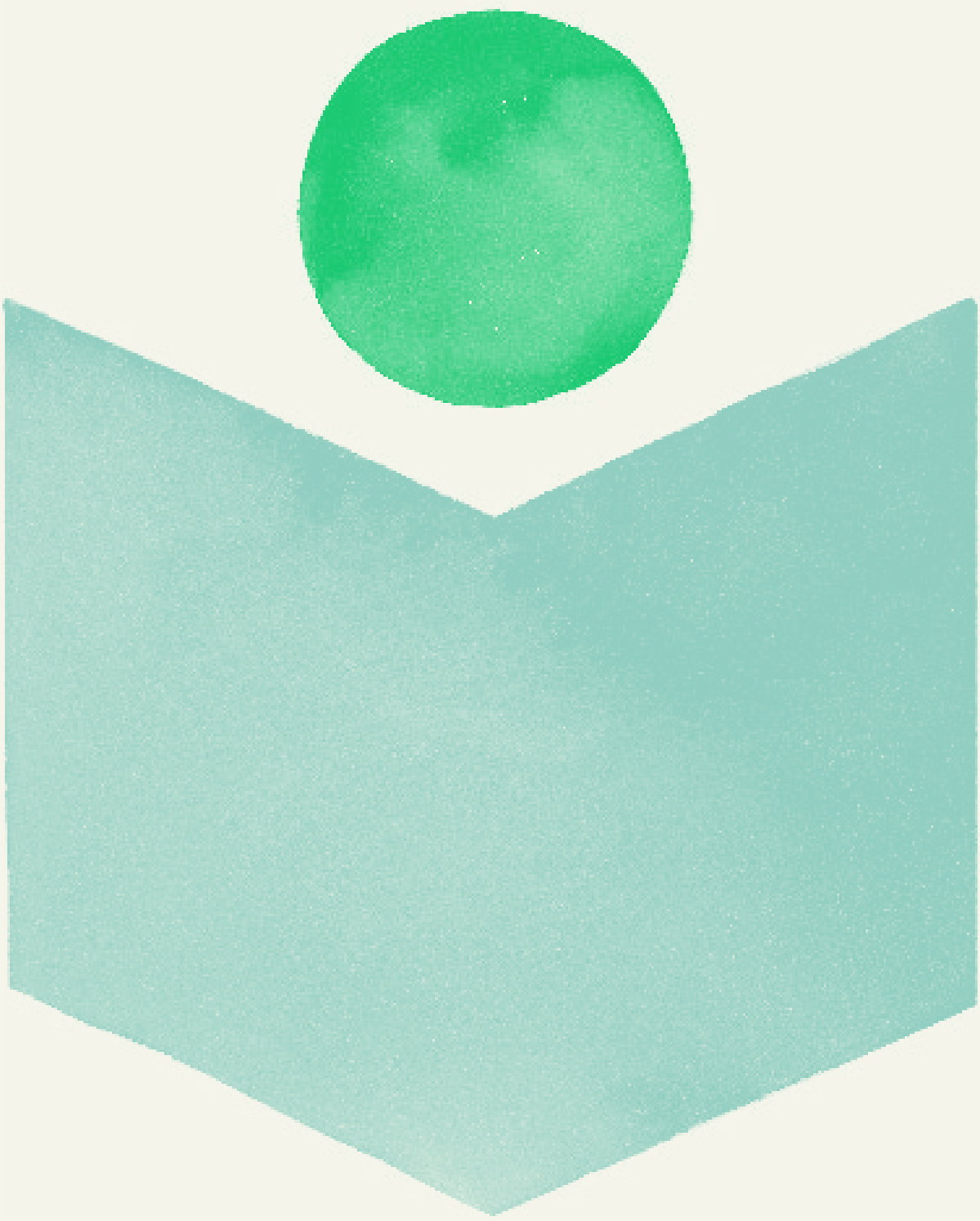
ieso



ieso Clinician Manual

version 1.2

iesogroup.com

Contents

1. ieso's Clinical Care Pathway

1.1. Referral Sources

ieso can accept referrals from multiple sources depending on the contract requirements, the area of the country the patient resides in, and their registered GP. These sources typically include:

- GPs
- IAPT services
- Psychology services
- Other statutory and third sector organisations
- Self-referral
- Employer
- Insurance providers

Different sites will have different requirements based on the processes they follow, and what they have contracted us to treat. For example, in Surrey we treat at Step 2, 3 and 3+, however, other sub-contracted sites may only contract us to work specifically at Step 3. This will mean that stepping up requests, discharges or onward referral processes may differ from site to site.

Please ensure you check the Site Protocols on the Therapist Hub regularly for updates.

1.2. Suitability and Eligibility

ieso is an excellent option for patients who:

- need sessions outside of working hours
- are struggling with inhibition due to the perceived shame of having a mental health problem
- have mobility problems or long-term health conditions
- want quick and easy access to therapy
- prefer to work online and learn best by reading, reflecting and writing
- are caring for young children
- are carers

SERVICE ELIGIBILITY CRITERIA

Eligibility criteria includes patients presenting with at least one of the following conditions, either as a sole or co-morbid diagnosis, where a psychological therapy intervention would be appropriate:

(Note – some sites have additional inclusion/exclusion criteria - see 'Site Protocols' on the Hub for information.)

Depression (including that relating to antenatal and postnatal mental health):

- Mild depression (DSM V Criteria and/or PHQ-9 score of 5-9)
- Moderate depression (DSM Criteria and/or PHQ-9 score of 10-14)
- Moderate – severe depression (DSM Criteria and/or PHQ-9 score of 15-19)

Anxiety including:

- Generalised anxiety disorder (GAD)
- Panic disorders (including agoraphobia)
- Phobias
- Social Anxiety Disorder (SAD)
- Post-Traumatic Stress Disorder (PTSD)
- Obsessive Compulsive Disorder (OCD)
- Health anxiety

Other disorders:

- Long Term medical Conditions (LTCs)

SERVICE EXCLUSION CRITERIA

- This service will meet the needs of patients aged 18 and over (16+ in some contracts) and will not discriminate based on age, gender, race, religion/belief, sexual orientation or disability.
- Our service is not targeted towards those who pose a high risk to themselves, risk to others or who are at significant risk of self-neglect. This may include "hard-to-engage" patients who have consistently rejected various treatment options offered.
- Starting a second course of therapy whilst already in another professional's care is not recommended. Those with a long history of mental health problems who already have an existing relationship with an individual are encouraged to continue with this where possible.
- Patients suffering from psychosis and those who have a pre-existing diagnosis of unstable severe mental illness are not suitable for ieso. Such individual's needs are best met via specialist or secondary community mental health teams and associated services.
- Similarly, those individuals who have a significant impairment of cognitive function (e.g., dementia), significant impairment due to autistic spectrum problems or learning difficulties are best served by specialist services. This also includes patients who need to be primarily referred for forensic or neuropsychological assessment.

- Individuals for whom drug and alcohol misuse are present will be referred to substance misuse services.
- Individuals who have a diagnosis of an eating disorder, where this either places them at significant risk or it is impairing their function.
- Diagnosis of BDD.
- Diagnosis of eating disorder with active symptoms (i.e., bulimia or anorexia).
- Symptoms/diagnosis of complex PTSD.
- Symptoms/diagnosis of a personality disorder and/or significant relational issues.

Cases entering the service go through a screening process based on information gathered from a self-assessment questionnaire. However, it is not always possible to pick up inclusion/exclusion criteria clearly at the triage stage. If upon further assessment, you believe that the patient falls into the exclusion criteria, please discuss with your clinical supervisor by raising a 'Suitability query' ticket (see section 5 on creating a supervision ticket and the different types of ticket).

1.3. Site Protocols

We work across several different sites. The sites all vary procedurally, and it is important to understand the requirements contracts which include inclusion and exclusion criteria.

A full list of therapy Site Protocols linked to these contracts are available on the Therapist Hub in Site Protocols. These should be routinely reviewed by clinicians who will need to understand and follow these guidelines depending on which route (e.g., GP or self-referral) and service/area the patient has accessed ieso from.

1.4. Stepped Care Model at ieso

Low Intensity Psychological Interventions at Step 2

Disorder	Psychological Intervention
Mild to Moderate depressive episode **Mild to Moderate anxiety disorders** **LTC (high function)**	• Provision of appropriate psycho-education materials • Problem solving • Activity scheduling • Behavioural Activation • Clinician assisted exposure and self-directed exposure • Signposting to alternative support/services • Mindfulness • Cognitive reattribution • Self-monitoring

High Intensity Psychological Interventions at Step 3 and Step 3+

Disorder	Psychological Intervention
Depression (single episode) **Depression (second or subsequent episode)** **Low self-esteem** **Panic disorder (with or without agoraphobia)** **Generalised anxiety disorder** **Health anxiety** **Specific phobia** **Post-Traumatic Stress Disorder** **Obsessive Compulsive Disorder** **Social Anxiety Disorder**	• Behavioural activation • Cognitive Behavioural Therapy (CBT)

If you are a CBT therapist intending to use third wave approaches, please ensure these are linked to evidence-based treatment plans and that your supervisor has authorised this. You should also note clearly in your clinical notes why you are not using a standard protocol.

See Step 3+ criteria.

1.5. Onward referrals

Referrals on to secondary care services will be expected if a patient's presentation involves complex co-morbidities or if they need:

- psychiatric assessment
- a multi-disciplinary team or care programme approach
- medication managed by secondary care/specialist mental health services

Please check the site protocol to see how to action an onward referral to secondary care. (For some areas we are only able to refer back to either the IAPT service, or the GP).

See section 4 on **writing an onward referra**l for further details about what to include.

1.6. Discharge Criteria

Discharge protocols are shared with patients, GPs (unless patient opted out of GP copies) and other relevant stakeholders. The discharge protocol includes patients who:

- have achieved recovery as assessed by the definition of non-caseness
- have achieved recovery as assessed by GAD-7 and PHQ-9 scores
- are referred into other more appropriate services
- have 2 DNAs/2 Late Cancellations or a combination of the two
- drop out of, or decline treatment, or who the service cannot contact following adequate attempts

Please speak to your clinical supervisor for any additional guidance or concerns regarding discharge criteria.

2. Starting therapy

2.1. Allocation system for new clinicians

You can input the number of patients that you can treat directly onto the Therapy Platform (see the 'How to use the therapy platform' guide as well as the times that you are available to treat them. This means you can update your general availability and capacity anytime without the need to email our Patient Services Team.

Please make sure you have set your preferences following your induction so that so that you can be allocated patients. **Following that, please remember to update this information when your circumstances change to avoid misallocation.**

You will then start receiving patient allocations. (Please note that, as per your contract, we cannot guarantee that you will receive the number of patients that you have set your capacity to.)

NB: If you are sick or on annual leave, please see **further information** in section 3.7 on what you need to do.

2.2. Booking the initial appointment

INITIAL APPOINTMENT

Depending on how the patient has accessed our service, we will need to offer an assessment/initial appointment before starting therapy.

Additionally, a risk assessment form will automatically be sent to the patient when you schedule the assessment/initial appointment. This is to ensure that any existing risk can be identified in the early stage of treatment.

WELCOME MESSAGE AND CONFIRMING FIRST APPOINTMENT

A welcome message should be sent to the patient within 48 hours of allocation. This should be with a view to introducing yourself and providing them with some basic information to help them to book the initial appointment. Examples of appropriate Welcome Messages can be found on the Hub in the **'message templates'** section.

Please feel free to use these template messages and make adaptations. Remember to keep the message warm and welcoming for your patient.

PREPARING FOR YOUR FIRST APPOINTMENT

When you are allocated a patient, there will be helpful information to review ahead of the first session. This can help shape the session and have an idea of questions to ask to ensure typed CBT will meet the patient's needs.

You can find this information in the following places:

- **Service Assessment:** If the patient has been pre-assessed, the service's assessment notes will be in the General Admin Notes (GAN)
- **Self-Assessment Questionnaire** - SAQ (both self-referrals and service referrals): This will give you lots of information in the patient's own words about their perceived primary problems, how they cope, previous support/ therapies etc
- **Triage Notes:** (Often written in the GAN or via supervision ticket) Referral- Co-ordinators might screen some referrals that come in - particularly if there is a flag identifying potential signs that primary care might not meet the patient's needs. Often there isn't enough information to make decisions from screening alone, which is where you will be asked to assess further. If you are unsure, please raise a 'Suitability Query' ticket to discuss with your supervisor
- **Risk Assessment:** Please follow the risk guidelines in **section 6** of this manual if risk of harm to self or others is shared in questionnaires, messages or the SAQ prior to the session
- **Consent to write to the GP:** See the 'Summary' section on the Therapy Platform > ARE YOU HAPPY WITH YOUR THERAPIST TO SHARE INFORMATION ABOUT YOUR TREATMENT WITH YOUR GP? The patient will have opted Yes/No

EXPECTATION-SETTING IN THE FIRST SESSION

Please remember that not all patients will have been assessed by the service, and it is likely that for those who self-refer you will be the first point of therapeutic contact for them. Therefore, it is important to manage expectations and provide them with support and guidance to ensure they understand how the service can help them, or to assess suitability further and facilitate a timely onward referral, if appropriate.

WHAT PRE-READING/PSYCHOEDUCATION CAN I SEND TO PATIENTS?

On the patient's home screen, they will have access to the following documents. You may want to signpost them to some of the information either prior to, or for homework after the first session. For example, setting their goals and reading 'What is CBT'?

- Help with this Website
- What is CBT?
- Online Therapy Guidelines
- How it works
- Setting Goals
- Noticing and managing suicidal thoughts

- Make a Complaint

You can view these documents under the **'What Your Patient Experiences'** page on the Hub.

2.3. Conducting the initial session

Initially, you will conduct a thorough assessment to begin to assess suitability for CBT and treatment. The function of the initial appointment (and in some cases the subsequent session) is to:

- Have a general idea of the presenting problem
- Have a general idea of what the patient wants to get out of therapy
- Assess risk
- Reflect on how the patient presents online (are they structured/how quickly do they respond)
- Make a provisional plan with the patient if enough information to do so, e.g., to work with the patient, to book another session to gather more information, or if it is evident from the first session that it will be an onward referral then this plan can be confirmed over the messaging function

Remember: Before you assess the patient, it is essential to assure them of confidentiality of the session and when you as a therapist have a duty of care to share information. The '**confidentiality statement'** template can be found in **'Message Templates'** on the Hub.

Please send this to all patients in their first session and ask whether they agree to the statement.

At the end of each session, you need to press "End Session" and choose the best description from the list of how the session went (see 'How to use the Therapy Platform' guide on the Hub)

AFTER THE FIRST SESSION, IF IESO NOT SUITED TO PATIENT'S NEEDS/THERAPIST UNSURE:

Sometimes even with screening and pre-assessments, it might be that once you talk to a patient in a live appointment, there are doubts about whether typed and/or primary care therapy will meet the patient's current needs (whether due to severity, a different therapy modality such as counselling indicated, or patient is declining the typed method).

In addition, due to the 'disinhibition effect' found in typed therapy, it might be that the patient discloses something in the initial session that was not shared in the service assessment (such as risk, or a problem that it not typically treated in primary care). If this happens, you can raise a 'Suitability Query' supervision ticket to gain further advice around whether typed therapy will meet the patient's needs (see within section 5 on Supervision for **how to create a supervision ticket** and **helpful information to include in a supervision ticket**).

You may need to consider a referral back to the service or secondary care. Please see section 4 on '**How to write a referral back to the service**' or '**How to write an onward referral**' for more information on this.

AFTER THE FIRST SESSION, IF IESO IS APPROPRIATE TREATMENT FOR THE PATIENT:

The therapist will need to continue to work with the patient to develop a collaborative formulation or a problem statement (one or two sentences that identifies and summarises the condition/problem that the patient is seeking to address in therapy), which should then pave the way to a clear provisional diagnosis and treatment plan. The treatment plan should be recorded in the Clinical Notes.

Remember, after completing the session you must:

- Add the diagnosis on the 'Case Details' tab
- Place the patient on a step (if not already stepped)

(NB: it is important to do this prior to booking your next session otherwise that will be classified as assessment, and you will not be able to select an appropriate 'treatment session' option)

- Complete **Clinical Notes*** within 48 hours of the session ending
- Complete **Assessment Letter** within 48 hours (if patient has self-referred)
- (Check the Site Protocols and your homepage 'tasks to be completed')

- PWPs to raise a S2 ‘New Patient’ Case Management supervision ticket (see **Section 5** on Supervision).

*Clinical Notes:
w Please note that transcripts are unavailable to services except in exceptional circumstances; therefore, please ensure that your Clinical Notes are comprehensive and demonstrate a clear record of what has been agreed and discussed within the session. For further guidance, see section 2.8.

2.4. Deciding which step

If it has not previously been determined, you will need to decide a step for each patient.

The specific site a patient comes from will guide the session duration you can offer. **Please check the relevant site protocol to confirm.**

For example, most contracts will follow this format:

- Step 2 patients are 45-minute appointments
- Step 3 and 3 + can have either 30-minute or 60-minute appointments

If the patient has not already been allocated a step, please decide after their assessment (with guidance from their self-assessment and MDS questionnaires) and change their step on the system. As a guide, indicative thresholds for each step are:

- Step 2 criteria: PHQ9 5-14, GAD7 5-14
- Step 3 criteria: PHQ9 15-19, GAD7 16-21
- Step 3+ criteria: Severe Depression, DSM V Criteria and/or PHQ9 20-27
- Severe OCD
- AND/OR Patients with common mental health problems (as listed in inclusions above) with additional psychosocial needs. They may present with co-morbid or historical difficulties (which will not be the focus of therapy) e.g., functional Autistic Spectrum Disorder (ASD), Chronic Fatigue Syndrome (CFS), Chronic Pain etc.)

Please raise a supervision ticket to acknowledge the change of step (see Section 5).

If you allocate a patient to a step that is not indicative of these thresholds, you will need to create a ‘Step Up Request’ Supervision ticket using the Supervision Tool on the Therapy Platform. It is essential that you give a clear and explicit rationale for doing so in the patient’s notes and in your supervision ticket (see section 5 for **how to create a ticket** and **what to include in different types of supervision ticket**). Your decision should be supported using disorder specific measures where necessary.

PWPs: If you feel that the patient requires a step up to step 3 CBT – please discuss this with your supervisor before changing the care pathway, if your supervisor agrees then please raise a ‘S2 step up request and reallocation’ supervision ticket.

Referrals onto secondary care services will be expected in all cases if they involve complex co-morbidities, psychiatric assessment, require a multi-disciplinary care or a care programme approach. This will include medication management supervised by secondary care, or specialist mental health services. (See guidance for how to make a referral on in section 4).

2.5. Session numbers for PWPs and CBT Therapists

At ieso, we do not limit the number of sessions a patient can have, as long as this is within NICE guidelines. We are interested in getting them better, with better outcomes being our targets, however this is balanced by consideration of therapy effectiveness and patient engagement and needs to be monitored closely in supervision.

It is vital that during the early phases of contact with us we are:

- Managing expectations (not promising outcomes and session lengths)
- Understanding patients' needs
- Identifying if we can offer evidence-based psychological therapy for the primary presenting problem
- Identifying patients for which Low and High Intensity CBT or the online method do not work and referring them to other options as quickly as possible

We want to achieve the best outcomes with the optimal dose of therapy needed. We know that for every hour of typed therapy someone has, they are/should be working on the site for another hour. The messages, goals and access to transcripts amplifies the effect of typed CBT. By using asynchronous messaging to encourage patients to undertake therapy tasks you can speed up progress significantly. This does not mean that you as a therapist should work hard between sessions. A carefully chosen question sent in the messages can encourage patients to think, reflect and learn.

SETTING PATIENT EXPECTATIONS AFTER ASSESSMENT

A couple of examples to help you think about managing expectations of brief therapy without imposing session limits can be found in the '**message templates**' section under 'post-assessment message' templates.

