

Anticipatory Care Plans in Lanarkshire

Evaluation

April 2010



INDEX

Background	3
Project Aim	4
Project Objectives	4
Step 1: What we did	5
Step 2: Development of the ACP	5
Step 3: Consultation	5
Step 4: The Pilot	5
Step 5: The Teaching Resource	6
Step 6: The Impact	7
• On A&E attendance	
• On admissions	
• On length of stay	
• On preferred place of care	
• On care home residents	
• On families	
• On care home staff	
Acknowledgements	15

BACKGROUND

As part of the Long Term Conditions Complex Care work stream a challenge was issued to produce an Anticipatory Care Plan (ACP) to support and direct the care of people with complex needs who were currently being cared for within a care home environment.

The term Anticipatory Care Planning fits under the umbrella of Advance Care Planning. The aim of advance care planning is to develop better communication and recording of decisions, thereby leading to provision of care based on the needs and preferences of patients and carers (SGHD 2008). The anticipatory element addresses the clinical aspect of the person's care where the patient or carer are aware of any change in clinical symptoms and know what action to take should the person's condition deteriorate. This includes recording the patient's preferred place of care and their preferred wishes for end of life care.

The process of anticipatory care planning is based on the discussion between an individual and their care provider. This discussion is completely voluntary and takes place in the context of an anticipated deterioration in the patient's condition. However, ACP is not legally binding and the caveat exists that the patient has the right to change their mind at any time.

Despite the use of numerous regular or routine care plans and the mental health framework for action, it was clear that if we used the definition above, 'Anticipatory Care Planning was neither a familiar term nor routine practice within NHS Lanarkshire.

This piece of work coincided with the publication of Living and Dying Well: a national action plan for palliative and end of life care in Scotland (SGHD 2008). The purpose of this action plan is to ensure that good palliative and end of life care is available for all patients and families who need it in a consistent, comprehensive, appropriate and equitable manner across all care settings in Scotland (SGHD 2008). One theme within this strategy is the need for patients to be involved in the care planning process and to be given the opportunity to discuss, express and record their preferred wishes for end of life care.

Evidence suggests that the success of advance or anticipatory care planning is based upon the availability of and access to the anticipatory care plans; that health and social care staff feel confident and competent to initiate the conversation with patients and their families, and that this ongoing conversation is updated regularly to continually reflect the patients wishes.

It has also been suggested that the anticipatory care planning process may help avoid unwanted or unnecessary hospital admission and as a result contribute to a number of HEAT Targets and Corporate Objectives.

PROJECT AIM

The aims of this project were to introduce Anticipatory Care Planning within Lanarkshire Care Homes prompting discussion about future preferences and wishes for care; to improve communication between residents, care home staff, and healthcare professionals and ultimately improve the overall experience of residents, with the concept of Anticipatory Care Planning being accepted as best practice.

PROJECT OBJECTIVES

- * To develop Anticipatory Care Plans and introduce the concept of Anticipatory Care Planning to Lanarkshire Care Homes.
- * To provide the necessary guidance and support to test the concept of Anticipatory Care Planning and the Anticipatory Care Plan documentation.
- * To develop a learning resource to support the ongoing use of Anticipatory Care Plans.
- * To establish the impact of Anticipatory Care Planning within 9 care homes during a pilot period.
- * To provide the Long Term Conditions Programme Board with a project report at the end of the project.

WHAT WE DID

Step 1: Expert Working Group

- 1.1 An expert multi-agency working group was convened to review the literature, identify the key deliverables which included an anticipatory care plan, guidance notes for health and social care professionals, patient and carer information leaflet and a teaching resource to support the implementation and ongoing use of the ACPs. The Chairperson of the Care Home Protocol Group received minutes of the working group meetings as part of the communication plan. Membership of the working group can be found in [appendix I](#).

Step 2: Development of ACP, Guidance notes, Patient and Carer Information Leaflet

- 2.1 The working group identified the key content of the ACP and guidance notes, including legal elements. A Solicitor was consulted to ensure accuracy of this detail. Following the development of the ACP and guidance notes, the patient and carer information was designed.

