Lothian NHS Board

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Date: 16/06/2025
Our Ref: 10025
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Dear

FREEDOM OF INFORMATION – MENTAL HEALTH ADMISSIONS DIVERT

I write in response to your request for information in relation to the Mental Health Admissions divert policy in NHS Lothian.

Question:

Please may I request a copy of your Standard Operating Procedures outlining clinical governance arrangements for when mental health admissions divert pathway is operational for admissions across Edinburgh and surrounding areas.

Answer:

I have attached the current clinical governance arrangements for mental health admissions divert in Edinburgh, East Lothian and Midlothian. This is the guidance in use currently. The policy is currently under review and may be revised.

I hope the information provided helps with your request.

If you are unhappy with our response to your request, you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at https://www.foi.scot/appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the reviewer at the address at the top of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI

Yours sincerely

ALISON MACDONALD
Executive Director of Nursing Midwifery and AHPs
Cc: Chief Executive

Clinical Governance Arrangements *when Mental Health (MH) Admissions DIVERT pathway is operational* for MH admissions in Edinburgh, East and Midlothian

Short Life Working Group

Last met 16/05/25. Further review through Gold command.

*This process **does not** cover the clinical governance of people who have not been assessed as requiring an in-patient mental health bed and **only** applies to the Emergency Department (ED) at the Royal Infirmary of Edinburgh (RIE).*

1. Key Principles

1.1 Diversion of admissions from the Royal Edinburgh Hospital (REH) is considered when Adult Mental Health Capacity is at "Critical" status.

1.2 All actions to address discharges, movement, capacity, and flow should be undertaken prior to enacting a divert, as outlined in the Mental Health Management Actions (2023) action plan.

1.3 The divert is formally authorised by the Royal Edinburgh and Associated Services (REAS) Service Director and Chief Officer (Acute) or their deputies/equivalents out of hours.

1.4 The RIE Duty Manager or Senior Manager on Call (SMOC), ED Emergency Physician in Charge (EPIC) and Nurse in Charge (NIC) should also be informed.

1.5 The staffing of the patients waiting for a MH bed is detailed below. This procedure is for people who have had a specialist assessment that confirms they require in-patient care and cannot be supported by the relevant home treatment team. The staffing arrangements are separate to the assessment role and function that MHAS and PLNs provide to ED.

1.6 Location of MHAS during DIVERT. MHAS will continue to manage community phone triage, ambulance and police advice/triage, and be the NHS24 senior decision maker for MH, but will move their base to the Psychological Medicine department at the RIE during the OOHs period ie 1700 – 0900 weekday and 1700 Friday to 0900 Monday. Currently there are not facilities for MHAS to perform all their roles at the RIE Monday – Friday 0900 – 1700. During this period it is likely that the MHAS team will be based at the REH but will travel to RIE if needed.

1.7 Expected patient functionality in TRAK should be used to book in people needing a face to face assessment, both in RIE ED and REH MHAS base.

1.8 The decision to divert (and to revert back to business-as-usual [BAU]) is communicated to the RIE Site Director or SMOC/Director on Call.

If any staff are uncertain whether the DIVERT is in place the Adult Bed Manager / Co-ordinating Charge Nurse (CCN) at REH can be contacted (bleep 7005 via switchboard). If the Adult Bed Manager / CCN is not clear this needs to be escalated to the manager on call for the REH.

The higher/specialist resident doctor led handover at the REH at 1630 Monday to Friday should be clear whether this procedure is activated or not at that point. The CCN will aim

to join the handover and will know the upto date position. If it unclear a member of the handover should escalate as above to clarify the current position.

See Appendix A and B for initiating Divert

2. Clinical decision to admit patient.

If divert in place a resident doctor ST4 and above, a speciality doctor or a consultant must be involved in the decision to admit. Any further questions should be escalated to the relevant consultant.

Assessing team/clinician confirms DIVERT is in place – this can be confirmed through Co-ordinating Charge Nurse (CCN) as above.

