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STANDARD OPERATING PROCEDURE EARLY INTERVENTIONS IN PSYCHOSIS (PSYPHER)

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CHANGE RECORD

Version	Date	Change details
1.0	*August 2022*	*New SOP. Approved by MH Division Practice Network (07/09/22).*
1.1	*April 2024*	*Reviewed with amends. Section 5.2 - CAARMS assessment is mandatory for all clients and all patients discharged from the hospital will receive a scheduled appointment with the team's psychiatrist as part of the patient's discharge plan regardless of the patient's level of engagement (PSIA number – 2023 10).* *Approved at MH Division Practice Network Meeting (3 April 2024).*

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1. Introduction

This document will provide operational details for Early interventions in Psychosis (EIP) service across Hull and the East Riding of Yorkshire locally known as Psypher.

The service is provided by Humber Teaching NHS Foundation Trust in partnership with Hull City Council.

PSYPHER is based at Townend Court and provides a service to people between the ages of 14 and 65 who are experiencing a first episode of Psychosis or who are at risk of developing one. The service works between the hours of 9am until 5pm Monday to Friday.

The team works closely with key stakeholders internal and external to the organisation including service users and carers, primary care services, and other local statutory and non-statutory agencies.

The service operates 3 distinct pathways in line with national guidance:

- First Episode Psychosis (FEP) support typically continues for up to 3 years but if treatment is complete, patients can be discharged or transitioned to other services.
- ARMS will require a period of active treatment lasting up to two years. They should be monitored regularly for at least another year after treatment. This means that those with ARMS will be seen for a minimum of two years and a maximum of three years in total.

first episode psychosis (FEP)

Term used to describe the first time a person experiences a combination of symptoms known as psychosis.

During an episode of psychosis, a person's perception, thoughts, moods and behaviour are significantly altered: each individual's experiences are unique and will include a combination of symptoms.

Core clinical symptoms 'positive', ie they are added experiences, including hallucinations and delusions.

Core clinical symptoms 'negative', ie where something is reduced, such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect.

Common mental health problems eg anxiety and depression may also be present, as well as co-existing substance misuse.

At risk mental state(ARMS)

ARMS provision is to delay or prevent the onset of severe mental health problems, including psychosis, as well as provide a stepped care approach for people experiencing emerging psychotic symptoms. ARMS provision should identify people who are experiencing an ARMS. This is particularly important in children and young people

Extended Assessment (EA)

can be up to 3 months maximum so that the team can make use of the time to fully understand the key difficulties a person is experiencing and decide upon the most appropriate care pathway/service. It is important to note that the extended assessment pathway and the at-risk mental state pathway have similarities but are in fact quite different

2. Scope

This Standard Operating Procedure (SOP) sets out how PSYPHER will manage referral to treatment pathways and includes safety & procedure information for the team. The document is for the staff team, including temporary staff, internal & external partners and rerefers to the service.

The national access and waiting time standard require more than 60% of people experiencing first episode psychosis commence a NICE-recommended package of care within two weeks of referral. The team aim for a 14-day target from referral to treatment.

3. Duties and Responsibilities

The service is a multidisciplinary community-based team that provides assessment, intervention and support to people experiencing or at high risk of developing psychosis. The defining characteristic of an EIP service is its strong ethos of hope and whole-team commitment to enabling recovery through the provision of individually tailored, evidence-based interventions and support to service users and their families / carers.

We have a principal aim to reduce healthcare inequalities to improve physical and mental health outcomes. The faster progression made in EIP the greater benefit to the individual, family, and the wider mental health system.

NHSE planning & performance guidance commits the NHS to 'STOP avoidable illness and intervene early.

Humber Teaching NHS Foundation Trust are committed to creating a culture of caring. This extends beyond caring for our patients and service users/carers to caring for each other. The Trust have established a staff charter that sets out the Trusts mission and vision along with three new values,

Caring, Learning and Growing

3.1. Responsibilities

Divisional Leadership - General Manager and the Division Clinical Lead Mental Health
Are responsible for ensuring that the Mental Health Networks aligned to the governance framework are well managed, provide assurances and escalate items as necessary to QPaS and Operational Delivery Group (ODG) in line with their respective ToRs.

Direct Division Operational/Clinical Leadership - Service Manager, senior Clinical Leads, and Clinical Specialists in therapy and nursing services.