LACK OF PROGRESS OR POOR ENGAGEMENT

If CBT does not suit a patient, you need to make this decision quickly and **discuss with your supervisor** the best course of action. Please note we do not hold patients to offer support while they are awaiting another treatment. If you feel the patient needs more sessions discuss this with your supervisor as well.

SESSION NUMBERS GUIDELINES

We ask all clinicians to review patients progress at session 3 to determine suitability, engagement, and treatment planning. At this stage if you believe the patient will require further treatment sessions beyond the average (see below) for Step 2, Step 3, or Step 3+ then you are required to send a clinical rationale to support this extension. For PWPs this will be reviewed after treatment session 3, via a 4 weekly review case management supervision ticket. For CBT therapists you will need to raise a supervision ticket.

These guidelines are derived from the extensive data we have collected, such as a significant indicator that there can be an inverse correlation with therapy extensions and recovery outcomes. However, this should not prevent patients having more sessions if it is clinically justified in consultation with your supervisor.

EXPECTED SESSION NUMBERS FOR PWPS

Step 2 (Low Intensity): Step 2 patients will have a clearly defined presenting problem, lower measures, high level of functioning, and will be motivated to engage in therapy, and out of session tasks.

At the start of therapy, inform the patient that they will not require very many sessions and there will be a strong emphasis on out of session practice.

Aim to complete therapy within 45-minute sessions with homework in between (in addition to the 60-minute assessment). **The average number of hours generally used at Step 2 is 3 hrs**.

If you feel that a patient would benefit from further sessions above the average, contact your supervisor to discuss providing additional sessions at Step 2, or stepping the patient up to Step 3 if they are more complex and this is available on the patient's site.

EXPECTED SESSION NUMBERS FOR CBT THERAPISTS

Step 3 or 3 + (High Intensity): Step 3 patients will have moderate to severe presentations. **The average number of hours generally used at step 3 is around 6.5 hours** (incl. 60-minute assessment).

Step 3+ patients will have more severe presentations. **The average number of hours generally used at step 3+ is around 9.5 hours** (incl. 60-minute assessment).

At the start of therapy, please suggest that you work together for 3 or 4 sessions and then review progress. At this point both you and the patient are likely to be in a better position to think about whether therapy is helpful and whether they are beginning to make progress etc. At this time, you can then agree (if appropriate) to work together for a further number of sessions and review progress again or complete the blueprint and discharge, depending upon engagement and progress.

If you feel that a patient would benefit from further sessions above the average, contact your supervisor to discuss providing additional sessions. For '**how to create a supervision ticket**' see Section 5.

Please do not inform a patient that they have "six hours of therapy". Please do not write this in the notes, in messages, or in a letter.

Requests for additional sessions should be submitted at session 3 or 4, so an agreed outcome with your supervisor can be completed by session 6. All additional extensions should be reviewed before final appointments with the patient. Additional extensions should be reviewed with time to discuss with your supervisor if needed.

2.6. Case Management supervision requests to extend treatment length

We require a 'Session Extension' case management ticket for extensions to therapy over 6 sessions for all patients (**see Section 5**). We recommend extension requests are raised at session 3 or 4 initially, to give time to discuss with your supervisor. Session extensions are then required every 4 sessions thereafter.

Extension requests are also helpful to identify patients that are not benefiting or engaging. Through clinical discussion and supervision support, you can work to overcome barriers to symptom relief or decide whether extending is not beneficial for the patient. These cases can also be discussed in live supervision (bookable via your **Supervision page** on the hub).

Regular reviews are required because:

1. Responding to indications that the patient is not improving in real time has been shown to prevent patient drop out and improve outcome.

2. Evidence suggests that early response is one of the strongest predictors of outcomes.

See **Supervision** (section 5) for guidance on how to raise case management supervision tickets and the details required for your supervisor to support extension decisions.

2.7. Supporting patient engagement

Providing therapy with ieso, whether CBT or another method, is easy. There are a few key points to note:

- It is important to make your patient comfortable whilst using the system. Reiterate that it's not essential that they spell everything correctly or use perfect grammar.
- Keep in touch with your patients between sessions using the messaging system. Use it to send homework or ask when they are next available. You do not have to reply to their messages instantly, but you must respond within 48 hours. There is a significant correlation between warm welcoming messages and patient engagement – please ensure that you use the standard ieso welcome message and carefully word any additional messages.
- You do not need to spread sessions weekly. If the patient would benefit from more or less frequent sessions book them at different times. NICE Guidelines for PWPs is to provide fortnightly sessions – to enable the patient to practice the techniques that are explained to them in session.

2.8. Clinical Notes

Your clinical notes need to be comprehensive and demonstrate a clear record of what has been agreed and discussed within the session. They must be updated within 48 hours of the session – this is to ensure Patient Services can add the notes to the site patient management system so providers are up to date and forms the basis of our contracts with providers.

Please include the following information formatted by this template:

- **Agenda for Session:** Document agenda items that you have set collaboratively with your patient. The agenda can be

set in messages prior to the session, this will encourage patients to actively engage in the agenda setting process
- **Treatment:** Target problem and treatment plan (including formulation and protocol being used), ensuring that if this has changed from the last session, it is made explicitly clear why. Change mechanism, these should relate to the protocol that you have selected and the patient's problems. Any action taken or changes to the proposed plan
- **Progress towards Goals and Engagement:** Include any issues relating to engagement
- **Homework and Feedback:** Homework Summary. Any problems or barriers to completion of homework
- **Risk:** Document discussions relating to risk (at minimum note PHQ-9 Score) and any action taken. Include patient's intent, plan, access to means, protective factors, and safety plan

Clinical notes should distinguish between clinical facts, your opinions, and information provided by others. Please do not add your personal reflections, your uncertainties about your own clinical practice, or your opinions about your CBT skills in the patient's clinical notes.

Remember, clinical notes are a legal document that are also shared with other services in the case of sub-contracts, and therefore should make sense independent of the transcript.

Data Subject Access Requests: Under the Data Protection Act 2018, individuals (including patients and service users) have a right to see information recorded about them. There are exceptions to this where sharing the information may cause harm or distress. **Therefore, write with the potential audience of the patient in mind.**

Consistent delayed and/or poor note keeping will result in a hold on allocations until this is remedied. Failure to remedy this in a timely and satisfactory way will result in action linked to that detailed in the HIT and PWP guides where clinicians are not meeting our minimum standards.

2.9. Use of questionnaires and other clinical measures

The Patient Health Questionnaire (PHQ-9), Generalised Anxiety Disorder Questionnaire (GAD-7), Phobia Scales, Work and Social Adjustment Scale (WASA), Employment Status and Medication Status all form part of the mandatory minimum data set and must be routinely used at every appointment.

Please feel free to add additional questionnaires if clinically indicated.

Both patients and clinicians can use these measures therapeutically to track progress. Patients have access to the outcomes of each questionnaire and can also view the results in a chart.

DIFFERENTIAL DIAGNOSIS

A penultimate and essential stage of assessment and formulation is the consideration of a differential diagnosis. There can be a 'blurring' of presenting symptoms that may lead a clinician to select an incorrect diagnosis. Careful consideration of a range of other possible diagnoses can enable the correct diagnosis to be reached and therefore enable the most appropriate choice of treatment. The use of additional disorder-specific measures can help with this.

ANXIETY DISORDER SPECIFIC MEASURES (ADSMS)

In addition to the standard Minimum Data Set questionnaires clinicians may select disorder-specific measures (ADSM) if the PHQ-9 and GAD-7 fail to be sensitive to the patient's presenting problem. This is particularly important in cases that present as subclinical on both the PHQ9 and GAD7.

WHEN SHOULD AN ADSM BE USED?

An ADSM should be used whenever a provisional diagnosis of a specific anxiety disorder is made. Diagnoses should ideally be reached upon the initial assessment/treatment session. However, it is recognised that in some instances the diagnosis may be established after two to three sessions. Once a diagnosis is reached it is important that the appropriate ADSM is used in assessment, and regularly after this, especially at each review and at the end of treatment.

SUMMARY OF ADSM'S LINKED TO DIAGNOSIS

Problem area to be addressed/ diagnosis	Recommended Measure	No. of Items	Cut-off score	Statistically reliable change
Depression	PHQ 9	9	10 (9\< Caseness)	>= 6
Generalised Anxiety Disorder	GAD 7	7	8 (7\< Caseness)	>= 4
Obsessive Compulsive Disorder	Obsessive Compulsive Inventory (OCI)	42	40 and above	>= 32
Social Phobia	Social Phobia Inventory (SPIN)	17	19 and above	>= 10
Health Anxiety or Hypochondria	Health Anxiety Inventory -Short week version; SHAI)	14	18 or above	>= 4
Agoraphobia	The Agoraphobia-Mobility Inventory (MI)	52	Above an item average of 2.3	>= 0.73
Post-Traumatic Stress Disorder	PTSD Checklist for DSM-5 (PCL-5)	32	32 or above	
Panic Disorder	Panic Disorder Severity Scale: self-report version (PDSS)	7	8 and above	>= 5 Use GAD7 in recovery calculation

2.10. Writing an Assessment letter

It is a contractual requirement for most of our services that we update the GP and patients with an assessment letter. This letter is addressed to the patient and is routinely sent to the GP too, unless there is no consent to do so.

If a patient requests that letters are not sent to their GP and this is not already noted, please make Patient Services aware of this so that they can update the system. **Note - it is a data breach if we subsequently send the GP a copy without further discussions with the patient.**

(You will be able to see the 'SUMMARY' section of the patient's case on the Therapy Platform and refer to: 'ARE YOU HAPPY WITH YOUR THERAPIST TO SHARE INFORMATION ABOUT YOUR TREATMENT WITH YOUR GP?' to check this. If they have said yes, then it is OK for them to be sent.

The therapy platform will bring up a template for completing the letter. Please do this as soon as possible following assessment as we aim to complete the letter within 48 hours.

A standard assessment letter should contain:

- Questionnaire outcomes will be included into the template automatically
- A summary of the presenting difficulties, including key symptoms
- An overview of treatment plan including a model you plan to use
- A summary of the risk profile and a brief safety plan
- Any additional information you feel is relevant to the presentation, for example safeguarding concerns, impact of difficulties

2.11. Requests for Supporting Letters

As much as we would like to support all our patients to full recovery, we are unable to provide supporting letters for evidencing a claim, supporting employment, insurance, school/university, social housing etc. If you need additional information on this, please discuss with your clinical supervisor and they can talk you through the additional options of how to support your patient. We would suggest you use the assessment or discharge letter as standard to inform the GP or any of the above other services.

2.12. Communication with the GP

At some points during the therapy process it may be appropriate to update the GP between sessions. These reasons could include:

- A change in risk presentation which you want to alert the GP to
- A significant change in symptoms or diagnosis
- A medication concern (has suddenly stopped taking prescribed medication for example)
- A safeguarding concern
- Other relevant information you feel the GP should be aware of

If you want to update the GP, write the content of the letter in the General Admin Notes (GAN) and email Patient Services with subject header 'Letter to GP re. Patient case number' on **therapist@iesohealth.com**. (NB: Remember not to use patient names via email.) Let them know there is a letter that needs to be sent to the patient's GP in the GAN. They will then action this for you and send it via a secure email.

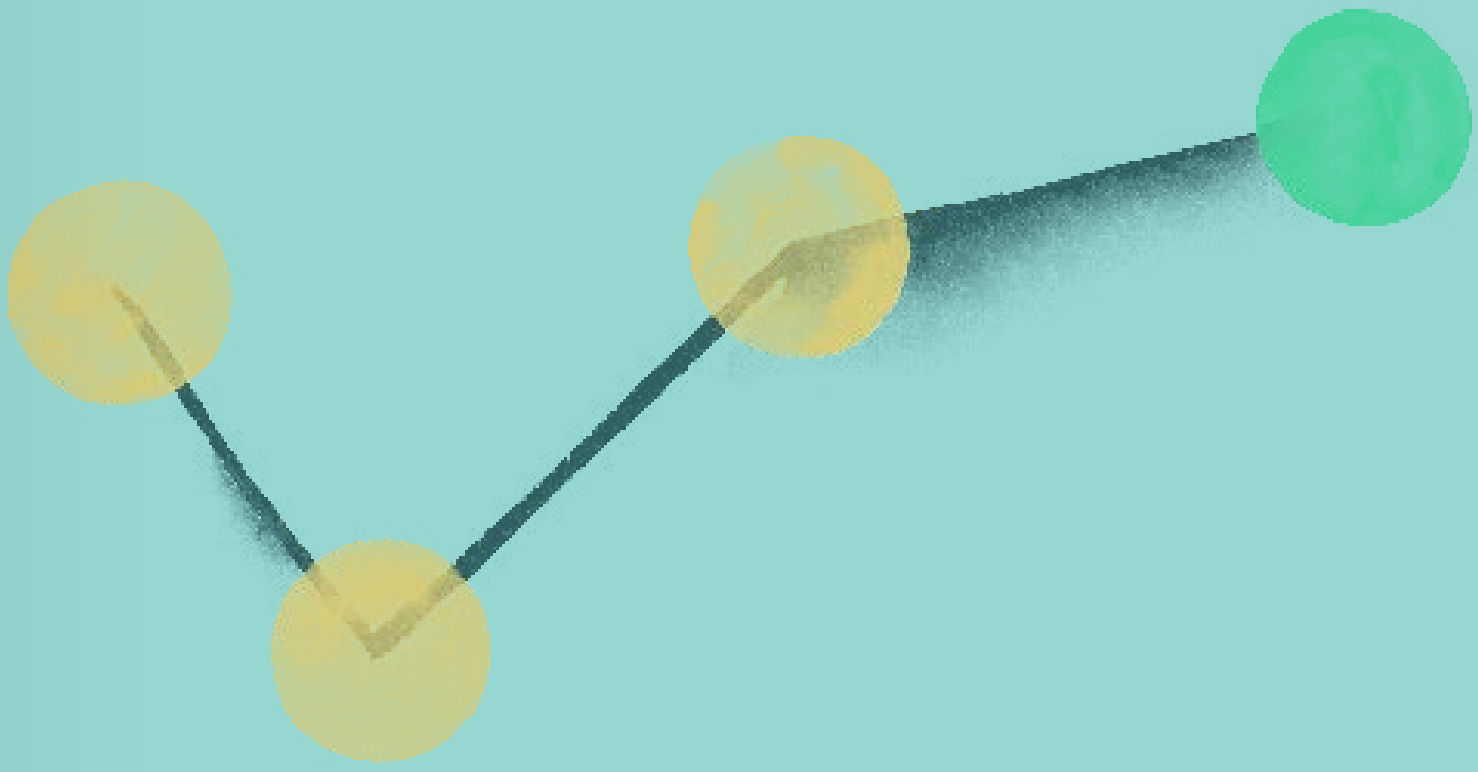
Assessment and discharge letters are routinely sent to the GP automatically, actioned by Patient Services, see the sections on **assessment letters** and **discharge letters**.

WHERE THERE IS NO CONSENT TO WRITE TO THE GP:

As standard, GPs are cc'd into assessment and discharge letters. Therefore, before you assess a patient, we strongly advise that you check the 'SUMMARY' section of the patient's case and refer to: 'ARE YOU HAPPY WITH YOUR THERAPIST TO SHARE INFORMATION ABOUT YOUR TREATMENT WITH YOUR GP?' If they have said yes, then it is OK for them to be sent. If it isn't ticked, please ensure you email **therapist@iesohealth.com** to ensure no letters are sent to the GP.

The caveat here is if there is risk. We have a duty of care to keep the GP informed of the patient's risk or changes to it. It is therefore essential that you share the confidentiality statement in your first session with a patient (see 'message templates').

Similarly, there may be cases when the patient has requested no post to home (e.g., if they are at risk from someone they live with). You can let Patient Services know that if it isn't logged already. They will add this to letter heads and letters can be shared with you in the GAN, and you can then message the letter to the patient in the messaging section of the platform (so it is sent securely).



3. Issues in Therapy

3.1. Complete non-engagement prior to treatment

Once you are allocated a patient and have sent the welcome message (within 48 hours of allocation), if your patient doesn't respond to arrange their first appointment you will need to use the following process.

- After 2-3 days of no response, you will need to send a message reminding the patient to book their first appointment with you. See 'Patient reminder to book their first appointment' in 'Message Templates' on the Hub.
- If the patient doesn't respond to either of these two messages, they will be removed from your caseload 7 days after the welcome message was sent.

If the patient has responded, even minimally, there is a different procedure - see the section on 'lack of consistent engagement' below.

3.2. Lack of consistent engagement

Patients must confirm or reject appointments offered by a clinician at least 48 hours before the appointment.

If a patient rejects an appointment, please offer an alternative appointment with at least 48 hours' notice if possible.

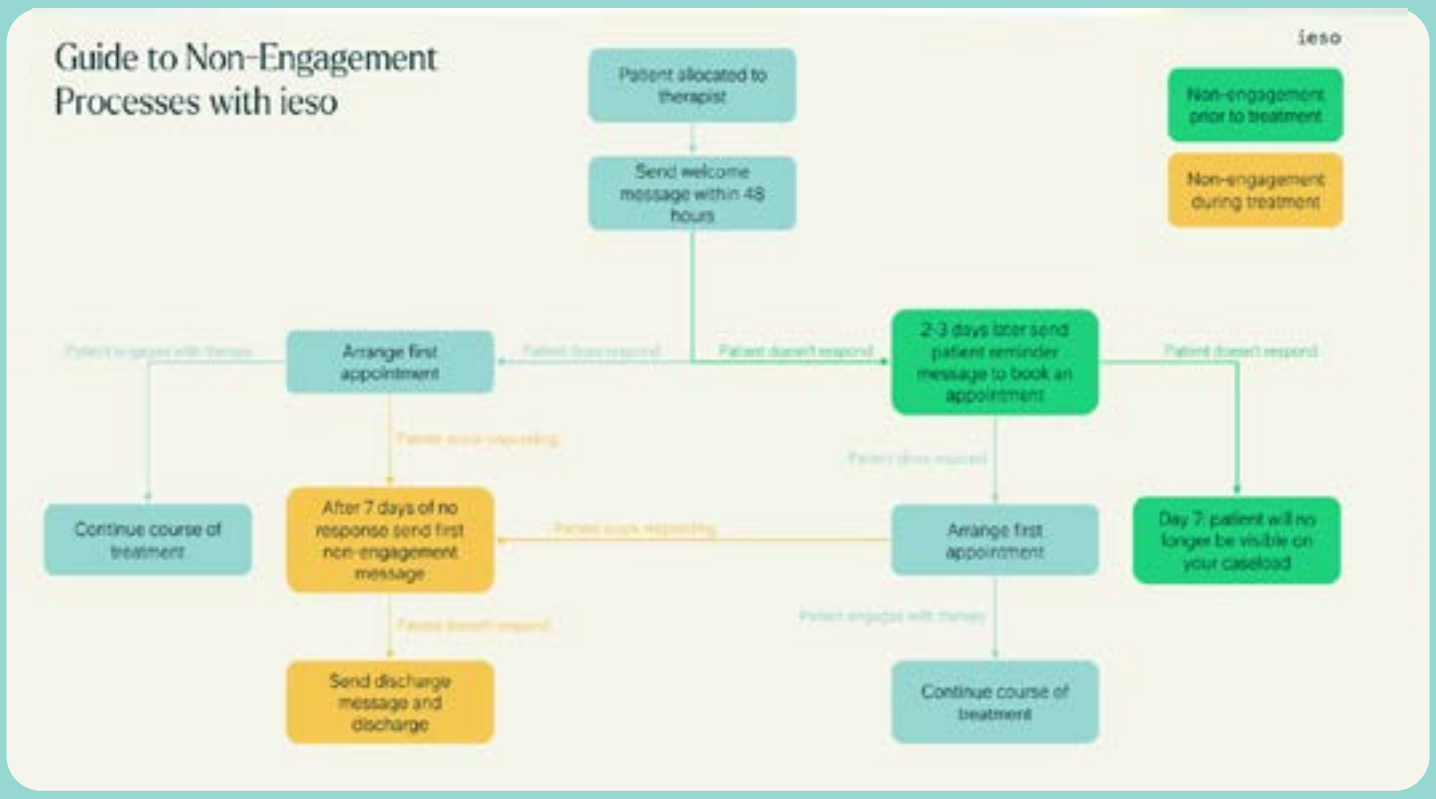
If they have made an initial response but do not go on to confirm/reject an appointment, you can remind them to via the messaging system. If they still do not confirm/reject the appointment you must cancel it yourself (and let them know you have done so). You can then send another appointment.

