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Overview

It is important that all documents are saved in the Client's record in a specific format. This should include the Division, Service ID, a hyphen & a meaningful succinct descriptor of the document.
e.g. "C&F CCNPC - Letter to GP"

Document Upload Guidance

Author	Enter the name (or Service) of the author of the document
Document Title	Follow the Trust Naming Convention (see examples below)
Document Date	Date entered on the document – it is not the upload date
Document Type	BCHC Document Type (see examples below)
Description	Non-mandated (use as required)

Examples of Trust Naming Convention

	Division Initials	SPACE	Service Abbreviation	-	A short, succinct descriptor
BCHC documents Admin/Clinical					
"CF CCNPC - Letter to GP"	CF		CCNPC		CCNPC
"R ACT - Appointment letter"	R		ACT	-	Appointment Letter
External documents					
"Client - Food diary "			Client		Food diary
"HH - Orthopaedics discharge summary"			HH	-	Orthopaedics discharge summary



Please note that some document types will allow documents to be shared with patients via the Patient Engagement Portal (PEP) or more widely with other healthcare professionals via the Shared Care Record (ShCR).

Why is this Important

Certain documents generated in Rio can now be shared automatically:

- With other clinicians across the region via the Shared Care Record (ShCR).
- With patients via the Patient Engagement Portal (PEP).

This improves care coordination and gives patients easier access to important information.

These are **additional options**, not replacements for existing upload processes or other document types already in use.

These new document types are **additional options**, not full replacements for existing upload processes – **except BCHC/SCR – Clinical Docs**, which can be used instead “BCHC Admin/Clinical” doctypes for GP letters.

Document Type	Purpose	Shared With	Notes
BCHC/SCR – Clinical Docs	Clinical letters, assessments, summaries	ShCR only	Can be used when uploading or when generating letters via Rio templates in DropZone. If sharing to GPs, tick “Send to GP” in DropZone to send the letter to GPs via DocMan. This replaces the BCHC Admin/Clinical option for GP letters, while still flowing to the ShCR. Not visible in PEP
BCHC/SCR – Care Plan	Care or intervention/action plans	ShCR only	For structured care/intervention plans requiring visibility across the ICS.
BCHC/SCR – Discharge Doc	Discharge summaries	ShCR only	Ensures timely discharge information is shared regionally
BCHC/PP – Info	Patient information leaflets/resources	ShCR & PEP	Uploaded documents flow to both clinicians via ShCR and patients via PEP
BCHC/PP – Apt Letter	Appointment letters	ShCR & PEP	Shared with both ShCR and visible to patients in PEP.

Important Reminder When Sharing

- Only **BCHC/SCR – Clinical Docs** integrates with the “Send to GP” DropZone function
- Patients only see documents under Info and Appointment Letter
- All BCHC/SCR types are visible across the ICS to other clinicians (not to patients)



Alternative Document Types (Non Sharing Documents)

Document Type	Purpose
BCHC Admin	Documentation relating to non-clinical correspondence originating from BCHC (appointment letters; billing; financials; labels; not specified; other correspondence)
BCHC Clinical	Documentation relating to clinical correspondence originating from BCHC (Clinical summary; body map; care plan & crisis plan; case notes; charts; clinic letters; clinical community screening notes; discharge summary; medication; MHA documents; other correspondence; referral document; referral letter; reports/assessments; restricted documents; waiting list letter; X-ray reports)
Consent	Documentation relating to Consent (Copies of signed consent forms; consent to photograph; consent to share information; consent to treatment; best interest)
External Documents	Documentation relating to Clinical correspondence originating from outside of BCHC (Hospital notes; other correspondence; self-assessment; police report; received documents; refugee status; student visa; visitor permit; work permit)
Genogram	Documentation genogram
Historic Documents	Documentation relating to historic records (Transfers in; historic paper records; temporary notes)
Images	Images to include equipment etc, NB this excludes Photo ID for the purpose meds administration
Lab Results	Documentation relating to TEST RESULTS (Test/investigation results)
Photo ID	Documentation Photo ID (specifically for the purpose of ID during Meds administration)
Safeguarding	Documentation relating to safeguarding (Risk related to safeguarding; safeguarding adult; safeguarding children; TAC documents)
Children in Care	Documentation relating to adoption & fostering only

Trust Naming Convention



EHCP – Education Healthcare Plan	Documentation relating to EHCP
Early Years / Early Help	Documentation relating to Early Years Service (Children's Centres)
PSAS (Confidential)	RESTRICTED ACCESS - named staff (PSAS STAFF ONLY - NAMED USERS ONLY)
Psychiatric Confidential Documents	RESTRICTED ACCESS - named staff (RESTRICTED ACCESS - NAMED USERS ONLY)

Important Reminder (Non Sharing Documents)

- The other types are extra options and do not replace existing workflows
- Continue using existing document types where required