WM QRS West Midlands Quality Review Service

NHS

West Midlands People with Learning Disabilities Care Pathway Group

Review of Health Services for People with Learning Disabilities

Report Date: October 2012 Visit Dates: May 2011 to January 2012

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INTRODUCTION

West Midlands Quality Review Service (WMQRS) was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on the WMQRS website: http://www.wmqi.westmidlands.nhs.uk/wmqrs

Reviews of mental health services, health services for people with learning disabilities, dementia services and care of vulnerable adults in acute hospitals in the West Midlands were undertaken between May 2011 and January 2012. Full reports of each visit are available on the WMQRS website, including details of compliance with Quality Standards and membership of the visiting teams. This report contains the learning disabilities section from each of the 2011/12 visit reports. These should be read in the context of the full visit reports, including details of compliance with WMQRS Quality Standards for Health Services for People with Learning Disabilities, Version 1.1 (December 2010).

These visits were organised by WMQRS on behalf of the West Midlands People with Learning Disabilities Care Pathway Group. The dates for each visit are given in Appendix 1.

The reports reflect the situation at the time of the peer review visits. Services may have changed and developed since these visits.

ACKNOWLEDGMENTS

The West Midlands People with Learning Disabilities Care Pathway Group and West Midlands Quality Review Service would like to thank the staff and patients of the West Midlands Learning Disabilities Services for their hard work in preparing for the reviews and for their kindness and helpfulness during the course of the visits. Thanks are also due to the visiting teams and their employing organisations for the time and expertise they contributed to these reviews.

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DUDLEY & WALSALL HEALTH ECONOMY

Dudley's specialist learning disabilities services were in the process of transfer to the management of the Black Country Partnership NHS Foundation Trust and were not reviewed as part of this visit. The provision and commissioning of health services for people with learning disabilities in Dudley will be reviewed later in 2011 and a supplementary report will be issued.

WALSALL SPECIALIST LEARNING DISABILITIES SERVICE

(BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST)

General Comments and Achievements

The Walsall Specialist Learning Disabilities Service (Black Country Partnership NHS Foundation Trust) was an impressive service which provided a good range of care including two in-patient units and community teams. The community teams consisted of learning disability community nurses, a health facilitation team, a behavioural support team, physiotherapy, occupational therapy, speech and language therapy, a re-provision nurse, psychiatry team, psychology, a forensic nursing team, a transition community nurse, a dementia community nurse, a long term conditions education and development clinical nurse specialist, an acute liaison nurse, a community nurse support worker, clinical team leader, clinical service manager and two administrators. The team worked closely with social care staff although social workers were no longer integrated in the service's structure. Staff were highly committed to responding to the needs of service users and carers. The service had strong, dynamic leadership and staff were passionate about improving the care which they offered. There were good relationships with commissioners of services for people with learning disabilities. A visioning event had been held, looking at priorities for the future.

Good Practice:

1 This service had many examples of very good practice, including the speed of response to changing needs of service users and carers. Of particular note were:

a. The Health Action Plan was an excellent document and was given to all service users and clearly used by many.

b. Specific information had been developed for service users with diabetes and epilepsy and to help clients access national screening programmes.

c. Access to health and social care services for people with learning disabilities was through a single telephone number.

d. A good range of surveys of users' and carers' experiences had been carried out.

The health facilitation team had a very proactive approach to working with primary care, including ensuring information was available for carers in the 'Carers' Corner' (available in some general practices).

e. The transition team had developed very good information for young people moving to adult services. There was a good transition pathway and a network group which linked children's and adult services. All young people transferring to adult care had a Health Action Plan and also received an 18th birthday card.

f. Speech and language therapy staff had offered 'Makaton' training to carers. A staff training programme on recognising and intervening in dysphasia had been developed and there were plans for this to be offered free to carers.

g. Community teams were actively involved in preventative health interventions.

h. A good range of augmented communication systems was available.

i. The refurbished Orchard Hill Assessment and Treatment facility was able to care for people with additional physical and complex needs. The reviewing team was impressed by the environment and the accessible information for service users and families that was available on the unit.

Immediate Risks: None

Concerns: None

Further Consideration

1 **Maintaining service quality**

The service was facing several changes: management responsibility had moved to the Black Country Partnership NHS Foundation Trust, social care staff were no longer integrated with the service and the office base for the Clinical Service Manager was moving away from the building where commissioners were based. It will be important to ensure that the quality of services and the close working relationships are preserved despite these changes, and that all staff continue to have access to the information that they need to provide good quality care.

2 Some of the Easy Read information included words which the service user reviewers considered were too long and complex. It may be helpful to involve local service users in reviewing the information available. It may also be useful to acknowledge the user input on the information which is developed.

3 A good range of advocacy services was available for service users and carers with different needs. A simple guide for staff and for those trying to access advocacy may help to avoid confusion.

4 The Suttons Drive service provided a forensic step-up / step-down service. Reviewers heard several different views about the role and function of this service. A booklet about the service had been developed but was not clear about the admission and discharge criteria (see also Further Consideration 5). Staff were available to provide therapeutic interventions but the expected interventions were not documented in Care Plans. The bathroom was rather 'clinical'. It may be helpful to review the role, function and plans for the future development of this service.

5 Admission and discharge criteria and discharge planning arrangements may benefit from review to ensure timely transfers occur across services.

6 The reviewers met with a small number or service users and carers but it was not clear to the reviewing team the level of input of carers had into service consultation.

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COMMISSIONING – SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

WALSALL HEALTH SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

General Comments and Achievements

A small integrated health and social care team commissioned all services for people with learning disabilities, led by the Local Authority and with a pooled budget with a Section 75 Partnership Agreement. Commissioners worked closely with the specialist learning disability service and long-standing working relationships were strong. Commissioners were well aware of the issues which needed to be tackled and had clear plans to address them. Good progress had been made on personalisation with some service users and carers holding personal budgets and employing staff themselves. Commissioners had also recognised the need for changes to the Partnership Board and a revised structure had been implemented, including focus groups for service users and carers to enable input from a wider range of people.

Good Practice: See general comments and achievements.

Immediate Risks: None

Concerns

1 Commissioner capacity was insufficient for the range of services commissioned. Two people commissioned health and social care services for people with disabilities, including those with learning disabilities, physical, sensory and neurological disabilities. Reviewers were concerned that this did not give sufficient resources for quality monitoring and for ensuring effective service user and carer involvement in commissioning arrangements.