Some patients can start to show signs of fluctuating engagement during treatment if, for example:

- they do not confirm an appointment for a second time
- they reject an appointment for a second time and do not respond to your message to schedule a more convenient time

In this case, you should reflect on whether all barriers for engagement have been considered and all problems with this were solved with your patient.

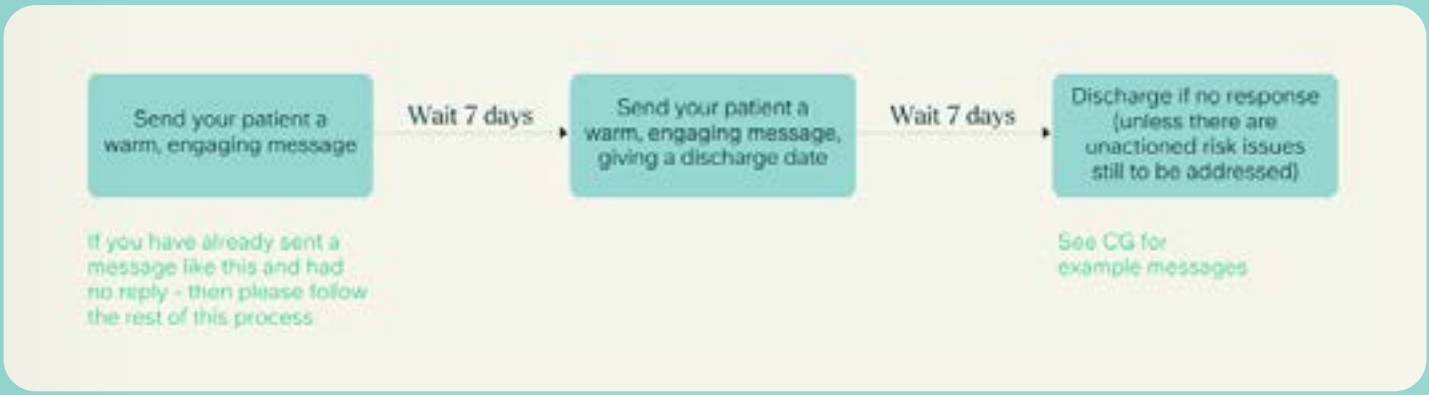
Where a patient is not engaging, the following ieso processes apply:



THE 7-7 RULE

- Send a warm, engaging prompt message asking the patient to arrange an appointment at the point of initial lack of engagement.
- Wait 7 days, if no response, send a warm, engaging message similar to the 'engagement message template' in 'message templates' on the Hub stating that you would very much like to arrange an appointment with them and look forward to hearing from them soon. The message contains a 7-day timeframe and a discharge date if they do not respond.
- If you do not hear from them within 7 days, then you can assume that they no longer require therapy, and you can send them the 'discharge message' template.

- Please then allow a final 48 hours for them to respond to the 'discharge message' before discharging – as once they have been discharged, they will be unable to communicate with you and this has been a source of patient complaints.
- If you do have some contact from the patient within the 7-7 time period but the patient is not committing to actions in the messages, please raise an "engagement" supervision ticket for discussion of next actions and consideration of discharge rationale.



Please be compassionate but clear in your communication and encourage the patient to message you if they have any questions or concerns about the therapy. If you do discharge having not heard back, do encourage them to consider a referral again in the future if now is not the right time. It is often helpful to acknowledge the steps it takes to access therapy and encourage them to call the office or send a message if they are unsure or would like to ask further questions before continuing.

3.3. Cancellations

Patients can cancel a session, without penalty, 48 hours or more before it is due to start. You will be automatically informed via email if your patient cancels a session. If this happens, please message them to discuss when they would rather have their appointment. You will then need to set the alternative appointment up on the site and wait for them to confirm it. As above, the **patient needs to accept the appointment at least 48 hours before the start time**. If the patient does not confirm the appointment 48 hours before, you can see this as cancelling by default and you must cancel it on the site.

We cannot regard a non-confirmed appointment as a DNA if they do not turn up – and we cannot pay you for this.

Please ensure that you have communicated the requirement to confirm appointments within 48 hours of the appointment start time before cancelling it to give patients every opportunity to attend. They do have access to this information in their terms and conditions, but it is therapeutically intuitive to gently remind the patient of this before proceeding with such action in the first instance.

If you want to wait longer before you cancel a session, then you can. For example, if there is an internet connection fault and you agree with the patient to try again the next day, you can set up an appointment within the 48 hours. This relies on a trusting relationship with your patient as if they do not confirm we cannot treat it as a DNA/late cancellation, and as such no payment will be made.

For further information about payments related to cancellations and DNAs, please see the HIT and PWP Guides.

3.4. DNA/Late Cancellation policy

This section will help you know what to do when patients DNA appointments or cancel late. This will help you to ensure you give good patient care whilst being sure that you are always paid fully for your sessions.

If patients are not fully aware of the policy, it also can cause a lot of distress if they find themselves being discharged unexpectedly. It's important to always make sure they are clear on it (through using the suggested

message templates) and to follow it accurately yourself.

WHAT IS A LATE CANCELLATION?

If a patient confirms an appointment on the system but then cancels it within 48 hours before it is due to start, this a "Late Cancellation"

If a patient joins an appointment but then cancels within the session, this is also a "Late Cancellation"

WHAT IS A DNA?

A DNA is when a patient does not attend a confirmed session without giving any prior warning.

WHAT IS AN ABORTED SESSION?

This category is reserved for sessions where there has been a technical difficulty. It applies if you or the patient lose connection for 10 minutes or more.

WHAT SHOULD I DO IN THE CASE I HAVE A LATE CANCELLATION, DNA OR ABORTED SESSION?

All patients are told in the online therapy guidelines that if they a) do not attend a confirmed appointment, or b) cancel with short notice, on two occasions, our standard policy is that we will discharge them (as long as they have been given warning after the first occasion.) Please be aware that the late cancellations and DNA's are counted by patient episode, not therapists or step.

It is a requirement that you reiterate this policy to your patients after their first late cancellation or DNA.

What should I say? See '**Message Templates**' for First DNA and Second DNA templates (with variations on the wording for good prior engagement and minimal prior engagement).

How long should I allow patients to respond? We would like you to follow the "7-7" rule when communicating with patients about DNAs or late cancellations, see diagram below.

A patient has cancelled an appointment late. What should I do?

If it is their first late cancellation, and they have never previously had a DNA, respond to the patient sensitively using the 'Late Cancellation message template' in the '**messaging templates**' section on the Hub, pointing out our policy which is that patients may be discharged should another session be cancelled late or not attended. You should try to rearrange the appointment.

If it is their second Late Cancellation or they have had a previous DNA, you should carefully consider their engagement levels and whether they should be discharged (as with DNAs below). See different messaging template options for good prior engagement and minimal prior engagement which can be adapted to fit late cancellation from the Second DNA templates in the '**messaging templates**' section on the Hub.

TOP TIP: Make sure your messages remain warm and understanding. From our experience patients often panic when they miss a session so it's nice for them to get a reassuring message from their clinician.

BEST PRACTICE WHEN DISCHARGING THE PATIENT DUE TO DNAS/LATE CANCELLATIONS

DNAs or late cancellations can indicate a lack of engagement in therapy – especially if the patient has not contacted us with an explanation. HOWEVER, sometimes patients may have experienced an emergency or an adverse situation preventing them from attending an appointment, and sometimes they are not fully aware of the DNA policy.

Therefore, **always be warm and understanding** when having any conversations around this, making sure you understand the full story before making any decisions. Along with this, review the case carefully before another session is offered. If someone has given what you consider to be a legitimate reason for a DNA/late cancellation such as an emergency, for example, we should not penalize them – we rely on your clinical judgment. If you are unsure, you can always contact your supervisor to discuss any clinical rationale for extending cancellation/DNA allowance.

In all cases, please allow 48 hours to give your patients a chance to reply before discharging.

For further information about payments related to cancellations and DNAs, please see the HIT and PWP Guides.

3.5. What to do if a patient is late for a session

If you are waiting for a patient to log into a session and you think they might DNA you can do the following:

1. If it's a step 3 patient, wait for 15 minutes before ending the session if Step 2 wait 10 minutes.

2. In the meantime, type inside the session that you will wait for 10/15 minutes (depending on if Step 2/3), and that after which you will close the appointment.

3. At the same time, message the patient to say you are waiting for them in the appointment and check if they are ok. If the patient receives this in their inbox, it may prompt them to attend the session.

If the patient then attends, carry on until the planned end time of the appointment and mark as "completed late" at the end of the session. You do not need to make up for the time the patient missed at the beginning of the session.

4. If 10/15 minutes goes by, (depending on if Step 2/3) and still no response, close the session.

5. You now need to message them again to say that you were sorry to not have your session today, and that

you hope they are ok. If this is the first time it has happened, remind them gently of our DNA policy. You can use the template for 'First DNA' in '**message templates**' on the Hub and go from there.

If this is the second time this has happened, it might be that you need to discharge the patient. You can use one of the 'Second DNA' templates in '**message templates**' on the Hub depending on their level of prior engagement. Please allow 48 hours for them to respond to your final message prior to discharging them.

3.6. Disruptions to internet connection / Aborted sessions

This applies where technical difficulties have persisted for 10 minutes or more preventing the session from continuing. The session should be ended and marked as 'aborted session'. The clinical notes should be updated with what has happened and the patient messaged to rearrange ASAP.

CLINICIAN CONNECTION:

If you should lose contact with a patient for more than ten minutes during a session, exit the appointment and click the "Aborted" drop-down. Please enter a summary into the Clinical Notes to explain the issue.

Please message the patient and schedule another appointment for as soon as possible.

If you cannot get online for a session occurring within office hours, please let us know so that we can let the patient know. Please get in contact with the patient as soon as you are back online. Please also record what happened in the appointment notes.

PATIENT CONNECTION:

If your patient has technical issues with the site, you can instruct them to contact Patient Services (0800 074 5560, Monday – Friday 9am – 5.30pm) who will be able to talk them through the problems.

If it is out-of-hours, and you need to access the patient's view of the therapy platform to provide basic assistance, you can find it in the '**What your patient experiences**' section on the Hub.

If the patient is experiencing reoccurring difficulties, you can advise them to call Patient Services during office hours for some troubleshooting prior to your next session together.

ieso site issue: If the ieso therapy site is down, please go to our **patient website** for updates from our technical team.

For further information about payments related to aborted sessions, please see the HIT and PWP Guides.

3.7. Who do I contact if I am sick, on holiday or otherwise can't attend a session?

PLANNING LEAVE:
If you are planning to take leave, please update your absence dates on Cezanne and email therapist@iesohealth.com with the dates you will be away, and the case reference numbers. We will confirm receipt and advise the next steps. If you are intending to take a holiday of two weeks or more, we would be grateful if you do not take on any new patients in the two weeks preceding this and ensure that a risk management plan is in place with all patients.

ON-THE-DAY ABSENCES:
If you cannot attend an appointment due to illness or an emergency arising on the day, please let your patient know as soon as possible via messaging.

If you cannot get online at all or miss the appointment, please let Patient Services know by calling the office on **0800 074 5560** from Monday to Friday between 9am-5.30pm as soon as possible so that we can get in touch with the patient.

If you are unable to attend an appointment outside of office hours, please do your best to notify the patient as soon as possible.

3.8. Patient requesting to be put on hold

If a patient lets you know that they are not able to access therapy for a while (for example, if they are going away) it is useful to let us know. We can then account for gaps between therapy sessions. Please discuss with your supervisor before putting a patient on hold. The maximum time we might expect this to be is between 4-6 weeks.

Please also contact Patient Services using therapist@iesohealth.com so that they can change the case status and update the service.

3.9. Complaints

Clinical complaints can be made by existing or former patients. It is essential that staff and clinicians experience the investigation of complaints as being fair and objective. To support clinicians, ieso has a separate procedure for managing habitual complainants.

The outcomes from all complaints will be disseminated to clinicians through their clinical supervisor.

COMPLAINTS PROCESS:
Most complaints will be resolved through local resolution.

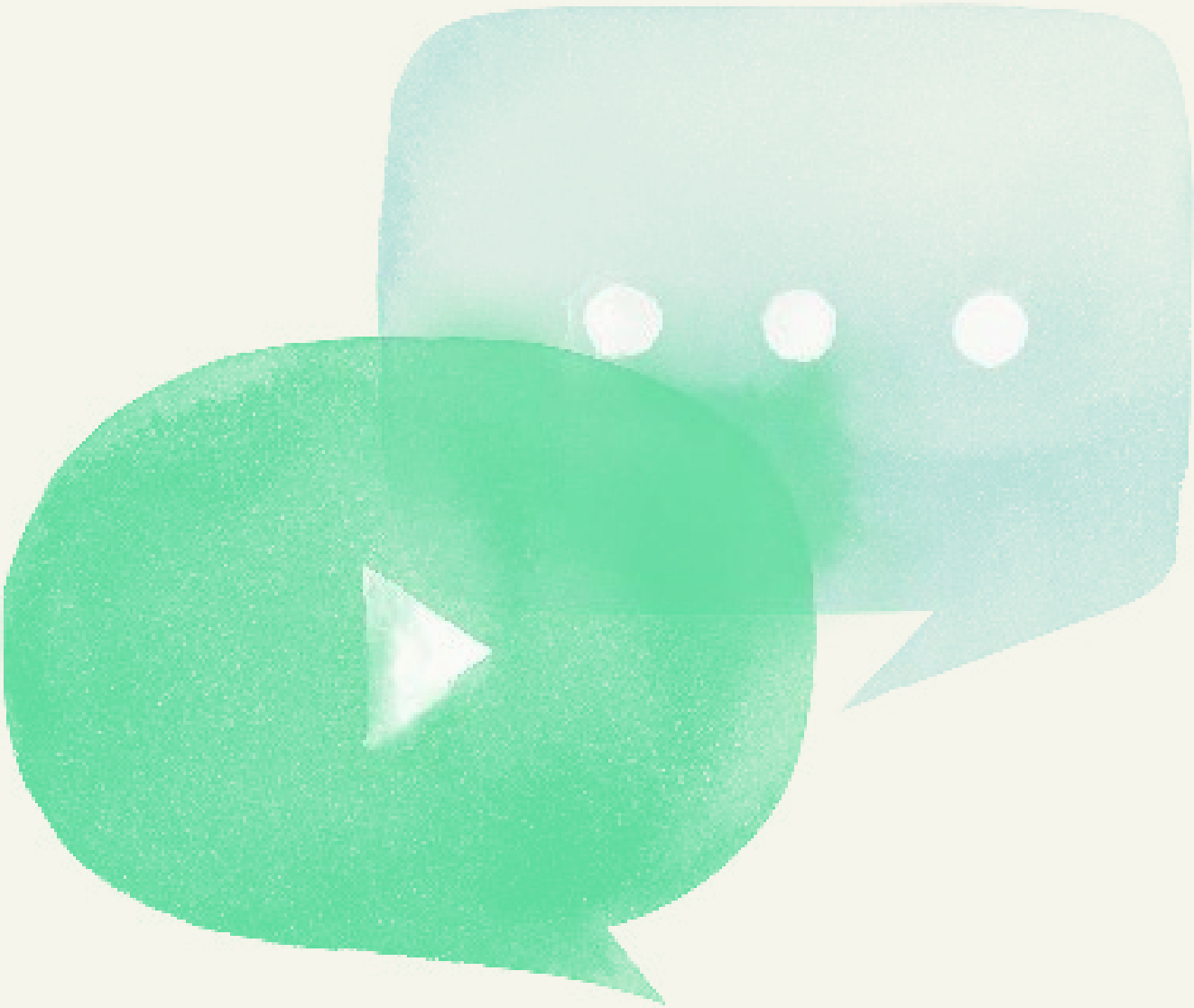
If the complaint has been made via the online messaging service or in the therapy session via synchronous text, the clinician must decide whether it can be resolved directly or whether it should be referred to their clinical supervisor.

Often the clinician can deal quickly and sensitively to the complaint and resolve the issue to the patient's satisfaction, but if the complainant remains dissatisfied with the response, the clinician will notify their clinical supervisor and advise the patient that they can make a complaint using complaints@iesohealth.com.

It is essential that patients who wish to make a complaint are encouraged to do so and are advised on the procedure for this.

When a complaint is made about a clinician that involves the therapeutic relationship or process of therapy, there is a procedure for a feedback loop to the clinician in the interest of supporting them to be the best clinician they can be.

The Clinical Supervisor will be responsible for feeding any information back to the clinician via supervision to support them to make positive changes to their practice and will keep appropriate documentation of this.



4. Ending Therapy

4.1. Selecting the correct discharge status

Whatever the reason for discharging a patient, there is a formal discharge process that you need to follow.

You will need to select an appropriate discharge status, which will generate a prepopulated template letter. The categories you will choose from are:

- Did not engage
- Completed Treatment
- Dropped out of treatment
- Not suitable for service
- Referred back to Provider

Further details of each category are below:

DISCHARGE – DID NOT ENGAGE

Use when: the patient is not replying to any messages, not accepting any appointment times, or cancelling their appointment. The patient will not have attended any appointments.

Please follow the policy detailed above in section 3.3 'Cancellations' and/or 3.4 'Late Cancellations/DNAs' before discharging. Please allow 48 hours following the final discharge message for the patient to respond before moving into the discharging pathway. Once you move a patient into "discharging" they will no longer be able to message you and will only be able to contact you via Patient Services.

DISCHARGE – COMPLETED TREATMENT

Use when: a patient has finished their course of treatment, or you have agreed an early ending.

Early ending: A patient may let you know that they no longer wish to engage with therapy. In this case, discuss the reasons with them then follow the discharge process. If they have had more than 3 sessions, please record in clinical notes as 'agreed early completion of therapy' and discharge using 'completed treatment'. Please be aware that a Supervision case management Ticket must be raised if the patient is not in recovery (see Section 5.2 on raising a supervision ticket and 5.3 on completing a ticket for a non-recovered patient. If the patient has requested this in a session or in messages, please copy the relevant section into the GAN so we are able to evidence this for the service.

Do let the patient know that they will retain access to their transcripts and goals following the end of their treatment.

A Patient Experience Questionnaire (PEQ) is automatically sent to all patients after discharge. Please take a moment to read the results after they complete it – it's very good feedback for you, as well as ieso.

DISCHARGE – DROPPED OUT OF TREATMENT

Use when: a patient stops engaging but have already had some/the majority of their therapy sessions.

As you know, patients drop out of treatment for many reasons. Online, dropping out can be demonstrated in the patient suddenly not attending sessions or replying to messages. If you think this is happening with a patient, you need to keep trying to engage with them. **Please follow the policy detailed above in section 3.3 'Cancellations' and/or 3.4 'Late Cancellations/DNAs' before discharging**.

Please allow 48 hours following the final discharge message for the patient to respond before moving into the discharging pathway. Once you have moved a patient into "discharging" they will no longer be able to message you and will only be able to contact you via Patient Services.

