Mental Welfare Commission for Scotland

Report on announced visit to:
Royal Edinburgh Hospital, Myreside Rehabilitation Ward, Morningside Road, Edinburgh, EH10 5HF

Date of visit: 09 April 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

There have been changes to the rehabilitation service in the Royal Edinburgh Hospital (REH) since the Commission's previous visit to Myreside in September 2023.

We were told that the changes were instigated due to an increase in demand for men requiring inpatient mental health rehabilitation care, treatment and support. We heard that the waiting list for men requiring inpatient rehabilitation was increasing and that they were having to wait for prolonged periods of time in acute wards for a bed in the rehabilitation service. Changes were made to the service in January 2025 with the males in Craiglea Ward moving to Myreside Ward, (previously female rehabilitation ward) as this ward has capacity for 18 beds, providing an additional four beds. We heard that the move had been positive for both the men and women in these wards.

Referrals to Myreside Ward were received from a number of sources, including inpatient adult acute services, community services and forensic services. Some individuals referred to Myreside Ward have had contact with mental health services for a prolonged period, the longest admission being 16 years. The objective of Myreside Ward is to provide intensive rehabilitation to individuals with complex and enduring mental health needs, with the aim of preparing and supporting individuals to be discharged into the community.

We heard and saw that some of the individuals in Myreside Ward had reached their rehabilitation potential and that six individuals discharge had been delayed due to them requiring services either hospital based complex clinical care (HBCCC) or community services. We heard during the last visit that the health and social care partnership (HSPC) were commissioning a service in the community for individuals in rehabilitation services as there was a gap in service provision to meet the complex needs of these individuals. We were concerned to hear that no progress had been made in this planning and the negative impact this had on discharge planning.

During our last visit to this service in September 2023, which was an unannounced visit, we made recommendations on care plans, staffing levels, activities and the ward environment. The response we received from the service stated that all care plans would be reviewed at the weekly multidisciplinary team (MDT) meeting, an open day to support recruitment would be arranged and the environment would undergo a deep clean and outstanding repairs completed.

On the day of our visit, there were 18 people on the ward and no vacant beds. We wanted to follow up on the previous recommendations, meet with individuals, relatives/carers, staff and view the new ward environment.

Who we met with

We met with, and reviewed the care of eleven people, eight who we met with in person and eleven who we reviewed the care notes of. We also met with three relatives.

We spoke with the chief nurse, clinical nurse manager (CNM), senior charge nurse (SCN), charge nurse, nursing staff, student nurses, consultant psychiatrists, psychologist and the art psychotherapist team lead.

Commission visitors

Katheen Liddell, social work officer

Anne Buchanan, nursing officer

Dr Juliet Brock, medical officer

What people told us and what we found

The individuals we met with on the day of the visit were mainly positive about their care, support and treatment in Myreside Ward. Their feedback included comments such as “I am treated like a king”, “staff support and help me”, “I feel involved in decisions made about me” and “my care plan is supporting my discharge needs and I hope to be discharged soon”.

All individuals told us they had a key nurse that they met with regularly. Most individuals were aware of their care plan and told us they had participated in the completion of it. We also heard from individuals that they met with their consultant psychiatrist and all members of the MDT regularly and mainly felt listened to and involved in decisions regarding their care, treatment and support.

Many of the individuals we met with told us they felt frustrated at the amount of time they had been in hospital. Some individuals did not feel as though they needed to be in hospital and were concerned there was no discharge planning in place for them. These individuals told us that they had access to advocacy services and that they had provided their views to the MDT during the weekly MDT meetings and the three-monthly integrated care pathway (ICP) meetings.

All of the individuals we met with provided positive feedback on the activities available in and out with Myreside Ward. In particular, individuals spoke positively about the psychological therapies available in the ward, music and art therapy. One individual commented that they “found talking difficult” and engaging in music therapy provided them with an opportunity to express and explore their emotions, thoughts and feelings.

All individuals were aware of their activity care plan and fed back that there was a good mix of activity to support their rehabilitation needs as well as promoting their interests/hobbies and having an opportunity to have connections to the community and socialise with others.

Some individuals raised concerns about the environment. Many of the individuals we met with shared a room with no en-suite facilities. We heard from individuals that they felt their privacy and dignity was compromised. We also heard individuals’ dissatisfaction that there were only three showers for a ward of 18 people.