Step 3: Consultation

- 3.1 The DRAFT ACP, guidance notes and information leaflet were sent for comment to a wide range of stakeholders. This included a range of clinicians, GPs, Independent Care Homes, Local Authority Care Homes, North and South Lanarkshire Councils, the Lanarkshire Care Home Protocol Group, the Care Commission, Carers organisations and Patient and Public Involvement Groups. The working group were very keen to obtain the expert opinion of as many people as possible and stakeholders were positively encouraged to make suggested changes.
- 3.2 Overall comments were constructive and very supportive. Comments were collated and suggested changes were incorporated into the final version.

Step 4: Testing (the pilot)

- 4.1 It was felt that the ideal place to test the content, design and usability of the ACP, guidance notes and information leaflet would be within GP aligned care homes.
- 4.2 Eight care homes were invited to test the ACP, guidance notes and information leaflets. One care home approached the project facilitator and asked to be included in the pilot.
- 4.3 These care homes included:
 - Summer Lee House Care Home, Coatbridge
 - Park Springs Care Home, Motherwell
 - Greenhills Care Home, Biggar
 - Whitehills Care Home, East Kilbride
 - Meldrum Gardens Care Home, East Kilbride
 - Mckillop Care Home, East Kilbride
 - McWhirters Care Home, East Kilbride
 - Dewar House Care Home, Hamilton
 - Canderavon Care Home, Stonehouse

- 4.4 The Anticipatory Care Plan Facilitator attended the care home staff meetings, residents meetings and met with individual families to discuss the purpose of the ACP.
- 4.5 Many ACPs were introduced and full analysis is discussed in section 6. However to establish early impact a small snapshot of 100 care home residents were monitored. Participating care homes were asked to capture information over the month of July 2009. Of the 100 plans in use at that time, care homes reported:
- * 17 Residents used their ACPs to influence the length of their hospital stay by being discharged within 24 hours.
 - * 12 Residents used their ACPs to influence their preferred place of care and avoid hospital admission using the Red Flags (anticipatory) section. In these cases the GP and care home staff admitted to being more proactive in avoiding hospital admission.
 - * 5 patients died in their preferred place of care.

Step 5: The Implementation Support & Learning Resource

- 5.1 During the qualitative data collection and learning needs analysis it became clear that lack of confidence to enter or prompt ACP discussion could be a potential barrier to the implementation. It was thought that this lack of confidence could also be linked to a lack of knowledge and lack of experience of prompting such discussions with patients and their families.
- 5.2 Reflecting upon this it was clear that staff would need a resource to provide the necessary background information, theory and practical guidance to initiate the ACP process.
- 5.3 The project facilitator undertook a review of the literature in relation to educational support for Anticipatory Care Planning. A search was also made for other such resources.
- 5.4 At the same time the 9 Hospice Consortium in partnership with NHS Education Scotland launched an Advance Care Planning facilitators training pack. The project facilitator attended these training events and with permission from the authors extracted elements of the training material for use within NHS Lanarkshire.
- 5.5 The Anticipatory Care Planning implementation support pack was developed. Clear aims and learning outcomes were developed ([appendix II](#)) together with a compact disc containing 4 supporting presentations and a Digital Versatile Disc which shows the whole ACP process in action.
- 5.6 This ACP implementation support and learning resource will be issued to all care homes following completion of the project.

Step 6: The Impact - Project Evaluation

- 6.1 During the life of the project a total of 346 ACPs were completed. This figure includes 55 care home residents who sadly died. On further investigation the 55 care home residents who died, died within their preferred place of care which was their wish identified and recorded during the ACP discussion. These residents were not included in the 3 cohorts discussed below.
- 6.2 During the period of June 2009 to August 2009 the ACP discussion was initiated with 129 care home residents and their wishes recorded within an Anticipatory Care Plan. To identify the impact of this in relation to visits to the A & E department, hospital admission and length of stay, the care home residents were monitored for 6 months following completion of their ACP. This was compared with their acute hospital contact 6 months prior to the ACP discussion. A further 37 residents were monitored for 5 months before and after ACP, and a further 33 residents were monitored 4 months before and after ACP. The findings are illustrated in the tables below.