Accountable for ensuring team/service/practice level governance meetings in place and are well managed. Ensure compliance with the CQC KLOES across their respective areas. In doing so they will ensure that there are systems and processes in place to audit, monitor standards and compliance and share learning.

All Clinical and Non-Clinical Staff - All staff both clinical and non-clinical of all grades are responsible for ensuring that they attend governance meetings as per required meeting ToRs. They are responsible for ensuring that they deliver agreed actions from CQC inspections, incident and complaint investigations and Patient Safety Incident Analysis, reporting safety and performance issues through agreed mechanisms such as Datix.

Each profession is accountable for ensuring that they maintain high-quality standards of care, leading and participating in governance.

Service Manager, Team Leader, and Clinical Lead - Responsible for the implementation of policy and procedures and training for relevant staff groups in their areas of responsibility.

It is the responsibility of the service leadership team to review waiting lists regularly and act as required to ensure patients wait no longer than is necessary. The wider leadership team will support the service in providing responsive and timely packages of care and for monitoring waiting times within their operational structures. Where factors adversely affecting waiting times are identified, they will act to address these as swiftly as possible with the support of the Service Manager and other senior management.

They will work closely with corporate support services, and the performance management team to provide a clear line of sight for the Trusts senior management team regarding any emerging pressures within the service.

Information and Performance Management Teams - Will provide appropriate performance reports, technical advice, systems support, and tools to ensure PSYPHER are able to manage referral to treatment pathways in an effective and efficient manner.

Employees - All employees will comply with this Standard Operating Procedure.

4. Procedures

Psypher is routinely audited by the Early Intervention in Psychosis (EIP) audit of the National Clinical Audit of Psychosis (NCAP). The team are measured against criteria relating to the care and treatment we provide, so that the quality of care can be improved. The audit has been running since 2017 and is commissioned by HQIP on behalf of NHS England and Improvement.

NCAP standards

- Timely assessment
- Cognitive Behavioural Therapy for Psychosis (CBTp)
- Family Intervention (FI)
- Carer-focused education and support
- Physical health screening and intervention
- Medication related interventions including commencing Clozapine.
- monitor progress via Recording Outcome Measures

4.1. Waiting Times

EIP has a 2-week target from referral to treatment which is a national standard.
Measuring the clock start: referral, recognition and initial assessment procedures are in place. The team report performance against the referral to treatment (RTT) waiting time requirement.

Maintaining national standards for waiting times are important to PSYPHER because:

- The patient's condition may deteriorate while waiting and, in some cases, the effectiveness of the proposed treatment may be reduced.
- The experience of waiting can be extremely distressing.
- The patient's family life may be adversely affected by waiting.
- The patient's employment circumstances may be adversely affected by waiting.

A comparatively short period of waiting which is managed in the patient's best interests, in order to support the appropriate scheduling of routine or more urgent care with the practitioner who is most suitable may occur. Or in order to ensure the most urgent patients are seen first. Excessive waiting times, however, must be reduced and as such we make this commitment to users of our service:

- We will strive to keep waiting times to a minimum. All referrals will be allocated on caseload to a named worker within 5 working days.

- The named worker will maintain regular/frequent contact and provide support, update care plans and any risk assessments etc and the patient will have access to the duty officer in the absence of a named worker.
- We will ensure we monitor waiting times to address any emerging problems that may adversely affect waiting times and act within the means at our disposal to address these.
- Will keep people informed of how long they can expect to wait for care and will provide them with a named individual who will be a point of contact whilst they await an assessment for any questions or concerns, they may have. This person will also keep in regular contact with them on a regular and agreed basis.

4.2. Referrals & Caseload

The trust has multiple routes for referrals. The majority of new referrals will be triaged via MHTAT who will triage, initially assessed, and then transferred to Psypher. Other services such as Child & adolescent Mental health and school mental health teams may contact the team directly. We encourage clinical discussions before any referral.

Out of Area Care Program Approach (CPA) transfers where the individual is already under the care and treatment of specialist mental health services or as a minimum who has a robust treatment plan in place may be accepted without having been through the trust's internal pathways as detailed above, subject to review by the multidisciplinary team meeting.

Referrers are reminded that EIP has a 2-week target from referral to treatment which is a national standard. Measuring the clock start: referral, recognition and initial assessment procedures are in place. The team report performance against the referral to treatment (RTT) waiting time requirement.