If the patient is not in the ED department the CCN/Bed manager at REH contacts RIE ED NIC to inform them of the patient details and arrangements for the member of staff who will support the patient.

If patient is already in ED department when decision that in-patient care required is made (After usual triage / assessment pathways have been followed) the CCN at REH should be contacted to facilitate staff support whilst waiting for a bed in ED.

Arrangements for the member of staff who will be supporting the patient in the ED department will be arranged and communicated by REH bed manager or CCN to ED.

3. Clinical Documentation and Prescribing

Episode in TRAK starts with completion of Core Mental Health Assessment by assessing clinician (may be MHAS but many teams assess for admission in the community). Documentation of further clinical care using Mental Health (MH) TRAK functionality as per guides available on intranet:

(http://intranet.lothian.scot.nhs.uk/Directory/eHealth/Training/TRAKCourses/TrakMentalHealth/Pages/default.aspx)

Prescribing in ED follows usual practice in the ED and should NOT use HEMPA.

Clinical information should be entered into the MH assessment episode in TRAK. The expectations of clinical documentation are the same as for anyone admitted to an in-patient stay ie shift by shifts entries, and use of MH risk assessment in TRAK to develop risk management strategies.

4. Clinical / Staffing Handover

To ensure the quality of care patients receive while on divert, at least one registered nurse should be in attendance from REH. Their role is to have oversight of the patients presentations, provide a co-ordination role to confirm patient needs are met, staff are allocated breaks and that clinical notes are completed on TRAK. The co-ordination role also includes a nursing handover to the next shift and an update for the CCN based in the REH. There should be one additional nurse, compared to patient numbers, to allow rotation of tasks and breaks. The co-ordinator will also act as the point of contact for any information or updates required e.g. patient presentation, ability to manage care in the ED environment, additional nursing resource required etc. Where there are more than 5 people waiting in ED for a REH bed there should be 2 registered nurses to share the workload. The Co-ordinator role will allocated to one of them. Where one registered nurse is a bank or agency nurse the REAS nurse will assume the co-ordination role.

Where possible patients should be cohorted in one area to reduce the impact on ED usual business.

All nursing care delivered to patients on DIVERT to ED will be recorded on TRAK as usual. A computer on wheels can be used by asking the ED SCN or buzzing for assistance then requesting a computer.

A nursing handover will be given to the oncoming team using the usual guidance:

http://intranet.lothian.scot.nhs.uk/Directory/AdultMentalHealthInpatientServicesREH/Documents/SOP%20for%20Shift%20Leadership%20and%20Handover.pdf

At the change of shift Nursing staff from the Royal Edinburgh hospital should make every effort to ensure they arrive in ED to allow staff to finish on time. DIVERT shifts should not be shortened to allow sufficient time for a handover to happen with no impact on patient care.

Shift by shift handover should take place using the guidance:
http://intranet.lothian.scot.nhs.uk/Directory/AdultMentalHealthInpatientServicesREH/Documents/SOP%20for%20Shift%20Leadership%20and%20Handover.pdf

During the out of hours period the Rota C doctor (psychiatry) will be contacted by CCN to inform them that a patient is/will be in the ED department.

Mental health assessment will have already been documented in TRAK by admitting clinician, usually be MHAS staff.

Clinical assessment should focus on immediate safety and prescription of medication with the use of MH TRAK functionality to do this. A full 'clerking' can be used to provide a reliable and structured approach to this assessment, particularly for less experienced clinicians.

Prescription of medication that may be required will be in ED by the psychiatry doctor (from when the decision that an in-patient bed is required and the patient is going to have to wait in ED).

If Rota C has other demands/workload is too high Rota C to contact Adult Psychiatry consultant on call.

Adult Psychiatry consultant on call can discuss with CAMHS consultant on call re workload demands for rota c doctor and 2 higher trainees on call.