Dates of ACP	No of patients with an ACP	No of months before and after analysed	Prior to ACP months			
			No of A&E attendances	No of patients with an emergency inpatient admission	No of emergency inpatient admission	Total hospital length of stay
June - August	129	6	47	24	36	378
September	37	5	8	4	5	34
October	33	4	11	4	4	61

Table 1. Acute Hospital Contact Pre ACP.

- 6.3 Within table 1 we can see acute hospital activity for the first 129 care home residents 6 months **prior** to completion of their ACP. From the period of January to June 2009 before the ACP discussion, 36 inpatient admissions were recorded; these admissions were attributable to 24 of the care home residents included in the ACP pilot. The total length of hospital stay was **378** days.

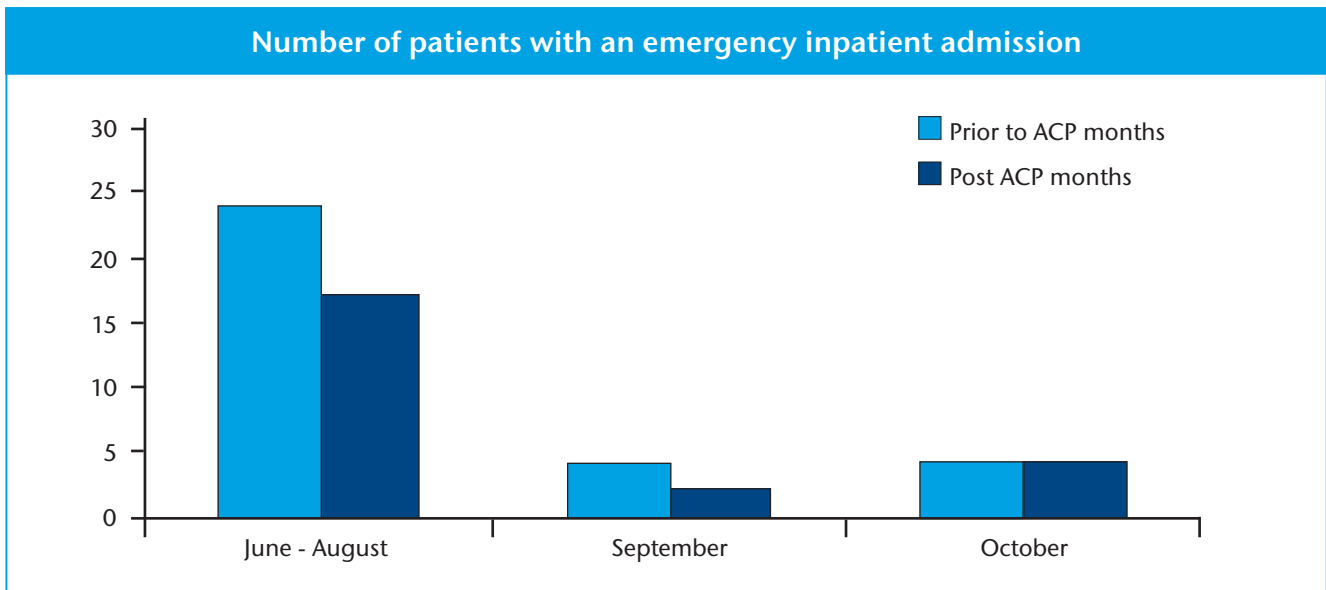


Figure 1. Number of patients with emergency inpatient admission pre and post ACP

6.4 The 129 care home residents were followed for 6 months **after completion** of their ACP. From the period of July to December 2009, 23 inpatient admissions were recorded; these admissions were attributable to 17 of the care home residents included in the pilot at that time. The total length of hospital stay was **186 days**.

Dates of ACP	No of patients with an ACP	No of months before and after analysed	Post ACP months			
			No of A&E attendances*	No of patients with an emergency inpatient admission	No of emergency inpatient admission	Total hospital length of stay
June - August	129	6	47	17	23	186
September	37	5	4	2	2	33
October	33	4	6	4	4	5

Table 2. Acute Hospital Contact Post ACP.

* 19 of the June - August attendances were for the same person (only two of the prior attendances belong to this patient).

