide Psychiatric assessments regarding psychopharmacology, comorbidity, diagnostic uncertainties, and advanced risk assessments in order to aid the clinical interventions delivered within the Wellbeing team. This will normally be a one-off assessment with advice to the Wellbeing service and the GP. The post holder will provide consultation to patients with limited expectations of follow up appointments or taking on a specific case load.

Social Workers

Social Workers will be responsible for providing the professional lead, guidance and information to the Wellbeing Team in areas of Social Care and to support more complex patients to engage with the Wellbeing Service. They will carry out and document a social care assessment and may arrange the provision of social care services where appropriate through Needs Outcome Assessments.

They will carry out Carers Assessments, provide guidance around Safeguarding issues for both Vulnerable adults and children and will liaise with Hertfordshire Community Services in circumstances where provision of community services may be required. They will also provide signposting and advice on housing, benefit and debt problems and provide general Wellbeing assessments

Support workers

Provided through a partnership with MIND under a subcontracted arrangement, these workers will provide practical support for patients to engage in treatment and support access to other specialist services. They will also undertake a significant role in the promotion of the service across the county. They will be embedded within the

Wellbeing (IAPT) Service and employed by MIND. MIND support workers will receive clinical supervision within the service.

Access Lead

The Wellbeing Team access Lead will hold responsibility for and co-ordinate the promotion of the Wellbeing Service. Their role is around finding innovative ways to increase access for hard to reach and previously under represented populations. They will work together with the Teams and Senior Wellbeing staff to ensure that access targets for the service are achieved.

13. Working procedures

Agreed interventions will be provided from community based accommodation including GP surgeries, health centres, HPFT community sites and other community venues. In exceptional circumstances home visits will be offered to service users who are otherwise unable to attend appointments. In such cases ongoing treatment may be offered via telephone support or online. Where the location requires the person to be seen without the presence of other staff (whether HPFT staff or other staff) the Lone Worker Policy will be followed.

Where possible each GP surgery will have a link worker, the worker will be responsible for promotion, providing interventions, and liaising with GPs regarding referrals in that surgery.

Audio or Video Recording clinical sessions is an important aspect of CBT, particularly during training. Patients should give informed consent to recording, and must be competent to do so. A consent to recording form should be completed by the patient.

Any recordings that are transported for the purposes of supervision or assessment must be encrypted, and all appropriate procedures relating to maintaining confidentiality followed. Any recordings submitted for assessment during training remain the property of HPFT and must be returned to the trainee for deletion once the assessment needs have been met. The Trust policy on Audio/Visual Recordings of Service Users should be adhered to.

14. Making treatment decisions / Interventions offered

Step 2 Low intensity Interventions

Low intensity interventions are typically delivered by PWPs and may include: pure self-help; guided self-help; behavioural activation; group work / psychoeducational courses or cCBT. They can be delivered face to face, individually or as part of a group, over the telephone or via computer programmes. Interventions are based on CBT principles and are brief (i.e. approximately 6 sessions). Patient choice and the principle of offering the least intrusive but most appropriate intervention first will determine the treatment that is delivered. Signposting to other Services may also be a PWP intervention.

A best practice guide to low intensity interventions can be found at:
http://www.iapt.nhs.uk/silo/files/psychological-wellbeingpractitioners--best-practice-guide.pdf

Computerised CBT (cCBT)

cCBT is suitable for patients with mild to moderate depression or anxiety. The support for this intervention is provided by PWPs and by Assistant Psychologists, where appropriate.

Psycho-educational courses / groups

Psychoeducational courses at step 2 are suitable for patients with mild to moderate depression or anxiety. Course material is based on CBT principles and is similar to that which is delivered via guided self-help. Patients attending the groups have an allocated PWP as case manager, to contact as necessary. Patients join the course following an initial assessment to determine suitability and are also reviewed afterwards to determine any further input required.

Guided self-help (face to face, online and telephone)

Guided self-help is delivered, typically by PWPs, online, face to face or over the telephone. Treatment usually lasts for an average of 4-6 contacts with each patient. At step 2, telephone and online appointments are used wherever appropriate. Each patient should always be enabled to make an informed choice in respect of the range of possible appropriate interventions.

Signposting / referral to another Service

In specific cases one-off information or signposting will be all that is necessary. In other cases another Service will be more appropriate for the patient. PWPs in particular have an important role in facilitating patients to access help from appropriate organisations.

Links to Guided self-help materials:

http://cedar.exeter.ac.uk/iapt/lihandbook/resources/

http://iapt.nhs.uk/silo/files/reach-out-educator-manual.pdf

Please see:
NICE Guidance CG90 – Depression in adults: recognition and management

NICE Guidance CG113 - Generalised anxiety disorder and panic disorder in adults: management

NICE Guidance TA97 - Computerised cognitive behaviour therapy for depression and anxiety

NICE Guidance CG31 - Obsessive-compulsive disorder and body dysmorphic disorder: treatment

Step 3 interventions

High Intensity step 3 interventions are offered by CBT therapists, clinical and counselling psychologists and counsellors with specific training in IAPT compliant step 3 interventions.

Cognitive behaviour therapy (CBT)

Cognitive behaviour therapy (CBT) is based on the idea that the way we feel is based on our thoughts, beliefs and behaviours. It is a “doing” therapy, focused on making changes in the present, to the way we think about situations and what we do about them. It is recommended as the first line treatment for panic, agoraphobia, social phobia, specific phobias, generalised anxiety disorder, health anxiety, obsessive compulsive disorder (OCD) and post stress disorder (PTSD) and mild to severe depression.

Treatment is usually face-to-face or online, and may take place either on an individual basis or within a group. A course of treatment usually averages 12 sessions (but may extend to 20), with a progress review at approximately 6 sessions. Treatment is often delivered weekly, with sessions lasting between 45 and 60 minutes, although sometimes, longer sessions may be most appropriate. To optimise learning, patients are encouraged to complete individual work between sessions, often in the form of experiments, and then bring their findings back to the next session.

