Health Education England

Developing people for health and healthcare

Pan-London Quality and Regulation Unit

Barking, Havering and Redbridge University Hospitals NHS Trust Trust-Wide Review

Quality Visit Report

18 November 2015

Final Report

THE NHS CONSTITUTION

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Visit Details	
Trust	Barking, Havering and Redbridge University Hospitals NHS Trust
Date of visit	18 November 2015
Background to visit	The Care Quality Commission (CQC) inspected the Trust in October 2013, and found there were serious failures in the quality of care and concerns that the management could not make the necessary improvements without support. The Trust was placed in special measures in December 2013. Since the inspection a new executive team had been put into place including a new chair, new members of the board, a chief executive, medical director, deputy chief executive, chief operating officer and a director of planning and governance. The executive team was being supported by an improvement director from the Trust Development Authority. A director of medical education had also just been appointed. The Trust developed an improvement plan ('unlocking our potential') that was being monitored and contributed to by all stakeholders on a monthly basis. The CQC re-inspected in March 2015 in order to check on improvements, apply ratings and to make a recommendation on the status of special measures. Overall, it was found that the Trust still required improvement. Both Queen's Hospital and King George Hospital were rated as 'requires improvement'. Of the five key questions that the CQC asked, they rated the Trust as 'requires improvement' for caring, safe, effective and well-led; responsive was rated 'inadequate'. A Trust-wide Review had not been conducted by Health Education England since May 2013, and in the interim, there had only been one specialty-focused visit to geriatric medicine in April 2015. A Trust-wide Review was therefore arranged for November 2015 and various parallel specialty-focused sessions took place alongside (see separate specialty-focused reports for further details) in line with the red outliers in the 2015 General Medical Council national training survey.
Visit summary and outcomes	The visit team met with members of the senior executive team, the postgraduate medical education team followed by a number of trainees and trainers from a variety of specialties not being reviewed in the parallel specialty-focused sessions, namely haematology oncology, otolaryngology, obstetrics and gynaecology, care of the elderly, paediatrics and general practice. The trainees interviewed were on the whole happy with their training and would have no objections to family or friends being treated at the hospital, provided that staffing levels were appropriate. All the trainees interviewed during the Trust-wide Review session reported that they would recommend their jobs. The visit team was impressed by the new educational governance structure and the enthusiasm of the education team. The consultant body felt supported by them. There were good examples of inter-professional learning including in simulation. The visit team, however, was concerned by the varied trainee involvement in clinical governance. The visit team felt that the incident reporting system required strengthening so that trainees were given appropriate feedback and that there were clear lessons learned. The culture of enquiry and learning from incidents required improvement. In addition, there was a lack of awareness of the need to report clinical incidents across the board. The visit team suggested that the general practice (GP) trainees needed educational leadership with a Trust nominated leader for GP trainees across the board who would liaise with the GP School. The visit team heard that there was still room for improvement in educational resources on this site, e.g. improved library access and a dedicated seminar room for paediatrics. Trainees reported being at the receiving end of patient aggression and did not always feel adequately prepared to manage these situations. Although the visit team heard that the quality patient safety summits were in place, trainees as a whole did not yet seem to be aware of these meetings.