Further Consideration

1 Maintaining service quality: See Specialist Learning Disabilities Service section of this report.

2 Commissioners were aware of a lack of services for adults with Autistic Spectrum Disorder (with or without learning disabilities) and were developing an 'Autism Strategy' with plans to address this. This work needs to continue.

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COVENTRY & WARWICKSHIRE HEALTH ECONOMY

Services reviewed included:

- Community teams for Solihull, North Warwickshire, South Warwickshire, Coventry and Rugby, which included a health facilitation team and staff working with general acute services
- The Gosford in-patient unit at the Caludon Centre, Coventry

The review did not cover:

- In-patient wards at on the Brooklands site as these had already been reviewed by the Royal College of Psychiatrists AIMS-LD review programme.
- Services for children and young people with learning disabilities
- Respite units at Solihull, Nuneaton and Rugby
- Domiciliary care service at Coventry

PRIMARY CARE

Findings relating to primary care services are given below in the Specialist Learning Disabilities Services section of this report.

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SPECIALIST LEARNING DISABILITIES SERVICES

COVENTRY, WARWICKSHIRE and SOLIHULL – ALL SERVICES

General Comments and Achievements

Community teams within Coventry and Warwickshire were in a process of transition. The four teams worked very differently and were moving towards a single point of entry in each locality. Work on care clusters and service re-design was also taking place. The development of staff with special interests was being considered and a nurse specialising in epilepsy was already in place.

The Gosford Unit at the Caludon Centre was a calm and welcoming ward. En-suite facilities were available for all service users. Reviewers commented that, for an assessment and treatment service, the environment was relatively clinical and secure. The lead psychiatrist was actively involved with the running of the service. A garden was available, although redesign of some aspects was being considered.

Good staff training on MCA and DOLS was in place and there was a range of accessible information on these subjects.

Reviewers met only one service user and no carers. This section of the report may not therefore reflect the views of service users and carers to the same extent as other parts of the report.

Good Practice

1 A good discharge and transfer policy was in place. A relapse prevention policy was linked to the discharge and transfer policy.

2 Good links with acute hospital services were evident with good information for patients.

3 There was a good folder of information for GPs about community services for people with learning disabilities. This folder had been distributed to all GPs. It included details of a wide range of groups for people with learning disabilities that were available at a range of settings. Groups included, for example, bereavement and loss, men with learning disabilities, health and well-being, and a CHAT group for young people during their transition to adult services.

4 The Solihull service had lots of assistive technology available for supported living, including enuresis alarms, trips and falls monitors, electronic medication dispensers, door key safes and alarms, and smoke alarms. Lots of information was available in Easy-Read about the assistive technology.

5 In Solihull, health facilitation and information on physical health was excellent. There was very good data collection relating to primary care. The Coventry and Warwickshire Health Action Team also provided good support for physical health care and links with GPs.

6 A good 'leaving the unit' book was available in the Gosford Unit. This book approached leaving the unit from service user's perspective.

7 A CLIC communication media programme was available and was being further developed by speech therapists.

Immediate Risks: None

Concerns

1 The Medicines Management Policy provided to reviewers was dated 2007 and was due for review in 2008. The Medicines Management Policy did not cover rapid tranquilisation, immediate life support or resuscitation. A revised Trust policy had been agreed but staff in the learning disability services were not aware of this.

Further Consideration

1 **Care Planning**

Reviewers did not see evidence of active, consistent use of CPA or another structured process covering assessment, care planning and active review. Care plans were in place for individual issues but there did not appear to be a coordinated, holistic approach to care planning. It was not clear how the care plans were linked to the assessment process. There was evidence of some reviews but these were relatively sparse and those seen by the reviewers showed little progress. Arrangements for follow up within seven days of

discharge from in-patient care did not appear to be robust. There was no evidence that the care plan was understood by the service user.

2 The criteria for acceptance by, and discharge from, the community teams were not clear. The therapeutic interventions being contributed by the community teams were also not clear. Reviewers were told that some clients were 'kept for ever' and some community team clients were not receiving active therapeutic interventions.

3 The separation between services for adults and those for children and young people was not clear. Some community teams said that they were working with children as well as adults with learning disabilities. One individual issue about separation of young people and adults was raised with the Trust during the review visit.

4 Pharmacy input to the multi-disciplinary care of people with learning disabilities was not apparent. Reviewers would have expected this to be in place, especially because of the level of risk associated with caring for some clients.

5 There was not a systematic, standardised approach to recording patient information. It appeared that each service had a different approach to recording patient information and approaches varied between different professional groups. This could make information difficult to find, may not help multi-disciplinary working, and may not make it easy for staff to move between services, for example, to cover absences or respond flexibly to changes in need for services.

6 NHS funded respite care was provided in three locations and it was not clear that these were meeting the expected Quality Standards for in-patient services for people with learning disabilities. A domiciliary care service was provided for Coventry. The therapeutic interventions contributed by these services were not clear and they appeared to reviewers to be providing primarily social care.

7 The Trust had plans for the future development of the Brooklands site. In taking these forward, the Trust will need to ensure that, wherever possible, clients continue to access community facilities.

8 Services in the different localities were different and it was difficult to assess whether all clients were having their needs met by the current arrangements. Links with Partnership Boards were in place although these worked in different ways. Some collaborative work between the Partnership Boards may be helpful so that the Trust is, wherever possible, providing services which are consistent and so that best use can be made of staff time and expertise.

9 A new advocacy group had been in place for less than 12 months. Mechanisms for service user and carer involvement, including feedback from services, may benefit from further consideration.

10 Changes to the management arrangements for primary care liaison and health facilitation were planned, with these teams becoming integrated with community services. It will be important to review and evaluate these changes and their impact on care for people with learning disabilities.

11 The development of specialist roles, such as in epilepsy, was being pursued and was supported by reviewers. Reviewers suggested that the model for these roles needed to ensure that a) all staff maintained their skills in these areas and b) cover was available for planned and unexpected absences of the specialist worker.

12 Team / service leaders within the learning disabilities service were not generally aware of Clinical Quality Review (CQR) meetings with commissioners and did not know who was responsible for commissioning their services. (CQR meetings did take place and involved the most senior staff from the learning disabilities service.) Enabling more contact between team / service leaders and commissioners may be helpful for all concerned.

