C09/S(HSS)/b

2013/14 NHS STANDARD CONTRACT FOR VETERANS' POST TRAUMATIC STRESS DISORDER PROGRAMME (ADULT)

PARTICULARS, SCHEDULE 2- THE SERVICES, A- Service Specification

Service Specification No.	**C09/S(HSS)/b**
Service	Veterans' post traumatic stress disorder programme (Adult)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Veterans' charity Combat Stress have completed a number of clinical audits that demonstrate that 75% suffer from chronic post traumatic stress disorder (PTSD) with 62% of these patients suffering from co-morbid depression as well as long term drug and alcohol misuse. These clinical audits also demonstrate that 92% have been exposed to multiple psychological traumas associated with their military service and 52% have had significant exposure to childhood trauma and childhood attachment difficulties prior to enlistment (Busuttil, 2009a). Many veterans give a history of social isolation, repeated relationship failure, frequent periods of homelessness and a severe feeling of loneliness and disconnection from mainstream society. Issues concerning poor adjustment into civilian life after leaving the military are common. Some 75% of new clinical cases are unemployed.

In terms of referral audits completed by Combat Stress, only 3% are referred to Combat Stress by the NHS; 56% self-refer or are referred by their partners or wives; and 34% are referred by other ex-service charities, welfare agencies or the Service Pensions Veterans Agency. The majority of new referrals indicate that it takes an average of 14.3 years from leaving their military service to the point of referral to Combat Stress.

A study conducted amongst veterans, including those accessing Combat Stress

services, demonstrated that delayed onset PTSD is 33% more common in veterans as compared to a civilian population (Andrews & Brewin, (2009), and that delayed onset clinical symptoms are likely to occur 18 months after service personnel leave the military. The average length of military service of veterans accessing Combat Stress care is 10 years.

It should be noted that extensive US studies have demonstrated that combat veterans suffering from chronic PTSD are more likely to develop serious physical illness including hypertension, myocardial infarction, strokes, and diabetes. The research has demonstrated that they develop these conditions some ten years earlier than their veteran counterparts unaffected by PTSD. Premature death resulting from these conditions is also evident (Boscarino, 1997; 2004; 2008). Many patients seen by Combat Stress also suffer similar serious physical conditions (Fletcher, 2007; Busuttil, 2009a).

The number of veterans in need of short-stay residential treatment in England accounts for some 300 new patients per year. Between 75% and 79% (224) of these veterans have complex needs as defined by Fletcher (2007) and Busuttil (2009a) (see also section 1.1 above for the definition).

Little is known about the population treated by Combat Stress, or about the long-term British veterans' long-term mental and physical health and welfare. To date, Combat Stress has strived to promote local internal and external academic and even national research into veterans' mental health. It is hoped that such research will promote national service planning as well as international services for veterans with mental health disorders.

The phasic rehabilitation model of care that will be provided by the intensive rehabilitation programme outlined in this specification has been adopted in keeping with the recovery model and with presentations of complex PTSD (Herman, 1992; Nice, 2005; UKTG; 2009; Foa et al, 2009). Combat Stress delivers phasic treatment interventions based on sound theoretical principles (Herman 1992), with an evidence base for its use in veterans and those exposed to childhood trauma (Creamer et al, 1999; Busuttil, 2006; Forbes et al, 2008; Foa et al, 2009). Successful phasic treatments for chronic complex PTSD rely on adequate preparation for eventual trauma focused therapy to be delivered in conjunction with rehabilitation (Creamer et al, 1999; 2002; Forbes et al, 2008).

This model incorporates four phases of stepped care interventions adopted across all Combat Stress clinical and welfare services which are as follows:

Phase 1 Preparation for (or / and) initial evidence-based treatments – community outreach welfare and outreach interventions.

Phase 2 Stabilisation – for those who are very unwell – incorporates a more detailed residential assessment and psychoeducation and might include a rolling programme of residential stabilisation admissions before proceeding to treatment

using psychological trauma focussed interventions

Phase 3 Therapy programmes – structured residential treatment programmes which include a block of trauma focussed evidence-based interventions – including Trauma-Focused Cognitive Behavioural Therapy (TF CBT); Eye movement desensitization and reprocessing (EMDR) (can also be delivered in already established rolling programme but this can take many admissions - will be better delivered in the new intensive programme commissioned by the NHS England.as described in this paper).

