NHS
Warwickshire North
Clinical Commissioning Group

2. Cardiovascular disease

Vision for quality:
A framework for action
- technical document

Quality & Equality First

Contents

This document is part of the Warwickshire North Clinical Commissioning Group's Vision for Quality clinical strategy.

The Vision for Quality clinical strategy is formed of a series of chapters:

- Vision for Quality - provides a general overview of the strategy

This is supported by a series of chapters that provide more detailed information on the individual health service areas:

- Urgent, emergency care and emergency general surgery
- Cardiovascular disease, stroke, transient ischaemic attack and heart failure
- Frailty
- End of life
- Mental health
- Dementia

1.0 Introduction

Cardiovascular disease (CVD) is a common condition caused by atherosclerosis, furring or stiffening of the walls of arteries. Although CVD may manifest itself differently in individual patients, CVD in practice represents a single family of diseases and conditions linked by common risk factors and the direct effect they have on mortality and morbidity. The family of diseases or conditions include coronary heart disease (including heart failure), stroke, hypertension, hypercholesterolemia, diabetes, chronic kidney disease, peripheral arterial disease and vascular dementia.

1.1 Cardiovascular disease is the biggest killer in Warwickshire North, with deaths from both stroke and ischaemic heart disease equalling 570 in 2011/12.

Cause of death in WNCCG (2011/12)	Numbers
Ischaemic heart disease	425
Stroke	145

The health outcomes framework, shown over the page, illustrates how we perform in comparison to other CCGs with a similar population. The table demonstrates that our outcomes are worse than the England average in the mortality rate from cardiovascular disease for those under 75.

CVD is often preventable in younger people by having a healthy lifestyle and by having medical conditions which increase the risk of CVD, such as high blood pressure, high cholesterol and diabetes, managed well.

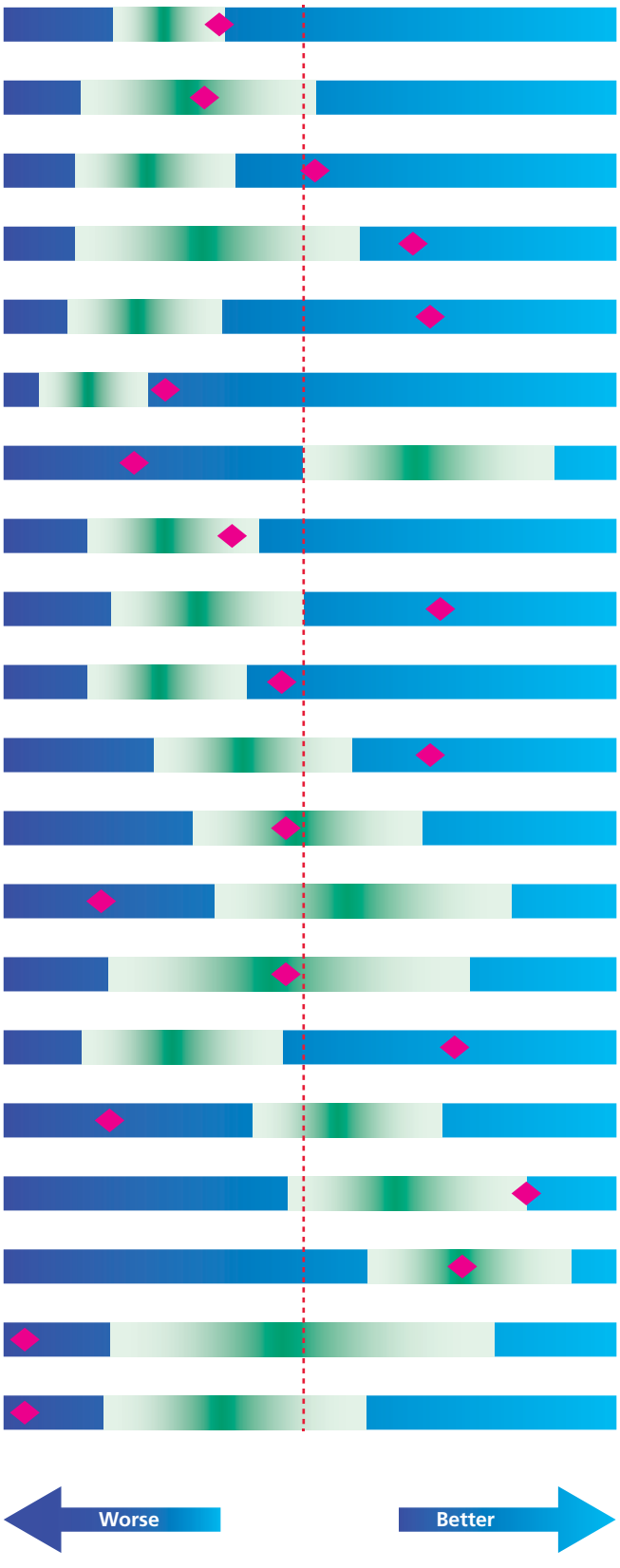
1.2 Heart failure comprises a group of conditions often caused by the heart muscle being damaged in some way so that not enough blood is pumped around the body. This often results in breathlessness which can be very severe. Heart failure can rarely be cured and people with severe heart failure often have repeated attacks of worsening breathlessness which result in frequent admissions to hospital.