The feedback from the relatives and carers we met with was very positive. We were told that “staff go beyond their call of duty” to ensure individuals are provided with opportunities that promote all aspects of their care and well-being, including religious and cultural beliefs. We heard that communication with the staff team was good and that relatives were provided with regular updates from the staff team. Relatives commented on the strong leadership in the ward and highlighted the SCN as being very supportive.

All of the relatives that we spoke with felt involved in discussions and decisions regarding their loved ones' care and treatment. We were told that relatives had attended MDT and ICP meetings and felt their views had been taken into account. We also heard that relatives felt able to contact the MDT if they had any concerns. We were told that staff were "available and accommodating".

We were pleased to hear that individuals with families, had positive experiences of the staff team promoting and supporting contact between fathers and their children. We heard the benefit to the individual and their children and we were pleased that duties under Section 278 of the Mental Health (Care and Treatment) (Scotland) Act 2003 were promoted and supported.

Relatives who spoke with us told us that they could see improvements in their loved ones mental and physical health since admission to Myreside Ward. One relative commented that it was the "physically the healthiest" they had ever saw their loved one.

The rehabilitation service offered monthly carer support groups that relatives and carers could attend.

We heard that there had been many changes in the staff team in Myreside Ward since the last Commission visit. We were pleased to hear that additional staff had been recruited and that there was only one nursing vacancy in the team. We heard from staff about the benefits of having a full team in terms of being able to provide consistent care to the individuals and of the positive impact on staff morale. We were told by staff that they felt supported by the ward management team and that the new SCN was "a great addition".

We met with various members of the MDT during the visit. All of the staff that we spoke with told us that they enjoyed working in Myreside Ward and felt supported to undertake their role. We heard that training and skill development was promoted and encouraged to support staff to enhance and maintain the specialist skill set, and knowledge required to work in mental health rehabilitation.

Many staff raised concerns over the environment and the negative impact it could have on providing care to individuals. We heard from staff that they made efforts to support the environment to be homely and comfortable however, the ward required decoration. Staff also commented on the lack of access to outdoor space and told us that although there had been suggestions of creating a private garden space off the ward, this would still not provide an outdoor space that all individuals could access. Staff highlighted concerns over a lack of privacy for individuals due to sharing rooms and insufficient access to washing and toileting facilities.

We heard from staff about their frustrations with the lack of progress of the new build phase of the REH where rehabilitation services were to move to. We also heard

concerns that there were insufficient community services available for individuals in rehabilitation services, leading to delays in discharges.

Care, treatment, support, and participation

We reviewed care plans that were recorded electronically on TRAKCare. The Commission would expect a rehabilitation service care plan to be based on a whole-systems approach, with a clear focus on recovery. We were pleased to see that there had been an increase in the amount of care plans recorded for the individuals in Myreside Ward.

The individuals whose care plans we reviewed had a focus on mental health, physical health, activities, violence and aggression, psychosocial needs, ICP goals and a recovery action plan. The addition of these care plans supported a whole-system approach to care, support and treatment.

We had made recommendations in previous reports in relation to care plans, that they should correlate to ICP and that care plans should be regularly reviewed. We were pleased to find that improvements had been made in both recommendations.

We saw that the care and treatment goals in the care plans reflected those recorded in the ICPs and that they were regularly reviewed. The care plans we reviewed were individualised, goal focussed, person-centred and adopted a strengths-based and holistic approach. We found that some of the information recorded on interventions, did not provide comprehensive detail of the MDT interventions required to support the individual to meet their care goal and outcome. However, this information was comprehensively recorded and easily identifiable in ICPs.

The care plans reviewed evidenced participation of the individual, and where appropriate relative/carer involvement. Most of the individuals that we spoke with were aware of their care plans and had participated in them. Relatives and carers also felt involved in the care planning of their loved one.

We saw that some of the individuals in Myreside Ward had been in hospital for a prolonged period. The Commission's 2020 themed visit report on rehabilitation services, highlighted the link between long-term mental health problems and an increase in physical health problems.

From our review of the care records, we found that some of the individuals in Myreside Ward had physical health care needs and we were pleased to find that there was a significant focus on physical health care. There was evidence of these needs being addressed and followed up by medical staff. We also saw evidence of individuals being supported to attend routine and national health screening appointments which is essential in reducing health inequalities for individuals in hospital.

On review of the care plans, we found evidence of a culture that supported a healthy lifestyle, particularly in relation to diet, exercise and mental well-being. The occupational therapists (OTs) in Myreside Ward provided opportunities for individuals to engage in regular exercise and support with diet and nutrition.