Other high intensity interventions recommended by NICE

Couples therapy for Depression

Couple therapy can help people with their relationship and the emotional difficulties that sometimes flow from problems between partners. IAPT offers a particular type that has been developed to help people suffering from depression.

Competency framework for Couple therapy for Depression:

http://www.ucl.ac.uk/clinical-psychology/competency-maps/couples-therapy-map.html

Brief Dynamic Interpersonal therapy (DIT)

Dynamic Interpersonal Therapy or DIT is a time limited and structured psychotherapy, typically delivered over 16 weekly sessions. It aims to help patients understand connections between current symptoms and their impact on relationships, by looking at repetitive patterns in relationships that can be traced back to childhood. Once this pattern is identified, it can be used to make sense of difficulties in relationships in the here-and-now that contribute to psychological distress.

Competency framework for Brief Dynamic Interpersonal therapy:

http://www.ucl.ac.uk/clinical-psychology/competency-maps/dit-map.html

Interpersonal Psychotherapy (IPT)

Interpersonal Psychotherapy (IPT) is a time-limited and structured psychotherapy typically delivered over 16 weekly sessions. It looks at the ways in which current difficulties in relationships contribute to psychological stress and the ways in which psychological problems affect relationships. Its central idea is that psychological symptoms, such as depressed mood, can be understood as a response to current difficulties in relationships and affect the quality of those relationships.

Typically, IPT focuses on conflict with another person, life changes that affect how you feel about yourself and others, grief and loss, difficulty in starting or keeping relationships going.

Competency framework for Interpersonal Psychotherapy:

http://www.ucl.ac.uk/clinical-psychology/competency-maps/ipt-map.html

Eye Movement Desensitisation Reprocessing (EMDR)

EMDR is a NICE guidance recommended evidence based treatment for Post-Traumatic Stress Disorder. EMDR is designed to treat traumatic memories and experiences and their psychological consequences.

Please see:

NICE Guidance CG90 – Depression in adults: recognition and management

NICE Guidance CG113 - Generalised anxiety disorder and panic disorder in adults: management

NICE Guidance CG31 - Obsessive-compulsive disorder and body dysmorphic disorder: treatment

NICE Guidance CG26 - Post-traumatic stress disorder: management

Long Term Conditions (LTC)

The NHS Five Year Forward View (2016) sets out a central ambition for the NHS to become better at helping people to manage their own health. It provides further evidence of the NHS system's shift towards further enabling patients' self-management of long term conditions. Our services have the potential to offer a significant role in facilitating further integration of mental and physical healthcare services, through supporting more effective ways of working holistically.

The aim of the service is to maintain and improve access and recovery rates for people with long term conditions. This is done through exploring new ways of working with long term conditions, promoting effective IAPT interventions and further developing partnership working with local health service providers.

Counselling for Depression (CfD)

In Hertfordshire this modality is mostly provided by external organisations (AQP); however it may be delivered by appropriately qualified IAPT staff . Counselling can help people with emotional difficulties and problems in relating to people. The main focus of treatment is on building a trusting relationship with a counsellor and on seeing the person as a "whole" rather than focusing on their symptoms, with the aim to helping them understand and express the feeling presumed to underlie their depression. There are many different types of counselling. IAPT offers a particular type of counselling, recommended by NICE, that has been developed to help people suffering from mild to moderate depression.

Treatment typically lasts 6-10 sessions, delivered over 8 - 12 weeks.

Competency framework for Counselling for depression:

http://www.ucl.ac.uk/pals/research/cehp/research-groups/core

Sub-contracting arrangements

Where an intervention above is provided by a sub-contractors, an appropriate communication will be made to that service including any relevant assessment and/or treatment information and access provided to the patient record on PCMIS (if appropriate).

It is the responsibility of the HPFT service to oversee the referral and transfer of patients to sub-contractors, including clinical review and discharge arrangements.

15. Caseloads

Caseloads typically comprise the following:

Worker	**Minimum caseload**	**Minimum attained contacts equating to 20 clinical hours**
High intensity worker	23 - 30	23 each week
High intensity trainee	12 (+/- 3)	12 each week
Low intensity worker	50 - 70	35 each week
Low intensity trainee	30 - 50	24 each week

If sessions of other clinical work are undertaken as agreed with the Service Manager (e.g. providing supervision, co-facilitating a CBT group, or duty work), the line-manager where appropriate will recalculate expected clinical hours.

The Service Managers will check caseloads on a weekly basis to ensure that allocation is occurring appropriately during supervision. S/he will monitor on a weekly basis any breaches of time targets to assessment and/or treatment that are likely to occur, and allocate such cases as necessary. If there is not sufficient capacity within the service to allocate safely, the Service Manager must notify the Clinical and Service Leads of any such potential breaches.

16. Medical Cover and Medication

During any period of intervention or treatment by a Wellbeing (IAPT) Service worker, medical responsibility remains with the GP.

If the Wellbeing (IAPT) Service worker has cause for concern in regard to any medication for, or mental health problems, the worker will discuss with the Consultant Psychiatrist for advice and an appointment either within a primary or secondary care setting. Concerns regarding Physical Health should be discussed with the GP.

17. Managing Risk

Risk is an important issue that should be attended to at every contact as necessary. Risk assessment is a mandatory field on PC-MIS at assessment, and workers should therefore satisfy themselves that they have enough information to be able to answer the PC-MIS risk questions. Both risk to self, risk from others and risk to others including children & vulnerable adults must be attended to in line with HPFT Policies and Procedures. Any significant level of risk should immediately be discussed with the senior clinician, team manager or deputy clinical lead. In the event that a worker is unable to meet with a senior staff member to discuss risk, they are able to access advice via a telephone “risk rota” system which is manned during working hours by senior clinicians, team managers and Deputy Clinical Leads.