PSYPHER is open to referrals between the ages of 14 and 65 years old across 3 pathways.

4.3. Referral and Triage Process

The care pathway is highlighted in Appendix 1.
The team will need as much detail as possible from the person referring to the team to establish and ensure they are appropriate for an Early Intervention in Psychosis service. The team will not decline referrals based on cooccurring needs. However referees are advised that PSPHYER is a service which specialises in first episode psychosis.

Every new referral will be reviewed within 24 hours (Monday –Friday) by Office Duty to review for the completeness of required referral information and appropriateness for the service.

The referral will then be the Clinical Lead/Team Leader allocated for an assessment and following the assessment, discussion within the MDT within the national timescales for allocation if appropriate or signposting/discharging to a more appropriate service.

4.4. Management of New Referrals & Assessments

Once a referral is accepted by PSYPHER, the service user will be contacted by telephone in the first instance to organise an assessment within 3 -10 working days from acceptance.

Appointments will be provided to meet the needs of the patient and the PSYPHER service. They will receive written confirmation of their intended appointment. This letter will provide information and contact telephone numbers for the patient to discuss alternative arrangements should this appointment not be convenient.

The Comprehensive Assessment of At-Risk Mental States (CAARMS) tool will be used for all new patients, to identify people who are at ultra-high risk (UHR) of developing psychosis. (*PSIA number – 2023 10).*

Following a comprehensive assessment, the patient will be allocated to a relevant treatment pathway as defined by the national service specification (FEP/ARMS/EA).

Management of patients will be consistent and transparent communication with patients and/or families will be clear and informative, and decisions taken regarding treatment will be based first and foremost on clinical need which will be agreed upon within a multi-disciplinary approach.

For people being referred from inpatient units the Mental Healthcare Act 2017 mandates discharge planning will be completed and documented before any discharge to PSYHER. Discharge planning should be based on a thorough assessment of the needs of the patient and the Family should be actively involved in the planning process. For new referrals to the team & for discharge planning to be effective, an assessment of the specific needs should be first performed using the Comprehensive Assessment of At-Risk Mental States (CAARMS) tool.

All patients discharged from the hospital will receive a scheduled appointment with the team's psychiatrist as part of the patient's discharge plan regardless of the patient's level of engagement. PSIA number – 2023 10) From the point of acceptance of the referral the individual is classed as being under the care of the team and can contact the duty person between the hours of 9-5 Monday to Friday should they need to discuss their care further and the named worker/care coordinator is unavailable.

If the demand for the service out ways, the team capacity the team manager is responsible for caseload management and business continuity.

4.5. Intervention Pathways

The team offer a wide range of Effective intervention pathways following NICE recommendations and evidence-based treatment protocols that match treatment intensity to clinical outcomes. NICE recommends that specific therapeutic interventions should be delivered in the context of a holistic and recovery-focused service model.

- Cognitive Behavioural Therapy for Psychosis (CBTp)
- Family Intervention (FI)
- Carer-focused education and support
- Physical health screening, health promotion and intervention
- Medication-related interventions & and medical reviews by the team psychiatrist.
- Psychosocial interventions
- Psychological interventions
- Social support to build community connections, Social Inclusion, activities, roles, and routines of everyday life.
- Opportunity for Work, education, and training.
- Improving patient experience/wellbeing
- Opportunity to monitor progress via Recording Outcome Measures – HONOS/DIALOG / REQOL 10.

4.6. Caseload Management

The team currently work in a traditional way of allocating cases based on care coordination capacity. In light of national changes with CPA and the introduction of personalised care planning this now allows us to review the way we deliver the service. The operational policy will be updated to reflect the changes once implemented.

Staff members will be allocated several patients and it is the responsibility of the care coordinator and leadership team to ensure the patients are safely and effectively managed. This should be regularly discussed in managerial and clinical supervision.

4.7. Management of Appointments

Reasonable adjustments in line with engagement and building a therapeutic relationship are essential within PSYPHER. A strengths-based process that supports recovery and wellness. We will seek to make services accessible and responsive to needs and will proactively engage with our service users to try and ensure that anyone wishing to access our services can do so easily and promptly.