1.3 A Stroke is a kind of brain attack. It is caused by a blood clot or bleeding in the brain. Strokes can be fatal or cause damage that can in the worst cases leave people very disabled, affecting their ability to communicate, as well as physical and mental damage. This can have a huge effect on not only people who have had them, but also on loved ones and families.

1.4 A transient ischaemic attack (TIA) is a less serious or minor stroke where the effects pass quickly and leave no lasting damage. TIAs can however precede a more serious stroke, therefore rapid assessment and treatment of a TIA can prevent someone having a more severe stroke.

Health Outcomes Framework

Outcome Indicator		CCG and ONS cluster distribution
1a	Potential years of life lost (PYLL) from causes considered amenable to healthcare	
1.1	Under 75 mortality rate from cardiovascular disease	
1.2	Under 75 mortality rate from respiratory disease	
1.3	(Proxy indicator) Emergency admissions for alcohol related liver disease	
1.4	Under 75 mortality rate from cancer	
2.	Health related quality of life for people with long term conditions	
2.1	Proportion of people feeling supported to manage their condition	
2.3i	Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults)	
2.3ii	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	
3.a	Emergency admissions for acute conditions that should not usually require hospital admission	
3.b	Emergency readmissions within 30 days of discharge from hospital	
3.1i	Patient reported outcome measures for elective procedures - knee replacement	
3.1ii	Patient reported outcome measures for elective procedures - hip replacement	
3.1iii	Patient reported outcome measures for elective procedures - groin hernia	
3.2	Emergency admissions for children with lower respiratory tract infections	
4.ai	Patient experience of GP services	
4.aii	Patient experience of GP out of hours services	
4.aiii	Patient experience of NHS dental services	
5.2i	Incidence of healthcare associated infection (HCAI): MRSA	
5.2ii	Incidence of healthcare associated infection (HCA): C Difficile	