Phase 4 Rehabilitation – part of residential programmes as well as outreach and welfare follow-up care.

2. Scope

2.1 Aims and objectives of service

The national veterans' Post-Traumatic Stress Disorder (PTSD) programme is commissioned by the NHS England to provide a six-week intensive rehabilitation programme in a residential setting for the population of England. The national service aims to treat those veterans who have served in the British Armed Forces and are suffering from complicated presentations of severe traumatic stress disorder resulting from multiple exposure to traumatic events whilst in combat, or as a result of their military service, and who have a co-morbidity in physical illness or injury, addictive disorder or problems in childhood that have an adverse affect on coping skill development.

The rehabilitation programme will provide intensive expert intervention in a safe controlled environment and will be delivered once the individual is stable. In particular, it will allow intensive trauma focussed treatment to be accessed by the veteran population. It is expected that the national service will treat 224 new veterans per annum who present with complex psychiatric needs and who are diagnosed with chronic moderate to severe PTSD, with significant psychiatric co morbidity, who also consequently suffered severe social breakdown.

This sub-group of the veteran population shows multiple adverse outcomes including poor control of anger, impulsive and often explosive behaviour, violence, deliberate self harm, suicide and homicide; they are also at risk of social exclusion through long term unemployment, isolation and homelessness.

It is essential that the rehabilitation programme complements existing services and provides improved care and treatment for this veteran population, for whom their military service has been detrimental to their mental health and who for various reasons are often not engaged, or are poorly engaged, with NHS services. This group is at risk of coming to the attention of society via a variety of crisis intervention

services including the criminal justice system, often presenting with a wide range of serious social problems, if this disorder is not effectively treated.

The rehabilitation programme is required to be positioned within a stepped care approach, which is appropriate for the veteran population in aiding access to treatment and in supporting transition into mainstream NHS services when appropriate.

The aim of the service is to improve the mental health state of veterans suffering with chronic moderate to severe PTSD present with co-morbid disorders, through an intensive rehabilitation programme tailored to their needs in a safe environment. It will do this specifically by:

- improving mental health and maintaining wellness;
- reducing the burden of the disorder and treating psychiatric symptoms;
- minimising the risks posed to themselves and to others;
- improving quality of life;
- promoting social inclusion and a return to employment;
- improving function in daily life to the best of their ability.

The main areas of service delivery are:

- the provision of National Institute of Clinical Excellence (NICE)-approved treatments focusing on specialised high-intensity 'trauma-focused' psychological therapy services;
- an increase in access to evidence-based treatment options that complement existing mainstream NHS services, improving care pathways and speed of access through greater collaboration and joint case management;
- provision of a service that is evidence-based and which provides value for money;
- a system for clinical outcomes data collection;
- an increase of evidence-based and informed choice by people using the service;
- provision of access to information and other support for people who are referred but may not at present be eligible for the service.

The services aim to provide an effective and cost-effective comprehensive residential intensive rehabilitation programme (six-weeks) for the most severely disabled patients with PTSD by working in collaboration with local services. Services are available for ex-military personnel and combat veterans.

The service objectives are to:

- provide an exemplary and comprehensive service for all eligible veterans referred with severe PTSD;
- provide expert diagnosis of severe PTSD utilising the most up-to-date validated assessment / diagnostic tools and knowledge;
- target those in greatest distress and who have the most severe needs;
- provide expert management and rehabilitation of veterans with a confirmed

diagnosis of severe PTSD through the use of the most up-to-date clinical protocols for therapeutic interventions and symptom management;
- provide therapeutic support and care for veterans and their families that is focused to maximise their experience of care within the nationally designated providers;
- effectively monitor patients to ensure optimal daily function and social inclusion;
- reduce the number of veterans being sentenced to a prison term;
- reduce acts of domestic violence, public disorder and violence;
- prevent family breakdown
- act as the leading clinical service and a source of expert advice for the diagnosis and management of severe PTSD within the NHS;
- support local mental health and social care providers to manage veterans with severe PTSD whenever it is clinically appropriate and safe to do so;
- provide high quality information for veterans, families and carers in appropriate and accessible formats and mediums;
- develop shared care arrangements and more effective care pathways between veterans' specialist provision at Combat Stress and the NHS, that reduces health inequalities, improves access, and enables smooth transition of care when appropriate;
- develop the experience, knowledge and skills of the multi-disciplinary team (MDT) to ensure high quality sustainable provision;
- operate a rolling programme of clinical audit to test current practice and inform the evolution of care and therapeutic intervention for severe PTSD and co-morbidities.