DISCHARGE – NOT SUITABLE FOR SERVICE

See **Suitability** for the service thresholds and information within the **Site Protocols** on the Therapist Hub for patients out of scope for treatment with ieso.

Very few patients struggle to use the online service, but if they do it is important to identify this quickly and discharge them so that they can access another type of therapy. If you think the patient needs a little guidance on how to use the site, Patient Services (0800 074 5560) can help them during office hours (Monday to Friday 09:00 to 17:30). After hours, you can email **therapist@iesohealth.com** with the case reference number and the issue and Patient Services will contact them when they are back in the office.

If you do not think the patient you are treating is suitable for ieso, please discuss with your supervisor before agreeing to discharge the patient. You can do this either in a clinical supervision session or via case management supervision tickets (see Section 5.2 for how to raise a ticket and 5.3 for helpful information to include in the ticket).

DISCHARGE – REFERRED BACK TO PROVIDER

Use when: you do not think the patient you are treating is suitable for ieso intervention, but they would benefit from face-to-face/telephone therapy with the IAPT service locally. See below 4.3 'How to write a referral back to service' for further details about the process and Section 5.3 for what to include in the '**Referral back to service**' Supervision Ticket.

4.2. Completing the discharge letter

The discharge letters are automatically generated on selection of a discharge category and addressed to the patient. They are also sent to the GP if we have consent to do so.

The patient discharge letter should include:

- MDS scores which are auto generated in the template letter
- Model used and summary of sessions to date
- Summary of risk profile
- Outcomes and recommendations going forward

Your letter is then actioned by Patient Services.

Note: We send out discharge letters in the post and therefore need to keep them relatively brief. Your letter will be sent back to you with a query if there is too much confidential information contained in it.

All letters should be written to the patient and will be sent to the GP where we have consent. If you need to write a separate letter to the GP (where consent has been obtained) or another service, write it in the general admin notes (GAN) and email **therapist@iesohealth.com**. If the patient has requested that we do not send a discharge letter, please email therapist@iesohealth.com to inform our Patient Services team that GP consent has been withdrawn. They will then update the patients record to reflect this change.

You will also need to check the **Site Protocols** as there are specific processes for each service when discharging a patient.

4.3. How to write a referral back to service

If you do not think the patient you are treating is suitable for ieso intervention and would benefit from face to face/ telephone therapy with the IAPT service, please draft a rationale and send to your supervisor via a **supervision ticket**, "Referral back"(see below in this section). You will need to write your rationale in the ticket for your supervisor to approve. This will also help you complete a transfer of care form/referral form for those services that require one.

Below is a guideline of key areas to consider to provide a robust rationale for review by the service we are referring back to, given that they cannot see transcripts. Please note, some services have forms that need to be completed for the referral to be accepted. Please check the **Site Protocol** as they often have Referral Back Instructions for the requirements (whether supervision ticket is sufficient or whether a form is needed).

Book into supervision to discuss if you are not sure.

- Consider referring if the patient has had 0 or 1 sessions and if:
- They did not realise we were a typed based intervention, and they prefer not to use this
- They do not have the ability to access the platform easily.
- They want a different modality that is provided by the referring service.

Information to include in the ticket (being thorough will reduce the chance of a referral being declined or replied to requesting more information):

- Presenting Problem
- Number of sessions
- Recent MDS or/and any ADSMs if known
- Risk

If the patient has received 2 or more appointments: it is less likely the referral will be accepted by the service if it is a service referral. If it is a self-referral, we would need to review the options.

If they have had 2 sessions or more, please review the following:

- Can the symptoms be treated within primary care? If no, consider a step 4/secondary care referral (separate guidance)
- Does the service accept referrals back (some self-referral sites we discharge to GP- please check Site Protocols)
- If not suitable for ieso, why?
- Are there any barriers that could be overcome in a different way (seek supervision to explore this)
- If it is for risk management, please raise an urgent or non-urgent ticket and discuss with a supervisor
- Is it the patient's preference?
- Has the patient consented to a referral back?

- Goals of the patient
- Any treatment completed/or why ieso isn't suitable
- Clear Rationale for referral back to the service

HOW DO I KNOW WHAT THE LOCAL IAPT SERVICE OFFERS IF I WANT TO REFER BACK TO THEM?

We work alongside and on behalf of the NHS and have contracts with many IAPTs all over the UK and they all offer a variety of different psychological therapies. Many can be seen on their own websites – however, we are aware that these aren't always up to date due to waiting lists and therapist capacity.

As this is the case, if you are considering making a referral back and would like to know what the service offers, we advise you to draft them an email requesting this information, place it into the GAN, and then ask Patient Services (therapist@iesohealth.com) to send it on your behalf.

Remember that this email isn't requesting them to look into a specific patient's details, it is only asking what they offer as a service.

Once we have an outcome, we can discuss in supervision via a Ticket as to whether we feel that we can or are able to attempt a referral back on behalf of the patient.

WHAT HAPPENS NEXT?

Once your supervisor has reviewed 'Referral Back to Service' ticket and approved it, they will then close the ticket.

Once the ticket is closed, the member of the Patient Services Team who work with the patient's referring site will be alerted. They will then send the referral request to the service.

Please message the patient letting them know that the referral has been sent and you will update them with the outcome. Remember that when we are referring back, we are requesting it is reviewed. We cannot guarantee the outcome and we cannot give information on waiting times etc.

Patient Services will email you to let you know if the referral has been accepted. If accepted, please update the patient via the messages, and then you can discharge. If the referral is not accepted, you can review this with your supervisor to decide the next steps. We are unable to process the discharge until we have confirmation of the service accepting or rejecting the referral.

*Please note, the Patient Services Team do not get notifications when something is added to the GAN alone. If there is something in the GAN you would like them to see/action, please email therapist@iesohealth.com or open the relevant supervision ticket which when closed will prompt the required action.

4.4 How to write an onward referral to another service

If you do not think the patient you are treating is suitable for ieso or primary care and would benefit from a secondary care intervention a good starting point is to check the **Site Protocols**. These will have details on whether you can refer patients to, for example, secondary care services local to them and how to do this. There may also be specific information that you need to include for specific referrals detailed there.

Assuming an onward referral is possible, please draft a rationale and send to your supervisor via a supervision ticket category "secondary care referral – non urgent"

If the referral is urgent and you deem it necessary to process the same day, please raise a secondary care urgent ticket and see section 6 Risk Onward Referrals for further guidance.

Book into supervision to discuss if you are not sure.

Below is guidance of the minimum information needed for a Secondary Care service to review. Some sites have either templates that they request are completed or detail more information about the types of support available within their

Key areas to focus on:

- Summary of the presenting difficulties, severity, and comorbidity, including any situational complexities (for example ongoing court case/relationship difficulties/childhood trauma etc)
- Any additional diagnoses that are relevant (Neurodiverse, dementia, personality disorders, Axis II historical or current etc)
- Current therapy intervention to date with ieso. What models/protocols have you been using, which interventions, successes and difficulties encountered with treatment
- Summary of historical interventions with other services (if known) or first presentation
- Any knowledge of beliefs which may make treatment within primary care more difficult to engage with
- Summary of risk, including current risk level and management plan. Summary of any risk to others or safeguarding concerns
- Recommendations and why

Time spent to complete rationales/referrals are routine as part of expected admin time paid as part of the session rate; and we offer included on-demand supervision support to offer timely guidance. However, if you feel that a referral has required a lot of consultation and admin over and beyond usual, please discuss this with your clinical supervisor.

Example 1: written in a summary paragraph

Aby has attended 6 ieso appointments with a CBT therapist. During these sessions we have focussed on assessment and formulation. We have identified that Aby has struggled with symptoms consistent with OCD for many years. Aby identified that from a young age she has engaged in checking behaviours that now consume her life. She is no longer able to leave the house due to the severity of fear she feels for contamination. During our sessions we attempted some behaviour experiments, but Aby reported this to be too distressing to continue. Aby's behaviours are now escalating, and risk has now increased. She reports having thoughts and plans but no intent to act on these currently, she has a good management plan in place and would engage with the safety strategies discussed. Aby has also disclosed she has a history of an eating disorder and was an inpatient for 2 years (age 12-14) during her childhood. Aby agrees that although she is much better now, this often feels that it could relapse when out of control. Aby lives alone as her relationship has recently broken down due to the levels of OCD behaviours impacting on the relationship. Aby has engaged with psychotherapy for eating disorders when she was younger and has had 2 previous attempts to treat her OCD within primary care. Aby reports although these have been helpful at the time, she has found them difficult to apply, suggesting there is a strongly held beliefs which is difficult to undermine in a brief psychological therapies service. Therefore, we are asking for this patient to be reviewed with your service for consideration for a referral on to secondary care.

Example 2: Written in list form.

Summary: Presenting with severe OCD contamination symptoms, impacted on relationship and now the relationship has ended.

- Previous eating disorder diagnosis, inpatient from age 12-14
- Has attended 6 appointments with ieso, focussed on assessment and formulation, attempted behavioural experiment but Aby reported this too distressing
- Was an inpatient from age 12-14, during which engaged with psychotherapy with good effect. Has attended 2 episodes of care for OCD within primary care with limited successes. Although helpful at the time, struggled to apply any changes outside of therapy
- Beliefs are likely to be strongly held and difficult to undermine due to longevity and historical difficulties
- Risk – has suicidal thoughts and plans but no intent, has a management plan and is happy to engage with this if needed. Risk has escalated since relationship breakdown
- Requesting review of symptoms within the service with a view of needing secondary care involvement

4.5 How to provide a discharge rationale

If your patient falls under the below categories, then no supervision ticket request will need to be sent (please still upload the rationale into the clinical notes):

- The patient has requested to be discharged
- The 7-7 messaging procedure has been followed (this is for cases where the patient has never messaged or those where they have dropped out)

If your patient has recovered, no approval is needed. Please simply submit a discharge letter and this will be acted on as soon as possible.

Non-recovered discharge

If you are discharging a patient who has not reached recovery:

1. You will need to ensure that there is a discharge rationale available in the General Admin Notes (GAN)

2. You will need to submit a supervision ticket for supervisor approval of the discharge, including your discharge rationale (the case will not be closed before this is received)

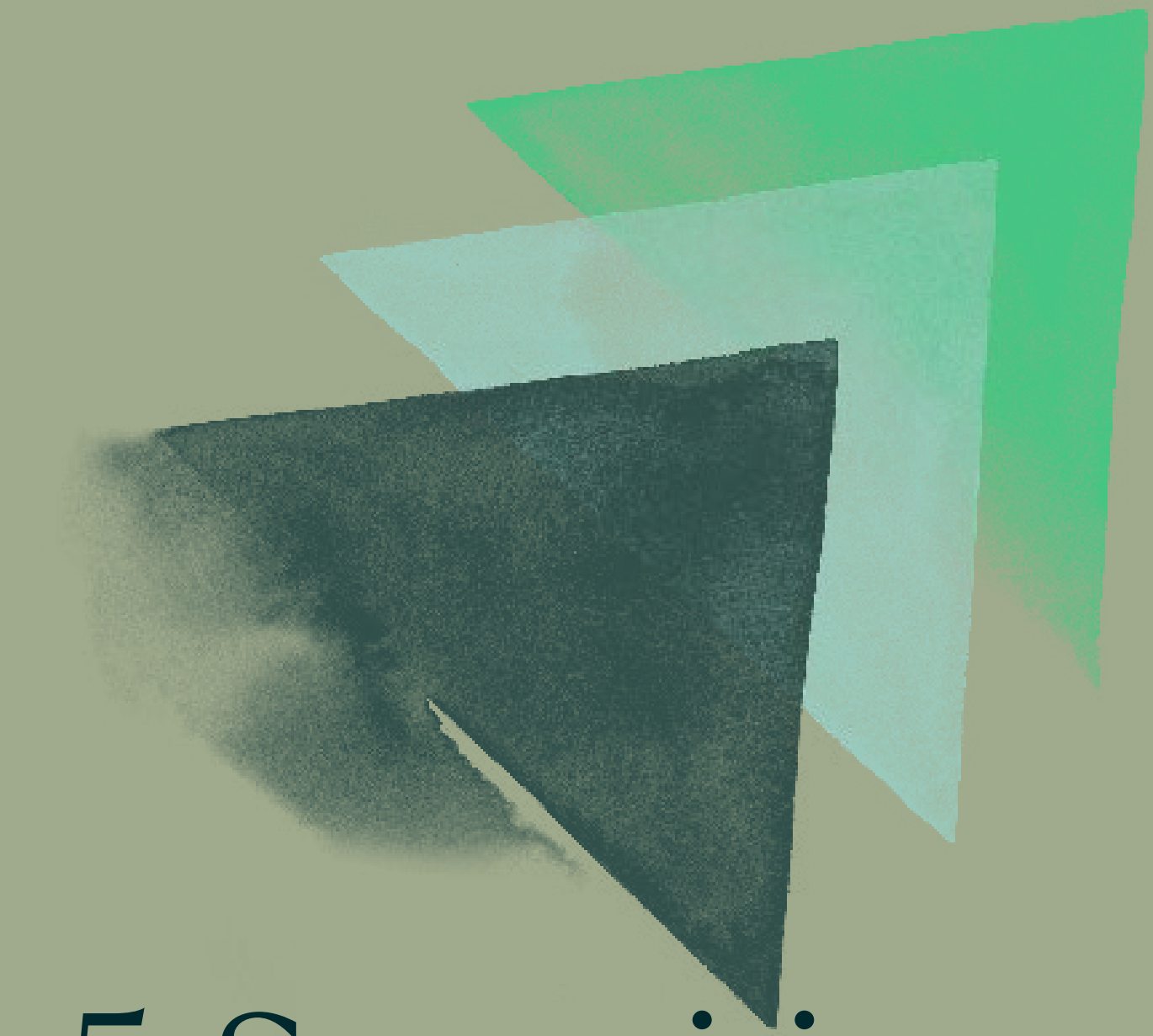
3. On the Hub you can review the **Discharge Rational Checklist** which can help you work through some steps (depending on the reason for discharge) to ensure that you are able to report a clear and detailed rationale, including what has been attempted

4. Our Patient Services team will help to remind you if attempt to you discharge somebody without this rationale

If you are discharging your non-recovered patient as 'completed treatment', the discharge rationale will need approval. **Please do not submit a discharge letter until you have this approval, or it will be cancelled.**

4.6 Gifts

Patients will at times want to show their appreciation for the work you have done and want to thank you by offering to send you a thank you. Please can we request you politefully decline any offers for gifts and explain we are unable to accept gifts as part of our contracting. If you are having difficulties with these types of conversation, please discuss this with your supervisor.



5. Supervision

5.1 Different types of supervision available at ieso

All clinicians, regardless of their caseload, have access to a selection of support and development opportunities. Our supervisors are committed to supporting your learning and development. They advocate reflective practice and encourage and support you to be the very best practitioner you can be. Supervisors have access to all live therapy material to support case management and supervision. Supervision follows the Roth and Pilling competency framework for supervision of psychological therapies.

From our enhanced model of clinical supervision, you can expect:

- A dedicated experienced supervisor who wants to build a collaborative supervisory relationship with you
- A range of 1:1 and group supervision slots available throughout the week
- Option to join small-sized supervision groups with time to reflect on your work and learn with other clinicians
- Ability to raise supervision questions via '**tickets**' on our Therapy Platform for text-based supervision
- On call duty supervision for urgent risk 8am – 8pm every day (including weekends)
- Option to request a debrief after a difficult session
- Case Management and Clinical Skills supervision – may include a mix of case discussions, role-plays, and self-practice/self-reflection

- Smart tools to have an effective overview of your work and provide you with feedback to help you tailor and develop your clinical practice
- Option to request a 1:1 to discuss your skill development

ieso patients should only be discussed with your ieso clinical supervisor and not in supervision outside of ieso.

In accordance with the IAPT supervision models:

CBT Therapists –have access to group or 1:1 supervision with their named clinical supervisor, as well as Case Management Support through text-based supervision tickets.

PWPs – should have Case Management Support delivered by their named clinical supervisor through the supervision ticket system. This is linked to the PWP best practice guidelines (IAPT Reach Out manual) case management approach to flagging and discussing new cases, non-response to treatment, 4 weekly reviews, DNA's, high risk etc.

PWPs are also expected to attend monthly Clinical Skills supervision. This is a safe space where PWPs can discuss patient cases, interventions, processes and contribute to discussions around Step 2 delivery with a supervisor and fellow peers for support.

This supervision model is offered for free. We understand that what is offered will benefit your continued professional development, therefore, clinicians do not pay for attendance at these sessions.

Preparation for supervision and note taking

In preparation for your supervision please spend some time devising a brief case summary and stating a specific supervision question, then submitting this using the Supervision Tool on the Therapy Platform. For information about how to use this, see the Supervision Tool page on the Hub.

Please do not email any patient formulations or supervision prep forms to your supervisor. If you need your supervisor to look at anything, please add it to the General Admin Notes (GAN) and inform them to check there, using the case reference but no other client identifying material.

5.2 How to raise supervision tickets and case management requests on the platform

The supervision Tool/Ticket system on the Therapy Platform allows you to discuss patients and raise concerns for text-based support and case management. We use the Supervision Tool/tickets to have collaborative written discussions about the patients on your caseload. (Establishing suitability, extension requests, or onward referrals/referrals to secondary care etc.) We aim to respond within 7 days.

If you need to create a Supervision Ticket for a specific case, please follow the following steps:

1. Within the Therapy Platform, go to the case that you have a query about
2. In the left-hand side bar, you can see 'Supervision' in the list. Click on it to access the supervision tool
3. Once you are on the 'Supervision' page, you can see a button that says, 'Create Supervision Ticket. Click on it
4. Choose a case management request category from the drop-down list. Please note, you can see a brief description of the categories, once you have chosen
5. Tell us what you are requesting and why in the comment box below. You will need to provide adequate detail here to ensure your case management supervisor can respond accordingly
6. Click 'Create' to submit your request for review
7. Await confirmation. Additionally, the supervisor may come back to you with questions which you will be notified of

Ideally tickets are not for Clinical Supervision. Although some guidance can be given, it is difficult to fully answer in depth clinical queries through non-live supervision. We provide free bookable video supervision which you can book with your allocated supervisor via the Hub. PWPs can request this via their supervisor.

Clinical Supervision can be delivered via live video conferencing, or via the tickets. If you choose to use the tickets to access clinical supervision, be prepared to reflect, enter into dialogue with your supervisor, share hypotheses around formulation, and have more information to uncover. If you are unsure which modality is for you, we encourage you to use both and see. Many people use a combination of the two.

Please email therapist@iesohealth.com with any questions you have about the process or visit the **Supervision Tool page** on the Hub.

5.3 Specific types of Supervision Case Management Tickets

There are a range of Supervision Tickets that you can raise for on demand supervision queries.

- New Patient
- 4-weekly Review
- Clinical Supervision
- Risk: non-urgent
- Risk: urgent
- Engagement Difficulties
- Modality Change
- Other
- Referral back to service
- Request to discharge non-recovered
- Secondary Care referral: non-urgent
- Secondary Care referral: urgent
- Session Extension
- Step-Up request
- Diagnosis Query

In line with best practice guidelines as part of the national PWP role. Every PWP should submit Case Management Supervision tickets for the following:

- Every new patient assessed or reallocated to them (This includes following a 45-minute treatment session for a pre-assessed patient.)
- Every patient following x1 assessment/mini assessment and x3 treatment sessions- known as a 4-weekly review
- Support if required
- High scores

See below a description of each ticket, and some examples of what to include to help your supervisor answer your questions.