We were pleased to see that individuals were being offered regular input from spiritual care to promote spiritual well-being.

We saw regular review of care plans that evidenced robust information including summative evaluation regarding the efficacy of targeted nursing intervention, as well as the individuals' progress. We saw that individuals had participated in their reviews. We were pleased to find that some of the individuals we met had made significant progress. For other individuals, the reviews highlighted areas of increased need and support, and changes made to the care plan to support the individual.

In addition to care plan reviews, we also found there were reviews through the ICP process. We found comprehensive and detailed information recorded in the ICPs. These documents evidenced a holistic approach to all aspects of the individuals' care and treatment and included a psychological formulation, involved the individual, their family and all members of the MDT. We were told by individuals that they found the found the ICP process supportive as it provided an opportunity to discuss all aspects of their care and treatment, especially in relation to future planning and discharge. We were pleased to see that advocacy were present at many of the ICP meetings.

We were told that there were six individuals in Myreside Ward whose discharge was delayed. We heard that the rehabilitation service met weekly with the discharge co-ordinator to discuss all individuals who were affected by this. We saw from our review of the care records that discharge was discussed mainly during the ICP process. We noted that for those individuals who were not assessed as ready for discharge, there was a lack of detail recorded as to why discharge was not appropriate and what was required to support discharge.

Many individuals we met with raised that they felt frustrated at the lack of information about discharge planning and from the information reviewed, the Commission would prefer that more comprehensive information on readiness for discharge is recorded and shared with the individual. We raised this with the CNM and SCN on the day of the visit, who recognised the importance of individuals having more detailed information in relation to discharge.

We found risk assessments to be of a high standard and included a chronology of risk, triggers, stressors, protective factors and a risk management plan with clear strategies to manage the assessed risks. We found that the information in the risk

assessment linked to outcomes of the violence and aggression care plans and the risk assessments completed as part of the ICP.

Care records
The care records were recorded on a pre-populated template with headings relevant to the care and treatment of the individuals in Myreside Ward. From review of the care records, we saw that some individuals in Myreside Ward required high levels of staff motivation to engage in their care plan. We saw that all members of the MDT were involved in providing regular prompting and support to individuals in Myreside Ward to support them to engage in their care plan goals to promote their recovery.

On review of the care records, we were pleased with the level of comprehensive and individualised information recorded by all members of the MDT. The information recorded was person-centred, strengths based, outcome and goal focussed and included forward planning. It was evident from reading the care records how individuals had spent their day, which MDT members had undertaken interventions with them and the outcome of interventions.

There was evidence of frequent one-to-one interactions between individuals with all members of the MDT. The individuals we met with told us that they met with their key nurse and other members of the MDT regularly. The one-to-one interactions reviewed were comprehensive, personalised and strengths based. We saw positive and regular examples of staff promoting rights-based care by having discussions with individuals regarding views on their care plan, future planning and any issue of concern.

We were pleased to find that the case records included regular communication with families, welfare guardians and relevant professionals including community teams.

Multidisciplinary team (MDT)
The ward had a broad range of disciplines either based there or accessible to them. In addition to the nursing staff, there was a consultant psychiatrist, higher trainee, junior doctors, psychologist, art psychotherapist and OT. We heard that the ward clerk, housekeeper and domestic were valued members of the MDT. We saw that the MDT had good links with mental health officers (MHOs) and social workers.

We met with the psychologist and heard and saw that individuals were offered psychological input on a one-to-one basis and in group settings. The psychologist attended MDT meetings and ICP meetings and individuals who required one-to-one support were identified at these meetings. Psychological formulations were completed as part of the ICP process and supported a collaborative approach to the individuals care, treatment and support by developing a shared understanding of the individual's difficulties and exploring factors that contributed to challenges.

We also heard that the weekly interpersonal group discussed themes such as relationships, values and how to respond to emotions and develop coping strategies. We heard that the group ran as a 'drop-in' option and that it was well attended by individuals.

In addition to art psychotherapy, we heard and saw that music therapy had been available in Myreside Ward for a period of nine months. Individuals and staff spoke very positively about having access to both art and music psychotherapy as they promoted a whole systems approach necessary to support individuals in rehabilitation services meet their care, treatment and support outcomes. We heard from individuals and staff that regular access to music therapy supported their emotional, cognitive and social needs by offering a safe and supportive environment for promoting well-being. We were disappointed to hear that funding for music therapy had ended. We highlighted our observations on the benefit of this input continuing to individuals in Myreside Ward with the senior management team on the day of the visit.