It is essential that the service develops integrated care plans with NHS services to ensure that the mental illness is prioritised and successfully treated. Sufferers of PTSD need to be stable for their wider health needs before psychological interventions for PTSD are started. Management plans need to have clear agreement among individual healthcare professionals about their responsibility for monitoring patients with PTSD – this agreement must be in writing and must use the Care Programme approach

2.2 Service description/care pathway

The national veterans' Post-Traumatic Stress Disorder (PTSD) programme will provide specialist multi-disciplinary clinical treatment at residential treatment centre(s) in England that is tailored to the individual needs of veterans who require a six-week intensive rehabilitation programme. The provider will ensure that the service meets the need of the national caseload and ensure that location of service is not a barrier to accessing treatment. This service is to provide integrated care with community outreach services across England including in mainstream NHS services.

The service will provide an intensive rehabilitation programme that delivers evidence-based trauma focused psychological interventions and cognitive

behavioural therapies (CBT), including:

- exposure therapy to confront a veteran's traumatic memories as well as situations and people that are associated as a traumatic stressor,
- cognitive therapy to modify excessively negative cognitions (thoughts or beliefs) that lead to negative emotions and impaired functioning,
- stress and anger management
- Individual or group trauma-focused CBT programmes
- Eye movement de-sensitisation and reprocessing

The service will be delivered by providing the following interventions in a structured day approach as part of the rehabilitation programme. A draft programme being worked on currently includes the following:

i. trauma-focused individual CBT (96 sessions, 16.25 hours each over 12 week period);
ii. trauma-focused group CBT (18 session over 12 week period);
iii. therapy sessions, supplemented by guided self-help;
iv. group bonding (4 sessions);
v. group therapy (18 sessions);
vi. didactic / group psychoeducation (34 sessions);
vii. creative therapy (4 sessions);
viii. symptom management skills (51 sessions);
ix. individual psychiatric review (24 sessions – once every 2 weeks);
x. cognitive restructuring (9 sessions);
xi. weekend stress inoculation training – home work (3 weekends);
xii. alcohol management;
xiii. problem-solving;
xiv. family education / carer groups (2 half days);
xv. recreational activities 7 days a week.

(NB: duration of session is 1-1.5 hours)

The providers are responsible for case management and communication with the Community Mental Health Teams, consultant psychiatrists, psychologists, managers or care-co-ordinators, and GPs when required, including referral to alternative specialist services.

All patients will initially be offered a specialist assessment / screening, which will focus on the presenting problem; a risk assessment, and referral on to other agencies, if appropriate. This will include the following elements:

- Prior to the start of treatment all patients should be 'stable' on medication and abstaining from substance use.
- Patients will receive a comprehensive 'patient centred' assessment that clearly identifies the full range and impact of their severe PTSD and mental health problems and any linked employment, social and physical health issues.
- Risk (suicide, harm to others, etc) should be assessed at initial contract and as

appropriate thereafter.

- All patients must have their clinical, work and social outcomes assessed using standardised measures that are appropriate to the condition being treated. Key measures should be given at regular intervals in treatment to inform effective care planning and case management.
- The service should aim for pre- and post-treatment outcomes for all patients.
- The service should aim to meet the access standards for referral to decision to treat, and first treatment.

Following initial assessment patients who are clinically stable, and who are assessed as fulfilling clinical inclusion and exclusion criteria, will be offered a place on a six-week intensive rehabilitation programme in one of the three nationally-designated centres at Tyrwhitt House (Surrey), Hollybush House (Ayrshire) and Audley Court (Shropshire), including the following:

- All patients must be offered an evidence-based CBT treatment appropriate to their condition, as indicated in current NICE PTSD guidelines.
- The evidence-based treatment should be given at the frequency and dose that is necessary to maximise recovery.
- Responsibility for prescribing medication will continue to reside with either the patient's local General Practitioner or CMHT.
- High-risk patients (i.e. suicidal ideations, severe self neglect, severe injurious behaviour, psychotic symptomatology) identified through clinical judgement and/or objective risk outcome tools should be urgently discussed and referred where appropriate, to local specialist mental health services. In such cases, these patients will need their risk managed and symptoms treated first in a mainstream mental health service / inpatient facility to stablise their condition prior to trauma-focused therapy.
- Patients should be given a choice about where they wish to be seen, and should also be offered flexibility in terms of appointment times and the manner in which contacts are made.
- Appropriate information about the national service should be developed, distributed and updated regularly by providers.

