Mental Welfare Commission for Scotland

Report on unannounced visit to:
Royal Edinburgh Hospital, Balcarres Ward, Morningside Place, EH10 5HF

Date of visit: 9 May 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

Balcarres Ward is a 16-bedded acute mental health assessment, care and treatment ward for adult males. Balcarres Ward covers the catchment area that includes the northwest and northeast areas of Edinburgh.

On the day of the visit, the bed capacity had been increased to 19 beds with the use of three additional rooms that would usually have been used for meetings and communal quiet space as temporary bedrooms.

We were told that some individuals who met the criteria for the ward were boarding in other admission wards across the hospital site due to bed capacity being full in Balcarres Ward. Furthermore, we were told individuals who met the criteria for admission were also accommodated in the Royal Infirmary of Edinburgh (RIE) emergency department.

Where the Royal Edinburgh Hospital (REH) has reached bed capacity, a 'divert protocol' is put in place. Individuals will be accommodated in a general hospital with nursing staff for support until a mental health bed becomes available. On the day of the visit, we were told there were three individuals in the RIE waiting transfer to REH to commence care and treatment in a mental health hospital. A further three individuals from Balcarres Ward were also boarding in older adult wards based in the hospital; their consultant psychiatrist maintained responsibility for their care and treatment over the duration of their admission to hospital.

We last visited this service in April 2024 on an unannounced visit and made recommendations on providing opportunities for individuals to actively engage and participate in their care and treatment. We recommended that care plans should evidence agreed goals, interventions and reviews, to determine progress and that daily notes should provide evidence of interactions between individuals and members of the multidisciplinary team (MDT) for example, in one-to-one sessions and what were the outcomes from those sessions. We recommended that where restrictive practice had been identified, we asked for managers and medical staff to ensure individuals were provided with opportunities to understand the need for this and that all practices were to be proportionate and lawful. Where recreational engagement was not routinely documented in individuals' care records, a recommendation was made to highlight this as an area that required attention.

In our last visit report in 2024, we were concerned individuals admitted to Balcarres Ward were expected to sleep in rooms that were not designed as bedrooms; this had also been raised as a concern during our visit in 2023. For this reason, we made another recommendation to highlight our continuing concerns that this practice had continued. Lastly, NHS Lothian's 'no smoking policy' was not being adhered to, with individuals smoking throughout the ward and in the garden. We made a

recommendation to ensure managers supported individuals in relation to smoking cessation and for people to comply with NHS Lothian's own policy.

We received a detailed action plan from the service with actions for each recommendation and specific timescales.

Who we met with

We met with five people and reviewed eight sets of care records. No relatives/carers requested to meet with us on the day of the visit.

We spoke with the senior charge nurse, the charge nurse, the ward-based staff along with staff from older adults' service in which three individuals were receiving care and treatment. We also had the opportunity to meet with the senior leadership team including the clinical nurse manager (CNM) and chief nurse.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

Sandra Rae social, work officer

What people told us and what we found

The individuals we met with on the day of the visit were mostly negative with their feedback about their experiences of care and treatment in Balcarres Ward.

We asked whether people had felt involved in terms of decisions about their care and whether they had been given opportunities to participate in care planning and setting out goals to aid recovery. Of the five individuals we met with, they were unaware of their care plans, the details held in these, who specifically would support their recovery and whether there had been regular reviews to determine any progress.

We also discussed whether individuals had the opportunity to discuss arrangements for their discharge from hospital and what plans were in place to support the return to their communities. Again, this was an area that had not been routinely discussed with them and was a source of frustration.

We also had the opportunity to meet with ward-based nursing staff who told us the continuing decision to admit people to rooms that were not designed to be used as bedrooms was a challenge. Staff recognised those decisions were not providing people with a safe and therapeutic environment. Rooms that had previously designed for communal quiet sitting areas and interviews were not routinely available therefore, the ward felt overcrowded and exceptionally busy. With 19 people based in the ward, three individuals boarding in another ward and individuals admitted to the RIE, we were told increased competing demands was impacting upon the opportunities for therapeutic engagement with all people admitted to Balcarres Ward.

We met with the SCN who had been appointed shortly before our visit in March 2024. What was brought to our attention by individuals that we met with was that there had been significant tensions in the ward-based staff group. The SCN provided an update in terms of staff relationships and culture. They had felt there had been an improvement in terms of communication with each other and behaviours which were identified as a cause of concern to individuals admitted to the ward were less of an issue.