KEY

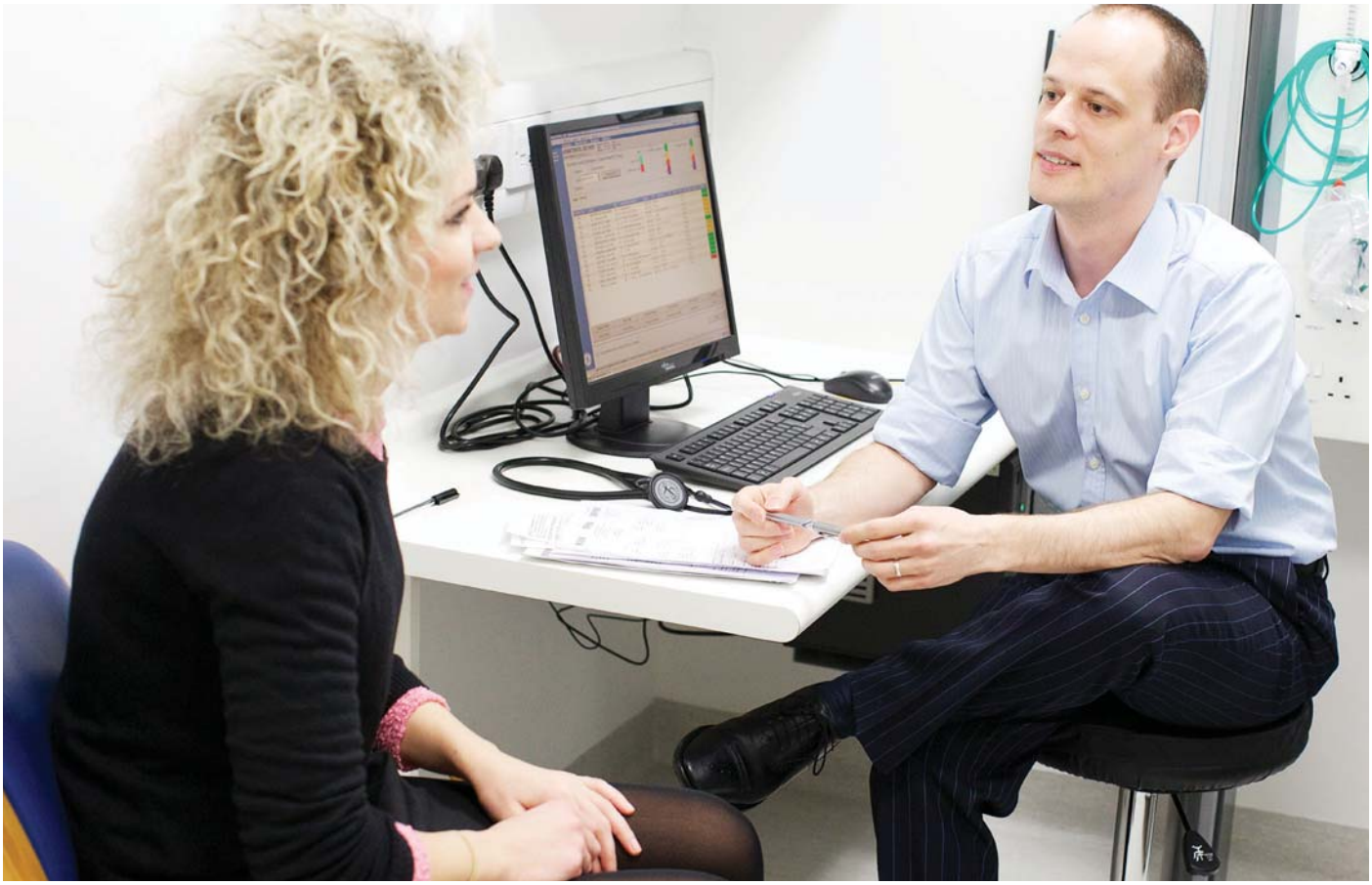
- England average
- NHS Warwickshire North CCG
- ONS cluster with darkest shading being the cluster average

2.0 The current situation in Warwickshire North

2.1 Cardiovascular disease

The Quality and Outcomes Framework (QoF) 2011/12, shows, against key CVD, blood pressure and diabetes indicators, how our GP practices are performing in comparison to an England average. In four of the 14 indicators, less patients are potentially being treated that the England average, it should be noted however that all patients may not be appropriate for treatment.

For example, 71.7% of patients in our CCG who are known to have coronary heart disease (CHD) are treated with a beta blocker, whereas the England average is higher at 74.2%; this means that there are potentially some 1,485 patients who are not being treated, as shown in the table on page 4.



Extract from the Quality & Outcomes Framework 2011/12

Indicator	WNCCG	England	
CHD10. The percentage of patients with CHD who are currently treated with a beta-blocker	71.7% ↓	74.2%	1485 less patients potentially being treated than the England average
CHD12. The percentage of patients with CHD who have had influenza immunisation in the preceding 1 September to 31 March	93.5% ↑	92.5%	
CHD6. The percentage of patients with CHD in whom the last blood pressure reading is 150/90 or less	89.8% ↓	90.1%	604 less patients potentially being treated than the England average
CHD8. The percentage of patients with CHD whose last measured total cholesterol is 5mmol/l or less	77.6% ↓	80.4%	1244 less patients potentially being treated than the England average
CHD9. The percentage of patients with CHD with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anticoagulant is being taken	93.8% ↑	93.3%	
BP4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months	92.4% ↑	91.0%	
BP5. The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less	81.8% ↑	79.7%	
DM17. The percentage of patients with diabetes whose last measured total cholesterol within the preceding 15months is 5mmol/l or less	83.5% ↑	81.7%	
DM26. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59mmol/mol or less in the preceding 15 months	70.8% ↑	69.9%	
DM27. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64mmol/mol or less in the preceding 15 months	79.5% ↑	78.7%	
DM28. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75mmol/mol or less in the preceding 15 months	89.3% ↑	88.6%	
DM29. The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low, 2) increased risk, 3) high risk) or 4) ulcerated foot within the preceding 15 months	90.3% ↑	89.6%	
DM30. The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less	90.7% ↑	89.9%	
DM31. The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less	70.3% ↓	70.7%	2588 less patients potentially being treated than the England average

Early detection and prevention are key for CVD. NHS Health Checks were introduced in Warwickshire North in 2011 in order to detect risk factors for CVD early. The Health Checks offer patients a range of routine health tests and standard questions to identify any disease and/or their risk of developing heart disease, stroke, kidney disease, type 2 diabetes or some forms of dementia. Health Checks are for adults in England between the ages of 40 and 74.