Refer to Appendix 6 for more detailed risk assessment and management guidelines (Protocol for Assessing and Managing Risk of Harm to Self) .

Patients should be routinely given details of the HPFT mental health helpline and the option of contacting their GP surgery if they are in crisis out of office hours.

- **Safeguarding**

  During any assessment or intervention, Wellbeing Service (IAPT) workers will ensure that any issue causing concern in relation to a person’s vulnerability will be dealt with according to HPFT’s Safeguarding Children and Adults Policies and Procedures

  A child’s welfare and safety is paramount and it is the responsibility of all staff to ensure they identify and respond to concerns. Where concerns have been identified, under Safeguarding Children policy, the worker should discuss this in the first instance with his/her supervisor or line manager and may wish to contact HPFT’s Named Nurse for Safeguarding Children.

Where appropriate, a written referral to Children's, Social Services must be made, in accordance with the HPFT Safeguarding policy.

Safeguarding Adults –If any member of staff becomes aware of abuse or historical abuse or thinks abuse may be occurring or have occurred, this should be discussed with their manager. Staff must be familiar with the Trust Safeguarding Adults policy which should be followed in conjunction with the Hertfordshire Interagency Procedure for the Protection of Vulnerable Adults.

- **Step Ups to Secondary Care**

Where significant risk to self or others is identified the patients' needs become inappropriate for Wellbeing (IAPT) Service, and they should be referred to the appropriate secondary care service.

The clinician will make a referral following discussion in supervision.

The Wellbeing Service will ensure the referred person is made aware of the discussion and the planned intervention by the receiving team.

The referred persons referral, notes and change of need letter will form part of the referral information shared with the receiving team, prior to the EPR record being discharged. Service users are not to be discharged from Wellbeing until confirmation of receipt of referral by Secondary Care has been received.

If imminent risk is identified a direct referral to the crisis team may be appropriate. The GP should be kept informed with a telephone call and/or in writing.

18. Services for Carers

All regular and substantial carers identified will be offered an assessment of their own needs (Care Act 2014).

If they wish to proceed, the Carers Assessment will be arranged by the service best placed to carry out the work. This may be either the Wellbeing Service (IAPT) service or the service giving clinical input to the cared for individual. Wellbeing Service (IAPT) workers should facilitate this process with the support of the team Social Worker.

Carers will be offered appropriate services within resources available and will have a written care plan, which will be reviewed no less than once annually.

Carers will be informed of services offered by Carers in Hertfordshire and also of local support groups.

19. Disputes Resolution

Professional disputes can arise and all attempts should be made, as soon as possible, to resolve the dispute at a local level.

a. Early discussions between the Wellbeing Service (IAPT) Worker, the GP and other relevant Managers should take place to identify any actions that need to occur to resolve the dispute. If necessary an Action Plan should be agreed.

b. If it is not possible to resolve the dispute locally the matter should be referred to the Service Manager who will arbitrate on any dispute between the Wellbeing Service (IAPT) and other services. In the interim, an agreed plan should be put in place to ensure an appropriate response/service to the patient whilst the conflict is resolved. This must be confirmed in writing between all parties, including the patient to avoid any confusion or error.

20. Induction, supervision and training

20.1 Induction

All newly appointed staff undergo a comprehensive induction programme in line with HPFT policy. They may attend the first day of the Trust's corporate induction programme. It is the responsibility of the Service Manager to ensure a local induction is provided and signed off on the Induction Check List.

During the first week of employment it is the Service Manager's responsibility to ensure the new member of staff is registered for the use of PCMIS and undertakes training in order to be competent in its use.

20.2 Supervision

Staff development and training is a high priority for HPFT and each member of staff has an annual appraisal and a Personal Development Plan identifying training needs.

20.2.1 Line Management Supervision

All staff will receive management supervision given by their Line Manager in line with the HPFT Supervision Policy. Sessions are documented, are held regularly, and offer an opportunity to focus upon professional role, workload and professional practice.

Line management responsibility rests with the identified Line Manager within the team as delegated by the Service Manager. When required the clinical supervisor and the line manager will work together to resolve any difficulties.

20.2.2 Clinical Supervision

All clinical staff will receive clinical and case management supervision in line with the HPFT Supervision Policy.

Supervision at step 2

Each PWP (qualified or trainee) will have a named qualified senior PWP, HIW or Senior Clinician as their supervisor. Each PWP will receive one hour of supervision weekly to discuss the worker's cases. Although discussion of cases should be prioritised according to clinical need, all the PWP's cases must be discussed within a 2-4 week period. Each PWP is clinically accountable to their individual supervisor.

In addition PWPs will meet for 2 hours of group supervision each month with a senior clinician, focussed on more detailed case discussion with a view to the further development of clinical knowledge and skills.

Supervision at Step 3

Qualified HIWs will have supervision with a senior HIW, senior clinician or psychologist. Supervision must occur on a regular basis, usually weekly, but may be less regularly if deemed to be appropriate by the Deputy Clinical Lead. As a minimum for more experienced practitioners supervision must occur monthly, with the HIW's entire caseload being discussed within a 2-4 week period. Each HIW is clinically accountable to their individual supervisor.

Trainee HIWs will have one hour of supervision weekly with a qualified HIW or senior clinician. All supervisors of Trainee HIWs must be accredited by the BABCP, or eligible for accreditation. The Trainee HIW's entire caseload must be discussed within a 2-4 week period.

Experienced qualified CBT therapists will have at least one hour's supervision per month with a supervisor who is eligible for BABCP accreditation.

In addition HIWs will meet for group supervision for 1 ½ hours every month, facilitated by an accredited supervisor or someone eligible for BABCP accreditation.