General tips on what to include in your supervision tickets:

- Supervisors may not have time to read clinical notes or session transcripts. It is therefore important that you provide sufficient detail. Make sure that reading your request alone will help the supervisor understand the problem/ question fully. Although this can take a little longer, ultimately it will save time by reducing the likelihood the supervisor will need to reply to seek clarification
- We aim to respond to supervision tickets within 4 working days (except Urgent tickets which are responded to within an hour)
- If your supervisor is on holiday, another supervisor may get back to you. It may be responses are slower during your supervisor's leave, but they will email ahead to let you know
- If you don't label the ticket correctly, don't worry! Your supervisor can change the heading of the ticket when they close it

Specific ticket guidance:

NEW PATIENT TICKET

Purpose: For PWPs – allows case management of every new patient in line with best practice guidelines for PWP role.

Information Required: Please try to avoid copy and pasting your entire assessment notes, as all supervisors have access to notes and transcripts. If you can layout the supervision ticket with a clear summary to include:

- MDS/ADSM (e.g., PHQ9 – 10/ GAD – 13)
- Presenting Problem (e.g., Anxiety)
- Patients Risk (e.g., Low – scoring 1 on PHQ question 9, Fleeting thoughts, no plans or intent, protective factor – Kids)
- Patients Goals (e.g., To reduce my worrying thoughts and relax)
- Your Proposed Treatment Plan (e.g., Worry management with relaxation techniques)
- Any Questions (e.g., Do you have any resources on PMR)
- Any other useful factors (e.g., Patient does mention that they do suffer with some health worries – should I provide an ADSM?)

4 WEEKLY REVIEW TICKET

Purpose: For PWPs – allows case management of all patients at the point of review in line with best practice guidelines for PWPs.

Information Required: When raising a 4 weekly review ticket it can be helpful to provide your supervisor with a clear overview based on the current treatment plan

- Presenting Problem (e.g., Depression)
- MDS/ADSM (e.g., PHQ was 14 now 6/ GAD was 9 now 3
- Patient initial Goal (e.g., To improve my motivation to tidy the house and meet my friends at the gym again)
- Treatment Plan (e.g., Behavioural Activation with procrastination tips)
- Engagement (e.g., Attending session regularly and completing tasks in between sessions)
- Sessions (e.g., Completed 1 assessment and 3 treatments)
- Plan (e.g., To complete treatment in final session and go through relapse prevention)

CLINICAL SUPERVISION TICKET

Purpose: To formulate a supervision question ahead of a booked live supervision session and log that a patient's treatment has been reviewed & discussed to guide best practice.

Information required: The patient will likely be described verbally, but anything you feel might be helpful for the supervisor to know ahead of time (such as number of sessions, MDS, risk, presenting problem, protocol, response to treatment and supervision question etc.).

If a particular type of supervision input would be helpful (such as role-play, review excerpt from session, review message etc.) you could also specify this in the ticket.

Possible Action Points: After the supervision session, you and your supervisor can log the discussion with the key points you'd want to remember and any action points for the patient's ongoing treatment.

Action Required by Therapist: After your supervision session, please update the supervision ticket with key reflective points that will be most helpful to guide the next steps of treatment. Your supervisor may also add some notes.

Example:

Group supervision booked 10/10/22:

Number of sessions: 7

MDS: Their PHQ at intake was 18, now 12; GAD-7 16, now 15

Risk: There is no risk present (0 PHQ9 question 9)

Main presenting problem: Patient presents with OCD (OCI= 52). Patient checks windows, doors & appliances; as well as work tasks

Goals: The patient's goals are to reduces checking to 1-2 times; to go back to the gym twice a week; to feel more confident at work

Protocol/ techniques so far: protocol: ERP. Techniques: psycho-ed, formulation, hierarchy

Supervision question: Patient is struggling with ERP tasks/ not completing them. What can I do next?

RISK: NON- URGENT TICKET

Purpose: To share a patient's risk, the management of it so far, and ask for additional guidance as needed. This includes risk to self (self-harm/neglect/thoughts of suicide), risk from others (adult safeguarding/a crime), or risk to someone else identified (child safeguarding). This is for routine enquiries which do not need an immediate response from ieso. If the risk is Urgent (the patient or someone else is at imminent risk of harm), please follow the guidance in section 6.10 on the role of the supervisor in responding to risk and raise a 'Risk: Urgent' ticket which will be responded to within an hour. It's always good practice to log that risk has been discussed and seek support as needed.

In the first instance, please refer to Risk Management Guidance in section 6; and once actioned, always feel free to seek further guidance. Although we advocate clinical judgement and taking appropriate action before asking for help, your supervisor team will be happy to answer further questions, so you are not alone when making risk decisions.

Information Required: See example below for an advised template

Possible Action Points: Your supervisor might review your assessment so far and ask for additional information, make further suggestions (such as additions to a safety plan), or ask for further risk actions to be taken (e.g., writing to the GP to update on changes in risk).

Example:

PHQ 9 Q 9: 2 (more than half the days) Nature/ content of thoughts: Patient has thoughts of 'Everyone would be better off without me' more than half the days

Current plans/ preparations: Has thoughts of falling asleep and not waking up again to avoid the pain/ sadness of the day. No thoughts of means, preparations, or access to means

Current intent to act (0-10: 0 = I definitely won't, 10= I'm certain I will): 2/10. Patient states on some days they think about how they could make it happen; but immediately think 'I couldn't do that' and distract themselves

Historical risk: No previous acts towards life; no current or historical DSH

Current exacerbating factors: Patient has had difficulties at work and feels hopeless that the situation will resolve

Current protective factors: Patient has a very supportive partner and wishes to live; has some hope for the future and wants things to improve Risk Management Plan (RMP): I have sent the 'managing suicidal thoughts' booklet, given emergency numbers and completed risk management plan. Patient has no access to means, talks to partner regularly and has good rapport with their GP

Supervision Question: Any further action needed by the therapist? Should I write separately to the GP?

RISK (URGENT) TICKET

Purpose: For urgent, same-day support around a risk issue that has arisen with a patient.

Information required/actions: See Urgent risk section 6.10 on the role of the Supervisor in responding to risk

ENGAGEMENT DIFFICULTIES TICKET

Purpose: This could be if a patient has surpassed the number of allowed late cancellations/DNAs and you wish to run this past a supervisor, if there's difficulties in booking and confirming appointments, or there has been non-engagement with CBT between session tasks. Please be aware the 2 late cancellations or DNA's are per patient episode, not by therapist or by step.

Information required:

What is the engagement difficulty? Attempts to overcome difficulties so far and patient's response to it? Is patient aware of ieso policies/attendance expectations (this will need to have been messaged to the patient at each breach using templates on the hub)?

Possible Action Points:

- If the patient has surpassed the number of DNA's/cancellations but with a very good mitigating circumstance, there may be flexibility to continue with sessions (to be agreed case by case)
- If the patient has not confirmed multiple appointments within the requested time frame, your supervisor might help you to devise a clear boundaried message for an appointment to be booked & confirmed within a given time frame
- If the patient is not engaging with homework, you might discuss with your supervisor how to encourage this in a supportive manner or bring non-engagement into the patient's formulation. This could be booked as a live video discussion.

Example:

Patient presentation: depression

MDS: PHQ 9: 17; GAD 7: 12

Risk: Low. PHQ 9 Q9: 1. Fleeting thoughts of being better off not here- no intent (0/10).

Work so far: Assessment, 5 areas, baseline BA diary

Engagement difficulty: Patient has now not attended two sessions (DNA). The first time they forgot, the second time they slept in. After the first DNA <date> I sent a reminder of the policy. We talked about ways to prevent them forgetting (alarm on phone). Following the second DNA the patient was apologetic. Engagement with homework has been OK - they completed 3 days of the baseline diary and did find the 5 areas difficult to do.

Supervision question: I am unsure of what to do, as the reasons for not attending are part of the depression.

Reallocation Ticket

Purpose: If a patient or the clinician requests to be reallocated to a new clinician due to a rupture conflict, If the patient has requested this via patient services, your supervisor will be informed and will create a reallocation ticket for you.

1. Information required: Provide information on the context and reasons for reallocation and any actions if any, to resolve it.

Possible action points: If your supervisor agrees to the reallocation, they will then ask you for the following actions:

1. Complete any outstanding admin tasks i.e. clinical records from sessions
2. Complete any outstanding letters
3. Summarise the treatment to date in the GAN for the clinical handover
4. Request to book into supervision (if needed)

When all the actions above have been completed, your supervisor will close the ticket and the case will be reallocated.

Example:

John and I have had a rupture to the therapeutic relationship which is making treatment difficult. John has requested a new therapist at the end of our last session. During the appointment on XX date, we appeared to have a communication difficulty about the homework and compliance to complete it. This has been an ongoing theme throughout treatment. I would like to consider having this patient re allocated to a new therapist. I will book some time with you to reflect on this case and identify any learning points. John has now requested a new clinician.

OTHER TICKET

If your query doesn't quite fit with the suggested headings, and you are unsure, feel free to raise an 'Other' ticket. If it does fit under one of the above, your supervisor will happily guide you and can close it under that heading.

REFERRAL BACK TO SERVICE TICKET

Purpose: If you feel a patient is not suitable for ieso and requires a referral back to the service for review.

Information required: See referral back to service rationale in section 4 ‘How to write a referral back to service’.

REQUEST TO DISCHARGE NON-RECOVERED TICKET

Purpose: Although it is unlikely that all our patients will reach recovery, we do work hard to ensure patients have been given every opportunity to experience significant symptom relief after therapies.

Information Required: You can find full guidance on a discharge checklist here: Supervision Resources: Discharge Rationale Checklist (iesohealth.com). There could be a variety of reasons (such as agreed ending, patient requested discharge, patient disengaged, patient not engaging/ declines CBT approach). If Clinical Rationale, and the checklist above have been considered, discharge can be supported by your supervisor.

Possible Action Points: If you have provided sufficient rationale and discharge is warranted, your supervisor will close the ticket. You can then proceed with the usual admin (discharge letter) and Patient Services will process the discharge. If this supervision ticket has not been closed, the Patient Services Team will not be able to process the discharge and will put it on hold until it has been closed/resolved. If your supervisor has further recommendations/questions, they might suggest continuing with the patient.

Example:

This patient presented as Step 3+ due to severe depression.

PHQ 9 at intake: 21; now 13

We have completed __ sessions and they have engaged well.

We covered BA, cognitive restructuring, formulated longitudinally and worked on intermediate beliefs/ acting in line with new beliefs (behavioural experiments). I brought them to supervision (see previous ticket) and we agreed 3 sessions to give time for the patient time to consolidate and act in line with the ‘new me’ formulation. They have reported subjective benefits and learning from treatment but acknowledge they may need more time to work towards longer term goals.

Supervision Question: Can we end treatment now?

SECONDARY CARE REFERRAL: NON- URGENT TICKET

Purpose: For routine Secondary Care Referrals. Cases where a non-urgent screening and intervention are needed. Examples include diagnosis indicated not worked with within ieso (Axis II), highly impaired functioning not responding to primary care intervention; complex/type II trauma indicated.

Information Required: It is helpful to provide as much detail about the presentation in the supervision ticket as possible to help your supervisor support decisions about onward referral. This information can be used in any referral forms or rationales sent to the service.

Possible Action Points: If the secondary care referral is supported by your supervisor, and enough information is provided, please check the site protocol to see whether the protocol is to complete a referral form, or to add the rationale to the GAN in the form of a 'referral letter'. Once the information required is in the GAN, your supervisor will approve this, close the ticket and the Patient Services team will send the referral. You can discharge the patient once we have confirmation that the referral has been accepted. If risk is high and an urgent response needed, please see 'Secondary Care Referral: Urgent' below.

Example:

I have had two sessions with this patient.

They score 24 on PHQ 9 (severed depression) and 21 on GAD 7 (severe GAD)

During our second appointment the patient shared childhood trauma, that was prolonged and repeated. The patient described not having a sense of safety since this point. During their teen years, they regularly self-harmed and had CAMHS input. In adulthood, they have experienced abusive relationships. They are currently safe from harm, but they continue to feel depressed, have low sense of trust in others, relationship difficulties and describe frequent flashbacks to childhood events. Although they currently do not self-harm, they do describe dissociation and feeling detached regularly. They are struggling to work and have limited social support. Their GP has suggested EUPD diagnosis, but this has not been confirmed. I wonder if this patient's needs might be better met in Secondary care services due to multiple traumas, severe depression, history of CAMHS input, isolation, and frequent dissociative symptoms.

SECONDARY CARE REFERRAL: URGENT TICKET

Purpose: For Urgent Secondary Care Referrals. Cases where an urgent screening and intervention are needed. Examples include symptoms of an active psychosis, high distress and volatile behaviour requiring a response time quicker than a routine referral.

Information Required: It is helpful to provide as much detail about the presentation in the supervision ticket as possible to help your supervisor support decisions about onward referral. This information can be used in any referral forms or rationales sent to the service.

Possible Action Points: If the secondary care referral is supported by your supervisor, and enough information is provided, please check the site protocol to see whether the protocol is to complete a referral form, or to add the rationale to the GAN in the form of a 'referral letter'. Once the information required is in the GAN, your supervisor will approve this, close the ticket, and the Patient Services team will send the referral. You can discharge the patient once we have confirmation that the referral has been accepted.

Example:

I have had two sessions with this patient.

They score 24 on PHQ 9 (severed depression), Qu9 was 2 and 21 on GAD 7 (severe GAD)

During our first appointment the patient reported hearing voices. The patient told me they regularly hear voices and have been managing these until recently when they have suddenly become worse. They reported they have had these experiences before but have recently stopped taking the medication prescribed. They no longer have contact with secondary care services. Reports voices are getting more aggressive and is not sure what is real and what is not. Has not yet acted on any command from voices.

Risk: Scored 2 on question 9, no immediate concerns to harm themselves, but recognises symptoms have returned. Safety plan in place and is willing to tell family and friends of the current situation to gain support.

SESSION EXTENSION TICKET

Purpose: Although the average number of sessions for Step 3 is 6, and Step 3+ is 9, this is not a limit. We ask for session extension requests before session 6 and every 4 sessions thereafter for both Step 3 and Step 3+.

This is a valuable exercise to pause and reflect on sessions so far, what has been covered, and where you and the patient are 'on track'.

Information Required: See example below, but we will need enough information about treatment so far, how many sessions are being requested and proposal for further sessions.

Possible Action Points: Additional sessions approved, less than requested sessions approved, more information requested.

Example:

Presenting problem: GAD
MDS: PHQ 9: 12; GAD 7: 12
Number of sessions so far: 5

Protocol (if appropriate) or treatment so far: Formulated using Dugas; worry awareness training; hypothetical vs practical problems; problem solving

Engagement: Engagement is good, patient completes homework & reports sessions have been helpful. No further supervision questions due to treatment going well do far.

Number of sessions requested: 4 (taking to 10)

Proposed content of sessions: Continuation with Dugas protocol (challenging positive beliefs about worry; behavioural experiments re. tolerating uncertainty and if appropriate, worry exposure)

STEP UP REQUEST TICKET

Purpose: Patient is meeting criteria for Step 3+, and request is for step to be changed from 3 to 3+.
Information Required: any information that will confirm whether the patient meets the following criteria for Step 3+: Step 3+:

- Depression (including that relating to antenatal and postnatal mental health):
- Severe Depression (DSM Criteria and/or PHQ9 20-27)

AND/OR

- Patients with common mental health problems (as listed in inclusions above) with additional psychosocial needs. They may present with co-morbid or historical difficulties (which will not be the focus of therapy) e.g., functional ASD, CFS, Chronic Pain etc.)
- Severe OCD
- Possible Action Points: This will either be approved & changed by your supervisor, or if criteria are not met, will be left as Step 3. If the case does not meet Step 3+ criteria, do not worry. If there are other factors not included in the criteria that will impact on the trajectory of treatment and amount of time needed for sessions, you can still extend sessions as needed using the 'Session Extension' Ticket.

Example:

I have assessed this patient and they score 19 on PHQ 9 question 9. They have also been diagnosed with Chronic Fatigue - which is impacting their energy and mood; and they become frustrated with themselves that that they can't do what they used to do. We are formulating using Beck, while acknowledging the impact of their condition on their depression/energy and activities. Would this patient meet Step 3+ criteria.

DIAGNOSIS QUERY TICKET

Purpose: If you are unsure of what to log for a patient's diagnosis and/or they present with multiple presentations. To ensure that we measure recovery accurately, it's important to have a correct diagnosis and corresponding ADSM that corresponds with the treatment protocol/plan.

Information required: Any current information about symptoms, or summary of formulation so far.

Possible Action Points: Your supervisor might ask some additional questions or recommend another ADSM is sent with a next appointment, or if a shared decision is come to, you might be asked to change 'Diagnosis' and 'protocol' on the case summary.

Example:

This patient has attended 2 sessions and is presenting with GAD type worries, but also depression (PHQ 9= 17; GAD7= 18). I am currently unsure whether to look at worries from a Dugas perspective, or whether worries are more related to self-criticism and depression.

Most recent 5 areas summarised below-

Situation:
Thoughts:
Emotions:
Behaviours:

Question: Should the diagnosis be depression, or GAD, given that GAD is in severe range?

5.4 Using data to improve outcomes

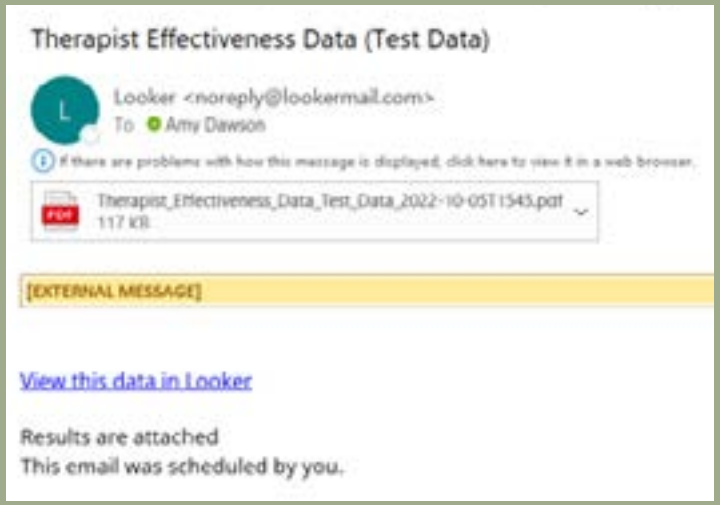
Clinicians working with us have proven themselves to be above standard in their ability to deliver evidence-based interventions with fidelity to the CBT model. Once you begin treating patients, ieso begins to collect a wide range of data that is used to inform future continuing professional development. The data is made available to you monthly following successful completion of the validation process.