Due to competing demands the ward-based team continued to feel a degree of pressure and felt there was less time to spend with people in their care, which was an ongoing source of stress and frustration. We were told the sickness/absence level was high and there were a range of physical and stress-related issues associated to the ongoing high absence rate. Nevertheless, we were told there were improvements in relation to the culture in the ward and staff had felt more supported to discuss their concerns with the leadership team in the ward.

Care, treatment, support, and participation

Following our last visit to Balcarres Ward in April 2024, we made two recommendations in relation to care planning. On that visit we were concerned there was little evidence of meaningful engagement between nursing staff and individuals, and this was reflected in their electronic records as we could not consistently locate goals, interventions and reviews to determine whether the individuals were reaching their optimum level of recovery.

To ensure participation and supported decision making, staff should be able to evidence how they have made efforts to do this and that actions which are part of the care plan are clear and attainable. We were keen to review care plans and individual's care records which continue to be held electronically on TRAKCare.

We would expect to have found detailed assessments that provide a subjective view from individuals admitted to the ward, as well as their immediate goals and expectations from their admission to hospital. We would also expect an objective view from individual staff or MDT to evidence their professional considerations to determine which interventions would be required and this would include a comprehensive risk assessment too.

Unfortunately, of the care records, assessments, including risk assessments and care plans we reviewed, we could not find any progress in this area. We saw care plans that lacked any evidence of participation between staff and individuals. We could not find where goals had been agreed and how reviews would evidence progress.

As part of our review of documentation, we cross referenced assessments, including ones specifically related to risk and care plans. We could not find evidence of direct correlation between assessments and care planning, particularly for individuals who were admitted to hospital due to increasing concerns for their safety. From the action plan provided by the service, we could see both care records and person-centred care planning was going to be an area of focus in terms of learning and development for staff. Unfortunately, we were unable to identify or evidence progress in this area. We have therefore made a similar recommendation to what was made in 2024.

Recommendation 1:
Managers must ensure that individuals are fully involved in each stage of their recovery and that care plans are person-centred, reflect care needs and that individuals are aware of the clear interventions and care goals, they are working towards to enable recovery.

Recommendation 2:
Managers should carry out an audit of care plans to ensure all individuals admitted to Balcarres Ward are provided with documented evidence of how care is to be delivered and by whom.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

In relation to our discussions with individuals around the plans for their discharge, most of the people that we spoke with did not feel they were part of this conversation with the ward-based team, nor had not been provided with information or guidance, such as if there likely discharge date and who would support them post discharge from hospital.

When we reviewed individual's care records, we typically could not see evidence of discharge planning either in specific discharge care plans or in the records of the multidisciplinary team (MDT) meeting. We brought this to the attention of the senior leadership team as we appreciate successful and sustainable discharges from hospital-based care require a robust approach that is consistent and specifically person-cantered, including relatives and carers, where relevant. We were told medical staff met with community mental health teams (CMHT) weekly to discuss discharge planning. We would therefore expect individuals to be provided with consistent communication while also invited to participate in discussions to ensure they are supported to achieve a successful transition from hospital-based care to home.

The senior leadership team recognised that for individuals who had been admitted to the general adult wards, planning their discharge from hospital-based care could be a challenge. There was an intention to recruit two staff into new discharge coordinator posts and, with support from Edinburgh Health and Social Care Partnership (HSCP) social work staff, this new resource should improve pathways from hospital to the community.

Care records
Information on individual's care and treatment was held electronically on TRAKCare. We found this electronic record system easy to navigate.

We were pleased to find all staff had input to the information on TRAKCare; this included allied health professionals (AHPs), such as occupational therapy (OT), arts psychotherapists and psychology. Daily continuation notes were captured using a 'canned text' framework that provided several areas of focus, for example, mental health and well-being, activities, daily risk assessment and medication. Where we saw evidence of one-to-one interactions between individuals and staff, there was a

richness of detailed narrative. There was both a subjective and objective views and this allowed the reader to appreciate how the individual's mental health and well-being was at the time of the meeting.