Supervision – general

A focus on case-management is an important aspect of supervision for all clinicians. All supervisors will provide case-management supervision on a regular basis, and up to date guidelines are available to assist them with this. Any ongoing issues, breaches or concerns that come to light as a result of case management must be discussed and taken forward with Senior management.

Supervisor alerts must be discussed and dealt with and appropriate supervision notes kept on the patient's clinical record on the PCMIS data system.

At all times supervisors must ensure that their supervisees are holding the minimum caseload expected. Supervisors also have delegated responsibility for ensuring that their supervisees are meeting the minimum contact levels expected. Supervisors have responsibility to take note of whether clinicians adhere to Trust Policies and

Procedures (i.e. record keeping, safeguarding, DNA/cancellations, etc) and any breaches must be discussed and addressed in supervision. Any performance issues that have not been resolved in supervision should be bought to the attention of the supervisee's line manager by the supervisor.

Supervision provided by university staff as part of clinical training should be regarded as advice and guidance. Clinical accountability remains with the Wellbeing Team supervisor.

In accordance with the policy, clinicians must ensure that there are paper copies of supervision notes, which are signed by both the supervisor and the supervisee.

20.3 Training and development

Mandatory Training contributes to the safe delivery of Services by ensuring that employees have the knowledge and skills to work safely. By understanding procedures and policies, employees are familiar and competent to proceed with the role and responsibilities expected, maintaining safety for Service users, carers and other colleagues. Employees have a responsibility to ensure that their mandatory training is a minimum of 90% compliant at any time, and refreshed when required.

Please review the HPFT NHS Trust's Learning and Development homepage for further information relating to mandatory training opportunities.

(http://trustspace/InformationCentre/learningDevelopment/default.aspx)

20.4 Professional Development Plan/Continuous Professional Development

The Trust is committed to the principles of performance review and provision of development for every member of staff. The Performance and Development Review has been designed to support the development of a culture of performance excellence, embracing the Trust values and behaviours framework and includes a process of performance related pay progression.

Within the Wellbeing Teams, each member will be informed of their performance, receive adaptive feedback, and assisted to identify training and developmental opportunities to enable them to perform within their current role to the standard required, and also have access to opportunities to develop their potential.

This feedback may be provided in the form of informal meetings, regular clinical and line management supervisions and during annual Performance Development Reviews.

Please refer to the HPFT NHS Trust's Professional Development Plan Policy for further information regarding identifying and accessing professional development opportunities

Within the restraints of ongoing funding, the Wellbeing Team will aim to provide staff with access to a free CPD programme each year. Staff are to agree their annual CPD allowance with Team managers and discuss CPD priorities with their clinical supervisors.

21. Comments, compliments and complaints

All comments, compliments and complaints should be dealt with in accordance with the Trust Compliments Concerns and Complaints Policy and Procedure (see Policy document).

The policy requires all verbal or written complaints to be acknowledged within two working days with copies forwarded to the appropriate line manager and the Complaints Manager at Trust Head Office, The Colonnades, Beaconsfield Road, Hatfield. Comments and Compliments, once responded to, should be sent for information to the Complaints Team at Trust Head Office. Leaflets outlining the procedure are available at all Wellbeing Service (IAPT) locations.

22. Communications

The treatment and information patients are given should meet the individual's communication needs especially where there are specific language and sensory communication requirements. The HPFT guidance on Communicating with Service Users from Diverse Communities provides further information and the procedure for the interpreting service.

Where there are specific cultural/religious practices which affect compliance with treatment the service users should be given the opportunity to discuss and agree adjustments or alternatives to enable treatment to go ahead**.**

All organisations that provide NHS must identify and record information and communication needs with service users:

- At the first interaction or registration with their service
- As part of on-going routine interaction with the service by existing service users.

This includes accessible information and communication support to enable individuals to:

- Make decisions about their health and wellbeing, and about their care and treatment;
- Self-manage conditions;
- Access services appropriately and independently; and
- Make choices about treatments and procedures including the provision or withholding of consent.

23. Record management, confidentiality and access to records

All staff are responsible for all records that they create or use in the course of their duties. This responsibility is defined both in law and in other professional guidelines covering the handling of records. For example, the Public Records Act 1958, the Data Protection Act 1998 and the Freedom of Information Act 2000. The Trust's Records Management Policies give full details of those responsibilities and the standards we need to meet.

All information must be dealt with in line with HPFT's Information Asset Management policy and procedure. Clinicians should be particularly aware of the potential for confidentiality breaches as a result of email communication. Clinical contact via email should therefore be avoided. If it is necessary to communicate clinical information using email then relevant HPFT policies should be followed.

All matters relating to service users' health and personal affairs and matters of commercial interest to the Trust are strictly confidential and such information must not be divulged to any unauthorised person.

23.1 PCMIS

PCMIS is the care electronic patient record used by the Wellbeing Team. All staff will be required to record all contacts with the individual in a timely manner on PCMIS.

PCMIS training is a mandatory requirement for all staff, and should be arranged within each team by the Team Manager.

In order to provide evidence that the best possible care and treatment is given to patients, staff must follow the record management and confidentiality polices listed below:

- Care Records Management Policy
- Clinical Information Filing Policy
- Protection & Use of Service User Information Policy
- Formal Access to Service User Records Policy
- Freedom of Information Act Policy
- Written & Electronic Communications Policy
- Corporate Records Management Policy

23.2 Clinical records / therapy notes

The IAPT minimum data set must be collected at every clinical contact (See Appendix 7 for relevant questionnaires: PHQ-9, GAD-7, Phobia Scales, Employment status questions, and WASAS).

A clinical contact is defined as any contact made for the purposes of assessment or intervention, even if the intervention is relatively minimal.

Accurate, relevant and up to date records must be kept on PCMIS. PCMIS forms the patient's clinical record, and as such in addition to the minimum data set PCMIS

notes must be kept of contacts made, type of intervention and outcome, including progress made.