The ward MDT meeting took place weekly. Individuals and relatives/carers were invited to attend. We heard and saw that both individuals and carers regularly attended the MDT meeting and found it a positive experience.

We found detailed recording of the MDT discussion, decisions and personalised care planning. We were pleased to see clear links between MDT discussion, the ICP and care plan outcomes. It was clear that everyone in the MDT was fully involved in the care of the individuals in Myreside Ward and committed to adopting a holistic approach to care and treatment.

We saw that where discharge planning was progressing, the community rehabilitation team (CRT) were involved to support discharge.

Use of mental health and incapacity legislation

On the day of the visit, 18 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and one person was subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). All documentation relating to the Mental Health Act and the AWI Act was electronically stored on TRAKCare and easily located.

Part 16 (section 235 to 248) of the Mental Health Act sets out conditions under which treatment may be given to detained individuals who are either capable or incapable of consenting to specific treatments. This includes the requirement for a second opinion by an independent designated medical practitioner (DMP) for certain safeguarded treatments and the authorisation of medications prescribed beyond two months, when the individual does not consent to the treatment or is incapable of

doing so. Treatment must be authorised by an appropriate T3 certificate, or a T2 certificate if the individual is consenting.

On cross-checking the electronic records for everybody, the responsible medical officer (RMO) had completed either a T2 or T3 certificate for all eighteen individuals in Myreside Ward. On review of the documentation, we found three individuals who had medication prescribed, which was not authorised by the T3 certificates. We highlighted this issue on the day of the visit and were assured by the CNM and SCN that an urgent review of the T3 certificates would be undertaken and individuals would be made aware of the unauthorised treatment and their rights in relation to this.

Recommendation 1:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, that all psychotropic medication is legally authorised and that an audit system is put in place to monitor this.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where someone had nominated a named person, we found this documentation recorded in TRAKCare.

For the person who was subject to the AWI Act, we found copies of the order and powers granted were recorded on TRAKCare and that there was regular communication with the guardians.

Rights and restrictions

Myreside Ward continued to operate a locked door, commensurate with the level of risk identified with those in the ward.

The individuals we met with during our visit generally had a good understanding of their rights and detained status, where they were subject to detention under the Mental Health Act.

All of those we met with were aware of their right to advocacy support and many had active advocacy involvement, provided by the local mental health advocacy service, AdvoCard. Some individuals had legal representation and had been supported to exercise their rights by appealing their detention. For individuals who were assessed as not being able to instruct a solicitor, we saw that a curator ad litem had been appointed to safeguard the interests of the individual in the proceedings before the Mental Health Tribunal for Scotland.

We were pleased to see that information on rights was promoted in a variety of ways in Myreside Ward, including being displayed on information boards in the ward. Information was sent to the individual and named persons by the RMO detailing legal

status, their rights in relation to this and contact numbers for advocacy to support individuals and named persons to exercise their rights. We noted that ICP meetings also reviewed and discussed rights.

The Royal Edinburgh Hospital (REH) has a patient council group that offers collective advocacy and drop-in sessions that some of the patients in Myreside Ward attended.

Sections 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. Three individuals were specified on the day of the visit. We were able to locate the documentation and reasoned opinion authorising the restrictions. We were satisfied that the restrictions were proportionate to the assessed risk, the least restrictive principle had been applied, and the individual was informed of the restrictions during regular review and made aware of their rights.

The Commission has produced good practice guidance on specified persons[1].

When we are reviewing care records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under s275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. On the day of the visit one person had an advance statement in place. Most of the individuals we met with were aware of advance statements and had chosen not to complete one. It was evident during review of the care records and during discussion with some of the individuals that they were not at a point of their recovery to be able to make decisions regarding their future care and treatment.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We heard and found evidence of a broad range of activities that were available for individuals in Myreside Ward. The activity and occupation in the ward was provided by OTs, nursing staff, art psychotherapist and volunteers. The individuals we met with spoke very positively and were complimentary about the activities offered in the ward and in the community.

[1] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

There was an activities board located in the ward that provided information on activities on offer. The activities available included art therapy, decider skills, pool competition, gardening project, art group, football tournament, music jam, smoothie group, cooking group, computer lessons, creative writing group and mindfulness groups. We heard and saw that many of the individuals were talented musicians and artists and were impressed by the excellent artwork individuals had produced. We saw that volunteers attended the ward and provided therapet sessions and some individuals volunteered in the library.