Of the 10,124 people who attended health checks in 2011, 1077 were found to have one of the conditions listed below that had not previously been diagnosed:

- 668 were found to have high blood pressure
- 213 people were found to have diabetes
- 114 people had chronic kidney disease
- 51 people had established ischaemic heart disease
- 31 people had atrial fibrillation

This demonstrates that there are significant levels of undiagnosed need within the population.

2.2 Heart failure

Warwickshire North CCG has 1,343 patients identified on a register for heart failure.

Overall the GP practices in WNCCG are performing around or above the national average for the management of heart failure.

Indicator	WNCCG	England	Potential number of patients not treated
HF2. The percentage of patients with a diagnosis of heart failure which has been confirmed by an echocardiogram or by specialist assessment	96.9%	95.7%	18
HF3. The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACEi or ARB	89.5%	89.3%	62
HF4. The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACEi or ARB, who are additionally treated with a beta blocker licensed for heart failure	84.5%	83.9%	64

During 2012 there were 1,413 emergency admissions to George Eliot Hospital due to cardiac conditions. 23% of these were due to ischaemic heart disease and 38% were due to heart failure and artrial fibrillation/flutter Although most of the CCG's patients with heart failure attend GEH for treatment, there is currently no agreed pathway of care across primary and secondary care. In addition, there are some long waits (up to eight weeks) for echocardiograms which is an important test to confirm the diagnosis of heart failure.

2.3 Stroke

There are different phases to the stroke pathway:

Hyper-acute - patients who have had a stroke in the last four hours and require immediate imaging and clot-busting drugs.

Acute - the phase after a patient has initial treatment for stroke to help them to recover.

Stroke rehabilitation -there are two types of rehabilitation - Early Supported Discharge (ESD) required for six weeks post discharge and then community rehabilitation. Rehabilitation services are currently insufficient for patients in Warwickshire North. The demand for this service is estimated at some 110 patients per year for ESD (based on 40% of the 275 patients who are discharged requiring the service) and 66 patients a year (based on 60% of patients who complete the ESD phase requiring the service) for community rehabilitation.

Currently the pathway and activity for patients with TIA, hyper-acute stroke and acute stroke are as follows:

2.4 Transient Ischaemic Attack

Current local service TIA	TIA clinic activity	Key quality standards	Issues/Impact on patient
GEH: 365 days a year consultant leadership. CNS delivered service. Carotid doppler provided at University Hospitals Coventry and Warwickshire (UHCW). **UHCW:** Seven day one stop consultant delivered service with on-site carotid doppler.	**GEH:** 228 new patients a year and 161 follow-up appointments. **UHCW:** 46 new patients and 2 follow-up appointments.	Proportion of people at high risk of stroke who experience a transient ischaemic attack assessed and treated within 24hrs. National standards One stop outpatient assessment including carotid doppler.	Patient has to travel to UHCW for investigation. Provider to provider SLA for carotid doppler so commissioner only pays once.

Current local service

Hyper-acute phase

Hyper-acute stroke services for Coventry and Warwickshire are provided by University Hospitals Coventry and Warwickshire (UHCW) as a tertiary service. Networked pathways of care have been in place since around 2007 to ensure that all patients potentially eligible for thrombolysis and hyper-acute management are taken directly to UHCW for their care.

After the hyper-acute phase is complete, patients are either repatriated to George Eliot Hospital (GEH) for a period of acute care prior to discharge, or will be discharged direct to home with community support if appropriate.

Acute phase

Current local service	Activity	Key quality standards	Issues/Impact on patient
GEH: 18 acute stroke beds 4 step down beds 1 stroke assessment bed **UHCW:** 6 hyper-acute stroke beds 30 acute stroke beds.	**GEH:** 180 emergency admissions 12/13. **UHCW:** 55 emergency admissions 12/13 (N.B. includes hyper-acute admissions).	National stroke standards and pathway developed by the Midlands and East expert panel. The specification includes staffing establishment and skill mix standards within the service specification.	Some local workforce gaps identified against the specification in the consultant, nursing and therapist provision for both hospitals. Long length of stay at GEH.