In line with the HPFT Care Records Management Policy, clinical notes must be entered at the time the care is provided (within the standard of 2 working days). Where this is not possible and there is a significant delay in recording the information, an explanation should be added at the start of the note, giving the reason for the delay and the date and source of any original notes taken.

Initial sessions with a high or low intensity worker following referral screening will be recorded on PCMIS as “assessment and treatment” under contact type.

The Wellbeing Team aims to be a paper-light service, whilst a case is open the referral letter, assessment, contact details, and key documents from PCMIS may be held in a paper file. This is to facilitate contingency plans should IT systems fail. These must be kept in line with HPFT policy on Information Asset Management.

All matters relating to service users’ health and personal affairs and matters of commercial interest to the Trust are strictly confidential and such information must not be divulged to any unauthorised person.

Formal applications for access to records must to be made in writing to the Service Manager. An Access to Your Health Records" leaflet can be obtained from a member of staff. Applications for access to records held by the GP must be made in line with GP practice and procedures.

There are special rules regarding legal access to records. If any case arises where legal access is requested staff should refer to the Access to Records Policy and discuss with the Service Manager. There are also special rules relating to the sharing of information regarding children and adolescents. These are to be found in the policy on “Child Protection: Guidelines for Sharing Information and Involvement in the Legal Process of Child Protection”

24. Health and safety

Every employee and those persons working on behalf of the Trust have a duty to take reasonable care for the health and safety of themselves and other persons who may be affected by any acts or omissions by themselves. To cooperate with the organisation so far as it is necessary to enable management to carry out its legal duties relating to health and safety matters i.e. follow instructions and training, use equipment provided for their protection, report defects/damage/ health and safety concerns.

All staff have a duty to remedy and or report any hazards or unsafe working practices in the immediate working area to the appropriate manager or supervisor. All staff are required to participate in the Trust’s accident/incident reporting systems and to comply with the Trust’s procedures and techniques for managing risks.

25. Lone Workers

Members of staff who during the course of their work, work out of office hours or are lone workers must with their managers, carry out a written Risk Assessment to identify potential risks and agree the control measures which need to be in place. This includes when carrying out home visits. For further information refer to the HPFT Lone Workers Policy.

26. Practice Governance

26.1 Team Meetings

The Wellbeing Service (IAPT) locality teams will hold monthly team meetings of up to 1 ½ hours. These meetings will provide an overview of the current functioning of the team, including a focus on any clinical and operational issues impacting upon the team's effective delivery of the clinical service, in addition to any wider issues affecting the team. The meetings will include standard agenda items on Quality and Risk, Service User and Carer Experience, and Workforce and Organisational Development. The meetings will be attended by team members and will be chaired by the Team Manager or in their absence the quadrant Senior Clinician.

26.2 Business and Governance Meeting

The Wellbeing (IAPT) Service Business and Governance meeting will be held on a monthly basis, to be attended by all senior clinical and senior operational staff, team managers and team leaders. The purpose of this meeting will be to discuss clinical and operational issues affecting the teams at a countywide level. Key decisions regarding the operation of the services will be discussed at these meetings. These meeting will also have a focus on the clinical and operational performance of the services, including a focus on clinical governance issues.. The meeting will include standard agenda items on patient safety, workforce and wellbeing, risk and performance.

26.3 Other Meetings

The senior clinicians within the Wellbeing (IAPT) Service will meet bi-monthly. The senior clinicians meeting will focus on clinical issues and practice developments, both local and national.

The Clinical Lead (or the Deputy Leads) and Operational Leads will attend meetings as required by the CCG/Commissioning Team and feedback to the monthly Business and Governance meetings.

Senior clinicians and/or managers within the Wellbeing Service (IAPT) should attend interface meetings with secondary care [psychological therapy leads at least every three months, in order to discuss any issues arising with regards the stepping up and down of patients between the services.

High intensity staff will meet with GPs regularly and attend GP Practice Meetings when required, with a view to maintaining good communication with primary care staff

The Clinical Lead, or deputy Clinical Lead will meet separately and regularly with the High Intensity and Low Intensity Trainees to provide a forum for discussion about training issues relating to either University or Employment & any obstacles/challenges to the successful completion of the course.

27. Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

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The following table reflects – specifically for this policy – how the design of the service and processes involved has given consideration to all protected groups so ensuring equality and dignity for everyone.

Service user, carer and/or staff access needs (including disability)	The needs of people with disabilities and differing communication needs must be given appropriate adjustments within the service/process/workplace to facilitate better access. Interpreters should be arranged as necessary, and the location of services, access to physical and sensory impairment etc. taken into account when planning service delivery. Reasonable adjustments should be made for staff members with disabilities or health needs Staff within the service should ensure that the potential for inequality is minimised.
Involvement	Opportunities that are made available within the service/process for service users and carers to be involved in making contributions to the Trust and development of services. Service user involvement should be sought in order for the potential for inequality to be minimised.
Relationships & Sexual Orientation	Staff members should take into account the needs of people in different relationships as well as those in none. This should address issues around sexual orientation (and any barriers for people around their orientation) as well as any relevant issues re: nearest relatives and family carers. For staff this may also include an awareness of the needs of LGB staff in workforce and an understanding of how an open workplace culture improves the experience for staff working in the Trust. This should also reflect how potential for inequality is minimised.
Culture & Ethnicity	Ethnic minority service users should receive a cultural appropriate experience from the service. This should include issues of language, diet, hygiene and personal care etc.
Spirituality	Issues of spirituality should be attended to for the service user or carer where necessary. This should focus around the HOPE model for: **H** – Sources of Hope **O** – Needs re: organised religion **P** – Personal belief structure (including non-faith) **E** – Effects on care of practicing spiritual beliefs. (positive and negative)
Age	The service should take into account the needs of different age groups. Access for older adults in particular, who historically are underrepresented in the service, should be targeted for additional support.
Gender & Gender Reassignment	The service should provide equal treatment for men and women or – where justified – one group is favoured (e.g. single sex accommodation). The needs of transgender service users and carers should be acknowledged appropriate support offered.