	At the end of day one, the visit team issued the Trust with **four immediate mandatory requirements**, as follows: **Safe resuscitation of a child in the emergency department** The visit team heard that the paediatric resuscitation bay was not always adequately equipped and staffed to receive a sick child. In the resuscitation area, the visit team heard that on recent occasions the appropriate drugs were not available which meant that they needed to be collected from the paediatric emergency department. Although the numbers of paediatric trained nurses in the paediatric emergency department had increased and attempts had been made to improve the adult trained nurses' skills, there were still times when a paediatric-trained nurse was not available and this resulted in a skills gap. The visit team requested assurance that there were appropriate clinical skills and equipment to guarantee the safe resuscitation of children in the emergency department. The visit team also required the Trust to ensure that there was a responsible person for the drug cupboard in the resuscitation area to guarantee that it was fully stocked on a daily basis. **Plus One Patients** Patients were being transferred from the emergency department or the medical receiving unit and were left on trolleys or in wheelchairs for several hours in the corridor outside the ward while waiting for a bed to become free. The visit team felt that there was a risk that these patients could deteriorate in the corridor without appropriate monitoring. This was found to be an issue in the Trust-Wide Review, Medicine and Foundation sessions on day one, but was also raised as an issue by trainees in the surgery specialty-focused sessions on day two of the visit. The visit team required the Trust to ensure that these patients were being safely monitored while they were waiting for a bed and provide any relevant policies. **Emergency department triaging** Patients re-presenting to the emergency department with deterioration after discharge from haematology oncology or acute gynaecology were not routinely triaged before being transferred to the specialist areas. Similar issues were identified on the interface with medicine with Rapid Access and Treatment occurring, but without the 'treatment'. There was a lack of clarity as to where clinical responsibility lay; very sick patients were waiting for medical review for a long time while deteriorating clinically, while receiving no treatment. The visit team required the Trust to ensure that patients re-presenting to the emergency department were assessed appropriately (triaged) before being transferred to specialist areas. The visit team required the Trust to ensure that there was a policy in place whereby the patients remained the responsibility of the emergency department and received treatment while they were awaiting medical review. **Otolaryngology** There was a lack of core trainees in otolaryngology (ENT) which resulted in an over-reliance on short-term locums, who were not provided with appropriate access to Trust electronic systems; this had led to patients not being appropriately handed over or on occasions lost. On day two of the visit, many of the surgical trainees highlighted similar issues with the often sub-optimal standard of short-term locums, who had received no induction to the department or the correct passes to access the Trust's electronic systems. The visit team required the Trust to ensure that locums were adequately trained and provided with the necessary access to Trust electronic systems to guarantee that they could carry out their duties appropriately and ensure safe handover.

Visit team			
Overall Lead Visitor	Professor Tim Swanwick, Postgraduate Dean, Health Education England - North Central East London Office	**Lead Visitor**	Dr Helen Massil, Trust Liaison Dean, Health Education England - South East London Office
Trust Liaison Dean	Dr Indranil Chakravorty, Trust Liaison Dean, Health Education England - North East London Office	**Healthcare Professions Representative**	Louise Morton, Associate Dean for Healthcare Professions, Health Education England - North Central East London Office
LETB Representative	Khalid Adam-Saib, Commissioning Manager	**GP Representative**	Dr Naheed Khan-Lodhi, Associate Director, North East GP School
Lay Representative	Jane Gregory, Lay Member	**Visit Officer**	Jane MacPherson, Deputy Quality and Visits Manager

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	Requirement / Recommendation
	Educational Structure and Overview During the meeting with the senior corporate management team, the medical director, who had started in post in January 2015, gave a presentation on the Trust's plans to become an outstanding organisation. During his presentation he commented that Barking, Havering and Redbridge University Hospitals NHS Trust had been a 'troubled Trust' in late 2013, due to leadership instability, financial deficit since 2005, poor reputation and negative media and poor performance against national standards. He stated that the Trust was working hard to address these underlying issues and that between 2014 and 2015 the Trust was focused on the 'unlocking potential' stage of its journey towards 'outstanding'. The next phase, from 2015 to 2016, involved developing resilience to deliver the Trust's potential and from 2016 to 2017 the Trust intended to establish new models of delivery to ensure the sustainability of the Trust. He also commented that the Care Quality Commission (CQC) visits provided the Trust with a good opportunity to build partnerships with the Trust's regulators to make positive change. The visit team heard that the CQC had placed the Trust in measures in December 2013 and had later re-inspected the Trust's hospitals in March 2015. In March 2015 several areas of outstanding practice were noted by the CQC, in addition to 30 must-do actions under four domains. The medical director informed the visit team that there could be another unannounced CQC visit at any time from December 2015 onwards. The medical director reported that the Trust's vision was 'to provide outstanding healthcare to our		

community, delivered with pride'. This was connected to the operational plan for 2015 to 2016.

He also stated that despite the Trust's financial issues, investment had been made in a number of service developments to try and move the Trust towards 'outstanding'. He cited the Trust's involvement in a number of high profile partnership programmes, e.g. Vanguard.

The medical director highlighted the Trust's clinical structure and commented that he was responsible for performance managing the various divisions. He stated that he would like each college tutor to lead on education for each of the different divisions. The visit team heard that a new director of medical education had recently been appointed who would be instrumental in helping to set up the new divisional structure.