6.5 The total number of emergency inpatient admissions during the pilot period can be seen in figure 2.

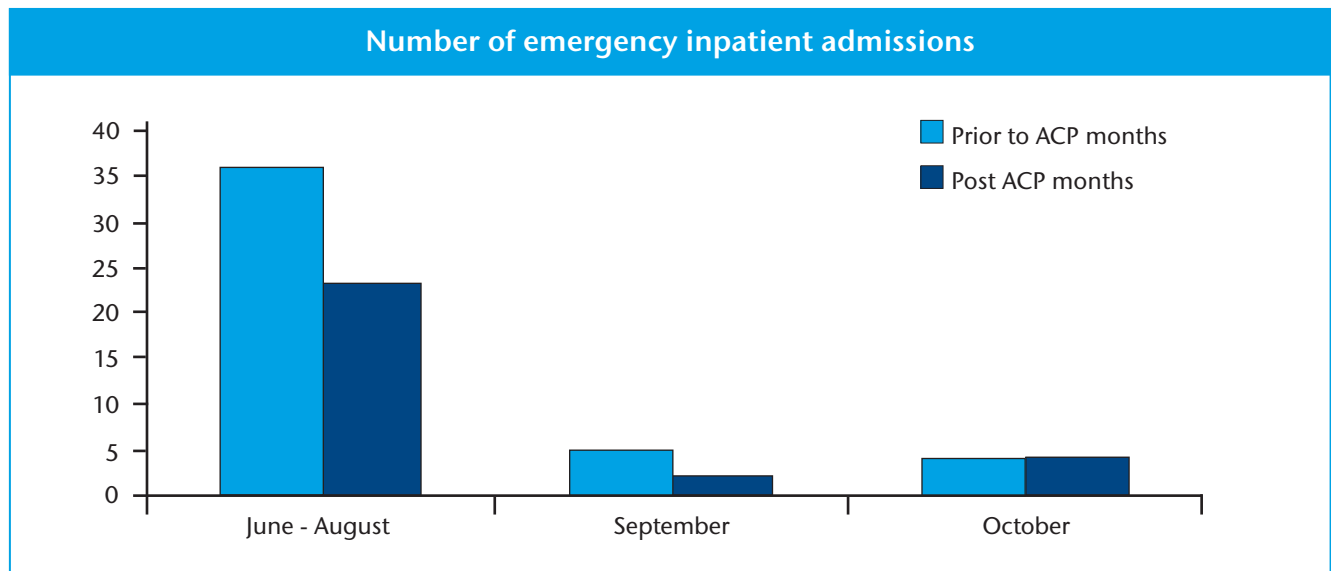


Figure 2. No of emergency inpatient admissions pre and post ACP

6.6 The percentage difference for all acute hospital contacts pre and post ACP can be seen in table 3 below.

Dates of ACP	No of patients with an ACP	No of months before and after analysed	% Differences			
			No of A&E attendances*	No of patients with an emergency inpatient admission	No of emergency inpatient admission	Total hospital length of stay
June - August	129	6	0.00	-29.17	-36.11	-50.79
September	37	5	-50.00	-50.00	-60.00	-2.94
October	33	4	-45.45	0.00	0.00	-91.80

Table 3. % Difference following introduction of ACP.

6.7 From analysis of the data it is clear that following the introduction of ACPs a significant difference can be seen on the number of emergency hospital admissions (fig 2) and length of stay (fig 3), especially with the care home residents who completed their ACPs within the June to August 2009 period.