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COMMISSIONING

NHS COVENTRY AND WARWICKSHIRE - HEALTH SERVICES FOR PEOPLE WITH LEARNING DISABILITIES COMMISSIONING

Further Consideration

1 Team / service leaders within the learning disabilities service were not generally aware of Clinical Quality Review (CQR) meetings with commissioners and did not know who was responsible for commissioning their services. (CQR meetings did take place and involved the most senior staff from the learning disabilities service.) Enabling more contact between team / service leaders and commissioners may be helpful for all concerned.

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BIRMINGHAM & SOLIHULL HEALTH ECONOMY

PRIMARY CARE

A programme of training and development for primary care staff was run by the Health Facilitation Team.

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SPECIALIST LEARNING DISABILITIES SERVICES

BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

General Comments and Achievements

Reviewers met many committed and enthusiastic staff who were working hard to improve services. At the time of the review, staff were going through significant organisational change. The Trust had gained the Customer Service Excellence Standard.

Immediate Risks: None

Concerns

1 **Policies and Guidelines**

Some of the expected policies and guidelines were not available or were out of date. In some areas, several different versions of the same policy or guidelines were in use. Some policies were kept on the Trust intranet but staff were not clear what was available and did not appear confident in accessing intranet-based policies. Reviewers were told that this was because partly because of the creation of the new Trust from three different organisations.

2 **Mental Capacity Act and Deprivation of Liberty Policies**

Reviewers could not find a policy on use of the Mental Capacity Act or on Deprivation of Liberty Safeguards and staff were not aware of the Trust policies for these areas. Some staff had had appropriate training but robust arrangements for ensuring that all staff had appropriate training in these areas were not in place.

3 **Access to General Practitioners**

Service users who were in-patients, especially those who had been in-patients for long periods, did not routinely have access to a general practitioner. Reviewers were told that care for service users' physical health needs was from learning disabilities medical staff or from general acute hospitals. Annual reviews of physical health were not routine for people who had been in-patients for over a year.

4 **Access to Social Workers**

Due to reorganisation of social work within the area, social work staff were not actively engaged in planning discharges to supportive living. This was delaying discharges from some of the in-patient services.

Further Consideration

1 Service users and carers who met the visiting team expressed concern that they did not receive ongoing communication about planned changes to services. They were also worried about whether services would be available when their parents got older. Mechanisms for ongoing communication with, involvement of and feedback to service users and carers may benefit from review.

2 Access to assistive technology may benefit from review. A range of mechanisms were in place, including service users bring their own assistive technology with them. Staff were not clear about the assistive technology that was available and how to access assistive technology that may be required.

3 Some of the facilities visited were awaiting repairs and the timescale for completion of these was not clear.

4 Reviewers commented that little emphasis appeared to be being placed on personalisation and personalised budgets. Personalisation did not appear to be being actively promoted with service users and carers.

COMMUNITY SERVICES

SHORT BREAK AND DAY SERVICES - Hob Moor Rd

General Comments, Achievements and Good Practice

The short break service cared for eight service users who had access to between 42 for new clients and 60 days for existing clients respite days per year. Beds had been reduced from 12 following a review of single rooms. Service users with challenging behaviour were nursed in bungalow type accommodation linked to another bungalow type accommodation for people with complex physical needs at the other. Staff seemed committed and knowledgeable about the service. The service had a longstanding carer involvement group which met every two months. Interactive work with several clients was observed. Reflexology was available one day a week.

The Day Centre provided a day services for the whole of Birmingham. Clients could attend between one and five days per week depending on the assessment of their needs. Staff collected clients from homes, which provided an opportunity for interaction with carers. Reviewers were introduced to service users and support workers.

Immediate Risks: None

Concerns

1 **MCA and DoLS:** See 'Concerns' in Specialist Learning Disabilities section

2 **Unit environment:**

The environment of the day services was drab and in need of modernisation. Service users entered via the back entrance, which was unwelcoming. The Sensory Room had been unavailable for six months, although reviewers were told that finance to replace the unit had now been secured.

Further Consideration

1 Filing cabinets and boxes were in the corridor and a small heater was in the reflexology room. Reviewers recommended that a health and safety risk assessment of these issues is carried out.

2 Much of the information for service users and carers, and information about the service, was difficult to locate. Examples of information that was difficult to find were the user and carer feedback forms and training records

3 Staff understanding of restraint appeared variable. Some staff said restraining did not take place but breakaway techniques were used. Other staff commented that they had recently had to restrain. Further training on restraint may be helpful.

4 Limited activities were available for service users who arrived before 10.30 am.

SHORT BREAK & DAY SERVICES – Kingswood Drive

General Comments and Achievements

Service users who met the reviewing team were well cared for and happy with the service they received. Staff were enthusiastic and committed to providing a good service.

Immediate Risks: None

Concerns: None

Further Consideration

1 Service users gave feedback on their experiences but it was not clear that there was any feedback to them about actions taken and progress with implementing changes. It may be helpful to strengthen feedback to service users.

2 One of the rooms visited had a heavily stained carpet. This room was empty at the time of the review but reviewers were not assured that action would be taken before the room was used again.

IN-PATIENT UNIT – Birmingham Community Assessment and Treatment Service (BCATS)

General Comments and Achievements

This was a unit of six beds with an average length of stay of eight months. Staff were welcoming, professional, helpful and knowledgeable. Reviewers observed good interaction between service users and staff. Reviewers were able to talk to service users about their experience with BCATS.

Good Practice

1 The linked Social Worker helped to support the discharge process and was proactive about discharge, starting at the point of admission

2 Dementia booklets were available in easy read (GOLD project). These booklets contained clear and relevant information.

Immediate Risks: None

Concerns

1 **Policies and Guidelines:** See 'Concerns' in Specialist Learning Disabilities section

2 **MCA and DoLS:** See 'Concerns' in Specialist Learning Disabilities section

3 **Unit Environment**

The environment for service users and staff at BCATS was poor. The building was claustrophobic, the day room area had only one settee and a bean bag on the floor, the curtains had been removed in the day room following a ligature risk assessment and a replacement rail was awaited. Reviewers were told that some renovation work had taken place and that further redecoration was taking place. The environment was not homely and was not appropriate for service users with an average length of stay of eight months. Reviewers suggested that staff should visit other assessment units to gain ideas about ways to improve the environment until the planned new building is operational in mid-2013

Further Consideration

1 Reviewers suggested that the service should ensure that Easy-Read care plans are offered to service users. No Easy-Read care plans were included in the evidence folders and some service users were not aware that they existed.