Advancing equality of opportunity	The service should seek to develop in a way that ensures incorporates equality of opportunity through continual feedback and evaluation of the service.

This information reflects how staff will act in accordance with the Equality Act 2010 in meeting the needs of all protected groups.

All staff must be aware of issues relating to equality and diversity for service users and carers including:

- Understanding how to ask questions about culture, religion and ethnic background
- Arranging interpreters where necessary (refer to section 15)
- Offering adaptations for people with disabilities E.g. Hearing Loop, Downstairs meeting rooms etc.
- Opportunity to discuss relationships and issues relating to sexuality
- The needs of both men and women are represented equally – including the needs of trans service users.

Staff have a responsibility to challenge any discrimination they may witness and report back in accordance with risk management and complaints and incidents processes.

Staff have the right to be treated with dignity and respect. Any situations of harassment, bullying or other abuse must be dealt with in accordance with the Trust harassment & bullying policy and other associated guidelines. All staff are also entitled to access the Trust counselling service if needed.

Staff must also be aware of issues relating to Human Rights including how they apply to staff and service users. Information on this is available within the Trust Single Equality Scheme.

Disability access. If it is found that service users, carers or staff with disabilities are prevented from accessing any premises above ground level, a clear contingency protocol must be outlined in this operational policy.

28. Promoting and considering individual wellbeing

Under the Care Act 2014, Section 1, the Trust has a duty to promote wellbeing when carrying out any of their care and support functions in respect of a person. Wellbeing is a broad concept and is described as relating to the following areas in particular:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day to day life including over the care and support provided and the way in which it is provided;
- Participation in work, training, education, or recreation;
- Social and economic wellbeing;

- Domestic, family and personal;
- Suitability of living accommodation;
- The individual's contribution to society.

There is no hierarchy and all should be considered of equal importance when considering an individual's wellbeing. How an individual's wellbeing is considered will depend on their individual circumstances including their needs, goals, wishes and personal choices and how these impact on their wellbeing.

In addition to the general principle of promoting wellbeing there are a number of other key principles and standards which the Trust must have regard to when carrying out activities or functions:

- The importance of beginning with the assumption that the individual is best placed to judge their wellbeing;
- The individual's views, wishes, feelings and beliefs;
- The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist;
- The need to ensure that decisions are made having regard to all the individual's circumstances;
- The importance of the individual participating as fully as possible;
- The importance of achieving a balance between the individuals wellbeing and that of any carers or relatives who are involved with the individual;
- The need to protect people from abuse or neglect;
- The need to ensure that any restriction on the individuals rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary.

29. Process for monitoring compliance with this document

Action:	Lead	Method	Frequency	Report to:
Review policy and expected actions within team meeting and service area business and governance meeting	Wellbeing Service (IAPT)Clinical Lead	Review of operational practice / learning from incidents against policy requirements	6 months	Service Area Business and Governance meeting
Local audit of safety and quality of service	Team Leaders	Completion of local audit to ensure service compliance with operational policies and expected standards	Annually	Team Meeting Service Area Business and Governance meeting

Part 3 – Document Control & Standards Information

30. Version Control

Version	Date of Issue	Author	Status	Comment
V1	April 2008	Practice Governance Lead	Archived	Archived on Trust Server.
V2	December 2010	Wellbeing Service (IAPT)Clinical Lead	Archived	Archived on Trust Server.
V3	21st January 2014	Wellbeing Service (IAPT)& SPA Lead	Archived	West Herts SBU Quality and Risk Meeting 21.11.13
V3.1	1st May 2015	EPMHS & SPA Lead	Archived	Updated for Care Act 2015
V4	25 September 2015	Wellbeing (IAPT) & SPA Lead	Archived	New service delivery included, further care act update and name change from EPMHS to Wellbeing Service
V4.1	25 September 2015	Wellbeing (IAPT) & SPA Lead	Archived	Amendment to Section 5
V5	9th May 2019	Wellbeing Clinical Lead	Archived	Greater detail around service criteria, staff roles and interventions offered by the team
V6	14th August 2020	Senior Service Line Lead/PG Facilitator	Current	Reviewed in light of COVID. Information sharing statement update.

31. Relevant Standards

Relevant standards might be external and those upon which the procedural document is based or guide by.

32. Associated Documents

This policy should be read in line with relevant policies which can be found on HIVE:
https://hertfordshirenhs.interactgo.com/Interact/Pages/Section/ContentListing.aspx?subsection=5391

This policy (including its appendices) is impacted by the major incident management of Covid-19. Trust guidance is updated on an ongoing basis in line with government guidance and should be read on the HPFT Hive communication website (Link: https://hertfordshirenhs.interactgo.com/Interact/Pages/Section/Default.aspx?Section=5084)

All sites have a Business Continuity Plan detailing local arrangements for services during the COVID period. The Business Continuity Plan is kept up to date with updated requirements at team/unit level around the management of COVID-19. Staff should refer to their local Business Continuity Plan for up to date local procedures during the COVID incident management period.

The ongoing changes will have a specific impact on the following area:

- Infection prevention and control in relation to social distancing, increased cleaning regimes, COVID-secure office spaces, appropriate use of PPE and individual COVID risk assessments of staff.

All staff members are to be aware that the arrangements are in a state of change and if this policy (including its appendices) contradicts any of the covid-19 management guidance on the HPFT Hive then it is the HPFT Hive guidance that supersedes it.

33. Supporting References

- National IAPT guidance documents
- The Mental Health Act 1983 and Code of Practice
- The Human Rights Act
- The Data Protection Act
- The Health and Safety at Work Act
- Children Act (1989 and 2004)
- The Mental Capacity Act 2005 and Code of Practice
- National Assistance Act
- NHS and Community Care Act
- NICE guidelines on depression and anxiety
- Safety First, Five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
- The IAPT Manual 2019

34. Consultation

The Consultation section of the Policy Management System advises on the types of people to invite to express their views and give constructive suggestions to improve the draft policy being worked on.