Staffing resources

The visit team heard that the Trust had a vacancy rate of 12 to 13 per cent, but that many of these posts were filled by locums. From a nursing perspective, the medical director reported that the Trust was recruiting internationally and that the Trust was proactively trying to retain its nursing staff by offering trainee students permanent jobs as early as possible and by improving career development opportunities. The Trust was also working on improving the advanced nurse practitioner (ANP) role to try and improve retention of these staff members.

The medical director commented that additional consultant numbers were required in care of the elderly, acute medicine, general medicine and emergency medicine, although appointments had recently been made in the latter.

The medical director reported that investment had been made in radiology, a traditionally difficult area, in the last six to nine months and that this service had improved as a result.

Reconfiguration

The medical director reported that reconfiguration plans were still in the planning phase and that further discussions needed to take place with the community. It was likely that many elective services would be based at King George Hospital, as well as an urgent care centre.

Hospital at night

The medical director reported that this was still an unresolved issue and that little progress had been made since the previous Health Education England visit; however, he stated that work was taking place around devising a model which had the correct skill mix and workforce, for example by using physician associates.

Financial transparency

The medical director confirmed that there was financial transparency with the new divisional structure. The associate director of education was responsible for this area of work and she stated that the Trust Board ensured that any financial investment was ring-fenced and spent appropriately on education.

GMC Theme 1) Learning environment and culture			
TWR1.1	**Patient safety** **Safe resuscitation of a child in the emergency department** The visit team heard that the paediatric resuscitation bay was not always adequately equipped and staffed to receive a sick child. In the resuscitation area, trainees reported that on recent occasions the appropriate drugs were not available which meant that they needed to be collected from the paediatric emergency department which was in a separate area within the emergency department. Although the paediatric educational leads reported that the numbers of paediatric trained nurses in the paediatric emergency department had increased and attempts had been made to improve the adult nurses' skills, the visit team heard that there were still times when a paediatric-trained nurse was not available and this had resulted in a skills gap. The educational leads also commented that there were two paediatricians looking after acute medical emergencies on the shop floor. In the previous nine months, additional paediatric emergency department nurses had been recruited. They agreed, however, that there were still problems out of hours and at the weekend and that there was an over-reliance on adult nurses. They commented that a recruitment drive was in process. They suggested that an extra paediatric higher trainee on duty during the winter months would help ease the flow and maintain appropriate escalation. It was hoped that this would be in place soon. The educational leads cited the busy workload as the main issue and commented that the department was looking at using advanced nurse practitioners (ANPs) and phlebotomists, as well as involving nurses in skills and drills sessions so that adult nurses became more used to dealing with paediatric cases. The visit team heard that every alternate month, multi-professional training took place for paediatric nurses, doctors and anaesthetists to try and improve their confidence in dealing with paediatric cases.	The Trust must provide assurance that there are appropriate clinical skills and equipment to guarantee the safe resuscitation of children in the emergency department. The Trust should ensure that there is a responsible person for the drug cupboard in the resuscitation area to guarantee that it is fully stocked on a daily basis.	Immediate Mandatory Requirement
	'Plus one' patients The visit team heard numerous examples of patients being transferred from the emergency department or the medical receiving unit and being left on trolleys or in wheelchairs for several hours in the corridor outside the ward while waiting for a bed to become free. Trainees reported that the sister on the ward was under pressure to accept the patients from the emergency department before space was available. The trainees themselves felt under pressure to discharge patients to meet Trust targets. They confirmed that they had raised this as an issue with their supervisors. The visit team felt that there was a risk that these so-called 'plus one' (or even 'plus two or three') patients could deteriorate in the corridor without appropriate monitoring.	This was found to be an issue in the Trust-wide Review, Medicine and Foundation sessions on day one, but was also raised as an issue by trainees in the other specialty-focused sessions on day two of the visit. The Trust must ensure that these patients are being safely monitored while they are waiting for a bed.	Immediate Mandatory Requirement