IN-PATIENT UNIT – Sayer House

General Comments and Achievements

Sayer House was a six-bedded in-patient unit for older adults with Learning Disabilities and dementia which had recently widened its focus to caring for those with other life threatening conditions. Reviewers met staff who were very enthusiastic. Daily activities were planned and recorded and some clients accessed community activities, such as worship on Sundays. Personal development review and mandatory training were in place for staff. Reviewers met two patients who appeared comfortable and well cared for. Sayer House provided a good environment for palliative care. There was good interagency working and good continuity of care

Good Practice

1 A wall-mounted personal preferences chart meant that all staff were clear about service users' preferences

2 Nutrition scoring clearly identified service users' swallowing ability. This information clearly available for staff so they know what texture (1-3) the diet needed to be.

Immediate Risks: None

Concerns

1 **Policies and Guidelines:** See 'Concerns' in Specialist Learning Disabilities section

2 **MCA and DoLS:** See 'Concerns' in Specialist Learning Disabilities section

Further Consideration

1 Cleaning was done by nursing staff. This may not be the most appropriate use of nursing time.

2 Much of the staff training was on an in-house basis, sometimes using external trainers. The benefits of linking with other providers of similar services to access training should be considered.

IN-PATIENT UNIT - Tessall Lane

This was a step-down facility for clients with forensic needs. The accommodation was in three separate buildings. There were plans for purpose built accommodation which was projected to be available within 2 years. Staffing levels were high, including at night, as all patients were subject to restrictions. Staff communicated via walkie-talkies. Staff were enthusiastic and reviewers were told that morale and relationships with neighbours had improved. Case notes were well organised and a service user satisfaction survey had been undertaken. Service users had good legal and advocacy support and were involved and felt able to challenge plans for the building. The complaints process was available in easy read. A good range of activities was available and service users' care was being pro-actively managed.

Immediate Risks: None

Concerns

1 **Unit Environment**

Reviewers were seriously concerned that the environment of the unit was not fit for purpose. There was no ground floor accommodation and stairs were very narrow. Because of the three separate buildings, staff were heavily reliant on walkie-talkies for communication and for calling for help in an emergency. This could lead to delays in accessing support. The decoration was shabby.

2 **Access to General Practitioners:** See 'Concerns' in Specialist Learning Disabilities section

3 **Access to Social Work:** See 'Concerns' in Specialist Learning Disabilities section

Further Consideration

1 The service had a locum consultant. Interviews for a substantive post had just taken place and reviewers hoped that a substantive appointment would be made in the near future.

2 Cleaning was done by nursing staff. This may not be the most appropriate use of nursing time. The unit had no administrative support and so clinical staff were spending considerable time undertaking administrative tasks.

3 Clients told the reviewers that the use of walkie-talkies transmissions were very loud and they found this quite irritating.

IN-PATIENT UNIT – Handsworth Wood

General Comments and Achievements

This was a six-bedded in-patient unit for men, including some with forensic needs or challenging behaviour. Staff were enthusiastic. A weekly audit of medication had improved medicines management. New arrangements for review and learning had been implemented and regular multi-disciplinary meetings were in place. Clients and staff were very positive about the unit. Supportive discharge processes were evident. Clients had good access to advocacy. All documentation was archived and so it was easy to access historical information about service users and their care.

Good Practice

1 Activity planning for the forthcoming week took place each Sunday and clients were actively involved in this.

2 Very good support was available from the Health Facilitator. A lot of work had taken place to develop and implement robust care planning processes. The care plans that were reviewed were extremely comprehensive, showing interventions and outcomes and agreed with the service users. Consideration was being given to rolling out the format to other services across the Trust.

Immediate Risks: None

Concerns

1 **Policies and Guidelines:** See 'Concerns' in Specialist Learning Disabilities section

2 **MCA and DoLS:** See 'Concerns' in Specialist Learning Disabilities section

Further Consideration

1 Cleaning was done by nursing staff. This may not be the most appropriate use of nursing time. The unit had no administrative support and so clinical staff were spending considerable time undertaking administrative tasks.

2 Multi-disciplinary team meetings took place every two months. Staff commented on the usefulness of these meetings and would like them to take place at least monthly.

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COMMISSIONING

BIRMINGHAM JOINT COMMISSIONING

General Comments and Achievements

The Joint Commissioning Team had a good understanding of issues which needed to be addressed. A draft Commissioning Strategy for Service for People with Learning Disabilities was being developed.

Good Practice

1 Good work on reducing out of area placements had reduced costs from an £8m overspend to an under-spend.

2 Good use was being made of 'Supporting People' lay assessors who were reviewing social and health care services.

3 Over 100 Dignity Champions had been trained, of whom 70 were people with learning disabilities.

Immediate Risks: None

Concerns

1 **Services for people with learning disabilities aged 18**

Reviewers were seriously concerned that there was an apparent gap in the commissioning of services for people with learning disabilities aged 18. Reviewers were told that services for young people were commissioned up to 17 years and 11 months and those for adult from 19 years.

2 **Access to Social Workers:** See 'Concerns' in Specialist Learning Disabilities section

3 A commissioning strategy was being developed and was in draft form, but did not include timescales or an action plan for implementation

Further Consideration

1 Service users and carers who met the visiting team expressed concern that they did not receive ongoing communication about planned changes to services. They were also worried about whether services would be available when their parents got older. Mechanisms for ongoing communication with, involvement of and feedback to service users and carers may benefit from review.

2 Staff who met the reviewing team were not clear who was responsible for commissioning NHS out of area placements.

3 It was not clear that staff in all services understood about assistive technology that was available and how to access this to support their clients. Further work on publicising access to assistive technology may be helpful.

4 Although joint commissioning arrangements, with section 75 agreements, were in place, reviewers saw little evidence of joint working between health and social care at an operational level. For example, the PCT and local authority had reviewed day services separately. It was not clear why this had not been done jointly given that the new model for day services would affect the same service users.