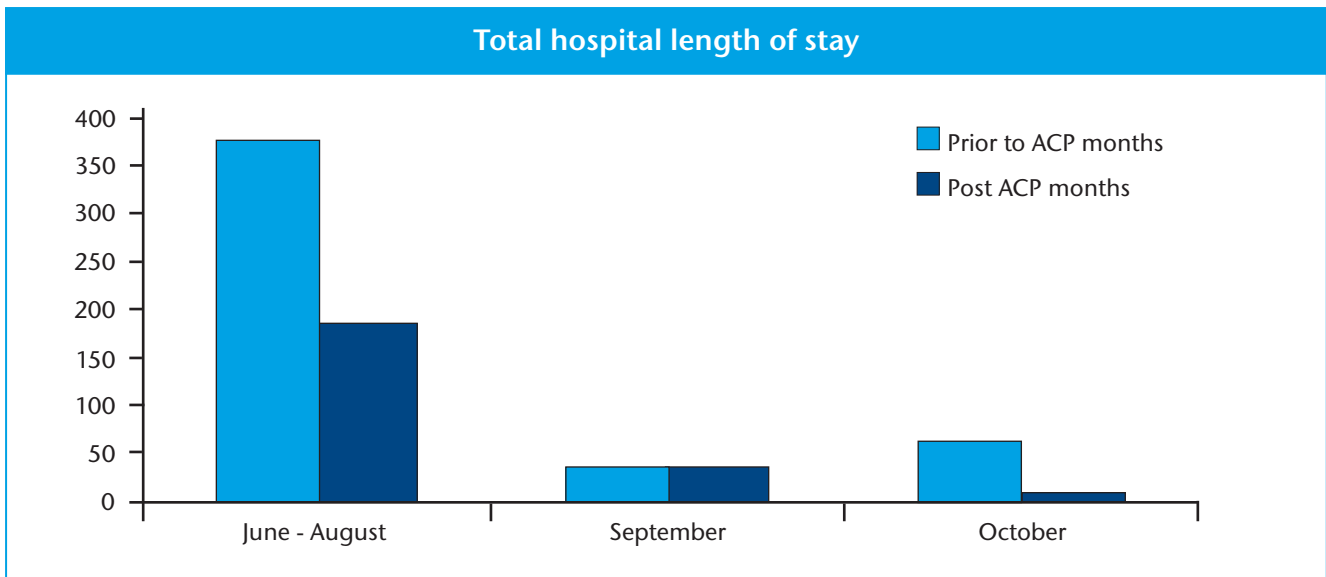


Figure 3 Hospital length of stay pre and post ACP

6.8 From initial exploration of A&E contacts during this pilot it would appear that the introduction of ACPs made no impact upon A&E contacts. (fig 4) However on further analysis, 19 of the A&E contacts of the June - August group post ACP were attributable to one resident who required the same acute intervention.

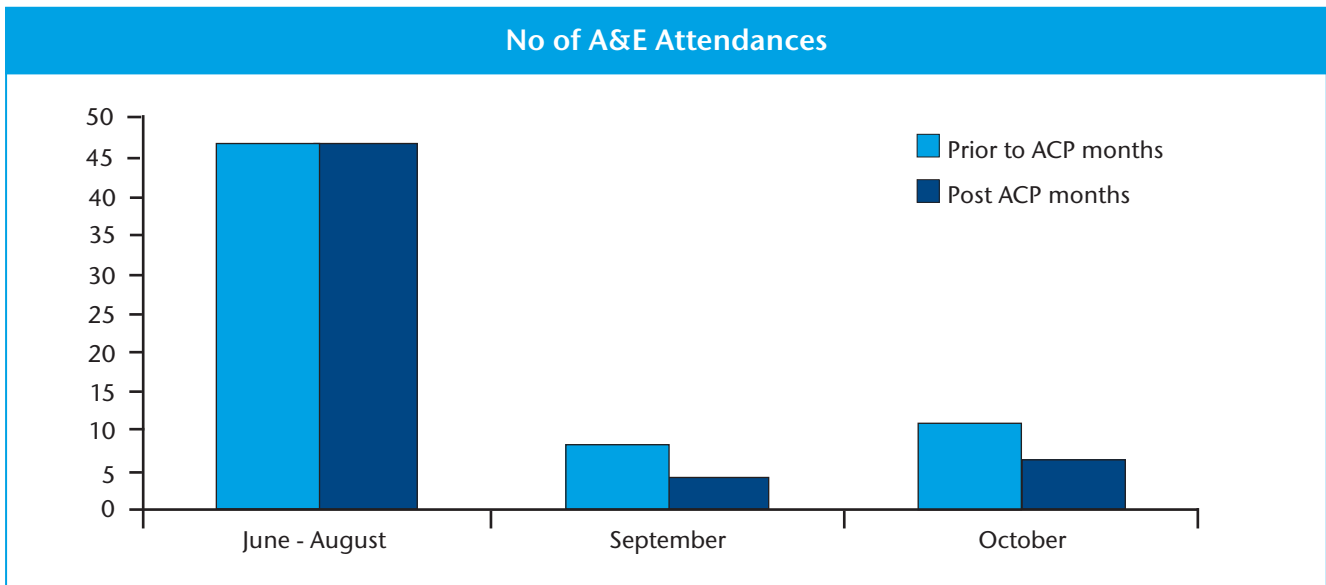


Figure 4 A&E attendances pre and post ACP

6.9 Indeed, for the group monitored 6 months prior to the introduction of Anticipatory Care Planning, 47 A&E contacts were attributable to 29 residents:

- * 18 individuals had 1 attendance
- * 6 individuals had 2 attendances
- * 4 individuals had 3 attendances
- * 1 individual had 5 attendances

Of the 47 A&E attendances pre ACP, 47% were discharged back to their care home with 53% requiring inpatient admission.

For the 6 months following the introduction of Anticipatory Care Planning, 47 A&E contacts were attributable to 25 residents:

- * 20 individuals had 1 attendance
- * 4 individuals had 2 attendances
- * 1 individual had 19 attendances

Of the 47 A&E attendances post ACP, 60% were discharged back to their care home with 40% requiring inpatient admission.

For the 37 residents monitored for a 5 month period before and after ACP, their pre ACP A&E attendance was as follows:

- * 4 individuals had 1 attendance
- * 2 individuals had 2 attendances

Of the 8 A&E attendances **pre ACP**, residents were discharged back to their care home on 6 occasions with 2 requiring inpatient admission.

During the 5 months **following ACP**, 4 residents attended A&E on 4 separate occasions. All were discharged back to their care home.

Similar findings can be seen in the group of residents monitored over the 4 month period illustrated in [figure 4](#).

6.10 From the information available it would appear that most of the A&E contacts were justified with residents requiring acute hospital intervention. ([appendix III](#))

The data to inform this analysis has been accessed from IsoftPMS, unvalidated data for inpatients ([may be subject to change](#)) and the EDIS A&E system.

6.11 To establish whether health professionals within the acute division acknowledged or made reference to the resident's ACP during the inpatient admission a total of 15 case note records were reviewed, 5 from each acute hospital. There was no mention of the resident's ACP within any of the case notes reviewed.

Impact on Care Home Residents

- 6.12 Comments captured from residents and their families during the project suggest that the introduction of ACPs has improved communication, has acknowledged the expressed wishes of residents and provided the opportunity for families and care home staff to discuss difficult and sensitive issues.
- 6.13 Questionnaires were issued to the care homes involved in the pilot to capture feedback from residents and their families about their experience and views on Anticipatory Care Planning. All feedback was completely anonymous.
- 6.14 Some of the comments captured from residents and relatives included the following:
- Resident** *“You have to live life,” “Not sit around in an armchair waiting for death. My future care will be based on my values and beliefs. Thanks”*
- Resident** *“One day soon I am going to die”. “All I am really scared of is losing my mind. In the meantime, I feel better now that I have talked over what I want to happen when I am unable to make any decisions with my family and my carers, and written it down in my plan.”*
- Resident** *“Thank you for giving me peace of mind as I now know that my wishes have been discussed and have been written down so that when the time comes and I am unable to make a decision for myself my family, friends and carers will know my preferences for my care. It feels like a weight has been lifted from my shoulders.”*
- Relatives comment** *“Thank you for helping to make a very stressful situation more bearable”*
- 6.15 During the introduction of Anticipatory Care Planning the ACP facilitator received many requests directly from relatives and care home staff for further copies of the ACP documentation which they wished to use for themselves and other members of their families. All care home residents invited to take part wished to do so, no one refused or withdrew from the pilot.

Impact on Care Home Staff

6.16 Care home staff were asked to describe their experience when completing an ACP and whether they had sufficient knowledge and skill to initiate the ACP discussion and process. Feedback included:

Staff nurse *“Great communication tool got all of us talking about sensitive issues that we do not think or talk about enough to each other”*

Care home manager *“Felt a bit uncomfortable at first as sensitive issues were discussed by residents but was amazed at the type of information that was revealed. One of our 85 year old ladies confided to me one of her wishes was to ride on the back of a Harley Davison motor bike. We got that arranged for her.”*

“Staff and relatives were reluctant at the beginning to talk about things like end of life care and resuscitation but with support and encouragement this was quickly resolved. Relatives were encouraging each other to fill in plans for their loved ones.”