The centres are to provide a clinically effective therapeutic environment that is highly supportive and sensitive to a military culture. The service will be provided by clinicians who are expert in providing trauma-focused psychological interventions and CBT, and who speak the same language as, and are culturally sensitive to, the veteran population, so that their needs are met. Staff should promote peer support throughout the rehabilitation programme.

Risk management

Care delivered by the providers must be of a nature, quality and safety to meet the Care Quality Commission standards, specification and agreement for the service. It is the providers' responsibility to notify the commissioner on an exceptional basis should there be any breaches of the care standards. Where there are breaches any consequences will be deemed as being the trust's responsibility.

Patients must be managed in line with the specification and care standards. Any deviation from these, which has not been approved by the NHS England, are at the trust's risk both clinically and financially. It is the providers' responsibility to inform the commissioners of any such non-approved deviations on an exceptional basis.

Where a patient's presentation challenges the assumptions that underpin the specification, service standards and contractual arrangements, it is the provider's responsibility to inform the commissioners on an exceptional basis, prior to any treatment (except for emergency treatment) so that the implications of the patient's requirements can be considered. This does not affect situations where the Individual Funding Application process applies.

Staff qualifications

Highly specialist, high intensity interventions will be delivered by professionals competent in the delivery of CBT and other evidence-based treatments. The team will be supported by the local mental health service and input from local General Practitioners. The multi-disciplinary team will comprise occupational therapists, psychotherapists, and registered mental health nurses, nursing assistants, psychiatrists and psychologists,

- Staff will be qualified to deliver the service proposed. They have multi-disciplinary backgrounds. Each psychoeducation group will be run by two staff members including, as appropriate, a qualified CBT nurse therapist or psychologist; with a time equivalent of two full time staff members for the group programme and individual therapy being employed.
- Those doing individual therapy will not be delivering didactic group work or group therapy as this will interfere with group dynamics and compromise the efficacy of the group and individual interventions.
- Staff team to include multi-disciplinary backgrounds including occupational therapy, psychiatry, nursing, and psychology.
- Other clinical governance staff not directly involved with the programme will also be recruited in order to ensure appropriate and robust clinical governance, audit, and outcome measurement.
- A consultant psychiatrist will oversee the treatment programme whilst in residential phase.
- A senior psychologist will take overall responsibility for the smooth running of the programme along with the treatment centre manager.

Care pathways

The national veteran's PTSD rehabilitation programme is required to fit into the overall recovery model adopted by the service. The programme will last for six weeks and be run by two full-time equivalent psychologists / CBT trained nurse therapists or their equivalent. These staff will be supported by consultant psychiatrists, Registered Mental Health nurses and other treatment centre staff. There will be access to all facilities in the treatment centre including an activity centre and gymnasium.

There will be up to eight participants per group.

The structured work day will be full-time from 0900 until 1700 hrs during week days with homework tasks and some therapy in the form of practical work being done at weekends. Two half-days for family/carer involvement are also scheduled.

Pathway in:
- multidisciplinary assessment – must include psychiatric assessment – five-day programme; rolling programme and/or outreach;
- psychometric measures of symptoms and function;
- stabilisation ensured first: medication via consultant psychiatrist; outreach work, CMHT; detoxification; rolling programme first for some.

Pathway out:
- back to locality - or
- groups run locally by outreach/NHS services– 8-12 over next year then discharge - or
- appropriate NHS referral if indicated - or
- back to Combat Stress rolling programme if indicated.

Follow-up for reassessment of outcome – repeated measures. Pre-treatment; midway through treatment if applicable; at end of treatment, exit satisfaction; then at least two post-treatment follow-up points, for example 3 months and 9 months.