There are two main ways that we feedback the data to you to help you learn and grow as a clinician:

1. The Therapist Effectiveness Rating ("TER")

2. The Therapy Insight Model ("TIM") which is our automated model based on the Cognitive Therapy Scale-Revised (CTS-R)

We will provide you with your individualised data monthly. Please note the email may arrive to your spam/junk or clutter inbox so please check on or around the 1st of each month. The data will be emailed to you by Looker, a secure data visualisation platform used at ieso and will look like this:



Your individual data profile

- Therapist Effectiveness Rating (TER)

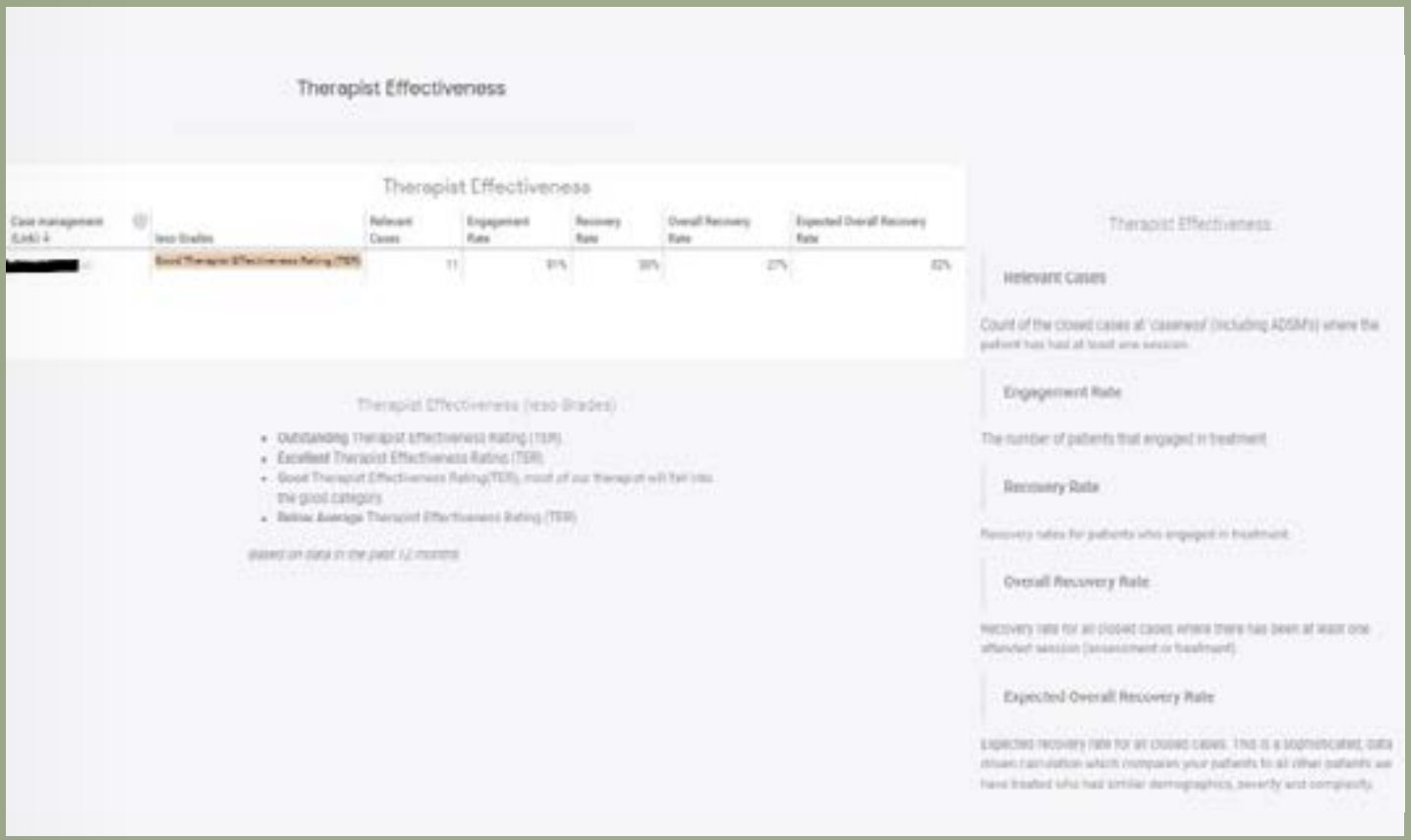
Rather than use the basic recovery rate to establish clinical effectiveness, we use a complex statistical model to tell us how effective each affiliate CBT therapist is. We call this our 'Therapist Effectiveness Rating' (TER). This model essentially controls for your case mix and gives a more balanced view than recovery rate alone. For example, if therapist A has a recovery rate of 75% and therapist B has recovery rate of 40%, it is not fair or reasonable to assume that therapist A is 'better' than therapist B, as there are so many patient and service variables that could mean therapist A has randomly been allocated less complex patients.

Our TER takes all these complex variables into account and can produce a much more accurate measure of effectiveness tailored to each practitioner. It is also able, in real time, to predict an expected recovery rate for you to be able to benchmark your work against. This is a sophisticated, data driven calculation which compares your patients to all other patients we have treated who have had similar demographics, severity, and complexity.

It's important to understand that the basic message is largely unchanged, engaging with patients and treating them to recovery will result in a higher TER rating.

Your TER cannot be calculated accurately until you have completed treatment with 10 patients, but we will begin our analysis from your very first session. Therefore, we recommend that you begin with a caseload of at least five patients, as to treat fewer from the outset will delay the calculation of this rating, and therefore delay the point at which we can give you accurate feedback on your work. It is also far easier for you as a therapist to adapt your existing skills to work within our methodology if you treat a higher caseload from the outset. The more patients you treat, the more feedback and guidance you will receive. We believe that as CBT therapists we should be learning from every patient that we treat.

Here is an example of a TER report:



- Therapy Insight Model (TIM or CTSRR)

The AI Scienetists' have also developed an automated CTS-R which we are calling the CTSRR. This is based on a model we call TIM, used in our published research papers. We use TIM in supervision and training to provide you with feedback on your work. Normally in CBT you might do a CTS-R a couple of times a year, and whilst we believe that this is a useful exercise, it does not give you the most effective overview of your work in real time. Imagine if you could have a CTS-R on every single therapy session you deliver - that's what we do with TIM.

Here is an example of a TIM report:

- Further data

You will also receive details of the current disorders that you are working with and the current protocols that you are using (see below):

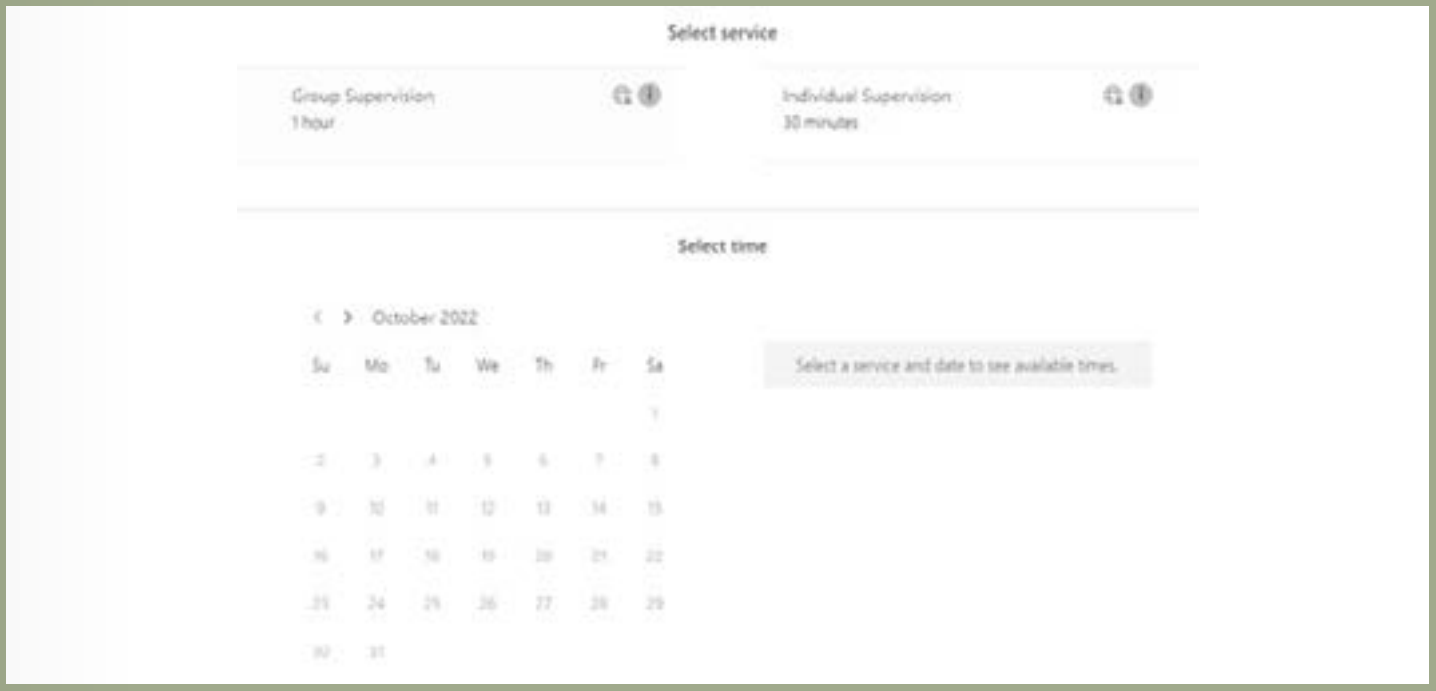
We really hope that this data can help you identify your strengths and reflect on areas you would like to improve. We recommend periodically booking in with your Clinical Supervisor for a 1:1 meeting to support your self-reflections on the data. Reflecting on patient feedback and outcome data is an important part of Continued Professional Development.

If you have any concerns or questions, please do not hesitate to contact your Clinical Supervisor who will be there to support you.

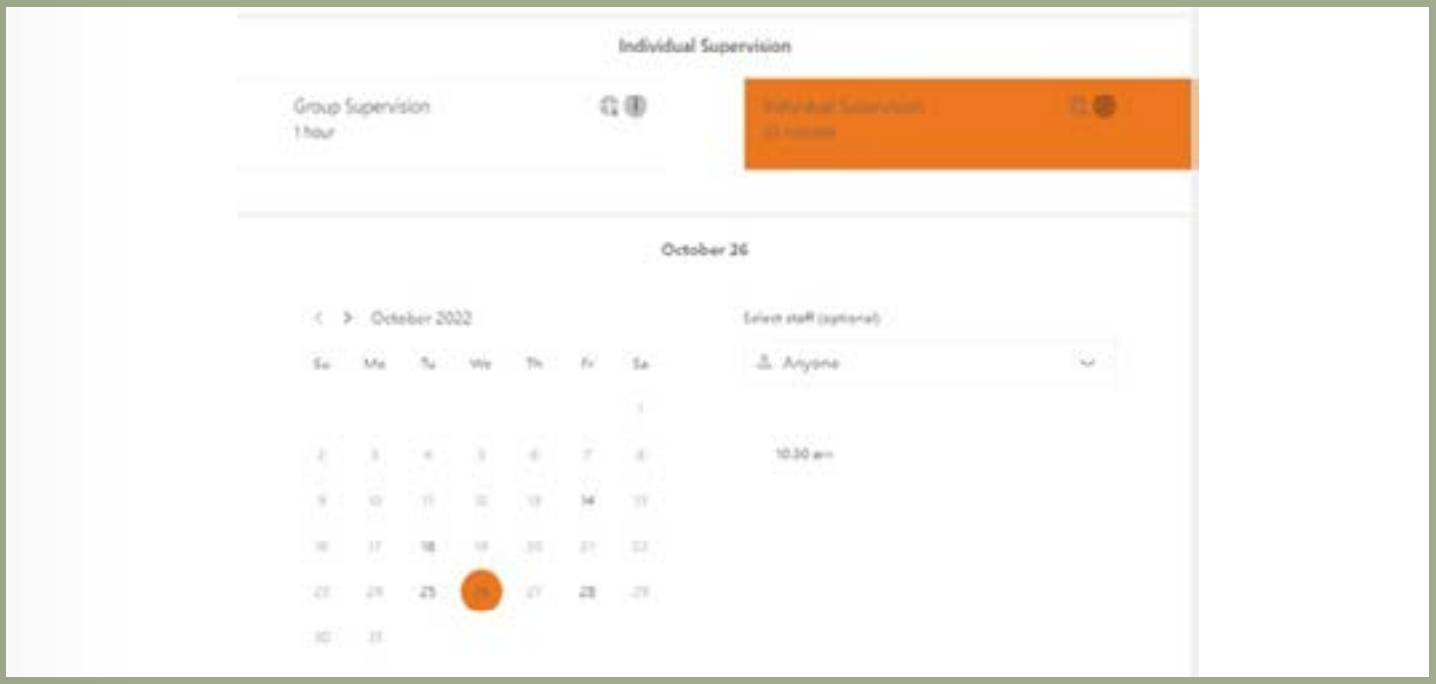
5.4 How to access group supervision for CBT Therapists

We encourage clinicians to access supervision regularly, and to discuss any difficulties within your practice. Therefore, we want to make supervision accessible as possible. To make a booking for your assigned supervision, log into the Hub, and select the supervision section. This will open a page showing your assigned supervision. Select the area with “your supervisor’s name”.

This will bring up a page showing the supervisor’s name and the supervision options.



Select the type of session you would like, 1:1 or group. Once this is selected, the options of the 1:1s and groups will appear on the diary in bold numbers. You can then select the date and the time options will appear on the right-hand side.



Select the date and time you would like and complete the mandatory information at the bottom of the form, (name etc.), and click the orange “Book” box. You and your supervisor will then receive confirmation of the booking.

6. Risk assessment and management

6.1 Overview

Risk assessment and management is a continuous process throughout therapy. As in all services, Clinicians need to ensure that:

- New Patients are automatically sent a risk assessment form to complete at the time of scheduling the in initial appointment
- A Risk Assessment form can be sent subsequently as selected by the clinician
- Risk is assessed via discussion at assessment and at further intervals, where relevant and necessary
- Where risk to self is evident, clinicians must ask the patient to rate their intent to harm/kill themselves on a 0 – 10 rating scale, where 10 indicates 'definitely will' and 0 indicates 'definitely will not.' This discussion must be documented in the clinical notes
- Where risk is identified, clinicians should ensure that the patient is suitable for treatment within our service, and a risk management plan is collaboratively developed and agreed upon
- All risk issues and actions must be documented in the clinical notes

It is important to recognise that whilst we need to take all reasonable steps to manage and highlight risk, we are not able to provide a crisis service. See onward referrals due to risk issues for further information.

Clinicians hold primary responsibility for assessing and managing risk, ieso provides a number of options for support with this both in and out-of-hours. We encourage you to ask for support if required! (See section 6.10 for support and supervision options.)

Support is available from Monday to Friday between 9.00am-5.30pm. Emails about risk which require urgent action (e.g., contact to be made with the G.P.) should be raised as a 'Risk (Urgent)' ticket on the platform.

6.2 Risk identified outside of appointment

SELF-ASSESSMENT QUESTIONNAIRE (SAQ)

All patients are asked to complete a self-assessment form when they are referred/self-refer to our service. Occasionally patients may communicate high levels of risk on this form.

- If you read the SAQ **several days** before you are due to assess the patient and the patient has communicated that they might be at risk (or if the patient DNAs their assessment) then you should message the patient with the 'New patient risk message' template (see Message Template section on the Hub).

If the patient does not respond/you are unable to book an appointment, please raise an Urgent or non-Urgent Risk Supervision ticket depending on level of risk for supervision guidance.

- If you read the SAQ **on the day of** your appointment, please complete a full risk assessment in the therapy session. You will need to allow sufficient time to do this whilst also building a relationship with the patient. Therefore, your initial assessment may run into two sessions. (Note: even if you continue to assess in your second session, please select the appropriate step and book it as a 'treatment' session.)

Note: In terms of patient expectations, they are informed that this form will be read by their Clinician/PWP on the day of their first appointment, and that if they need more urgent support that they should contact their GP, A&E, the Samaritans etc.

PHQ-9 ALERT

You will receive an alert by email if a patient scores 3 on question 9 of the PHQ-9. An alert is only meant to prompt you to reflect on risk. If you receive an alert, you do not need to do anything immediately, but within 48 hours you should have thought about any steps you may need to take with the patient.

If the patient is new to you and you have not seen them yet, you should message the patient with an adapted version of the 'New patient risk message' template (see Message Template section on the Hub).

If the patient does not respond/you are unable to book an appointment, please raise an Urgent or non-Urgent Risk Supervision ticket depending on level of risk for supervision guidance.

You should not discharge a patient without addressing risk issues, even if they are not engaging.

RISK COMMUNICATED IN MESSAGES

Patients may message you at any time and you will receive an email alerting you that a message has been sent. We do not expect you to check messages immediately, but please respond within 48 hours.

By the time you receive the message the patient may no longer be feeling as distressed. However, you should message the patient validating their distress and if appropriate ask for confirmation they are able to keep themselves safe. If you do not hear back, please use your professional judgement to take further actions in proportion to risk indicated.

If risk is not indicated as high, please gently remind the patient that we are not a crisis service and that if they are still feeling at risk then they should contact their GP. If there isn't a risk management plan in place, you should send the

'Noticing and Managing Suicidal Thoughts' ieso document in the Risk Resources section in the Hub. You should state that you can discuss what happened at your next appointment. You may wish to send another Risk Assessment form via the Therapy Platform for completion before the next session.

If you read a very recent message that indicates high level of risk, you may need to:

- Call the patient (withholding your number)
- Call 101, ensuring that the operator transfers you to the emergency services of the area of the patient's location, and ask the police to do a welfare check
- Dial 999
- Call the out-of-hours GP service

Following any actions like this, please open an "Urgent risk" ticket to gain support or to inform your supervisor of any actions you have had to take and document what steps you have taken in the General Admin Notes (GAN).

6.3 Risk assessment and management at initial and ongoing appointments

When risk is identified in an appointment, it is important to prioritise this and complete a full risk assessment to ascertain safety and the level of care needed (see guidance below).

ASSESSING RISK:

Nature/content of thoughts: be specific and ask what thoughts they have had around self-harm or suicide

If recent attempt: date of attempt, what was done, outcome (hospital? GP support? Crisis Support?), how patient feels following attempt, any noted or absence of remorse, safety now (see intent below)

Current plans/ preparations: do they have instant means? Have they collected or purchased means? Have they done extensive research? Do they have a date they'd planned?)

Current intent to act: (0-10: 0 = I definitely won't, 10= I'm certain I will)

Historical risk: attempts/ history, whether they feel the same way now, how they feel about previous attempts if there are any, or any prior secondary care/ crisis support. If imminent risk- may not be important to know, but if you have time to assess risk further, you can always check previous assessments (SAQ or GAN's) as this might contain historical information.

Current exacerbating factors: isolation? Recent life event e.g., relationship break up, bereavement by suicide? Alcohol/ drug use that could increase impulsivity?

Risk from others: Any identified risk from others, including safeguarding concerns (see safeguarding section). Internet safety concerns, reported bullying, domestic violence, stalking.

Current protective factors

Risk Management Plan (RMP): Do you have a RMP in place? Has the patient given confirmation that they can keep themselves safe? Do they have good resources/ support? Anyone else who is aware? Likelihood of being able to keep safe until next session (0= I am not confident I can; 10 = I am completely confident I can'.

POTENTIAL ACTIONS AFTER RISK ASSESSMENT:

The Clinician should take appropriate action, depending upon whether they judge the risk level to be low, medium, high, or urgent. Therapists are expected to use their clinical judgement and seek support as necessary. Please see section 6.10 'Role of Supervisors/On call Clinicians' for details of the Clinical support available to you when managing risk.

In cases where the risk level is judged to be **low/medium**, appropriate actions may include:

- Taking time in assessment to explore risk and protective factors

- Establishing an agreed upon meaningful safety plan/risk management plan
- Consideration of contacting GP (NB: If there is a change in risk profile or during treatment sessions, see **updating the GP** on risk issues. If risk is identified following assessment, include this in the assessment letter.)
- Discussion of risk assessment and any actions in routine clinical supervision

In cases where the risk level is judged to be high, in addition to the previous actions the following may also be appropriate, including:

- **Informing the GP** of risk and management plan
- Consultation of site-protocols for area specific risk procedures
- Consideration of a secondary care referral
- Creating an URGENT risk supervision ticket to seek same day ieso clinical support

If you think that **the patient (or other relevant adult/child)** is in immediate danger, you will need to act. The following actions may be appropriate:

- Calling the patient (withholding your number)
- Calling 101 and ask the police to do a welfare check
- Dialling 999
- Calling the out of hours GP service
- Writing a risk letter for the patient's GP

Open an **urgent risk ticket** to gain support or to inform your supervisor of any actions taken.

For this information in visual form please see the 'Risk flow chart' in the Risk Resources tab on the Hub.

INFORMING PATIENT SERVICES:
This is an important additional step as Patient Services are responsible for updating the services' patient management systems and can action any letters or messages that need to be sent to professionals via secure channels.

Please detail in the general admin notes (GAN) any highlighted risk and any risk letters that need to be sent urgently.