3.0 The case for change

3.1 Local evidence

There are a number of reasons why we need to make changes to the cardiovascular, heart failure, stroke and TIA services. Some of these are stated below and are grouped into local and national evidence.

CVD and heart failure

- There are high numbers of people whose lifestyle means that they are at greater risk of developing cardiovascular disease. We have over 30,000 people who smoke, over 2,000 who are admitted with alcohol-related problems and levels of obesity are high.

- More people could be identified for preventative programmes to reduce future cardiovascular risk and progress of disease.

- Coronary heart disease (CHD) data suggests under-diagnosis or under-recording of CHD in primary care (as identified by Quality and Outcomes Framework (QoF) data). In addition mortality from CHD is significantly higher than in England (44.98 rate) for both North Warwickshire and Nuneaton and Bedworth Joint Strategic Needs Assessment (JSNA 2012/2013).

- QoF data tells us that we are lower than the England average for the percentage of patients with CHD who are currently treated with a beta blocker, lower for the percentage of patients with CHD in whom the last blood pressure reading is 150/90 or less and lower for the percentage of patients with CHD whose last measured total cholesterol is 5mmol/l or less.

- The National Heart Failure Audit (April 2011 – March 2012) at George Eliot Hospital presented findings and recommendations based on patients discharged with a diagnosis of heart failure between 1 April 2011 and 31 March 2012. Findings included a lack of a specialist heart failure service.

- The West Midlands Quality Review Service (WMQRS) for Long Term Conditions (2012) including heart failure found that at GEH:
  - The heart failure staffing levels at the hospital were found to be low for a number of patients cared for by the team, although hospital staff were continuing to see patients that in other areas primary care would manage.
  - The heart failure team was entirely hospital based.
  - Most patients with heart failure could not access cardiac rehabilitation.
  - There was no system for routinely identifying patients in need of palliative care.
  - There was a lack of an integrated approach with primary and community services.

Stroke

- A regional Expert Panel produced a pathway for stroke care from the current best practice. Hyper-acute stroke care is currently provided by UHCW and other specialist hospitals. No change is suggested in the location of these services but there are some areas where the current services do not meet the requirements in this new pathway.

- The TIA service at GEH is not delivered by a specialist stroke consultant as outlined in the national and regional specification and recommendations; the current service operates with a consultant with a special interest in stroke.

- Like most areas, while we have information about some aspects of the stroke and TIA services, we do not have information about the outcomes for patients after a stroke or TIA.

- The ratio of expected to actual number recorded on the stroke register is lower than the England and Warwickshire average, suggesting an under-diagnosis/recording. There are higher mortality rates for all persons in the north of the county compared to England as a whole (JSNA 2012/2013).

- Local delivery of rehabilitation services after a stroke is limited.

- Our patients and voluntary sector told us they recognised the need to go to the right place for more specialist treatment but wanted to return closer to home as soon as possible with locally provided services. A number of comments were received on the lack of stroke rehabilitation and the need to focus on prevention.

3.2 National evidence

The Cardiovascular Disease Outcomes Strategy - Improving outcomes for people with or at risk of cardiovascular disease (Department of Health) states the key outcomes to achieve improvement are:

- To manage CVD as a single family of diseases.
- To improve prevention and risk management.
- To improve and enhance case finding in primary care.
- To better identify very high risk families/ individuals.
- Better early management and secondary prevention in the community.
- To improve acute care.
- To improve care for patients living with CVD.
- To improve end of life care for patients with CVD.
- To improve intelligence, monitoring and research and commissioning.

Quality Standards for Heart Failure (NICE)

The NICE quality standards define clinical best practice for the assessment, diagnosis and managment of chronic heart failure in adults, for instance:

- People presenting in primary care with suspected heart failure and previous myocardial infarction are referred urgently to have specialist assessment, including echocardiology within two weeks.