	Emergency department triaging The visit team heard that patients re-presenting to the emergency department with deterioration after discharge from haematology oncology or acute gynaecology were not routinely triaged before being transferred to the specialist areas. Trainees reported that although discussions had taken place to try and resolve this issue, the problem still persisted and trainees felt that any inappropriate referrals impacted negatively on their training experience and also represented a patient safety risk. The educational leads reported that the acute gynaecology workload was very heavy. A gynaecology improvement committee had been set up to try and address these issues. The educational leads reported that the Trust was trying to ensure that nurses received training to correctly triage patients and also carry out minor procedures. Discussions had also taken place regarding introducing a hot week and hot clinic system. Resources and funding needed to be sought for this. Similar issues were identified on the interface with medicine with Rapid Access and Treatment occurring, but without the 'treatment'. There was a lack of clarity as to where clinical responsibility lay; very sick patients were waiting for medical review for a long time while deteriorating clinically, and not receiving any treatment. (See specialty-focused visit report for medicine for further details).	The Trust must ensure that patients re-presenting to the emergency department are assessed appropriately (triaged) before being transferred to specialist areas. The Trust must ensure that there is a policy in place whereby the patients remain the responsibility of the emergency department and receive treatment while they are awaiting medical review.	Immediate Mandatory Requirement
	Otolaryngology There was a lack of core trainees in otolaryngology (ENT) which resulted in an over-reliance on short-term locums, who were not provided with appropriate access to Trust electronic systems; this had led to patients not being appropriately handed over or on occasions lost. On day two of the visit, many of the surgical trainees also highlighted similar issues with the often sub-optimal standard of short-term locums, who often had received no induction to the department or the appropriate passes to access the Trust's electronic systems.	The Trust must ensure that locums are adequately trained and provided with the necessary access to Trust electronic systems to guarantee that they can carry out their duties appropriately and ensure safe handover.	Immediate Mandatory Requirement
	Trainees based at King George Hospital reported that that since there was often no interventional radiology service at King George Hospital on certain days during the week, it was sometimes difficult to arrange a transfer to Queen's Hospital for any respiratory patients who required drains.	The Trust is required to review the current arrangements for interventional radiology and its impact on patient care on the King George Hospital site and provide a solution to any identified problems.	Mandatory Requirement
TWR1.2	**Serious incidents and professional duty of candour**	The incident reporting system requires	Mandatory

	The medical director highlighted the Trust's strong patient safety infrastructure and stated that there was a weekly patient safety summit every Tuesday at 1pm, which was chaired by the medical director or chief nurse. An associate director and Darzi fellow had been appointed to lead on this. He also reported that the Trust was trying to bring trainees into quality safety improvement. The visit team found that trainees as a whole did not yet seem to be aware of these summit meetings. The associate director of education reported that the director of medical education would have two deputies and that they would be involved in trying to strengthen the incident reporting process and subsequent learning mechanism. The visit team heard that when an incident was reported, the medical education manager, the deputy medical director and associate director for education were all alerted and would then be able to ascertain if a trainee had been involved. The visit team heard that if trainees were directly involved in a serious incident, they would be supported throughout the entire process by the education team. At the time of the visit, the reporting system was Ulysses, although it was hoped that the Trust would move towards using the Datix system. The associate director of education conceded that the whole area of serious incident reporting needed strengthening. She suggested that perhaps some trainees were fearful about reporting incidents, but that this was a remnant of the previously less open culture, which the Trust was working hard to change. Of the trainees interviewed, very few had reported incidents. Some had received feedback quickly whereas others had received none at all. Trainees commented that they were not fearful of reporting incidents, but instead rather reluctant to fill out the lengthy incident form at the end of a busy day. Some trainees, particularly those in obstetrics and gynaecology, otolaryngology, paediatrics and haematology, reported that they had good morbidity and mortality meetings and regularly discussed incidents that had occurred.	strengthening so that trainees are encouraged to report incidents, are given appropriate feedback and so that there are clear lessons learned. The culture of enquiry and learning from incidents requires improvement.	Requirement
TWR1.3	**Rotas** Most trainees interviewed were happy with their rotas, particularly in otolaryngology, obstetrics and gynaecology, geriatric medicine and paediatrics. The core haematology oncology trainees were not on the general rota and therefore only worked one in six weekends. The higher haematology oncology trainees reported that they often had to stay late during the week due to over-running clinics.		
TWR1.4	**Induction** The director of medical education reported that each department was working on producing a formalised, local departmental induction but that this was not yet fully in place across the board. The education team stated that following complaints about excessive queuing for identification	Although good induction processes exist in most places, additional work needs to be undertaken to ensure that all trainees receive an appropriate Trust and departmental induction prior to starting their jobs. Trainees and locums must	Mandatory Requirements