We were also able to appreciate the complexities of individual's presentations and the continued high level of acuity frequently experienced by individuals. In the records we reviewed, there were several that appeared meaningful and provided an opportunity for individuals to explore what was important to them in relation to their recovery. We were able to see some evidence where nursing staff had considered a strengths-based approach to working with and supporting individuals. Those interactions were informative, and we could see where assessments correlated with care plans. Once again, while we were able to find some evidence of a high standard of record keeping, this was not consistent throughout all the care records that we had the opportunity to review.

During the review of care records from our last visit in April 2024 we saw found repeated use of generic language for example "evident on the ward" and "keeping a low profile". We were disappointed to have found this once again. The limitations of those accounts of individual's presentations does not provide evidence of person-centred therapeutic engagement between an individual and nursing staff. From the action plan was provided by the service in response to the previous recommendation, we could see that documentation in care records was going to be an area of focus in terms of learning and development for all nursing staff. Unfortunately, we could see there were some staff who had invested in ensuring daily recordings provided a detailed narrative, but this was not consistent. We again make a similar recommendation to that of the last visit.

Recommendation 3:
Managers should ensure members of the ward-based team record personalised, strengths based meaningful information in individual's daily continuation notes.

Multidisciplinary team (MDT)
The ward had a broad range of professionals and disciplines either based there or accessible to it. In addition to medical and nursing staff, the MDT included a recreational nurse, a physician associate and a pharmacist. The ward also benefitted from having regular input from psychology, art psychotherapist and OT.

From meeting with individuals there was a consistent view that allied health professionals including OT and physiotherapy were highly valued. This was further extended to professionals delivering a psychotherapeutic and psychological model of care. Ward-based staff were positive in their feedback about various professionals and the regular input they provided to the nursing team too.

We heard there was one substantive consultant psychiatrist and a newly appointed locum psychiatrist. We are aware from our previous visits to the service that there had been a reliance on locum medical staff for a prolonged period and this hindered the provision of a consistent model of care and treatment for people admitted to the ward.

There were weekly MDT meetings held in the ward in which all disciplines were invited to attend and participate. Over the past two years the admission wards have adopted a mental health structured template for their MDT meetings. This framework captured key information and discussion between all professionals. During our last visit to the ward in 2024, we saw a considerable improvement in relation to the quality of information held on the document and were pleased to find that contributions from the MDT were recorded, with detailed reviews and actions.

On this recent visit, we were disappointed to find the quality of information had lessened, with little evidence of a whole team approach to reviews. We found medical staff were regular attendees; however, this did not extend to all AHPs or senior nursing staff. Information held on the template was lacking in detail with some areas not completed. The template offered an opportunity for reviews to consider progress or where actions had been indicated and achieved. Again, there was a lack of detail in relation to reviews and discussions with the wider MDT.

Furthermore, we were unable to consistently see identified actions required and any outcomes from those actions. This was disappointing, as we were aware from our last visit to the ward there had been considerable effort to have an MDT that worked together to support individuals in Balcarres Ward.

Lastly, where we would have expected to see the inclusion of individuals and their relatives in discussions at the weekly meeting, we were told individuals were not routinely invited into the meetings and outcomes were shared with them post-meeting. This was discussed with individuals we met with on the day of the visit, and we heard they did not feel included in discussions around their care and treatment which was a source of frustration for them.

Recommendation 4:
Managers should carry out an audit of MDT weekly meeting structure and template to ensure all individuals admitted to Balcarres Ward are provided with documented evidence of how the MDT gather information to support individuals throughout their admission and that their participation in these meetings is evidenced.

Use of mental health and incapacity legislation

On the day of our visit, 14 individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All

documentation relating to the Mental Health Act was stored electronically on TRAKCare and easily located.

Part 16 (sections 235-248) 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 medication 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 in these cases, or a T2 certificate if the individual is consenting.

We reviewed the prescribing of medications and treatments for all individuals, as well as the authorising of treatment for those subject to the Mental Health Act. Medication was recorded on the HEPMA (hospital electronic prescribing and medication administration) system. T2 and T3 certificates authorising treatment were stored separately on TRAKCare.

We have previously advised that navigating both electronic systems simultaneously can be a practical challenge for staff. We had previously suggested a paper copy of all T2 and T3 certificates be kept in the ward dispensary so that nursing and medical staff have easy access and opportunity to review all T2 and T3 certificates. We could not locate current certificates for individuals who required them. Once again, we proposed this situation was potentially problematic as it could reduce the ease of checking for the correct legal authority for prescribed treatments.