5 Commissioning of services did not appear always to take account of the holistic needs of service users. For example, reviewers were given examples of age-specific commissioning and separate commissioning to meet the mental and physical health needs of service users. Reviewers were told that this caused difficulties and delays for staff and therefore for service users.

6 The Joint Commissioning Unit has many staff with social care experience. It may be helpful to consider whether recruitment of staff with a health background, as opportunities arise, may help to improve communication with GPs and health organisations. The need for commissioning staff with specific expertise in services for people with learning disabilities may also benefit from further consideration. Reviewers commented that much of the language used in commissioning communications was complicated. Consideration of simplifying the messages, especially to GPs, may be helpful.

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HEREFORDSHIRE HEALTH ECONOMY

PRIMARY CARE

See Specialist Learning Disabilities Services section of this report.

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SPECIALIST LEARNING DISABILITIES SERVICES

[2]GETHER NHS FOUNDATION TRUST

General Comments and Achievements

Health services for people with learning disabilities were provided by a committed team, integrated with social care, who were actively developing the quality of the service. Service users and carers were positive about the services they received and the support available. Uncertainty about the future commissioning of the services was clearly being felt by staff and by service users and carers – who would have appreciated greater communication about the changes that were being considered.

Good Practice

1 A high uptake of Health Action Plans had been achieved with 78% service users having a Health Action Plan. This had been audited and a detailed analysis of those without a Health Action Plan was being undertaken in order fully to understand the reasons for this.

2 Links with general practice were particularly good which had contributed to the high percentage of service users with a Health Action Plan. A good training programme had been run for general practices which was tailored to the needs of individual practices.

3 The pathway for transition to adult care was very clear with a good 'time line' with roles and responsibilities clearly identified.

4 A 'banding matrix' was used to identify the resources required to support each service user to ensure that future and ongoing resource commitment was proportionate to their needs assessment..

Immediate Risks: None

Concerns

1 **Staffing Levels**

Staffing levels appeared low for the number of clients being cared for by the service. Cover for key individuals such as the consultant the primary care liaison worker was not available. Delays in appointing to some vacancies was of particular concern at the time of the visit as two occupational therapist vacancies had not been filled.

2 **Care Plans and Discharge Planning**

A range of documents was used for care planning, some of which appeared more appropriate for professional use than for communication with service users. Service users did not have a care plan in an accessible format. The therapeutic interventions being offered to each service user were not clear in the documentation seen by reviewers. There was little evidence of systematic discharge planning and information to support service users approaching discharge.

3 **Out of Area Placements within Herefordshire**

Reviewers were told that there were at least 100 of the adults with learning disabilities in Herefordshire were from out of area and had placements in Herefordshire care homes. Given that the total number of adults with learning disabilities was 575, represents 20% of all placements. These 'out of area' placements were putting particular pressure on local primary care services and 2gether NHS Foundation Trust's services which supported primary care.

4 **Clinical Supervision:** Arrangements for clinical supervision were not robust, although some informal clinical supervision was taking place. This issue was identified in several of the services reviewed

Further Consideration

1 **Clinical guidelines:** Clinical guidelines were not yet in place for therapeutic interventions offered by each service. Robust arrangements for data collection and clinical audit of implementation of guidelines were also not in place. This issue is identified as for 'further consideration' in this report but will be of concern if reasonable progress is not made over the next few years

2 Reviewers were told by some service users and carers that they thought services may be referring clients down a safeguarding pathway when advocacy may have been a more appropriate route.

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COMMISSIONING

At the time of the review, commissioners were undertaking an option appraisal about the future commissioning arrangements for services for people with learning disabilities.

The Specialist Learning Disabilities Services section of this report identifies several issues which require the attention of commissioners.

Further Consideration

1 Several aspects of the reconfiguration and modernisation of mental health and learning disability services for Herefordshire were being led by 2gether NHS Foundation Trust. Commissioner involvement in these changes was difficult because of the limited commissioning capacity for these services. The following issues were identified by reviewers as requiring attention quickly. Commissioners should ensure that they maintain appropriate involvement in planning and monitoring the changes that are being made.

a. Reviewers were told about plans for a Herefordshire primary care mental health team. The relationship of this team with the Improving Access to Psychological Therapy (IAPT) service was not clear. The IAPT model and funding from April 2012 were also not clear. Some staff described the primary care team as having three functions a) a triage and 'single point of entry' service, b) a crisis service aiming to avoid admission and c) a primary care education and support service. Others thought that it would take over IAPT functions or should become an integrated service with IAPT. Given the potential pivotal role in accessing services, the proposed role needs to be agreed quickly so that decisions about appropriate staffing and relationships with other services can be made.

b. Oak House was operating as usual while a decision about the future commissioning of the service was made. This was affecting some staffing issues and therefore delaying progress with resolving the position of some staff.

c. Options for the provision of future services for people with learning disabilities were being considered.

Several services had few staff available at nights and weekends and problems with access to services outside normal working hours are identified in several sections of this report. Reviewers suggested that a clear view of 'out of hours' services, staffing and responsibilities should be developed.

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WORCESTERSHIRE HEALTH ECONOMY

PRIMARY CARE

See specialist learning disabilities section of this report.

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SPECIALIST LEARNING DISABILITIES SERVICES

WORCESTERSHIRE HEALTH and CARE NHS TRUST

General Comments and Achievements

This service had impressive engagement of service users and carers and of staff. There was excellent integration of health and social care. The team had strong leaders who were pro-actively driving forward improvements in the care provided. Although the services were going through a reorganisation, service users and carers and staff were actively involved in planning for the future and were approaching the change very positively. Good links with primary care were in place, despite limited resources for this work (see below).

Many examples of good practice had already been implemented (see below). Other initiatives were in development, including: a) a criminal justice liaison pathway was being piloted, and b) the behaviour team was working on a system of accreditation of services for people with challenging behaviour. There were also plans for an in-patient assessment and treatment service and for increased medical sessions for the team.

Good Practice

1 Service user and carer involvement in the organisation and management of the service was excellent. Specific examples of this included service user and carer input to the development of transition services, the carer's policy at the acute Trust and re-provision of special bus passes. Service users and carers had prepared their own evidence for the review visit. They were actively involved in several forums and working groups.