	badges, changes had been made to try and streamline the process during the Trust induction. On the whole the trainees reported that the Trust induction was good. However, some trainees reported having to start on call or attend a busy clinic without having been appropriately inducted. Some returning trainees who had worked at Queen's Hospital but were then allocated to King George Hospital were not given an appropriate induction to the new site. It was also reported that there was no departmental induction for King George Hospital in medicine or in geriatric medicine at Queen's Hospital. These issues were specifically reported by the GP trainees. Some trainees commented that prior to their arrival at the Trust, they had found it difficult to know who to contact. Many trainees complained that it took at least a month for them to receive their username and password for the electronic systems to write up clinic notes and letters.	also be issued with ID badges, usernames and passwords in a timely fashion so that they can carry out their work safely.	
TWR1.5	**Handover** The GP trainees in medicine reported that they had a formal, safe handover in the morning and at night, which was normally led by a higher trainee. The handover system for obstetrics and gynaecology, paediatrics and haematology was also reported to be good.		
TWR1.6	**Protected time for learning and organised educational sessions** No major issues were reported in this area. Haematology oncology trainees were able to attend their weekly teaching sessions, and the higher trainees could all attend their regional teaching apart from one trainee who stayed behind to cover workload. The otolaryngology (ENT) trainees could normally attend their weekly teaching session unless it clashed with an operating list or clinic. The GP trainees reported that obstetrics and gynaecology teaching was tailored to their needs. None of the GP trainees reported any issues being released for their half-day teaching although some geriatric medicine GP trainees were unable to attend their departmental teaching as it clashed with their GP teaching.	Review the scheduling of this departmental teaching to ensure that it does not clash with the GP trainees' GP teaching.	Recommendation
TWR1.7	**Access to simulation-based training opportunities** The associate director of education reported that simulation opportunities were improving all the time. The simulation centre was working hard to involve more teams year on year, in particular with regards to multi-disciplinary simulation. Simulation teaching sessions were based at times on serious incidents but mostly on normal emergency cases that trainees were likely to see on a daily		

	basis.		
GMC Theme 2) Educational governance and leadership			
TWR2.1	**Effective, transparent and clearly understood educational governance systems and processes** The director of medical education reported that the medical director had set up workshops to try and involve clinical staff members in training and education. He also stated that with the new divisional structure, an educational lead would be appointed to each division, who would sit on the monthly divisional meetings. A trainee representative would also be invited. This new structure had recently been proposed to the senior executive team who had seemed supportive. The associate director of education handed out a document entitled 'The journey to rebuild the education service' to the visit team. This document detailed the education structure, the education portfolios and the new 'talent for care framework'. This framework had been established to provide a career pathway for consultants and a mentorship programme for new consultants. The visit team heard that education was a standing item on the Trust's Board agenda.		
TWR2.2	**Appropriate system for raising concerns about education and training within the organisation** The associate director of education reported that formal local faculty groups had been established in 98% of departments. Gastroenterology and renal local faculty groups were still in an embryonic phase. The associate director of education reported that the General Medical Council National Training Survey (GMC NTS) was on the Trust's executive agenda and that each division took ownership for the issues raised in the survey. Each division was expected to work with the education team to address the red outliers and this was reported back to the Board. The educational leads interviewed confirmed that local faculty groups were in place and that trainee representatives were involved. In haematology oncology, for example, the GMC NTS red outliers had been discussed at the local faculty group and subsequent actions had been taken to try and address the issues raised by the trainees. Obstetrics and gynaecology trainees were encouraged to raise any issues as they came up rather than waiting for the GMC NTS. Educational leads all stated that the education team was very supportive and that a robust system was in place for escalating any problems.		
TWR2.3	**Organisation to ensure access to a named clinical supervisor** Most trainees reported that they had access to a named clinical supervisor.	The visit team recommends that the general practice (GP) trainees have educational leadership with a Trust nominated leader for GP	Recommendation