Location of repeated follow-up measures will depend on logistics to some extent and may be conducted either via outreach services or as brief residential assessment.

Days/hours of operation

7 days a week with an opportunity for one weekend visit home.

Discharge planning:

Pathways out:
- care planning will be included as part of problem-solving end of programme exercises and will also involve the MDT at an appropriate time prior to ending of the group programme;
- back to locality, discharged from Combat Stress – put on passive list;
- groups run locally by Combat Stress/outreach/NHS services - 8-12 over next year then discharge;
- appropriate NHS referral if indicated – via GP or back to referring or involved CMHT;
- back to Combat Stress rolling programme if indicated, able to access residential treatment 1-3 times for up to 2 weeks per admission per year; monitoring and intervention in community by outreach services as well as referral back to the NHS.

If patient becomes unfit to continue with the programme he/she might be discharged back to the GP or CMHT or stepped back within the Combat Stress clinical services depending on circumstances. The commissioners will be informed of these events.

2.3 Population covered

The designated provider will deliver the service in residential centres that ensures there is good geographical coverage for eligible veterans.

Veterans who have a General Practitioner located in an English postcode will be eligible for this NHS England commissioned service.

2.4 Any acceptance and exclusion criteria

Referral criteria, sources and routes

Patients will be admitted to the programme depending on clinical need as demonstrated by clinical and psychometric assessment following MDT discussion; as well as whether or not they fulfill the inclusion / exclusion criteria.

Patients will be assessed by the welfare officer, and outreach services, then either in outpatients by a psychiatrist or more commonly by a MDT. Following a MDT discussion, patients are placed on an admission waiting list for the programme.

Inclusion into the six-week programme will take place within a multi-disciplinary discussion about each patient, following adequate clinical and psychometric assessment:

- referral via self-referral; through family; ex-service charities / agencies; GP, and NHS professional;
- Responsible Office, MDT outreach – initial screening psychometric tests, including Health of the Nation Outcome Scales (HoNOS);
- Five-day MDT assessment plus delivery of initial tool kit /or outpatient / outreach assessment – MDT or psychiatrist with MDT discussion;
- group programme specific psychometric tests;
- initial protocol;
- inclusion protocol;
- review midway, or three-quarters of the way, through programme;
- follow up reviews at two points at least;
- outreach follow-up via outreach groups.

The psychometric assessment protocol will be used to identify appropriate referrals to the new six-week intensive programme.

Post discharge:

- if required, referral to further individual therapy – Improving Access to Psychological Therapies (IAPT), NHS psychology services, Combat Stress outreach;
- if fail, refer back to Combat Stress rolling programme;
- eventual aim when there is a critical mass of patients in every outreach geographical area: outreach groups which meet once monthly for 6 number of months - discharge

Inclusion / exclusion criteria (lists not exhaustive):

MDTdecision on each candidate.

Veterans who have served in British Armed Forces included with:

- chronic moderate to severe PTSD with co-morbid depression, and/or other neurotic disorders such as anxiety, agoraphobia, obsessive compulsive disorder, alcohol and or illicit substance misuse currently abstinent – stable;
- exposure to multiple military traumas – two or more;
- childhood attachment disorders and/or history of childhood abuse – maladaptive coping behaviours (b*ut diagnoses of complex PTSD / borderline personality disorder, other personality disorder are exclusion criteria);*
- medication stable & compliant with medication;
- not currently psychotic;
- dissociation under control – not dissociating;
- not actively suicidal / homicidal / violent / not sex offenders;
- deliberate self-harm under control– stable enough to do therapy;
- stable physical disorders including chronic pain / no brain damage;
- history of social, family, work dysfunction;
- motivated; able to concentrate; do group work, do cognitive therapy;
- available for six weeks;
- literate / intelligent – able to understand and take part in cognitive behavior therapy;
- compliant and stable on medication;

Response time, detail and prioritisation

All non-urgent referrals, received in writing by the national service, will be assessed by the provider within 8 weeks of the date of receiving the initial Combat Stress registration form of the patient.

NB: Urgent / emergency referrals, due to self-neglect or suicidality, should be referred to non-specialist inpatient services locally and be referred to service once the crisis has been resolved.

The programme will be open to veterans of all ages as long as they fulfil the inclusion criteria and as long as they fulfil clinical assessment and psychometric protocols.