We were pleased to see that individuals were able to access activities out with the ward, some of these were provided by third sector organisations. These activities included The Hive, where individuals could engage in activities and socialise with others in the hospital. Some individuals attended the Glasshouses for gardening activities with support provided by the Cyrennians and Artlink.

We were pleased to see the opportunities provided to support individuals to attend community-based activities. We heard and saw that trips to local landmarks, music and sports events had been arranged. The feedback from the individuals was very positive and we were happy to hear that more community and social outings had been arranged.

We also saw and heard that individuals were offered activities to enhance daily living skills and promote rehabilitation outcomes. Individuals were supported to 'deep clean' their room weekly with the support of the housekeeper, domestic staff and their key nurse. Individuals were supported to launder their own clothes. Many individuals engaged in cooking groups and enjoyed cooking their own meals.

The physical environment

Myreside Ward was located on the second floor of the original part of the REH. After the move in January 2025, the individuals, relatives and staff that we spoke with agreed that the move had been positive.

The layout of the ward consisted of single and double bedrooms. There were shared toilets, showers and one bathroom. All but one of the double rooms had a secure partition between bed spaces, which supported a degree of privacy and dignity for individuals. However, we heard from individuals that they felt they were not afforded the same level of privacy, dignity and safety that a single room would provide and that this was an infringement of their human rights.

We were able to view a single and a double bedroom. Both were personalised and clean. The housekeeper supported individuals on a daily basis to tidy and clean their rooms, as well as supporting them with their laundry. The cleanliness of the ward was of a high standard.

There was a lounge area and separate dining area for individuals to access. Both areas were bright and spacious with artwork and plants promoting a more homely environment. We could see that further decoration was required and were told by the SCN that the ward was on a waiting list to be painted.

Recommendation 2:
Managers must prioritise addressing the outstanding environmental issues in relation to decoration and maintenance issues to make the environment more homely and therapeutic.

We heard that the staff team were regularly trying to source better conditioned furniture from other wards/office spaces to create a more comfortable and homely ward environment. Although we were pleased by the proactive efforts of the staff team to create a better environment for the individuals in Myreside Ward, it would be preferable that plans for the new build as part of the REH redevelopment project were progressed to provide an environment for the individuals that would promote their safety, privacy and dignity. We were concerned that the individuals' rights to privacy and dignity, which is protected by Article 8 of the European Convention on Human Rights, were being compromised due to the current environmental factors.

There was a recommendation in the previous two reports in relation to provision of outdoor space and garden areas for individuals in Myreside Ward. We were disappointed to see that there had been no progress on implementing this recommendation. Although we recognise the location of Myreside Ward makes it difficult to provide outdoor space, the lack of access to outdoor space continued to concern us and the staff team. We consider it important for individuals to have access to safe outdoor space, especially individuals who are experiencing stress and distress.

From conversations with individuals, family and staff, there was a clear view that if individuals had access to garden space during times of stress and distress, it could help manage some behaviours more therapeutically, as opposed to using other interventions, such as medication, to alleviate stress and distress behaviours.

Recommendation 3:
Managers should consider ways to achieve parity in relation to the ward environment, garden access, privacy and dignity for all individuals in the Royal Edinburgh Hospital.

Any other comments

The feedback from most individuals and all relatives spoken with in relation to their experience of care and treatment in Myreside Ward was positive. We saw evidence of high standards of care during the visit that endorsed this feedback. There was a clear commitment by the MDT to provide high quality, specialist and skilled care.

We were pleased and encouraged to find that progress had been made and changes implemented in some areas since the visit in September 2023.

We saw and heard evidence of positive leadership provided by the CNM. In addition, it was positive to hear from all staff spoken to, that they felt supported by the SCN. We were pleased to observe the positive working culture the SCN had promoted in the ward. It was evident that the ethos of the ward was a commitment to ensure and support staff to provide high standards of care and strive to provide holistic, strengths based, and recovery focussed care.

Summary of recommendations

Recommendation 1:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, that all psychotropic medication is legally authorised and that an audit system is put in place to monitor this.

Recommendation 2:
Managers must prioritise addressing the outstanding environmental issues in relation to decoration and maintenance issues to make the environment more homely and therapeutic.

Recommendation 3:
Managers should consider ways to achieve parity in relation to the ward environment, garden access, privacy and dignity for all individuals in the Royal Edinburgh Hospital.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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