Then send an email to Patient Services about anything which requires urgent action (e.g., contact to be made with the G.P.) contacting: therapist@iesohealth.com with the subject line – 'RISK/URGENT: Site and patient reference number. (Without including any patient identifiable information which should only be in the clinical notes secure in the Therapy Platform for them to pass on.)

6.4 Creating a Risk Management / Safety plan

When you have assessed risk and have identified that a patient is presenting with risk of suicide or self-harm, it is good practice to create a safety plan together.

An effective safety plan will help patients to identify personal ways of managing their safety and to understand when they should reach out for further support. Usually, you would start by looking at coping strategies the patient is able to use, such as distracting themselves from thoughts, or calming/enjoyable activities. You would then move on to look at the support system around them and how they can best utilise this, identifying who they feel comfortable talking to. For the last part of the safety plan there is a focus on what they can do and who they can reach out to when they feel like they need further support managing their risk – this would include emotional support services and mental health crisis support numbers.

The safety plan should be filled out together and should feel agreeable to the patient. The plan is not about guaranteeing their safety but about supporting the patient to learn how to manage their own risk and know when to reach out for additional support.

It's helpful to have a shared document that you both have access to and can refer back to when needed.

See the section on the Hub with further Risk resources for the template of the Safety Plan.

6.5 Safeguarding Adults and Children at Risk: overview and using Site Protocols

It is expected that you will integrate your knowledge from prior professional training into your practice to apply the principles of safeguarding in a safe and patient-centred way.

As an overview, we expect clinicians to act according to the risk, for example:

- By writing a safeguarding referral yourself and checking referral routes on site protocols
- Sharing risk concerns with GP

Consult the Site Protocols for the exact procedure for reporting safeguarding concerns. For example, there may be:

- A specific referral form
- A rule that you must inform the GP
- A rule that you must inform the referring organisation by summarising the situation and bringing it to the attention of a supervisor
- A clinical team member may need to first speak with the safeguarding team and/or specific service

Make sure clinical notes, including any telephone calls, are up-to-date and accurate.

Unless there is an imminent risk, seek support from your supervisor or the clinical team first by creating a non-urgent risk ticket. If it is an imminent risk, inform them afterwards via an urgent risk ticket.

It is the clinician's responsibility to ensure that an assessment of each patient's risk is carried out throughout treatment and, where required, a plan of action is formulated.

Clinicians should consider the needs of the parent/s and/or carers of the child/ren and be aware of where to refer them, to obtain additional support. Clinicians need to consider how a patient's condition may impact on any child/ren that their patient may come into contact with, either as a carer of that child or as a professional with responsibilities for children, for example: a teacher, teaching assistant, nurse or childminder.

Clinicians should record details of the patient's responsibilities in relation to children and reflect on the needs of children and parents/carers.

Clinicians should also consider the needs of a child who is caring for another child or an adult. This might include that child's right to request an assessment of their own needs.

In the case of any concern arising over the safety of a child/ren, the duty of care that the clinician has to that child/ren overrides any obligation to the patient, parent, or carer.

As well as this information, please check the Site Protocols for the procedures you need to follow when reporting safeguarding issues. The Site Protocols will provide you with the information you need for each site and contract.

It is the clinician's responsibility to pass on and/or make relevant safeguarding referrals as per these guidelines. Support and Guidance can be sought from the Clinical Supervisor or any other member of the Clinical Team see section 6.10 below.

Clinical Supervisors: Routinely, clinical supervisors will be the first point of contact for clinicians to discuss concerns about safeguarding via a 'Clinical Supervision' ticket if the risk is not urgent (see 5.2 on **creating a ticket** and 5.3 on the **different types of ticket**). The Clinical Supervisors role is to support and facilitate further action to be taken when a risk of harm to an adult or child/ren is identified. For example, this may be supporting the clinician to make a direct referral

to Adult/Children's Social Care or collating information to liaise with the local service to ensure safeguarding concerns are documented, and further action taken in line with the service's policies and procedures.

If a concern arises about the safety or wellbeing of a child (or unborn child) it is essential to seek guidance. The Clinical Supervisor and/or Clinical Management Team are available to support and offer guidance see section 6.10 below.

PROCEDURES FOR REPORTING SAFEGUARDING CONCERNS ACROSS DIFFERENT SITES:

All procedures for reporting safeguarding matters can be found in the Site Protocols on the therapist hub linked to each site and contract. It is best practice and policy that it is the clinician's responsibility to pass on and/or make direct safeguarding referrals as per these guidelines.

6.6 Specific categories of abuse and safeguarding reporting

The following is not an exclusive list of categories of abuse, both those where there are special considerations for safeguarding reporting.

- Physical abuse
- Domestic violence or abuse
- Sexual abuse
- Psychological/emotional abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational or institutional abuse
- Neglect or acts of omission
- Self-neglect

For further guidance please see the documents below:

Adults: **https://www.rcn.org.uk/Professional-Development/publications/adult-safeguarding-roles-and-competencies-for-health-care-staff-uk-pub-007-069**

Children: **https://www.rcn.org.uk/professional-development/publications/pub-007366**

DISCLOSURE OF HISTORICAL ABUSE

In the event of a patient disclosing past abuse, the clinician should ascertain whether the alleged abuser/perpetrator has current contact with children. The patient should be advised of a professional responsibility to safeguard children. Where the alleged abuser/perpetrator still has contact with children, this will need to be referred to the local authority Children's Social Care Service for further investigation by the local lead. The Clinical Supervisor and/or Clinical Management Team are available to support and offer guidance via raising a supervision ticket. If the risk is not urgent, this is through submission of a 'Clinical Supervision' ticket. If this risk is urgent, then this is through an 'urgent risk' ticket.

FEMALE GENITAL MUTILATION

A mandatory reporting duty which requires specified professionals to report known cases of FGM in under 18s to the police and to Children's Social Care. All cases of identified FGM should be reported to **your Clinical Supervisor** who will discuss with the ieso Safeguarding Lead who will provide advice, guidance, and signposting to relevant specific support agencies. This information will also need to be reported to the police. If the risk is not urgent, this is through submission of a '**Clinical Supervision**' ticket. If this risk is urgent, then this is through an 'urgent risk' ticket.

Forced marriage Forced marriage is a term used to describe a marriage in which one or both of the parties are married without their consent or against their will. A forced marriage differs from an arranged marriage, in which both parties' consent to the assistance of their parents or a third party in identifying a spouse. In a situation where there is concern that an adult at risk is being forced into a marriage they do not or cannot consent to, there will be an overlap between action taken under the forced marriage provisions and the Safeguarding Adults process. In this case action will be coordinated with the police and other relevant organisations. This scenario must always be discussed with your clinical

supervisor using an urgent risk ticket who will report to the ieso Safeguarding Lead. The police must also always be contacted in such cases as urgent action may need to be taken.

HATE CRIME

A hate crime is any criminal offence that is motivated by hostility or prejudice based upon the victim's:

- disability
- race
- religion or belief
- sexual orientation
- transgender identity

Hate crime can take many forms including:

- physical attacks such as physical assault, damage to property, offensive graffiti, and arson
- threat of attack including offensive letters, e-mails, abusive or obscene telephone calls, groups hanging around to intimidate, and unfounded malicious complaints
- verbal abuse, insults or harassment, taunting, offensive leaflets and posters, abusive gestures, dumping of rubbish outside homes or through letterboxes, and bullying at school or in the workplace.
- the use of electronic media to abuse, insult, taunt or harass

If the adult meets the criteria set out in of this policy, then **any safeguarding concern that is also a hate crime should also be reported to the local Police**. The Clinical Supervisor and/or Clinical Management Team are available to support and offer guidance via raising a supervision ticket. If the risk is not urgent, this is through submission of a '**Clinical Supervision**' ticket. If this risk is urgent, then this is through an '**urgent risk**' ticket.

PREVENT:

Preventing radicalisation to extremism. The scope of the Prevent Duty covers terrorism and terrorist related activities, including domestic extremism and non-violent extremism. Prevent defines extremism as: "vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces" Radicalisation is defined by the UK Government within this context as "the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups."

All Prevent related issues should be discussed with your **Clinical Supervisor** via **raising a supervision ticket**. If the risk is not urgent, this is through submission of a 'Clinical Supervision' ticket. If this risk is urgent, then this is through an 'urgent risk' ticket. Your supervisor will report this to the ieso Safeguarding Lead.

MODERN SLAVERY/HUMAN TRAFFICKING:

For any concerns relating to a child or adult becoming a victim of modern slavery or human trafficking then a referral should be made to the National Referral Mechanism as soon as possible. **Clinical Supervisors can support** this process via **raising a supervision ticket**.

More information can be found here: **https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slavery-england-and-wales**

6.7 What information might I need to report a Safeguarding Concern?

ADULTS AT RISK

To facilitate an onward referral and/or information sharing direct to Adult Social Care or the Police the following information will be required:

- Full name, address and contact details of the patient
- The date of the alert (how this information was obtained)

- The type and nature of the concerns (as specific as possible)
- If consent to share information has been obtained
- Names of the alleged perpetrator

The local authority has responsibility for adult protection investigations and will investigate allegations of abuse. The local authority will decide whether to proceed with an investigation and will be the lead agency for that investigation. Requests for clinical information will be in accordance with ieso's confidentiality policy and will be on a need-to-know basis to support a thorough investigation.

CHILDREN AT RISK

Understanding the purpose of the Children's Social Care assessment is essential in providing adequate information to children and parents/carers about what to expect, including:

- gathering important information about a child and family
- analysing their needs and/or the nature and level of any risk and harm being suffered by the child
- deciding whether the child is a child in need (section 17) or is suffering or likely to suffer significant harm (section 47)
- providing support to address those needs to improve the child's outcomes and welfare and where necessary to make them safe

To facilitate an onward referral and/or information sharing direct to Children's Social Care or the Police the following information will be required:

- Full name, address, and date of birth of the child/ren
- Contact details of the parent/carer/professional we are working with
- Child's developmental needs
- Capacity of child/ren's parents or carers to meet those needs including external factors
- The date of the alert (how this information was obtained)
- The type and nature of the concerns (as specific as possible)
- If consent to share information has been obtained
- Name(s) of the alleged perpetrator

The local authority has responsibility for safeguarding investigations and will investigate allegations of abuse. The local authority will decide whether to proceed with an investigation and will be the lead agency for that investigation. Requests for clinical information will be in accordance with ieso's confidentiality policy and will be on a need-to-know basis to support a thorough investigation.

Concerns relating to communication with other professionals: If, having reported a suspected incident of abuse or neglect, the clinician is concerned that the local authority is not responding appropriately to the concern, then the clinician should communicate that concern to the Clinical Supervisor and/or clinical management via **raising a supervision ticket**. If the risk is not urgent, this is through submission of a '**Clinical Supervision**' ticket. If this risk is urgent, then this is through an '**urgent risk**' ticket.

6.8 Confidentiality and Safeguarding Reporting

PATIENT CONSENT

Clinicians should seek the consent of the patient before acting, however there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give it or possesses capacity but refuses to give it.

If obtaining consent would increase the risk to the adult or child, then action should be taken and a plan to obtain consent and safely support involvement must be considered at an early stage.

REFERRING A SAFEGUARDING CONCERN WITHOUT PATIENT CONSENT

All safeguarding concerns that evaluate whether a patient is experiencing abuse or neglect, or at risk of experiencing abuse or neglect, should be referred to local Safeguarding authorities. This is regardless of a patient having capacity or there being no greater public interest considerations. It should clearly be documented if the patient has consented

to or declined, and are aware of, said referral, alongside their reasons and wishes for sharing or refusing consent. The professional must ensure they document all notes regarding the reasons for referral and what the patient's wishes were. If gaining consent would put the adult at further risk, then this referral ought to be made without consent or knowledge. All referrals received will be reviewed by the authorities in deeming the necessity of subsequent action, and in some cases action may not follow. A record should also be made of what information the individual was given.

6.9 Clinical Notes and Safeguarding Reporting

Clinicians and staff should maintain chronological notes on the therapy platform in the General Admin Notes (GAN), that document the events, details, decisions, and action.

The notes should clearly identify that safeguarding concerns have been raised and staff should also record any enquiries, consultations and referrals that have been made, and the outcome of the discussion.

Full details of the safeguarding concern, any immediate action taken, and contact details of other professionals involved, should be documented in the GAN.

If an individual or child/ren is at risk, action may be required to ensure the individual or child/rens' safety before completion of these notes.

6.10 Role of Supervisors/On call Clinicians in managing risk and safeguarding issues

Our supervisors do their best to provide timely support and guidance but even if they work full-time, they cannot be on call 7 days a week. Therefore, with risk and safeguarding issues, you will need to act on your own initiative, and after actions to assess/manage risk have been taken, use our on-call clinician support (see below).

Overview of support options relating to risk levels:

Your Clinical Supervisor will be your main point of contact for routine discussions of risk assessment and actions, and 1:1 ad hoc supervision to debrief following significant risk events. They will also be able to discuss authorisation for reasonable additional time to be paid where you have done a significant amount of work contacting out-of-hours services.

NON-URGENT RISK TICKETS:

For low to medium risk issues where you wish to check your risk assessment and management ideas you can create a 'non-urgent risk' supervision ticket (see section 5.3). A supervisor will get back to you within 4 days.

URGENT RISK TICKETS – WHAT TO INCLUDE:

On call Clinicians/Supervisors: For high-risk issues needing same day risk support during office hours (Monday – Friday 9.00am- 5.30pm) you can use the Supervision Tool and raise an 'Urgent Risk' ticket. So that the Clinician covering can respond quickly and effectively, please ensure you include sufficient detail about risk in the Supervision ticket. A format for presenting this is presented below:

Risk (Urgent)

URGENT RISK reported by patient, see details below:

Current PHQ 9 Q9 score =

Current suicidal thoughts =

Current suicidal plans =

Current suicidal intent rating from 0-10 (0= not at all, 10= certain I will) =

Past risk including date, frequency, details or any prior suicide attempts =

Current and/or past self-harm =

Current and/or past risk to others =

Current and/or past risk from others =

Current safeguarding concerns =

Additional relevant information regarding risk, e.g., alcohol use, impulsivity, deterioration in risk, significant life events/ ongoing triggers, vulnerability factors etc. =

Current protective factors =

RISK MANAGEMENT PLAN (including whether patient has agreed) =

ANY OTHER ACTION TAKEN BY CLINICIAN: e.g., written to GP, sent Noticing & Managing Suicidal Thoughts Booklet

SUPERVISION QUESTION: e.g., I need to refer to Secondary Care crisis team. I have checked the site protocol and it indicates I can do this. Can this be processed? Could you review my actions so far?

Important: Although Urgent Risk Tickets are responded to within an hour, please do not delay any action in dealing with the risk (e.g., calling patient if applicable, writing to GP, preparing onward referrals) and utilise other methods to receive support, such as checking the available risk guidance information (link to spreadsheet).

OUTSIDE OF WORKING HOURS:

(Mon- Fri 5.30- 8pm; Sat- Sun 8am- 8pm) you can use our 'On Call' System for the same purposes as above (see 'Contact Us' on the Hub for up-to-date contact details). The on-call Clinician will not necessarily have access to their laptop, so please be prepared for the call with sufficient information to relay verbally, so we can adequately advise you.

See 'Urgent Onward Referral Out of Hours' (section 6.13) for what to do in the rare cases that you need urgent guidance outside of our on-call availability.

SUPPORT FROM YOUR ALLOCATED SUPERVISOR

If you have had to deal with a risk issue your supervisor will be pleased to offer you debrief support and time to reflect at a time that is convenient to both of you.

If you have needed to spend additional time contacting out-of-hours services, your supervisor will be happy to discuss authorisation for reasonable additional time to be paid.

If you have any safeguarding concerns, you can **raise a 'Clinical Supervision' ticket** for non-urgent concerns on the platform, or an urgent risk ticket for any immediate concerns. See **s**afeguarding adults and children (section 6.5) for more information.

For urgent supervision queries out-of-hours: there is an on-call rota covering 5.30pm–8pm Monday to Friday and 8am–8pm Saturday and Sunday. Details of who to call can be found in **Contact Us** on the Hub. The on-call Clinician will not necessarily have access to their laptop,so please be prepared for the call with sufficient information to relay verbally, so we can adequately advise you.

6.11 How to report Serious Clinical Incidents

A serious clinical incident is an accident or incident in which a patient, member of staff or member of the public suffers (or is exposed to the risk of) serious injury, permanent harm, or unexpected death.

If a patient discloses any suicide attempts (including overdose and serious self-harm, or other incidents that you think may meet this definition), you should report this directly to your supervisor via email in the first instance with the subject heading 'SERIOUS CLINICAL INCIDENT/URGENT: Site and patient reference number', copying via email **therapist@iesohealth.com** to ensure that it is picked up the same day. No patient identifiable information should be

included in the email. This should all be held securely in the Therapy Platform GAN section for your supervisor and Patient Services to refer to. (It would also be helpful to log the incident by **creating an 'urgent risk'** ticket to be picked up the same day.)

When you report a Serious Clinical Incident, the following details will be helpful:

- What happened
- What actions you have taken so far
- If any other parties have been informed and if so who (e.g., ambulance, police) and record the incident number if available
- Details regarding the agreed plan with the patient
- Please only use the patient's case number, not their name

All serious incidents must be reported with sufficient information **on the same or next working day** to the clinical supervisory team so they can take further necessary action to report and investigate the incident as needed. Clinicians will be reassured that the primary function of an investigation is not to establish blame, but to learn what went wrong and to prevent future occurrences where possible.

6.12 Risk: onwards referrals

Please refer to the specific **site protocol** on the Hub for the patient for further detailed information on how to make an onward referral (as some sites may require referral forms). If the referral is non-urgent you can also refer to further information on '**how to make an onward referral**'.

If following a risk assessment, you think that a patient will require an onward referral you will need to review the site protocol and take the necessary steps depending on the type of referral required. Any referral documents or letters will need to be uploaded to the patient's general admin notes for actioning by Patient Services.

A collaborative agreement with the patient for onward referral is best practice. If a risk profile has developed that does not warrant an immediate emergency response but does warrant an onward referral, please discuss this directly with the patient to confirm a collaborative agreement for the referral, and then follow the protocol for onward referral for that particular service as detailed on the Hub.

All referrals to secondary care mental health services for risk issues should include the following information as a minimum:

- Full Name, Address, Contact Telephone Number, name of registered GP, GP address, and NHS number
- Detailed summary of patient current plans
- Detailed summary of patient current intent and actions
- Any preparation acts or means to act on thoughts of harm
- A clear description of the current difficulties - please include diagnosis where applicable, what and how the problem presents, any known triggers and moderating factors, and impact on functioning
- Any previous mental health treatment history (if known)
- Current medication
- Risk Formulation which should include a summary of current and past risks including both dynamic and static factors, alongside a description of the patient's current mental state and consideration of the patient's situation. If there are current risks, the risk management plan should be shared as part of referral. When alcohol or substance misuse is indicated, full details of current and historical use are to be included
- Evidence the patient is aware of the referral and informed about the process
- Any protective factors and safety plans

It is also good practice to **update the GP** via letter as soon as possible following any change or new information about risk by adding a letter to the GAN. Admin support is available from Monday to Friday between 9.00am-5.30pm. Emails about risk which require urgent action (e.g., contact to be made with the G.P.) should be sent to: **therapist@iesohealth**.com with the subject line 'RISK/URGENT: Site and patient reference number'. No patient identifiable information should be contained in the email. Everything should be securely held on the Therapy Platform in the GAN for Patient

Services to action.

Following any actions like this, please open an "urgent risk" ticket to gain support or to inform your supervisor of any actions you have had to take and update the General Admin Notes (GAN).