All attempts will be made to ensure that cancelled appointments are kept to a minimum, however, sometimes it is unavoidable. Where this is necessary the service user will be contacted at the earliest opportunity by the member of the admin/MDT or office duty, reasons for the cancellation will be provided if appropriate and a discussion held with the individual as to whether they require any additional support prior to their next planned appointment. If it is not possible to offer a planned appointment at this time the individual should be told of additional support options available to them.

Where cancelled appointments relate to long-term absence of a care coordinator (unplanned absence of more than 14-day duration) each service user will be written to explaining the situation and reiterating options for support in their absence. If the absence is expected to be longer than 14 days, then the caseload will be reallocated within the service. The MDT will review the provision of service and the practitioner's caseload to look at alternative options for the provision of treatment.

The cancellation of appointments will be monitored via the team and corporate reports, every week. Any themes or trends will be identified and discussed as part of our service improvement plan.

4.8. Did Not Attend (DNA) Appointments

Appointments will be provided to meet the needs of the patient and the PSYPHER service. They will receive written confirmation of their intended first appointment. This letter will provide information and contact telephone numbers for the patient to discuss alternative arrangements should this appointment not be convenient. Ongoing appointments will be arranged between the staff members and patient ensuring reasonable adjustments in line with engagement and building a therapeutic relationship. We will seek to make services accessible and responsive to needs and will proactively engage to try and ensure that anyone wishing to access our services can do so easily and promptly.

We will utilise approaches specific to the services and populations accessing them to minimise missed appointments.

In addition, the following will apply.

- Before the commencement of treatment every individual will have the opportunity to express preferences to the offered appointment day and time where possible.
- Where an individual does not attend for 2 consecutive appointments and has failed to make contact to let the service know. The case will be discussed by the MDT with consideration given to risk including any safeguarding risks, disengagement due to deterioration in mental health and the risk of discharge. The decision may be made by the MDT to discharge from our care. This will have been made explicit to the service user on entry to the service.
- If a decision is taken to discharge, then the usual discharge arrangements will be followed in terms of communication i.e., written confirmation to the service user, their GP and any other professionals involved in their mental health care provision explaining pathways back into services.
- All communications verbal or written need to be recorded on the EPR.
- DNA rates will be monitored at a practitioner level and will form part of the information board on display which will be reviewed for themes and trends within team business meetings and where appropriate this information will be utilised within individual supervision sessions.

4.9. Interface with Other Services

Collaborative care between organisations, departments, teams, or practitioners is essential to promote effective liaison and provide safe and high-quality care to patients who are transitioning between services.

All communications verbal or written need to be recorded on the EPR.
MDT notes will be recorded on the EPR.

Primary care will be updated on the person's treatment plan at assessment, CPA review meetings and discharge. Primary care also needs to be informed of any significant changes, particularly lack of engagement and changes in treatment plans.

Co-occurring needs such as substance misuse/physical health conditions may require joint working. This will require collaborative care planning and information shared between the teams (with the patient's consent)

4.10. Transfer of Care

- The team offer a 3-year service. First Episode Psychosis (FEP) support typically continues for up to 3 years but if treatment is complete, patients can be discharged or transitioned to other services. Regular reviews of caseload exceeding 3 years. will be managed by the Team leader.
- Discharge pathways to either primary care or secondary care service should be completed promptly.
- Expectation that if patients do require ongoing service, they will be transferred with a 3-month maximum time frame to another team. If this wait is exceeded this must be escalated to the service manager.

4.11. Using Informatics and IT

All records regarding the care delivered will be electronically maintained on the corporate electronic patient record. All patient information will be used in accordance with the Accessing and Sharing Information with Service Users and Carers Policy, the Operational Procedure for Sharing Information and the Caldecott and Data Protection Policy. All records are managed under The Records Management Code of Practice for Health and Social Care (2016).

Corporate Systems Team will support the management of electronic patient record (EPR). The service will use the electronic record to collect and record the service user's health information adhering to electronic information standards. Record keeping will be subject to weekly record keeping audit and review as part of supervision to ensure that the information recorded is entered promptly and captures an accurate record that identifies the consultation and any referrals delivered by all staff and also captures any contemporary risks including safeguarding emerging.