In the case of the Procedural Document Management System, the following have been consulted so far.

Job Title of person consulted
Wellbeing Service (IAPT)managers
Wellbeing Service (IAPT) senior clinicians
SBU practice governance lead
SBU Quality and risk group
SBU Practice Governance Facilitator

APPENDIX 1

Recovery Principles underpin all forms of care provided within the Trust

The HPFT Recovery Principles

The Principles of Recovery Orientated Practice, which underpin all services provided by the Trust, are:

1. Individual uniqueness and user centrality to service provision:

Recovery oriented practice:

- recognises that recovery is a personal journey and unique for each individual.
- understands that Recovery is not necessarily about cure. Recovery outcomes are personal and unique for each person and go beyond an exclusive health focus to include an additional emphasis on social outcomes and quality of life.
- places individuals at the centre of the care they receive. Through a person centred and needs led approach, individual recovery outcomes are achieved.

2. Real Choices:

Recovery oriented practice:

- supports people to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored.
- supports people to build on their strengths and to take as much responsibility for their lives as they can at any given time.
- is proactive in supporting people to take positive risks and to make the most of new opportunities whilst balancing responsibilities for duty of care.

3. Attitudes and Rights

Recovery oriented practice:

- involves listening to, learning from and acting upon the communications from individual service users, their relatives and others about what is important to each person.
- promotes and protects people's legal and citizenship rights
- supports people to maintain and develop meaningful social, community, recreational, occupational and vocational activities.

4. Dignity and Respect

Recovery oriented practice:

- consists of being courteous, respectful and honest in our interactions
- involves sensitivity and respect for each individual's values and culture.
- challenges discrimination and stigma wherever it exists both within our own services and the broader community.

5. Respectful Partnerships

Recovery oriented practice:

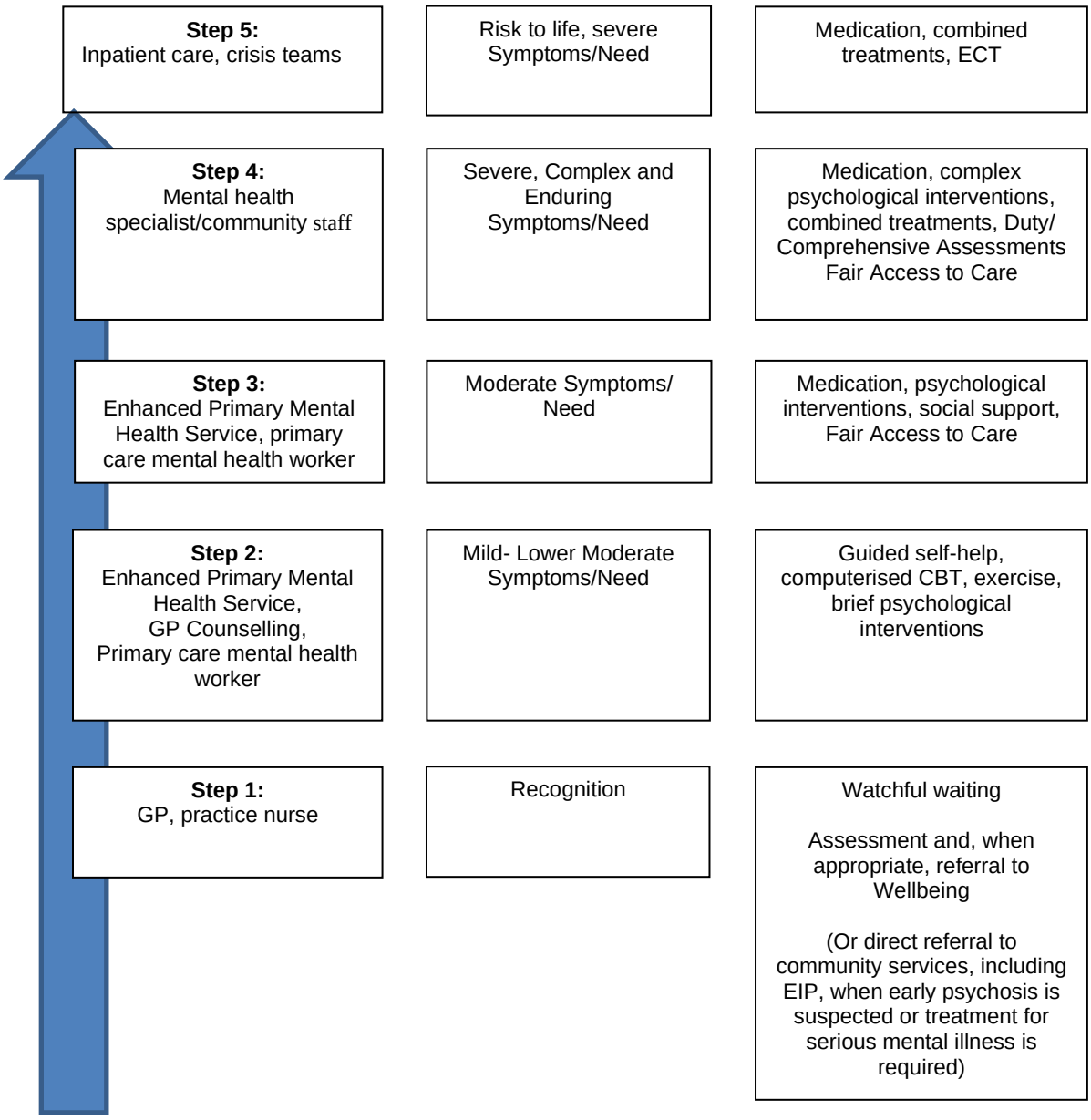
- acknowledges each person is an expert on their own life and that recovery involves working in respectful partnership with individuals, their relatives and carers to provide support in a way that makes sense to them.