“Still a new to us but has been very useful in getting everyone talking about a sensitive subject. Residents like it because they feel a sense of control as they have discussed their values and beliefs with their families before a crisis has happened and they have planned their future care.”

“ACP should not be rushed it gives the resident and their families the opportunity to talk about issues that are close to their hearts but it can be awkward in a busy care home.”

“I think at the beginning it’s a very difficult conversation to have with anyone and it was quite a new thing for a lot of our staff to be doing, so in the early days it was quite difficult and I think people skirted around the issues and words to use and things like that, but what we’ve found is that once we’ve actually asked the questions some residents or relatives have actually said “Oh I’m so glad you’ve asked” I think we should be proud of giving good end of life care. I mean, for somebody to die peacefully, we’re really kind of congratulating ourselves when somebody dies well and I think you know, that you’ve got very old people, very frail people and when they die it’s not a failure, it’s a real success if they have died well. We have had five residents who would have been admitted to hospital to die but we have carried out their last wishes to die peacefully at home as they requested in their plan. Everyone involved in their care feels that because their wishes were written down and discussed with the GP this ensured they died in their preferred place of care.”

6.17 Staff felt that having experience, confidence and time to enter into the discussion was absolutely essential to complete the ACP with the resident and the resident’s family.

6.18 In general, feedback from care home staff suggests that the process of completing the ACP encourages deeper discussion about sensitive issues with all those involved; it avoids crises and avoids unnecessary hospital admission.

7.0 Conclusion

Anticipatory care planning is a process of discussion between a patient/resident, their health care professional and the patient's family, and is fundamental to person centred care.

The process is reliant on the availability of the documentation, time with the resident, and the experience and knowledge of care home staff.

From the pilot it is clear that the introduction of ACP can have a positive impact upon the overall experience of care home residents and their families. It may also eliminate unnecessary acute hospital attendance and reduce length of hospital stay.

Although the scope of this project was limited to the introduction of Anticipatory Care Planning within care homes, anecdotal reports, our experience and actual findings suggest the concept may have relevance in other clinical and non clinical settings. Considering this, discussion is required with the wider primary care team such as GPs, Care Managers, the community nursing teams, and the Older People's Directorate within NHS Lanarkshire Acute Division to ensure that Anticipatory Care Planning is accepted as best practice and seen as a natural progression of person centred outcomes focused care.

RECOMMENDATIONS

Reflecting upon the findings of the ACP pilot the following recommendations should be considered:

- 1. Formally launch Anticipatory Care Planning throughout Lanarkshire.**
- 2. Develop and distribute ACP briefing to all GPs.**
- 3. Contact Emergency Response Centre to provide information on Anticipatory Care Planning.**
- 4. Distribute supply of ACPs and implementation support pack to all care homes in Lanarkshire.**
- 5. Support the use of ACPs in Care Management.**
- 6. Provide support to Care Managers to facilitate implementation**
- 7. Supply ACPs to Older People's Directorate within Acute Care Division.**
- 8. Provide support to Older People's Directorate to facilitate implementation.**

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Janice Slater, ACP Facilitator, NHS Lanarkshire

ACP Working Group

Janette Barrie, Nurse Consultant for Long Term Conditions

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Care Home Manager, staff and residents, Meldrum Gardens Care Home, East Kilbride

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Care Home Manager, staff and residents, Summer Lee House Care Home, Coatbridge

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Annette Newbiggin

Evelyn Ryan, District Nurse, Team Leader, NHS Lanarkshire

Denise Stewart

Hazel Towers, Information Analyst

REFERENCES

Scottish Government Health Directorate (2008)

Living and dying Well: a national action plan for palliative and end of life care in Scotland.

NHSScotland

Edinburgh.

Scottish Government Health Delivery Directorate (2010)

Anticipatory Care Planning: frequently asked questions

NHSScotland

Edinburgh.