2 Acute hospital liaison services for people with learning disabilities worked very well. Reviewers were particularly impressed by the alert in the hospital electronic record which ensured that the liaison team was notified if the person was admitted to hospital.

3 Two posts, based in the north and south of the county, focussed on the needs of older carers.

4 A very good quality assessment checklist for new providers of bespoke and out of area care had been developed.

5 A guide on reasonable adjustments and how it applied to the different professional roles had been developed.

6 All 68 general practices had a learning disability register.

Immediate Risks: None

Concerns

1 Several concerns about discharge arrangements were raised by service users and by staff. These included a) some confusion about discharge from a particular therapy (for example, physiotherapy or speech and language therapy) for users who needed ongoing care, b) communication with service users about the reasons for discharge, c) documentation of discharge planning in care plans and d) arrangements for re-accessing care for people who had been discharged.

2 There was insufficient Primary Care Liaison Worker time. The Primary Care Liaison Worker worked two days a week covering the whole of Worcestershire. The time for this role was insufficient¸ especially given the size and geographical spread of the county.

3 Reviewers were told of long waiting times for advocacy services and difficulty accessing advocacy services for people with complex communication needs.

Further Consideration

1 Improved documentation of the 'out of hours' pathway may be helpful. Although most service users and carers knew how to access help this was not clear in the information available.

2 The extent to which Health Action Plans were completed and used was variable. Several different formats were used and reviewers heard differing views about which was the best format. Reviewers suggested that further work was needed on ensuring uptake and usage of Health Action Plans.

3 A strategy for services for people with autistic spectrum condition was being developed but the timescales for this work, and for implementing the strategy, were not yet clear. Reviewers encouraged continuation of this work.

4 Reviewers were told of plans for four community teams across Worcestershire in future. As these will not map to Clinical Commissioning Groups, it will be important to ensure that responsiveness to commissioners of services is maintained. Also, staffing levels for some allied health professionals, especially physiotherapy and speech and language therapy staff appeared too low for the proposed model of service organisation.

5 Arrangements for transition of young people to the care of adult services. Reviewers were told of plans for a dedicated transition team which was to be implemented in the new financial year. However, there was concern that those users who had experienced difficulties with the previous transition arrangements still needed support and it was unclear how this would be addressed.

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COMMISSIONING

NHS WORCESTERSHIRE and ADULT JOINT COMMISSIONING UNIT

See specialist learning disabilities service section of this report.

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SOUTH STAFFORDSHIRE & SHROPSHIRE HEALTH ECONOMY

SHROPSHIRE COUNTY AND TELFORD & WREKIN

Primary Care and Specialist Learning Disability Services

TELFORD AND WREKIN COMMUNITY LEARNING DISABILITIES TEAM AND SPECIALIST DAY SERVICES (TELFORD AND WREKIN LOCAL AUTHORITY)

SHROPSHIRE COUNTY IN-PATIENT AND COMMUNITY LEARNING DISABILITY SERVICES (SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS TRUST)

Health services for people with learning disabilities in Shropshire and Telford & Wrekin were provided by teams which worked across both areas. These teams linked closely with social care staff in each local authority. Most of the issues identified by reviewers were common across Shropshire and Telford & Wrekin. A few issues were specific to either Telford & Wrekin or Shropshire services. This report gives the common points and then issues which were specific to services in the different localities.

TELFORD & WREKIN and SHROPSHIRE COUNTY

General Comments and Achievements

Primary Care and Community Learning Disability Services for Shropshire County and for Telford & Wrekin were provided by committed staff and reviewers found many good aspects of the care being delivered. The teams in both areas had a mixture of styles and special interests across health and social care. Psychological support was integrated into the teams and was seen to add significant value for both short-term and longer-term interventions. Reviewers were particularly impressed by the work with podiatry and by the easy read material that had been developed by service users and advocacy groups. Several locality groups were co-chaired by service users and user involvement was good throughout the services.

There was good awareness of the need for change in the services delivered. For example, there were plans to develop single-point of access services to replace the three possible routes of referral in place at the time of the review. Service users and staff who met the visiting team were, however, uncertain about future services for people with learning disabilities and the impact this would have on them. Management re-organisations were also impacting on staff morale.

Good Practice

1 A comprehensive and diverse range of easy read documents were available across the health economy.

2 The Common Assessment Framework database held information about individual's health needs and their emergency action plan. It linked to their Health Action Plan. The police, emergency services and GP out of hours service *ShropDoc* found this useful information in emergency situations.

3 Collaborative working across Shropshire County and Telford & Wrekin was well established. Service users and carers and staff had been fully involved in planning the changes to the learning disabilities services. This was particularly impressive because extensive changes were being considered. As a result of strong collaborative working, multi-disciplinary planning for people with complex needs had become more firmly established.

4 The "Taking Part in Life" programme was effectively engaging with over 57% of local people with learning disabilities. This programme could evidence improved outcomes and new initiatives were being added, for example, sexual health and GP clinics. 'Taking Part' also ran a 'mystery shopping' programme which included *ShropDoc* and the Princess Royal Hospital.

5 A worker had been employed to work with people with learning disabilities from black and minority ethnic communities. The post had already led to better engagement with this group of service users, weight management programmes and improved liaison with GPs.

6 A good referral pathway to maternity services had been developed with Shrewsbury and Telford Hospital NHS Trust.

Immediate Risks: None

Concerns

1 **Clinical Guidelines**

Clinical guidelines were not available and the therapeutic interventions provided by the service were not always clear. Staff had an informal understanding of the pathways of care and their contribution to them. Reviewers were also concerned that some staff did not fully understand the contribution which clinical guidelines make to providing effective, consistent pathways of care for service users and the need for governance of their implementation. Greater clarity about the therapeutic interventions offered by the service and their outcomes may help to raise the profile of the service and help its contribution to be recognised.

Further consideration

1 **Access to Care Records:** In some services social care and health staff were not able to access relevant IT systems and so may not always have the up to date information they needed. This issue was raised particularly by CMHTs and Assertive Outreach services but may also apply to others. The Trust said that all appropriate health and local authority staff had access to both local authority and Trust clinical systems but some staff who met the reviewers were not aware of this.