- acknowledges the importance of sharing appropriate information and the need to communicate clearly and effectively to enable effective engagement with services.
- involves working in hopeful, positive and optimistic ways with people who use our services, their families and carers, and the communities within which they live, to support them to realise their own hopes, goals and aspirations.

APPENDIX 2

A Stepped Approach to Care

Based on the NICE guidelines a stepped care approach to the delivery of mental health services recognises that people have differing needs depending on the severity of their condition and their personal circumstances. There are two key features to this approach. Firstly, that treatment is the least intensive available but which still produce a significant health benefit. Secondly, that treatment is monitored and 'stepped up' if there is no improvement in health.



APPENDIX 3

Wellbeing Service (IAPT) TRAINEE **CONSENT FORM**

Name of Patient:	**Name of Therapist:**
Consent to participate in treatment with a trainee therapist: I consent to participate in treatment with the above named therapist who is training in Cognitive Behaviour Therapy. I understand that my therapist will receive on-going supervision from qualified professionals; and may submit anonymous clinical reports regarding my treatment to the university programme team. This agreement has been discussed with me, and I have had the opportunity to ask questions regarding this agreement. I also understand that I may withdraw my consent at any time. Name..... Signed..... Date.....	
Consent to video/audio taping of sessions for supervision & assessment: I consent to being video/audio taped and I understand the recording will only be used for the purposes of supervision and assessment. I give my consent on the understanding that the recording will be erased once the above purposes have been fulfilled, and in a timescale not longer than one year. This agreement has been discussed with me and I have had the opportunity to ask questions regarding this agreement. I also understand that I may withdraw my consent at any time and have the tape erased. Name..... Signed..... Date.....	
Therapist Name..... Signature..... Date.....	Line Manager Name..... Signature..... Date.....

The original copy of this agreement should be kept in the patient clinical file, or scanned onto the electronic patient record.

APPENDIX 4

Assessing Risk in Primary Care

Assessing whether patients are a risk to themselves or others is an area which should be prioritised within the Wellbeing Service (IAPT) service. Although level of risk will have been assessed at initial assessment, the patient's level of risk may change on a daily basis, and therefore workers should maintain a constant awareness of this issue. Risk assessment is a mandatory field for initial assessment contacts on PC-MIS. In assessing risk the following areas are good indicators of level of risk to self:

Level of **ideation** and hopelessness
Extent of **planning**
Likelihood of **action** and previous attempts

At each contact the IAPT minimum data set questionnaires should be completed.

Attend particularly to PHQ 9 item 9: "Thoughts that you would be better off dead or thoughts of hurting yourself in some way". If the response is 1 or above (several days or more), then the following questions from PC-MIS should be asked:

Q1. Do you ever feel that bad that you think about harming or killing yourself?
Q2. Do you ever feel that life is not worth living?
Q3. Have you made plans to end your life?
Q4. Do you know how you would kill yourself?
Q5. Have you made any actual preparations to kill yourself?
Q6. Have you ever attempted suicide in the past?
Q7. How likely is it that you will act on such thoughts and plans? (0 – 10, 10 being certain)
Q8. What is stopping you killing or harming yourself at the moment?

In particular if the patient answers yes to questions 1, 3, 4, or 5 then this together with the intent rating on question 7 may indicate a high level of risk, particularly if intent is rated higher than 5. If you think that the patient may present a level of risk to themselves or others or then speak to a qualified clinician as soon as possible. In terms of risk to others supplementary questions will need to be asked if there are indications that the patient may pose a risk to others. E.g. anger problems. Also consider child protection issues. Again, areas to assess include level of ideation, extent of planning and previous history. The police may need to be informed if a serious crime is planned or disclosed. If that is the case, the duty triage worker or a senior clinician should be consulted as appropriate.

Please see the following attachment for risk management protocol:

Risk Protocol Wellbeing Team.pub

APPENDIX 5

PHQ- 9

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		A11 – PHQ9 total score			

GAD-7

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		A12 – GAD7 total score			

IAPT Phobia Scales

Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. Then write the number in the box opposite the situation.

0	1	2	3	4	5	6	7	8
Would not avoid it		Slightly avoid it		Definitely avoid it		Markedly avoid it		Always avoid it

A17	Social situations due to a fear of being embarrassed or making a fool of myself	☐
A18	Certain situations because of a fear of having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness)	☐
A19	Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying).	☐

IAPT Employment Status Questions

A14 - Please indicate which of the following options best describes your current status:

Employed full-time (30 hours or more per week)	☐
Employed part-time	☐
Unemployed	☐
Full-time student	☐
Retired	☐
Full-time homemaker or carer	☐

A15 - Are you currently receiving Statutory Sick Pay?

Yes	☐
No	☐

A16 - Are you currently receiving Job Seekers Allowance, Income support or Incapacity benefit?

Yes	☐
No	☐

Work and Social Adjustment

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

1. **WORK** - if you are retired or choose not to have a job for reasons unrelated to your problem, please tick N/A (not applicable)

0	1	2	3	4	5	6	7	8	N/A
Not at all		Slightly		Definitely		Markedly	Very severely, I cannot work		☐

2. **HOME MANAGEMENT** – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

3. **SOCIAL LEISURE ACTIVITIES -** With other people, e.g. parties, pubs, outings, entertaining etc.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

4. **PRIVATE LEISURE ACTIVITIES –** Done alone, e.g. reading, gardening, sewing, hobbies, walking etc.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

5. **FAMILY AND RELATIONSHIPS –** Form and maintain close relationships with others including the people that I live with

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

A13 – W&SAS total score

Our Values

Welcoming Kind Positive Respectful Professional