APPENDIX I: WORKING GROUP MEMBERS

Janette Barrie	Nurse Consultant	NHS Lanarkshire
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Mary Thom	Discharge Team Leader	NHS Lanarkshire

APPENDIX II: ANTICIPATORY CARE PLANNING IN LANARKSHIRE

Aim of Session:

To provide information and support for the application of Anticipatory Care Planning

Learning Outcomes:

At the end of this session participants will be able to:

1. Define the term anticipatory care planning
2. Discuss the importance of anticipatory care planning
3. Describe the role of practitioners in the anticipatory care planning discussion
4. Demonstrate through discussion where to access DNAR policy
5. Critically reflect on personal experiences of anticipatory care planning
6. Increase application of anticipatory care planning discussions

Overview:

Anticipatory care planning is a dynamic record that should be developed over time through an evolving conversation, collaborative interactions and shared decision making. It is a summary of “Thinking Ahead” discussions between the person, those closest to them and the practitioner (NHSScotland 2009).

Nurses and care home staff are well placed to identify the right time to enter into ACP discussions. This can help the patients, residents, families and other health care professionals as the individuals condition becomes more complex.

The process of anticipatory care planning requires regular, ongoing discussion and sensitive communication skills.

Content:

- * What is Anticipatory Care Planning
- * Policy Background
- * The Anticipatory Care Planning discussion
- * Communication skills
- * General skills in Anticipatory Care Planning
- * Adults with Incapacity (Scotland) Act 2000
- * What is Power of Attorney
- * How to use the documentation

KSF Links:

Supporting information:

<http://www.ecs.scot.nhs.uk/epcs.html>

www.scotland.gov.uk/livinganddyingwell

APPENDIX III: A&E ATTENDANCES

Group 1: June - August cohort (n=129): A&E attendance diagnosis pre ACP

Diagnosis	Number	%
Congestive Heart Failure	1	2.1
Direct referral: General surgery	4	8.5
Direct referral: medical	10	21.3
Dislocation of jaw	1	2.1
Fracture	8	16.9
Haematuria	1	2.1
Urinary retention	1	2.1
UTI	2	4.3
Minor Head Injury	6	12.8
Infection	1	2.1
Laceration	2	4.2
Hypoglycaemia	1	2.1
Epilepsy	1	2.1
Cerebral Transient Ischaemic attack	1	2.1
Acute lower respiratory infection	1	2.1
Exacerbation of COPD	2	4.3
Haematoma right knee	1	2.1
Other	3	6.4
	47	100

Group 1: June to August cohort (n=129): A&E attendance diagnosis post ACP

Diagnosis	Number	%
Acute myocardial infarction	1	2.1
Direct referral: General surgical	2	4.3
Direct referral: maxillofacial	1	2.1
Direct referral: medical	10	21.3
Dislocation of jaw	15	31.9
Fracture	5	10.6
Haematemesis	1	2.1
Urinary tract Infection	1	2.1
Head injury	1	2.1
Laceration	2	4.2
Seizure	1	2.1
Transient Ischaemic attack	1	2.1
Haematoma right hip	2	4.3
Other	4	8.5
	47	100

Group 2: September cohort (n=8) : A&E attendance diagnosis pre ACP

Diagnosis	Number	%
Abrasion Right Eyebrow	1	12.5
Fracture neck of femur	2	25
Laceration	1	12.5
Fall	4	50
	8	100

Group 2: September cohort (n=8) A&E attendance diagnosis post ACP

Diagnosis	Number	%
Abrasion Right Eyebrow	1	12.5
Fracture neck of femur	2	25
Laceration	1	12.5
Fall	4	50
	8	100

Group 3: October cohort (n=6) A&E attendance diagnosis pre ACP

Diagnosis	Number	%
Direct referral ENT	1	9.1
Direct referral Medical	1	9.1
Epistaxis (2 hours)	1	9.1
Seizure	1	9.1
Infection	1	9.1
Laceration head	2	18.2
Transient Ischaemic attack	1	9.1
Respiratory - cough	1	9.1
Soft tissue injury	2	18.2
	11	100

Group 3: October cohort (n=6) A&E attendance diagnosis post ACP

Diagnosis	Number	%
Acute coronary syndrome	1	16.7
Direct referral medical	1	16.7
Head injury	2	33.3
Seizure	1	16.7
Pain right shoulder - sprain	1	16.7
	6	100

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