2 Multiple care records also existed and reviewers were told that service users could have up to four sets of notes (CMHT, Crisis Team, in-patient and archived notes; archived notes were kept in Stafford and could not be accessed easily). As a result, clinical staff often did not have the full clinical picture when making decisions. (See also 'IT system and risk assessments' (above) about the lack of access to the latest risk

assessments.) The Trust said that an Integrated Mental Health Case File model was operational with strict criteria to regulate the use of temporary files but some staff did not appear to be aware of this policy.

CMHT staff were not able to update electronic records at the point of client contact. Hand-written notes were therefore kept which were later recorded electronically. This made it difficult for other staff to access the latest notes and difficult to obtain the service user's written agreement to the care plan or changes to it.

3 Further work may be helpful to ensure a) pathways for all service users are clear and b) effective liaison between services caring for people with learning disabilities is in place, including with acute hospital services.

4 A range of advocacy services was available but some service users were not clear how these services were being used and whether the support provided was appropriate.

5 Staff within the service did not fully understand changes taking place in the local health economy, including changes to commissioning arrangements. Briefing staff to ensure an understanding of the impact of these changes on services for people with learning disability may be helpful.

6 Services yet were not yet in a position to respond easily to individualised budgets and personalisation. Further work in this area will be important to ensuring the future relevance (and funding) of the services.

TELFORD & WREKIN

Good Practice

1 There was good recording of activity by service users who were able to determine the services they needed and what was working well for them. This feedback had also been incorporated into service planning and new developments in the service, for example, weight management and improving access to GPs.

Further Consideration

1 Reviewers commented that capacity within the joint community learning disability team may not be sufficient effectively to address primary care liaison and acute hospital liaison as well as other work. Reviewers suggested that commissioners should be more specific about the services that they wish to commission in order to clarify the service delivery priorities for staff. This was being addressed at the time of the visit through a 'Modernisation Review'.

2 As part of the management restructuring within Telford and Wrekin, it may also be helpful to review the employment arrangements for staff to ensure that line management arrangements fully support the way in which the team is working. Service users were aware of the management changes and staff moves and further communication about the impact for their care may be helpful.

SHROPSHIRE COUNTY (SS&SHFT)

Good Practice

1 South Staffordshire and Shropshire Healthcare NHS Foundation Trust had developed a good resource pack for primary care teams. This had information covering 'what is a learning disability' and about other health problems. Links to local and national websites were included. The Trust had also worked with both local authorities on programmes for people with learning disabilities about personal relationships, sexual health and parenting.

2 A 'steps to employment' group had been developed in response to the local needs in Shropshire. This group was helping service users to respond to the changes in the economy and changes in employment styles.

Further Consideration

1 Staff were undertaking some work that had not been specifically commissioned, for example work with people with Asperger's syndrome. It may be helpful to review with commissioners whether this is supported by them.

2 The nurse undertaking health facilitation was identifying significant unmet primary health care needs. Mechanisms for linking this service with primary care and ensuring feedback to GPs may benefit from further development. Further development of links with the Local Authority may also be helpful.

MYTTON OAK HOUSE, SHREWSBURY (IN-PATIENT) (SS&SHFT)

General Comments, Achievements and Good Practice

This ten bedded unit was located on the Royal Shrewsbury Hospital site. It provided mostly health review that, by default, was mostly respite care and some low intensity therapeutic interventions. The service was provided by committed staff who had tried hard to improve the environment for service users. Care records were good and all service users had a copy of their care plan. Integration with social care was good. There were good informal links providing advice and support to staff at Royal Shrewsbury Hospital. Telephone advice to staff based at Robert Jones and Agnes Hunt Hospital was also provided.

The service was co-located with the Shropshire base for the Community Learning Disability Service. Several of the issues identified above are therefore also applicable to the in-patient service.

Concerns

1 **Clinical Guidelines:** See Primary Care and Community Learning Disability Team section of this report

Further Consideration

1 The future role of the service was not clear. As part of the Trust-wide modernisation programme it will be important to clarify the need for in-patient care, the purpose of the unit and links with other in-patient provision. Service user, carer and staff involvement in this work will be important.

SOUTH STAFFORDSHIRE

Primary Care

Staffordshire and Stoke on Trent Partnership Trust (South Division) Primary Care

Staff were committed to providing good care for people with learning disabilities. Reviewers were impressed by the work with podiatry and by the easy read material that had been developed by service users and advocacy groups. Several locality groups were co-chaired by service users. The team had also worked with Mid Staffordshire NHS Foundation Trust and Burton Hospitals NHS Foundation Trust on the development of hospital 'picture pathways' and 'hospital passports'.

Further Consideration

1 Work to ensure that all people with learning disabilities have a Health Action Plan should continue.

2 The service was supporting the care of several people who were in prison and the training of some prison staff. It was not clear that the service was commissioned to undertake this role.

SOUTH STAFFORDSHIRE ADULT COMMUNITY LEARNING DISABILITIES TEAMS and SPECIALIST DAY SERVICES (SS&SHFT)

General Comments and Achievements

This service been through significant changes but staff morale was good and staff were committed to providing good care for people with learning disabilities. There were good relationships between social care and health staff despite the significant changes and budgetary pressures affecting both organisations.

Staff and service users' achievements were regularly celebrated. Cards were being made and supplied to a local shop. An allotment project at Kingsley Burton was also self-sustaining and offered service users the opportunity to gain skills in gardening.

A clearly defined pathway for transition to adult care was easy to follow and had been embedded into services.

Good Practice

1 A good range of easy read information was available.

2 A communication booklet contained additional information about the service user as an individual, including their likes and dislikes. On the front page, written in bold, was the statement "nobody can consent for this patient". This was designed to accompany the user wherever they went and to remind all professionals that the user's rights must be respected at all times. This was in addition to the Health Action Plan.

Immediate Risks: None

Concerns

1 **Staffing Levels and Skill Mix**

It was not clear from the information available that the service had sufficient staff with appropriate competences for the work being undertaken. Reviewers were informed that a National Development Team for Inclusion review was taking place at the time of the visit and the outcome from this review would include the appropriate skill mix needed to support the future strategy.

Further consideration

1 Service users with autistic spectrum condition reported variable experiences of care and said that engagement was effective only when the Community Learning Disabilities Team was involved. This pathway was being reviewed with key stakeholders and partner agencies.

2 The service was not yet in a position to respond easily to individualised budgets and personalisation. Further work in this area will be important to ensuring the future relevance (and funding) of the service.