6.13 Urgent onward referral out-of-hours guidelines

We recognise that on very rare occasions clinicians may need to contact other relevant professionals urgently to ensure the safety and welfare of the patients they are working with. As a significant number of treatment appointments are conducted outside of normal working office hours the following information is aimed at providing practical advice and guidance.

Please ensure you follow all site protocol information relating to onward referrals and all information contained in the clinician manual. For very exceptional circumstances that require an urgent referral to be made to another health professional, GP, or non-NHS services, the following advice should be followed:

1. As per these guidelines if you believe the patient or another person/child is in imminent danger, please consider calling 999 or 101 asking for the police to do a welfare check on the patient, advising of what your concerns are.

2. Should an urgent referral need to be made to a service outside of usual working hours, please make this over the telephone if possible. If a letter or referral form is needed, please advise that this will be sent as a matter of urgency the next working day by the Patient Services team when the office re-opens using the safe, encrypted NHS email service. Please also take their contact information at this time and send to **therapist@iesohealth.com** with the onward referral request. It would be helpful to copy your email to 'therapist@' into the General Admin Notes (GAN) section as well. The reason for not sending patient information direct from your email is to ensure the safeguarding of clinical information and to ensure that no confidentiality breach would occur if anyone hacked into the clinician or the service's emails.

3. If the referral is not accepted from verbal information alone and you are concerned that the patient cannot maintain safety until the working day that the referral is sent, please call 999 (for an ambulance to the patient's home) or 101 (for welfare check).

4. Please remember to document all information on the general admin notes section (GAN) of the patient's electronic case notes. Include the time, date and who you spoke to. Please record any further actions you have taken and any advice that you have been given.

Please update the on call clinical supervisor (working hours: **Urgent Risk ticket**; outside of working hours: on **call rota**).

The above scenario is very rare indeed and if this was to happen, we aim to offer you support and recompense for any additional work undertaken. We wish to support you with the duty of care you have towards the patients in your care as a clinician working with ieso.

6.14 Updating the GP on risk issues

For potential risk issues that are identified and may need further monitoring and/or sharing with relevant health professionals involved in the patients care, on some occasions it may be enough to share the initial identified risk factors with the individual's/family's GP.

Due the remote nature of ieso CBT, if a GP has met the individual/family before they may be better placed to monitor and escalate concerns during, or once treatment has been completed. Clinical judgement is needed in these situations alongside consideration of the factors outlined within this document.

OUT OF HOURS G.P. SERVICE(S):

An out of hours G.P. service is usually available in most areas. By calling the GP you will be directed towards sources of support which are open to you, for example, out of hours G.P. or NHS Direct.

If you want to update the GP, write the content of the letter in the General Admin Notes (GAN) and email patient service on **therapist@iesohealth.com**. Let them know there is a letter that needs to be sent to the patient's GP in the GAN. They will then action this for you and send it via a secure email. As above, please do not send any patient identifiable information using your own email – only the case reference and site.

WHERE THERE IS NO CONSENT TO WRITE TO THE GP:

As standard, GPs are cc'd into assessment and discharge letters. Therefore, before you assess a patient, we strongly advise that you check the 'SUMMARY' section of the patient's case and refer to: 'ARE YOU HAPPY WITH YOUR THERAPIST TO SHARE INFORMATION ABOUT YOUR TREATMENT WITH YOUR GP?' If they have said yes, then it is OK for them to be sent. If it isn't ticked, no letters will be sent. If a patient subsequently mentions that they do not want letters sent to their home in a session or a message, please ensure you email **therapist@iesohealth.com** to ensure no letters are sent to the GP.

The caveat here is if there is risk. We have a duty of care to keep the GP informed of the patient's risk or changes to it. It is therefore essential that you share the confidentiality statement in your first session with a patient and that you can respect their requests for the GP to not be informed, but not when there is risk.

As a reminder, here is the confidentiality statement:

What you share with me is confidential within our service. Your case may be discussed with my supervisor to ensure you are receiving the right support. There are exceptions to this confidentiality; if there are concerns about your safety, the safety of others, this information may need to be shared with other professionals. I will try to speak to you first about this if possible.

After today I will write a summary letter to you and (if you have given permission) to your GP as well. If you have not given us permission to write to your GP we would still share information about your safety if necessary.

Similarly, there may be cases when the patient has requested no post to home (e.g., if they are at risk from someone they live with). You can let Patient Services know that in case it isn't logged already. They will add this to letterheads and letters can be shared with you in the GAN, and you can then message the letter to the patient in the messaging section of the platform (so it is sent securely).

6.15 Summary of key actions to take on risk

- Complete a thorough risk assessment (whatever the patient's scores) at assessment including past risk history
- Where there is risk, even if low, send the 'risk assessment' questionnaire to the patient each week
- Review risk and report in the clinical notes what has been reviewed and the outcome
- In your risk review and reporting include PHQ-9 question 9 score, thoughts, plans, intention including likelihood, and safety plan
- Send the safety plan and the managing thoughts leaflet to your patient (see Risk Resources on the Hub)
- Check the **Site Protocols** for the specific processes regarding risk for each of our contracts, before submitting a risk/urgent risk supervision ticket

7. Information Governance

7.1. Confidentiality

Patients have a right to expect that all staff and clinicians will keep confidential any personal information that they acquire during professional duties, unless permission to disclose is given. They also have a right to know that in exceptional defined circumstances this duty of confidentiality may be overridden. It is important that all patients are informed about the limits of confidentiality in their opening session (see section 2.3) and Message Templates ‘confidentiality statement’ on the Hub.

Whilst we appreciate that you will all be mindful of these issues, we would like to reiterate the importance of maintaining confidentiality, particularly in relation to any data you may keep on your computer.

Incidental access: It is your responsibility to keep information secure whilst working remotely. Make sure that any computer screens, or other displays of confidential information (e.g., supervision notes) cannot be seen by anyone such as friends and family. Ensure that screens are locked when away from your desk.

Storage of Clinical Notes: In relation to a clinician’s clinical notes about a patient, ieso expects everything to go directly onto the ieso platform/be uploaded there, and not be held outside the platform. ieso discourages paper notetaking.

Process Notes (CBT Therapists only – not relevant to PWPs): If you keep your own process notes, and you need a record of these for your professional guidance, these should be kept in a secure locked cabinet in line within the guidance from your professional body and/or the BABCP.

Session Transcripts:ieso is a unique entity and data protection issues must be handled with extreme care. You will not have to keep transcripts in your filing cabinets as these will be kept on a secure server and accessible to you for the duration of the therapy, and a reflection period of 6 weeks post discharge. No transcripts or letters should be kept either on your computer hard drive or as paper copies in your house.

IT IS STRICTLY FORBIDDEN TO DOWNLOAD OR PRINT A TRANSCRIPT OR ANY PART OF THE PATIENT'S NOTES.

For your supervision sessions you must ensure names are not mentioned directly – only initials or reference numbers.

7.2. Sharing information

Any emails should only contain the patient's case reference number. Do not use any other patient identifiable information.

Do not email any letters. Assessment and Discharge letters are embedded into the site, and you can put the content of a risk letter in the patient's GAN.

Only provide the necessary amount of patient identifiable information, for example in a letter around risk, do not over disclose.

Only use patient case reference numbers or initials and no other patient identifiable information during clinical supervision.

7.3. Improper use of information

The protection of personal data is of utmost importance to ieso.

ieso takes multiple actions to secure confidential patient information and handle it according to privacy and security policies and procedures and relevant laws and regulations.

Patient Services (0800 074 5560 / therapist@iesohealth.com) must be contacted immediately in all cases of improper use or disclosure of personal information, and in all cases in which a patient claims that their data protection rights have been compromised. They will pass the information to the most appropriate member of the Clinical Team who will take forward our internal procedures.

Remember key information security principles, especially:

- Never share your passwords with anyone
- Never download, print, or copy a transcript, message notes or anything from an ieso therapy site
- Never use patient identifiable information other than the patient's case reference number in an email
- Never keep any information (e.g., letters) with patient information on your computers. Would recommend writing this on a word document and copying it directly into the GAN

GDPR and the obligations of being a Data Processor:

The General Data Protection Regulation (GDPR) is the primary law regulating how companies protect EU citizens' personal data. Although the key principles are the same as the Data Protection Act 2018, the definition of personal data has been widened to explicitly includes pseudonymisers such as NHS numbers and case IDs, IP addresses, and any information which could be grouped together to identify a living individual; and the burden of accountability and proof of compliance has been considerably strengthened and specific documents are required to uphold data subject rights have been key since 2018.

Where the services you provide on behalf of ieso require you to process personal data, Data Protection Legislation is engaged and establishes ieso as the Data Controller, and the Clinician as the Data Processor. You will have signed (at the same time as signing your initial Affiliate Agreement) a Data Processing Agreement to this effect which sets out the subject matter, type of personal data and categories of data subject, nature and purpose and duration of the processing, your obligations, and our rights. Please contact therapist@iesohealth.com if you do not think you have done this.

Obligations within this contract include, but are not restricted to:

- Take appropriate measures to ensure the security of processing
- Only process the Personal Data on documented instructions from ieso
- Assist ieso in meeting our UK/EU data protection law obligations in relation to the security of processing; the notification of personal data breaches (and notify ieso within 24 hours after becoming aware of a reasonably suspected, "near miss" or actual Data Security Incident); data protection impact assessments; and provide ieso with whatever information it needs to ensure we are both meeting our obligations
- Not to engage, use or permit any third party to carry out processing of any Personal Data without prior written consent
- Not, except to an Adequate Country, process or permit any processing of Personal Data outside the European Economic Area without express prior written consent from ieso (and see below)
- Not to respond directly to Data Subjects wishing to exercise their data protection rights unless expressly approved in writing in advance, but to pass the request to ieso and provide any assistance required to allow the data subject to exercise their rights under the UK/EU law (and see below)

Data Protection breaches

ieso as a Data Controller registered with the ICO has a duty under GDPR to log, risk assess and, where relevant, notify the ICO of these breaches. Any notification must be within 72 hours of becoming aware of them.

Clinicians, please contact Patient Services (0800 074 5560 / therapist@iesohealth.com) as soon as you suspect a breach has occurred. We also log near misses, so please also make us aware of these. Patient Services will pass the information to the most appropriate member of the Clinical Team who will take forward our internal procedures.

Here is a full list of the latest ICO data breach categories:

Type of breach (Art 29 WP, now European Data Protection Board)	ICO categorisation including new cyber breach types
Confidentiality	Data sent by email to incorrect recipient Data posted or faxed to incorrect recipient Failure to redact data Data of wrong data subject shown in client portal Verbal disclosure Failure to use bcc when sending email Hardware or software misconfiguration Cyber incident (phishing) Unauthorised access Other (Confidentiality)

Availability	Loss or theft of paperwork Loss or theft of unencrypted device Loss or theft of paperwork or data left in insecure location Denial of service attack Brute force attack Cryptographic flaws (e.g., failure to use HTTPS, weak encryption) Insecure disposal of paperwork Insecure disposal of hardware Other (Availability) Alteration of personal data

SENDING PATIENT INFORMATION VIA EMAIL:

The most common 'Near Miss' we experience is sending patient identifiable information by unencrypted email systems, which are inherently insecure and can lead to data leakage or unauthorised access.

Although the case ID is personal information, we have to make it clear which patient we are communicating about, so ieso protocol is that this is the only piece of patient identifiable information which can be included in an unencrypted/ password protected email.

By sending the information by standard email, we are exposing it to more risk than is necessary (of hacking, for example). Letters containing personal information should not be sent as attachments, they should be put into general admin notes and email notification of this should be sent to the Patient Services team including only the case ID.

If patient information is accidentally sent via email, the Patient Services team or your supervisor will contact you asking you to delete the email from your sent and deleted items folders to eliminate the hacking risk.

USING TEMPLATE DOCUMENTS:

To reduce the chances of a breach, please ensure you always use a fresh/clean template document. Don't copy and paste from a previous patient letter, formulation, or homework sheet.

7.4. Where to report a breach

A "Personal data breach" (under GDPR Article 4(12) means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data.

You need to notify ieso within 24 hours after becoming aware of a reasonably suspected, "near miss" or actual Data Security Incident, by contacting Patient Services (0800 074 5560 / **therapist@iesohealth.com**). They will pass the information to the most appropriate member of the Clinical Team who will take forward our internal procedures, including notifying our Data Protection Officer.

You will need to include a summary of the main facts (without opinions):

- Date
- Location (if applicable)
- Summary of the incident including details of who was involved and any contributing factors
- Brief description of any actions already taken

ieso's Data Protection Officer will determine whether there is also a need to notify the incident to others depending on the type and likely consequences of the incident, e.g., inform the CCG, affected patients, the ICO, ieso's insurer etc.

We have various internal processes and templates that a member of the Clinical Team will then be able to guide you through if the need arises.

DATA SUBJECT NOTIFICATION:
Article 34 of the GDPR makes it a legal obligation to communicate the breach to those affected without undue delay when it is likely to result in a high risk to individuals rights and freedoms.

ieso will provide written notification to the patient, personal representative, parent, or guardian without undue delay, in all cases where a high risk to the rights and freedoms of data subjects has been identified. (Most non-notifiable incidents are in fact reported to the data subjects by telephone but would be in writing if a connected complaint had been made.)

7.5. Computer and tablet security for therapy delivery

As a technical minimum to provide therapy on behalf of ieso, you are required to use a password/ biometrically protected laptop/ PC/ tablet with an up-to-date browser: one of the latest 2 releases of Microsoft Edge, Google Chrome, Apple Safari, or Mozilla Firefox. We expect you to keep your browser up to date once you have entered into a contract with us.

Keep your computer in a secure location, never leave your device in a public place. (This includes leaving it visible in an unattended car or leaving it in the hold of a plane.) Lock your screen when you step away from your computer. Ensure that you use a password/ biometrics to unlock your computer and a pin number/password/ biometrics to unlock your tablet.

Do not work with patient identifiable information where your screen can be overlooked.

Select a strong password and do not disclose it to anyone, including family members. Do not allow your device to save passwords to the ieso therapy sites. You may use a password management tool such as LastPass.

Always log-off applications and/or lock your computer if you are going away from your workstation or computer. Set an auto lock after a specified time of inactivity as backup (we suggest 5 minutes).

Do not save documents containing ieso or patient information on your desktop. Get into the habit of regularly clearing your downloads folder (to delete, for example, patients' homework sheets that they will send you). This should also be deleted from the recycle bin.

You will be held responsible for any information access or activity completed under your sign-on.

7.6. Mobile phones

Please do not use your mobile phone to deliver therapy.

7.7. Social media

Clinicians working with us have an obligation to protect the privacy and confidentiality of patients, subjects, their families and ieso employees, even when not at work.

Social Media sites like Facebook, Twitter, YouTube, LinkedIn, etc. require extra care to prevent privacy incidents.

- Never post patients' health information on social media, even if you believe it to be de-identified
- Be aware of the threats and associated risks using these services, which include damage to the patient, user and/ or organisation or risks of media exposure, civil penalties or infection by malicious computer software such as viruses or worms
- Sharing any private or confidential patient information on the internet is a contravention of patient confidentiality and a violation of the Data Protection Act, ieso policies and other applicable laws

- Do not discuss patient information on social networking sites; protecting patient privacy and maintaining a secure information environment is everyone's job
- It is your responsibility to report information privacy and security concerns to your supervisor

It is not permitted to use social media sites during therapy sessions as this is unprofessional, distracting, and discourteous to a patient.

7.8. Data Subject Rights

Under UK GDPR, there are eight data subject rights which may/ may not apply depending on data content and/ or the legal basis upon which we process the data:

- Right to be informed – we must be transparent in our dealings with them – usually covered mainly by Privacy Notices
- Right to access their personal data (Subject Access Requests - please remember that case reference is personal data so that any emails you send us may be disclosed to the patient)
- Right to rectification if they believe we hold incorrect data on them
- Right to erasure (sometimes referred to as the right to be forgotten)
- Right to restrict the processing of their data, for example whilst they pursue a rectification
- Right to data portability – to obtain & re-use data for their purposes over different services like switching bank accounts
- Right to object – to the basis on which we process their data
- Other specific rights in relation to automated decision making and profiling

These rights are not absolute in all cases, and for ieso, there are likely to be overriding legitimate interests in maintaining a record of healthcare activity for legal /accountability /clinical purposes, and the ICO specifically excludes healthcare data from the right to erasure, for example.

ieso is the Data Controller and ieso needs to communicate with the data subject regarding these rights, but the data subject can exercise their rights in any form to any point in the organisation. This means that they may do so to their clinician/practitioner. A request does not have to include the phrase 'subject access request' or Article 15 of the GDPR, for example, as long as it is clear that the individual is asking for their own personal data it should be considered a SAR.

If you spot anything believed to be an attempt to exercise a data protection right during a therapy session or within the messaging section, (for example, asking to access or delete their data) then please email **therapist@iesohealth.com** as soon as possible.

7.9. Providing therapy and accessing patient information from overseas

As part of a review of our information security policies, we have taken legal advice and developed new rules around delivering therapy outside the UK.

Despite storing all our UK data within the UK, viewing patient information and conducting therapy from abroad is considered a transfer of data by Data Protection Legislation. You are therefore not always allowed to deliver therapy or access patient records during a trip/holiday abroad. Before working in any country outside of the UK this should always be discussed and agreed with your Clinical Supervisor.

The European Commission makes decisions on the adequacy of the protection of personal data in third countries and have decided that personal data can flow safely between countries in the European Union, the European Economic Area (EEA), and other listed territories without any further safeguards being necessary: (**https://ec.europa.eu/info/law/law-topic/data-protection/international-dimension-data-protection/adequacy-decisions_en**)

Post UK departure from the EU, the UK has been granted adequacy by the EU, and the UK has accepted the European Commission's adequacy decisions for the UK too, and also included Gibraltar.

EEA Countries:		
Austria	Germany	Malta
Belgium	Greece	Netherlands
Bulgaria	Hungary	Norway
Croatia	Iceland	Poland
Republic of Cyprus	Ireland	Portugal
Czech Republic	Italy	Romania
Denmark	Latvia	Slovakia
Estonia	Liechtenstein	Slovenia
Finland	Lithuania	Spain
France	Luxembourg	Sweden

Other approved countries:		
Andorra	Israel	Japan (private organisations only)
Argentina	Jersey	Republic of South Korea
Canada (commercial organisations)	New Zealand	
Faroe Islands	Switzerland	
Guernsey	Uruguay	
Isle of Man	Gibraltar (approved by the UK)	

If you are outside these countries, it is not permitted to access patient information or conduct therapy sessions. Please remember this if you are holidaying outside these territories.

Please see the HIT/PWP Guides and **section 3** on taking leave, for guidance on who to contact when you will be unavailable for work due to a holiday or longer trip away.

8. Sanctions for IG breaches

ieso will handle reports of misuse and abuse of information and information technology resources in accordance with existing policies and procedures issued by appropriate authorities. Depending on the individual and circumstances involved, this could include the offices of Human Resources, Compliance, the CEO and/or appropriate law enforcement agencies.

Failure to comply with ieso policies designed around the security and privacy of information may result in sanctions relating to the individual's use of information technology resources (such as suspension or termination of access), the individual's allocated workload (up to and including immediate termination of the Clinical Affiliate contract), civil or criminal liability, or any combination of these.

The clinical team have the responsibility to reflect with clinicians where there is evidence of the clinical guidelines not being followed, be that with respect to case management procedures, clinical practice that does not adhere to evidence-based treatment protocols, or any other aspect of these clinical guidelines. Where there is evidence of this, the clinical team will agree a reflective exercise with the clinician and a plan of action to remedy the problem. This will often include a substantial input of clinical support and CPD from the service. Normal case allocation may be suspended during such a period. If subsequently the situation cannot be resolved, such that the clinical team has confidence the clinician's practice is now congruent with the clinical guidelines, then the clinician's services will no longer be used.

ieso

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