If many older veterans are eligible for the programme, an age sensitive group might be run. Similarly if a younger cohort is available, a younger cohort might be run. If veterans from a particular conflict are available to form a group of eight together then such groups might be run.

There will be no discrimination in relation to age, culture, disability and gender sensitive issues relating to accessibility/acceptability. The service must cater for the needs of both male and female veterans and should provide appropriate environment and clinical services to meet their individual needs.

The provider is required to undertake an Equality Impact Assessments as a requirement of race, gender, sexual orientation, religion and disability equality legislation

2.5 Interdependencies with other services

The nationally designated veteran's PTSD service provider is to be the leader in the NHS for patient care in this area and provide a direct source of advice and support when other clinicians refer patients into the national service. The provider is also required to provide education within the NHS, Military and social care sectors to raise and maintain awareness of veteran PTSD and its management.

The national provider will form a relationship with local health and social care providers and military services to help optimise any care for veterans with severe PTSD. This may include liaison with consultants, GPs, community nurses or social workers etc.

Specialist services will provide support for generic mental health services. This support will include:

- co-working for complex cases;
- good liaison and individual veteran care planning.

Relevant networks and screening programmes

The service is required to work within a clinical network that treats combat related PTSD in either service personnel or veterans.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

The provider must be Care Quality Commission (CQC) compliant for the provision of the treatment outlined in this service specification.

The national service must be fully integrated into the provider's corporate and clinical governance arrangements.

4. Key Service Outcomes

Outcome Measures.

The national service will routinely collect clinical outcome data prior to treatment starting, through treatment (pre- and end of treatment) and following treatment, and provide reports at an annual national clinical audit meeting.

There are a variety of measures used to gauge the severity of PTSD symptoms and the change of presentation over time. These measures are based on patient self-completion or structured clinical interview. The service is required to use one validated clinical and one patient reported tool detailed below:

Well-validated, structured clinical interviews that facilitate the diagnosis of PTSD include:

1. Post Traumatic Stress Disorder (PTSD) symptom scale – interview version (Diagnostic and Statistical Manual of Mental Disorders – edition 4)
2. Self-reporting instruments include:
3. Impact of event scale

The service will also complete an assessment (as outlined above) to identify eligibility for the clinical service prior to rehabilitation, and will use validated outcome tools throughout the programme to assess risk, physical, social and psychological needs:

1. Life events and traumatic events checklist
2. Hospital Anxiety and Depression Scale (HADS)
3. Novaco Anger Inventory – 25 (Short Form) (NAI-25).
4. WHODAS (WHO DisAbility Scale) 12 Item self-report questionnaire for disability and function
5. The Global Assessment of Functioning (GAF):
6. General Health Questionnaire- 28 Item. (GHQ-28)
7. Quality of Life Scale (QOLS);
8. IES (-R) Impact of Evens Scale – Revised for PTSD
9. Dissociative Experiences Scale version II. (DES-II).
10. AUDIT
11. Addictive Behaviour Questionnaire
12. Stages of Change.

The following clinical psychometric outcomes data will be collected by the service for 100% of patients admitted to the service:

- Life events and traumatic life events
- Depression, anxiety and anger
- Physical disability and function
- Global function
- Risk assessment (HoNOS)
- Psychiatric caseness
- Alcohol intake and problems; illicit drugs
- Quality of life
- Post traumatic stress disorder and dissociation.

Patient indicators or outcomes measures is to be completed for the following areas:

1. Patient satisfaction
2. Family involvement
3. Functional improvement – including return to work / work retraining / entering into education.
4. Symptom management – improved coping, and symptom improvement
5. Patient compliance – with medication; with therapy
6. Maintaining well-being
7. Access to mainstream NHS services in primary care, mental health, psychology, psychotherapy services
8. Access to physical health care – physical illness detected through the veteran PTSD services

Service outcomes:

- number of referrals / assessments
- number of completed intensive rehabilitation programmes
- occupancy levels – occupied bed days
- number of patients who fail to commence planned programmes
- number of patients who fail to complete planned programmes
- intensive follow ups
- average length of stay

5. Location of Provider Premises

- Tyrwhitt House, Leatherhead, Surrey
- Hollybush House, Ayrshire
- Audley Court, Shropshire