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COMMISSIONING

SHROPSHIRE COUNTY PCT and NHS TELFORD & WREKIN

Reviewers commented positively on commissioning arrangements for services for people with learning disabilities and, in particular, on the knowledge and insight which commissioners had about local services. Reviewers were also impressed that work had started on addressing the needs of people with autistic spectrum condition.

Several of the issues identified in the primary care and specialist learning disability services section of this report will require action and / or monitoring by commissioners.

SOUTH STAFFORDSHIRE (STAFFORDSHIRE JOINT COMMISSIONING UNIT)

General Comments and Achievements

Commissioners had good understanding of the issues that needed to be addressed and had commissioned a national review to help shape the future strategic direction. Commissioners had been actively engaged in monitoring and encouraging the development of local services. Services for people with learning disabilities were jointly commissioned by social care and health and it had been agreed that these joint commissioning arrangements would continue. Reviewers were also impressed that work had started on addressing the needs of people with autistic spectrum condition.

Further Consideration

1 It was not clear that outstanding 'campus closure' issues were fully integrated into service development plans to ensure that this group of service users have access to an appropriate range of alternative services.

2 The policy on managing out-of-area placements was not clear about the review process and reviewers were told that no dedicated staff time was allocated to managing out of area placements. This may benefit from further consideration.

3 Some service users had not yet received annual health checks and work to improve uptake should continue.

4 Local services were supporting the care of several people who were in prison. It was not clear that services were commissioned to undertake this role.

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NORTH STAFFORDSHIRE HEALTH ECONOMY

Good Practice

1 Strong 'People's Parliaments' and Partnership Boards were running in Staffordshire and in Stoke. Service users were actively involved in these and central to the work being undertaken.

PRIMARY CARE

General Comments, Achievements and Good Practice

Two primary care teams covered NHS Stoke and NHS North Staffordshire respectively with three health facilitators in Stoke and one in North Staffordshire. These teams linked effectively with general practices and with specialist learning disability services. A learning disability toolkit had been developed and training had been undertaken to support its implementation in primary care. All practices were involved with producing health action plans and registers had been audited. The health facilitators also provided support to people with complex needs who were living in the community.

Further Consideration

1 Health Action Plans were in a variety of formats but there were plans to develop a more standardised approach. Further work is needed to improve collection of data on the number of people with learning disabilities who have a Health Action Plan, and to improve the timeliness with which Health Action Plans are issued following annual health checks.

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SPECIALIST LEARNING DISABILITIES SERVICES

General Comments and Achievements

Specialist learning disability services were provided through two community learning disability teams, an 18 bed in-patient unit in Chebsey Close and the assessment and treatment unit (Telford). These services had been through a great deal of change, including organisational change, staff changes, national initiatives and local initiatives. In spite of this change, staff remained very positive about delivering services and about the need for further change.

Advocacy services were well developed and had good links with voluntary groups and volunteering opportunities. Some excellent community-based groups had developed including specific groups for women's health and men's health and also a relationship group which helped service users to manage their emotions more effectively.

The in-patient unit had developed a good relationship with the local GPs. All the residents were registered with a GP which gave them good access to primary care.

The in-patient facility had a multi-sensory room where service users could relax.

Good Practice

1 The activity worker provided very good, person-centred support to give service users, including picture maps and pictures including religious festivals and activities.

2 Several nurse-led initiatives had been developed including primary care liaison, sexual health and gender-specific groups.

Concerns

1 Senior leadership of the services with a clear vision for their future development was not yet in place. Staff who met reviewers were not clear about the strategic leadership above the service level and who was responsible for championing learning disabilities services in terms of appraising the good work taking place as well as the challenges facing the services across the health economy.

2 **Operational Policies and Clinical Guidelines:** Several services did not have up to date operational policies or clinical guidelines for the therapeutic interventions that were being offered. (Some staff seemed to think that the service specification was their operational policy.) As a result, operational processes and therapeutic interventions offered appeared to be dependent on informal arrangements and personal relationships between staff. Robust audit and monitoring of outcomes achieved compared with those expected could not be undertaken. Many staff had been in place for several years and relationships, especially within teams, were good – which reduced the risks associated with the informal arrangements. This issue adds, however, to the challenge involved in changing the way that services work.

3 In the inpatient unit at Chebsey Close, some service users had been on site for over three years. Some people had been resident since the 1990's even though the unit was for assessment and rehabilitation. Further work needs to be undertaken on the pathway for this group of users, including working with commissioners.

Further Consideration

1 The outcomes and objectives in the care plans seen reviewers seemed to be written for professionals with easy read incorporated for the initial components of the care plan only. Development of a full easy-read care plan should be considered.

2 Arrangements for clinical supervision were in place but supervision was sometimes informal and was not always documented. Many staff had worked together for a long time and it may be helpful to consider how appropriate challenge can be brought into clinical supervision arrangements.

3 The environment in the Assessment and Treatment Unit (Telford) may benefit from some attention in order to improve the service user experience.

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COMMISSIONING

NHS STOKE and NHS NORTH STAFFORDSHIRE

General Comments and Achievements

Commissioners had a good understanding of the strengths and weaknesses of the services that were commissioned. Commissioners were aware that a change in approach was needed and a national review had been arranged with the remit to challenge existing models of service provision. Commissioners were involving service users in order fully to understand their requirements of the service. Reviewers supported the approach that was being taken and did not underestimate the amount of work involved in moving to new models of care. There was evidence of good partnership working and collaboration between the commissioners for the two areas. An Autism Partnership Board had been established.

Concern

1 In the inpatient unit at Chebsey Close, some service users had been on site for over three years. Some people had been resident since the 1990's even though the unit was for assessment and rehabilitation. Further work needs to be undertaken on the pathway for this group of users.

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APPENDIX 1 VISIT DATES

Health Economy	Visit dates
Dudley & Walsall	9th - 13th May 2011
Coventry & Warwickshire	14th - 24th June 2011
Birmingham & Solihull	5th - 14th July 2011
Herefordshire	13th - 15th September 2011
Worcestershire	20th - 23rd September 2011
Birmingham (Learning Disabilities Service)	26th - 27th September 2011
South Staffordshire & Shropshire	4th - 13th October 2011
North Staffordshire	18th - 20th October 2011
Sandwell & Wolverhampton	17th - 19th January 2012