	Some issues were reported by the GP trainees who were not always sure of their clinical supervisor, particularly if they worked cross-site.	trainees across the board who will liaise with the GP School.	
TWR2.4	**Organisation to ensure access to a named educational supervisor** The trainees interviewed reported that they had a named educational supervisor.		
TWR2.5	**Systems and processes to identify, support and manage learners when there are concerns** The education centre was reportedly open from 7.30am to 6pm. The medical education manager reported that she had an open door policy but that any member of her team would be happy to speak to any trainees if they had any concerns regarding their training. This was confirmed by members of her team.		
GMC Theme 3) Supporting learners			
TWR3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The associate director of education stated that the Trust had a zero tolerance stance on bullying and undermining and that a strong management structure was in place to deal with any issues in this area. Dignity and respect in the workplace was reportedly a new organisational development (OD) programme which was being rolled out throughout the Trust. This was in addition to the Trust's values-based 'pride' programme. The visit team heard that there was also a Guardian confidential service which trainees could access if required. Some trainees reported being at the receiving end of patient aggression and did not always feel adequately prepared to manage these situations. The visit team heard that there was a high turnover of nursing staff; haematology oncology trainees suggested that this was possibly because some junior nurses felt at times bullied by certain senior nurses.	The visit team recommends that all trainees should undertake appropriate training so that they feel better equipped to deal with any patient aggression.	Recommendation
TWR3.2	**Access to study leave** Some paediatric trainees commented that they were only allowed to take study leave during certain weeks. This meant that they could not always undertake courses that they felt were most appropriate for their training needs.		
GMC Theme 4) Supporting educators			
TWR4.1	**Access to appropriately funded professional development, training and an appraisal for educators**		

	The visit team heard that the Trust was not currently on track to ensure that all trainers were accredited against General Medical Council (GMC) standards by summer 2016. The director of medical education suggested that the reason for this was that some trainers were still unaware of the deadline. He confirmed that one of his key roles from the outset would be to ensure that all trainers met these GMC requirements. The visit team did not have the impression that a responsible person in each department had been nominated to ensure that all trainers were accredited in time.	The Trust is required to provide a clear action plan to ensure that all named clinical and educational supervisors are accredited before summer 2016.	Mandatory Requirement
TWR4.2	**Sufficient time in educators' job plans to meet educational responsibilities** At the previous visit in May 2013, the visit teams had discovered that some educational supervisors were looking after too many trainees. The associate director of education felt that this issue had now been resolved. All the educational leads interviewed appeared to be looking after the right number of trainees, but some were still not being remunerated appropriately for this work. In obstetrics and gynaecology, for example, although programmed activity (PAs) had finally been agreed, the educational supervisors would only be receiving 0.25 PA regardless of how many trainees they looked after (some had two or three).	Ensure that all educational supervisors receive appropriate PAs for their educational activity (i.e. 0.25 PA for each supervisee, up to a maximum of four trainees).	Recommendation
TWR4.3	**Access to appropriately funded resources to meet the requirements of the training programme or curriculum** The associate director of education reported that at times the library was used for training sessions but that plans were in place to address this. The trainees confirmed that IT training often took place in the library. Some trainees reported that they could not access the library after 5pm and that wifi access was problematic. The paediatric department reported having to share its seminar room with other teams.	Educational resources still need improvement, e.g. improved library access and a dedicated seminar room for paediatrics.	Recommendation
GMC Theme 5) Developing and implementing curricula and assessments			
TWR5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** No major problems were reported in this area, although most trainees agreed that they needed to be proactive to be able to complete their workplace-based assessments.		
TWR5.2	**Opportunities for interprofessional multidisciplinary working**		

	The associate director of education reported that the Trust's aim was to be the employer of choice. She stated that a review of each team was being undertaken and that whereas previously departments worked in silos, in future there would be more interprofessional, multidisciplinary working. Paediatric trainees reported that they had a skills and drills session once a week which was run by a higher trainee but was also attended by core trainees and nurses. Trainees in ENT and obstetrics and gynaecology also confirmed that they had attended multi-disciplinary teaching.		

Good Practice	**Contact**	**Brief for Sharing**	**Date**

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Helen Massil*
Date:	*22 December 2015*