During our review we noted three individuals were receiving treatment which was not legally authorised either by a T2 or T3 certificate. We brought this to the attention of the senior charge nurse and the senior leadership team.

Recommendation 5:
Managers and responsible medical officers must ensure that all consent and authority to treat certificates are valid, and that all psychotropic medication is legally authorised, and audit processes are introduced to ensure compliance with this.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person had been nominated, we found this stored on TRAKCare.

Rights and restrictions

Balcarres Ward continues to operate a locked door, commensurate with the level of risk identified with the individual group. Unfortunately, on the occasion of this recent visit we could not locate a locked door policy which would usually have been displayed at the entrance of the ward. We asked the ward's leadership team to

ensure the locked door policy was clearly displayed for individuals and any visitors to the ward.

We were pleased to have found that all individuals who had been admitted to the ward had an up-to-date pass plan in place and accessible in their electronic records.

We were informed all individuals who are subject to the Mental Health Act had their rights discussed with them and this was documented in their electronic care records. On the day of the visit, we were not able to locate evidence of this and brought this to the attention of the senior charge nurse. During our last visit to Balcarres Ward we were pleased to see the ward-based team had developed an information board that included rights-based advice and guidance. Unfortunately, the board was not in place, as it had been removed by an individual and had yet to be replaced. We would urge the senior leadership team to replace this board as a matter of urgency as all individuals who are receiving their care either formally or informally require accessible information in relation their rights and contact details for legal representation and advocacy services.

The individuals we met with during our visit had a mixed understanding of their detained status and their rights under the Mental Health Act. From the files we reviewed, there was evidence of legal representation and advocacy involvement to support individuals in understanding their legal status and how to exercise their rights.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of the visit to Balcarres Ward, we were informed there were no individuals subject to Sections 281 to 286.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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. We did not see any copies of advance statements in individual's care records. Following on from our last visit where we were not able to locate advance statements on that occasion, we explored with the leadership team whether advance statements were discussed with people admitted to Balcarres Ward. While we acknowledged people are not always able to undertake formalising their views specifically in relation to future care and treatment, we would propose taking the opportunity to start a conversation with individuals to help them consider what is important to them would be helpful.

As part of discharge planning, it may be helpful for community teams to know if an individual has had support during their admission to consider future care and treatment and who may be able to encourage an individual with developing an advance statement.

The Commission has developed *Rights in Mind.* 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 were informed the recreational nurse had been in their post for over a year and had established their role to promote recreational and therapeutic engagement with individuals admitted to Balcarres Ward.

When we spoke with individuals on the day of the visit, they told us there were some activities that they enjoyed however, there were times where they felt bored during their admission. When we reviewed individual's care records, we looked for written evidence of when people had engaged with recreational activities and a subjective view of their experience. Unfortunately, in the care records we reviewed, we were unable to locate any evidence of when individuals had engaged with activities, with whom, and how that session had been of benefit to them. We recognise activities with individuals or in a group setting do not necessary require a formal structure, nevertheless, understanding what works well for people is essential and having evidence of engagement would be beneficial.

We heard OT was highly valued and had a role that included functional assessments, therapeutic engagement and providing links to community services. We saw detailed assessments and associated care plans undertaken by OTs. We heard from individuals how they felt regular input had provided an enhanced opportunity to learn new daily life skills and maintain existing abilities and extend this to post discharge from hospital-based care back into their community.

We also heard how art psychotherapy had provided individuals with opportunities to consider a therapeutic process to address symptoms of emotional distress. Sessions undertaken by arts psychotherapist and psychology were documented and held in TRAKCare and outcomes were shared with the MDT as part of an overall model that included recreational and therapeutic engagement. We were told there were challenges to having a regular structured programme of activities based on the ward as the ward has limited space to accommodate activities due to rooms that had been designated for activities had been used as 'surge' bedrooms.

For this reason, we were told most activities were based away from the ward in other areas across the hospital site. While this was an opportunity for some individuals to have time away from the ward and meet people from other wards, this was not a

viable situation for everyone for reasons of safety or confidence leaving the ward environment.

While there were some activities available for individuals admitted to Balcarres Ward, we were told there was a day service run by Scottish Action for Mental Health (SAMH) offered a range of activities and groups based in the HIVE, which was situated in the hospital grounds. Furthermore, there were opportunities for individuals to attend the hospital-based gym to promote health and well-being.