Informatics will be used across the service to improve the coordination of service user care information and management of plans set by the service user enabling live recording and co-ordination of care delivered. All service users accessing the service will be supported to be involved in their care planning. Copies will where appropriate be shared with the service users and families/carers. With exceptions considered risks are identified e.g. safeguarding concerns Consent will be considered throughout information sharing with an acknowledgment of the implementation of the Mental Capacity Act.

4.12. Risk Management Systems & The Patient Safety Incident Response Framework (PSIRF)

The triangulation of all governance information is essential to risk management. Psypher has a robust Risk Register in place to ensure that risks are identified, managed, and reported through organisational governance arrangements. The information from these risk registers is essential due to the confounding impact risks have on other elements of the real-time governance framework and to ensure that risk ratings are reflective of real-time service activity. The risk register will be reviewed at the team meeting level, Senior level, as part of the Mental Health Organisation Development Group and will be escalated further as required.

Alongside the Risk Register a Datix may also be completed. After each Datix has been reported an internal Safety huddle takes place between the corporate risk management team and senior staff. The safety huddle will be to discuss the current situation and level of risk, any feedback received from the trust, the next steps or if further escalation is required. The daily safety huddles will continue until the concern has been fully addressed and closed.

All incidents are reported via the Trust Datix electronic reporting and investigation system. All Datix are reviewed at the Trust corporate safety huddle each morning by senior clinicians within the Nursing Directorate. All submissions are reviewed and actions for further review include the following: The Patient Safety Incident Response Framework (PSIRF)

- Serious Incident (SI),
- Patient Safety Incident Analysis (PSIA, PSII)
- SWARM Huddles

This enables real-time reporting and alerting of incidents with set parameters on timescales for investigation. The huddle provides the opportunity to dial in and discuss Datix submissions made in the previous 24 hours. The management of the incident includes a full duty of candour provided to the individual and their family and learning the lessons approach to improvement.

The learning from initial incident reviews will be discussed in team meetings/debriefs/huddles via operational/clinical leads. The learning from serious incident investigations, PSIA and complaints will be disseminated via the Patient Safety & Clinical Assurance Meeting and shared with the wider staff team through team-level meetings. Assurance that the learning has been shared will be provided through team/service meeting minutes.

All incidents will require a DATIX to be submitted detailing the actions taken. Further investigation of such incidents will be undertaken as advised by the corporate risk team and/or senior clinicians and operational management. A reflective review including learning the lessons will be part of each episode of restrictive practice.

Before any group began in Psypher, a full risk assessment would be completed to determine if the working space was safe, practical, free from hazards and appropriate to work in. This would be rated based on likelihood and severity and then reviewed periodically by the Clinical Lead. Any concerns raised will require an action plan to be put in place to address the risk and ultimately reduce the risk down to a satisfactory level. If this is not achievable an alternative location will be allocated, assessed, and determined if appropriate as a temporary or permanent solution.

Terms of Reference (ToR) will also be required for each group detailing aims/objectives, access, exit and rationale for the group and expectations for service users.

4.13. Education, Training and Staff Wellbeing

All staff working in the service will be supported to maintain the values of caring, learning and growing. Education, training, and personal development will be individually and collectively identified through the appraisal process. Continuing professional development is critical in ensuring that the staff team have the necessary skills and knowledge to support them in delivering the highest quality of care to patients and their families. All new members of the team will be inducted into a training plan which will encompass all areas of their role before supporting service users.

All staff will be appraised annually via the personal development process with their first appraisal taking place 4 weeks after starting in post. The records of appraisals will be recorded on ESR.

Regular clinical, managerial (and where appropriate Professional) supervision structures will be in place to provide ongoing developmental review and identify any emerging training or wellbeing support for individuals.

All new staff will attend an induction programme alongside a 6-month probationary period. All staff will attend mandatory training sessions appropriate to their professional status, this will include the necessary level of training required to manage all areas of care delivery as identified in the individual services operational SOPS.

Service-specific training will be facilitated and include practice-based learning opportunities for all staff. Training will include (but not exclusive to):

- Statutory and Mandatory training
- Group workshops
- Peer shadowing
- Operational training including internal clinical systems training, administerial training, and trust policies.

Staff wellbeing will be supported from the trust induction through to divisional leads proactively promoting a positive health and wellbeing balance, ensuring the trust's health and wellbeing board actions are addressed and shared to evidence positive health and wellbeing approaches within the team. Alongside this, all Psypher staff will be supported by any team well-being initiatives including team catch-ups, informal catchups, supervisions to discuss well-being and being supported to refer themselves to Occupational Health to address any support they may require.