4.0 Views and opinions

4.1 Local GP opinion

GPs in Warwickshire North considered the stroke and TIA service in a workshop on 14 February 2013. Information on national best practice and outcomes for stroke and the latest stroke pathway defined by the regional expert group, with information on the local stroke and TIA services was presented to the GPs. This was considered alongside the day to day experiences GPs have treating patients who are at risk of stroke or who have had a stroke. The GEH consultant lead for stroke services attended a meeting with GPs later in the year to address some matters needing clarification. The key matters identified were:

- Practices should look to make improvements where their performance for the primary and secondary prevention of stroke was not optimal.
- Uncertainty of what services are available to help people improve their lifestyle to reduce the risk of them developing a stroke.
- All patients with a suspected TIA should be referred to a seven day a week, consultant-delivered one stop TIA clinic with access to imaging within 24 hours.
- The acute stroke team needs to work more closely with the community stroke team to ensure a seamless pathway for patients' discharge.
- The stroke service needs to ensure that it offers lifestyle advice to patients with a stroke or TIA.
- There should be routine collection and review of quality and outcomes data for the whole stroke service as this is currently a gap.
- There was support for a network approach to stroke care where patients who have been treated at UHCW are repatriated to GEH for local care following the hyper-acute phase.
- Concern that the current stroke rehabilitation service had insufficient capacity and that integration between acute care, community care and primary care was not always very good.

GPs considered CVD and heart failure in a workshop on 25 April 2013. Feedback was also received from a number of GP practices and there was an educational afternoon for GPs and practice staff on management of heart failure, led by a specialist doctor and nurse. Based on their experience of seeing patients on a daily basis and a learning event on heart failure led by a consultant and nurse specialist, key improvements suggested were:

- Improved management of risk factors (BP, cholesterol, diabetes etc.)
- A clear pathway for heart failure patients between primary and secondary care.
- Development of a cardiac rehabilitation service for those with heart failure in the community.
- Reduced waiting time for diagnostics to aid quicker diagnosis, especially echocardiograms.
- Ability to obtain quick specialist input from the cardiologists including same day clinic appointments to avoid admission to hospital.

4.2 Local patient opinion

The local patient opinion, gleaned from the patient workshop on 29 April 2013, identified that critical for the future patients needed:

- Access to services (refers to an individual's ability to receive a referral to a service).
- Information (refers to literature or other materials being available).
- Communication (refers to communication between individuals and organisations regarding patients and their treatments/ transfers etc.).

A number of patients stated the need for stroke rehabilitation. Comments included:

- 'We need local services in North Warwickshire',
- 'Rehabilitation should be provided locally in our medical centre',
- 'Important that there are enough after care services'.

4.3 Voluntary sector opinion

The voluntary sector event on 19 June 2013 considered CVD, although there was an overlap in discussion with stroke. Representatives, as with the patient representatives, felt that access to services (defined as an individual's ability to receive a referral to a service) and information about services, were critical for future services. There was discussion on the best place to be treated and a general consensus that patients should receive services wherever these are most effective. If this is not local they should be able to return to local services as soon as possible. Some comments from representatives were:

- 'Quality of care needs to be the first priority in commissioning services and then access.
- 'Go to right place for treatment but back to local services including GEH as soon as possible'.
- 'Take to UHCW for CVD so all services available, and then transfer to GEH as appropriate'.

In response to the question 'what works well?' people commented that the NHS staff, their ability and training was the most common theme of responses. There were positive comments about GEH and in particular Felix Holt Ward. When asked 'what doesn't work well?' workshop attendees' responses were mainly around transport, in particular transfers between GEH and UHCW; also access to services, predominantly rehabilitation and community services.
The importance of focusing on prevention was raised by at least three representatives:

- 'More localised preventative work within deprived areas'.
- 'More work around prevention needs to be done'.
- 'I think more needs to be done around preventative work and awareness, particularly with black and minority ethnic communities who are not approached'.

5.0 The future direction

There are a number of issues relating to cardiovascular disease, heart failure, stroke and transient ischaemic attack which have been raised by GPs and patients, through their local knowledge of commissioning and through the national direction for these services.