Recommendation 6:
Managers should consider addressing the availability of dedicated space in the ward while seeking clarity whether a structured programme of accessible ward-based activities would be routinely available for everyone.

The physical environment

We have raised in our previous report the use of 'surge' beds placed in interview rooms. On the day of this recent visit, we noted the dedicated interview rooms were still accommodating 'surge' beds and being used as bedrooms. A dedicated quiet room that should be in place for all individuals to use for listening to music or reading was also accommodating one individual as a bedroom.

We viewed those rooms that were being used as bedrooms and found the lack of washing and toileting facilities was an issue, along with the lack of privacy. To access washing facilities, individuals had to ask a member of staff to open the door to the communal bathroom which had a bath but no shower. We were told this was not ideal and had been their experience for several weeks. We again discussed this ongoing issue with the senior leadership team on the day of the visit. They agreed this ongoing situation was not at all desirable and did not offer privacy or dignity for people admitted to the ward.

We were informed on the day of the visit that the ward had reached its bed capacity, plus had an additional three individuals therefore there were 19 individuals currently receiving treatment in a ward that should accommodate 16 people. Moreover, a further three individuals were placed in an older adult ward based in the hospital. We were told a new purpose-built community facility would be opening to support individuals discharge from hospital-based care back into the community. At the time of our visit, we were not given specific timescales for the opening of the new facility therefore it was likely that the use of 'surge' beds would continue.

Due to continued use of 'surge' beds in the ward, we were told communal areas and private space for staff to meet with individuals was not available. This was a source of frustration for everyone we met with, including individuals and staff. Having dedicated private space was deemed to be essential, particularly for staff and

individuals to undertake one-to-one therapeutic discussions. The communal areas of the ward were used for socialising and for dining.

Recommendation 7:
Managers must review current bed management and boarding arrangements to ensure that the safety, welfare, dignity, and well-being of every individual admitted to the ward is prioritised.

There was a courtyard available for people to have direct access to however, on the day of visit we observed several people smoking cigarettes and vaping in it.

Our previous visit reports have highlighted the non-compliance with the Scottish Government's NHS no smoking legislation. This resulted in a recommendation that this was explained and complied with by all individuals and staff. We received a response from the service detailing their plan to ensure compliance with this legislation, including the provision of education, advice, smoking cessation interventions and signage. We were also told there would be a booklet available for all individuals admitted to the hospital to advise them the Royal Edinburgh Hospital is a smoke free hospital.

On the day of this visit, we wanted to follow up on these previous recommendations however, despite the information provided in the action plan supplied by the service, we were both concerned and disappointed to find that there continued to be limited progress in implementing the smoke free legislation. We repeat the recommendation we made in our report of April 2024.

Recommendation 8:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

Any other comments

Once again, we received less than positive feedback from individuals we met with during our visit to Balcarres Ward. We recognise for the ward-based team this may have a negative impact as we were told they were committed to providing person-centred care; however, this was frequently compromised by the many competing demands they experienced throughout the day.

With the increase in the number of people admitted to the ward, several people placed in other wards and the recent addition of admitting people to the RIE, this has decreased staff's ability to deliver therapeutic interventions to support individual's recovery.

We note the recommendations in this report are largely comparable to previous visit reports. This is disappointing although it reflects the ongoing challenges the service experiences. Throughout the day of the visit, we heard from both individuals receiving care and treatment on the ward and from nursing staff that while people continued to be admitted to the ward in increasing numbers, there was a likelihood that person-centred care and treatment would continue to be compromised.

Summary of recommendations

Recommendation 1:
Managers must ensure that individuals are fully involved in each stage of their recovery and that care plans are person-centred, reflect care needs and that individuals are aware of the clear interventions and care goals, they are working towards to enable recovery.

Recommendation 2:
Managers should carry out an audit of care plans to ensure all individuals admitted to Balcarres Ward are provided with documented evidence of how care is to be delivered and by whom.

Recommendation 3:
Managers should ensure members of the ward-based team record personalised, strengths based meaningful information in individual's daily continuation notes.

Recommendation 4:
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Recommendation 5:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, and that all psychotropic medication is legally authorised.

Recommendation 6:
Managers should consider addressing the availability of dedicated space in the ward while seeking clarity whether a structured programme of accessible ward-based activities would be routinely available for everyone.

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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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