4.14. Lone Working Procedure

Risks to staff members: risks should be identified at the point of receipt of referral and have been communicated within the internal referral process (internal referral decision making and form).

Risks can also be ascertained from the examination of any alerts (historical as well as contemporary) identified within Lorenzo. These risks can be personal (directly from the service user) from a carer or known associate or may be environmental. Due to potential risks posed by service user contact within a hospital and community setting, lone working procedures should always be adhered to. (Please see HFTT Lone working policy)

4.15. Safety Planning/Service User Risk and Escalation

Where the triage of a referral identifies a client as "at risk" and in need of a more urgent medical or psychological response, the client should be signposted onto the appropriate service. This includes service users who may need emergency medical care or are deemed at high risk of suicide based on what they have disclosed in their consultation.

All staff will offer re-assurance to the individual and seek the most appropriate support as follows:

- Dialling 999 for urgent medical assistance
- Contact the MHCIT Team if it is deemed an urgent mental health crisis.

If the incident occurs during a consultation, the individual should not be left alone until it is deemed safe to do so, this decision will be supported by the senior staff present within the building or by contacting the services Clinical Lead/Team leader. The event should be reported as an incident on DATIX as per the Humber Teaching NHS Foundation Trust Serious Incidents and Significant Events Policy and Procedure.

Each patient on the PSYPHER caseload will be encouraged to contact the team directly during office hours (Mon-Fri, 9 am – 5 pm) should they require any additional support, or their situation deteriorate or change. Everyone will be supported by the practitioner allocated to Office Duty on that day, who will assess the situation and liaise/escalate accordingly. Upon acceptance onto either caseload or waiting list (whichever is first) each patient will be provided with a list of out-of-hours contacts to ensure 24-hour accessibility to care and support.
Any deterioration in a patient's well-being or escalation of concern will be addressed and allocated and their current place on the waiting list will be reviewed in response to changing clinical needs, any such decisions will be monitored via the referral meeting and daily morning meeting. Intended actions or placement on the waiting list may be reviewed at this time in response to their changing needs.

4.16. Continuity of Service Risks

If an issue were to arise which impacted on provision of service such as estate, severe weather conditions, major incident etc. the PSYPHER Business Continuity plan would be put into place and followed. These special arrangements are required to be implemented until the service can return to an acceptable level.

4.17. Safeguarding

Safeguarding risks that are identified because of disclosure from all service users or observed during interaction with the service user or family will be immediately referred to the safeguarding team in

Humber Teaching NHS Trust and the appropriate local authority safeguarding team. The service user will be immediately protected from any further safeguarding concerns. All appropriate agencies will be involved in developing a safe plan for the patient.

5. Principles of Trauma Informed Care

The team will always follow the key principles of trauma-informed care with every interaction.

Safety: Patients and staff feel physically and psychologically safe throughout the organisation

Trustworthiness and Transparency: Decisions are made with transparency and to build trust.

Peer Support: Individuals with shared experience are integrated into the organisation.

Collaboration and Mutuality: Power differences are levelled between staff and patients and between staff.

Empowerment and Choice: Patient and staff strengths are recognised and built on.

Humility and Responsiveness: Biases and stereotypes and historical trauma are recognised and addressed.

Engagement and building a therapeutic relationship are essential within PSYPHER. A strengths-based process that supports recovery and wellness. Trauma-informed practice aims to increase the teams awareness of how trauma can negatively impact on individuals and their ability to feel safe or develop trusting relationships with health and care services.

6. References

HNHSFT waiting list and waiting times policy.
CPA guidance

Clinical risk management

EIP National Standards epin-standards-first-edition.pdf (rcpsych.ac.uk)

NICE guidelines NHS England report template-add image (psymaptic.org)

Psychosis and Schizophrenia in Children and Young People NICE guideline • Bipolar Disorder, Psychosis and Schizophrenia in Children and Young People NICE quality standard • Psychosis and Schizophrenia in Adults NICE guideline • Psychosis and Schizophrenia in Adults NICE quality standard.

NHS England North - Guidance clarifying EIP and ARMS referral criteria

Appendix A: Pathway Flowchart