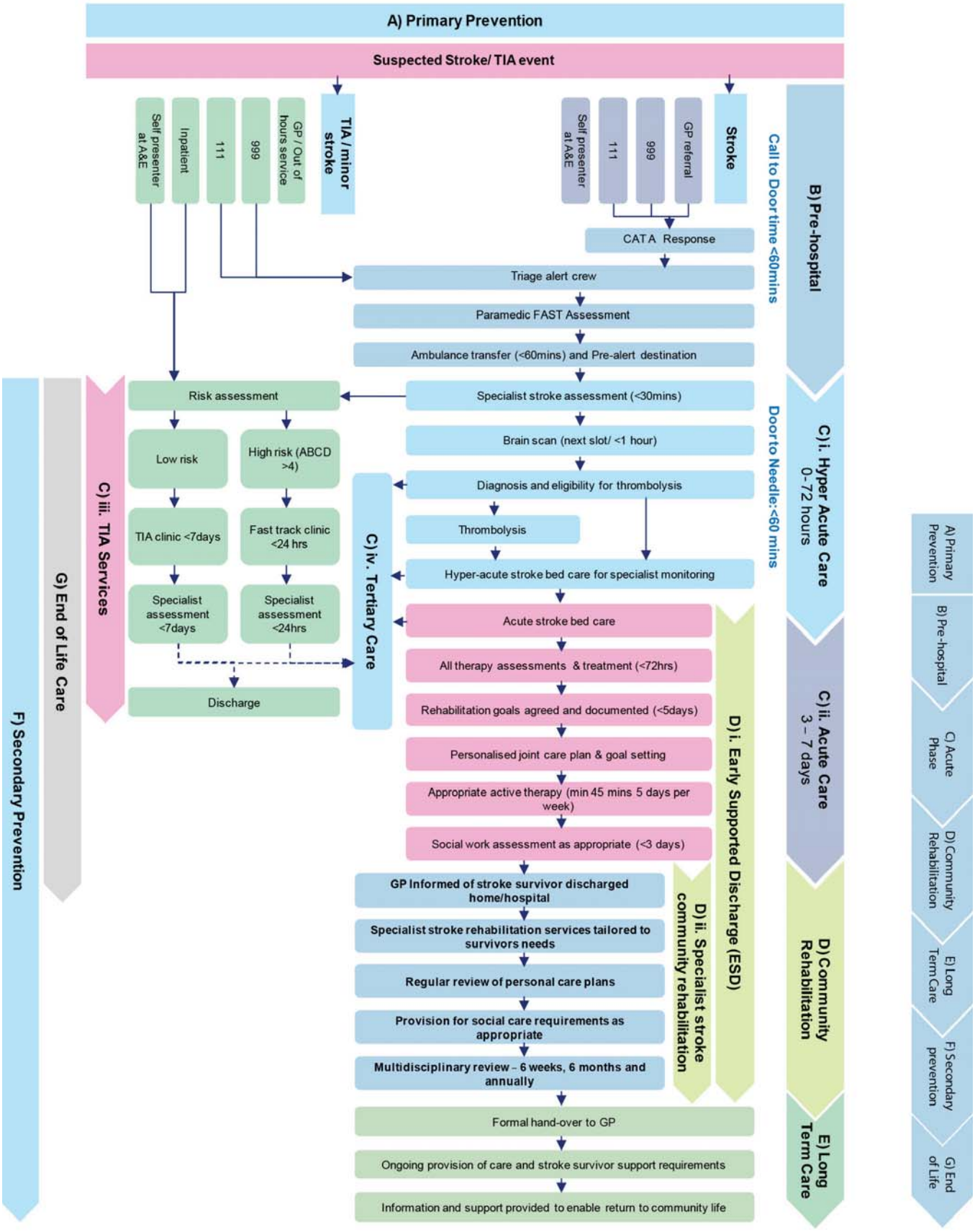
The table below outlines the:

- issues we need to address,
- actions we will take,
- outcomes we will expect.

What do we need to address?	What actions are we going to take?	Outcomes
Prevalence data suggests less identification of at risk patients for CVD/stroke than expected.	Work with partner agencies to collaborate on optimising the impact of all our actions to reduce cardiovascular risks. Maintain the provision of NHS Health Checks in all GP practices in Warwickshire North, ensuring vulnerable groups are targeted. Agree a plan to address any variation at practice level. Work with partners to create greater access and uptake of lifestyle management services where this is necessary. Improve management of medical risk factors for stroke/TIA such as high blood pressure and diabetes by peer review of GP practices.	Improved QoF performance for those indicators associated with cerebrovascular and cardiovascular disease. All patients identified as being at risk of stroke and CVD can access lifestyle management services. Improved mortality rates for CVD patients. NHS Health Check uptake increases in hard to reach groups.
Limited cardiac rehabilitation service for those with heart failure.	Procure a cardiac rehabilitation service, which builds on local lifestyle management services, exercise on referral schemes and offers more specialist services where it is appropriate.	Patients who have been admitted with a cardiac event have the opportunity to access a cardiac rehabilitation programme.
Workforce challenges in the acute cardiac service with low staffing numbers however, acute staff are also seeing patients that would in other areas be seen in the community.	Agree and implement a heart failure pathway between primary and secondary care with clear stages and responsibilities, in line with NICE guidance and creating improved integration of staff between community, acute and primary care. Standardise heat failure referral pathways and referral forms to improve the quality of referral.	Heart failure pathway followed across primary and secondary care, in line with NICE guidance. Primary, secondary and community teams work more closely together to deliver care.

What do we need to address?	What actions are we going to take?	Outcomes
No routine information on outcomes.	An annual report produced by the stroke and TIA service that reports activity, patient outcomes, patient experience and safety across the patient pathway as well as by organisation. This would allow the CCG and patients to be confident that the stroke and TIA services were helping patients achieve the right quality outcomes.	An annual report for commissioners and the public which outlines performance of the stroke service both across the pathway and by individual provider responsibilities.
No standardised way to access urgent specialist advice for patients with heart failure. Waits for echocardiograms are too long.	Access to urgent specialist opinion for GPs to prevent patients being admitted unnecessarily. Reduce echo waits to two weeks in line with NICE guidance.	Patient has quicker diagnosis and treatment.
Insufficient stroke rehabilitation capacity to best treat patients, post-discharge, in line with the regional specification (model shown on page 13).	Procure a stroke rehabilitation service with two distinct phases: (1) early supported discharge (ESD) service (for up to six weeks post-discharge from hospital) and (2) community rehabilitation service which takes patients following their discharge from the ESD service.	All patients who are discharged after a stroke, and are clinically appropriate, are seen and treated by the ESD team. All patients who are discharged from the ESD team, and are suitable for community rehabilitation, are given the opportunity to access services. Improved long term independence rates for stroke patients.
The regional workforce specification states that the "TIA service should be led by a specialist stroke consultant and provided by a specialist in vascular services with access to the consultant lead or specialist stroke nurse with appropriate specialist competency (where appropriate)". The TIA service at GEH does not meet all of the specification.	Centralise admissions of all patients with an acute presentation of cerebrovascular disease in a specialist centre to maximise their care and then repatriate them to GEH when it is clinically safe to do so.	All hyper acute presentations of stroke treated at UHCW, in line with regional guidance. Patients repatriated after hyper acute stroke/TIA diagnosis treated at GEH.

Summary stroke pathway diagram



Note: No scale: shape sizes not indicative of time

6.0 What will change for our patients?

There are times when the system does not work for our patients and we want to improve this for them. The following scenario provides an insight into what can happen now (when the system does not work well) and what would happen in the future following the proposed changes.

Now	Future
Rita is 68 years old, she is staying with her daughter out of Warwickshire and presents to her daughters local A&E within two hours of a disturbing event of weakness in her right arm and leg. She has spontaneously recovered. She is seen by a junior doctor and a TIA is not recognised or diagnosed. Rita is sent home. Five days later she represents having had a dense hemiplegic stroke.	Rita is 68 years old and presents to the Urgent Care Centre with two hours of weakness in her right arm and leg. She has spontaneously recovered. She is seen within an hour by a senior doctor from the Specialist Medical Assessment Team (Frailty) who diagnoses a TIA. She is booked in for the TIA clinic at UHCW and an ambulance is arranged to take her. Rita attends the clinic on the same day and has brain imaging and carotid duplex straight away. Her risk factors are treated and her significant carotid stenosis is operated on as soon as possible. She is discharged home two days later.

7.0 Timeframes for action

Warwickshire North CCG believes that the changes we have proposed will benefit patient safety and improve quality of care. We anticipate that within the next three years all of these changes will have been implemented. A more detailed schedule of action is shown below.

2014/15	2015/16	2016/17
Year 1	**Year 2**	**Year 3**
• Maintaining the provision of NHS Health Checks in all GP practices in Warwickshire North, targeting specific groups. • Improve Quality of Outcomes Framework performance against relevant indicators, especially blood pressure. • Agree and implement a heart failure pathway. • Standardise referral pathways and referral forms (for the heart failure pathway) to improve the quality of referral through the GP pathway system. • Ensure the echo waits are reduced to two weeks in line with NICE guidance. • Production of an annual report by the stroke and cardiology service. • Public Health to ensure sufficient capacity in lifestyle management to meet increased demand. • Improve identification of patients at risk of cardiovascular disease and stroke. • Production of cerebrovascular disease annual report. • Centralise treatment of transient ischaemic attack patients. • Design Early Supported Discharge Service.	• Ensure workforce to deliver the pathway is sustainable and integrated across community and secondary care. • Procure a cardiac rehabilitation service for heart failure. • Commission more lifestyle management if necessary. • Commission Early Supported Discharge service. • Design Community Rehabilitation Service.	• Commission Community Rehabilitation Service.

Personal notes

Personal notes

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