Consideration of asking higher trainee or Rota B to attend to RIE based on relative workload and urgency. If the Rota B doctor is off site then only one resident doctor would be available for any medical emergencies for that period

Any issues should be discussed with higher trainee or relevant consultant as needed.

5. Weekend Reviews

Patients who have been waiting for a bed in ED from decision to admit should be discussed at REH Handover at 9am. The registered nurse in ED will co-ordinate the list of names and should join the handover via teams. The Rota C doctor should also join the handover via teams from the RIE site. This will delay the start of the assessments co-ordinated by the PLNs by around 15-30 mins.

The need for further clinical review to be triaged by the Psychiatry Consultant led handover, and these will be assigned to the most appropriate doctor considering activity across MH sites. The Rota C doctor is expected to see overdose assessments until lunchtime Saturday and Sunday and may also have significant work in the CAMHS YPU.

Nursing staffing will be co-ordinated by the CCNs and CNM on call, who will be attending the handover.

There will be agreement at handover who in the psychiatry team will review Emergency Detention Certificates for patients in ED who have been diverted to wait for a MH bed in ED.

6. Clinical Risk assessment and escalation

Cohorting of patients (where possible) in one area provides an opportunity for REH staff to support each other with patient care and allows the ability to take breaks, but it is accepted that this is not always possible.

It will also allow the normal assessments of patients to be completed, including searching belongings, removal of bin liners, assessment of ligature points or access to items that could be used to harm self or others. It will also allow whether, following medication, the patient can safely be supported in an ED environment. The relevant SOPs are available via the intranet by searching under REAS procedures.

If team supporting patient in ED have concerns re the ongoing safety of the patient in ED this must be escalated to the CCN at REH and/or consultant on call.

If there is doubt the patient can be safely managed in ED, due to the level of violence and aggression or repeated attempts to leave the ED, this should be escalated to the on-call Psychiatry consultant and on call Manager for REH for discussion and consideration for transfer to REH. Risk should be considered from a wider perspective including which environment is best suited, as neither is likely to be ideal given capacity concerns.

The CCN and Psychiatry Consultant on call should discuss the options with the manager on call for the REH. Consideration of staffing levels, medication and/or safer locations should be discussed and agreed. The risk of significant violence and aggression is likely to be the key determinant in consider a change of location for the patient. Senior psychiatric review of the patient will be required to inform the decision to move location – this will be determined by the consultant on call.

7. In hours working (0900-1700 Monday – Friday) and Communication with Psychological Medicine Team/Liaison Psychiatry

Responsibility for staff support to ED continues to be with REH CCNs. Staff being asked to and doing the shifts in ED should follow the advice on handover and documentation in section 3. If staff require to discuss/escalate any issues this should be to the ward that the patient is waiting for. If, after that discussion, further input or review is required this can be escalated by the RMN leading the shift in ED to the relevant CCN.

- If there are concerns regarding the clinical presentation of a patient in ED this should be escalated by the RMN to the REH CCN. This will then be discussed with either the Clinical Director for AMH in-patient care at the REH, Jane Cheeseman or Associate Medical Director, Andrew Watson. They will contact the liaison psychiatry medical team at the RIE if a face to face psychiatric assessment is required.
- The aim is for every patient to move into a MH bed at the latest the next working day (see above for weekend working). Stays greater than 1 working day should be escalated as the previous point for triage and facilitation of psychiatric review.

8. Medical Handover

Monday - Friday

- Patients still waiting in ED at 1700 Monday - Friday should be handed over to the Rota C doctor (phone number via switchboard).
- Handover of patients from evening Rota C doctor to night doctor C at 2100.
- Handover to Resident Doctor for Psychiatry in ED at 0900 Monday – Friday
- Should be in person in ED at 0900. The RNM leading the care in ED should be involved.

- If not possible then an email handover should be sent to annamaria.czesak@nhs.scot, andrew.watson11@nhs.scot and jane.cheeseman@nhs.scot.
- Any emergency issues can be escalated by phone to Dr Cheeseman or Dr Watson

Weekend:

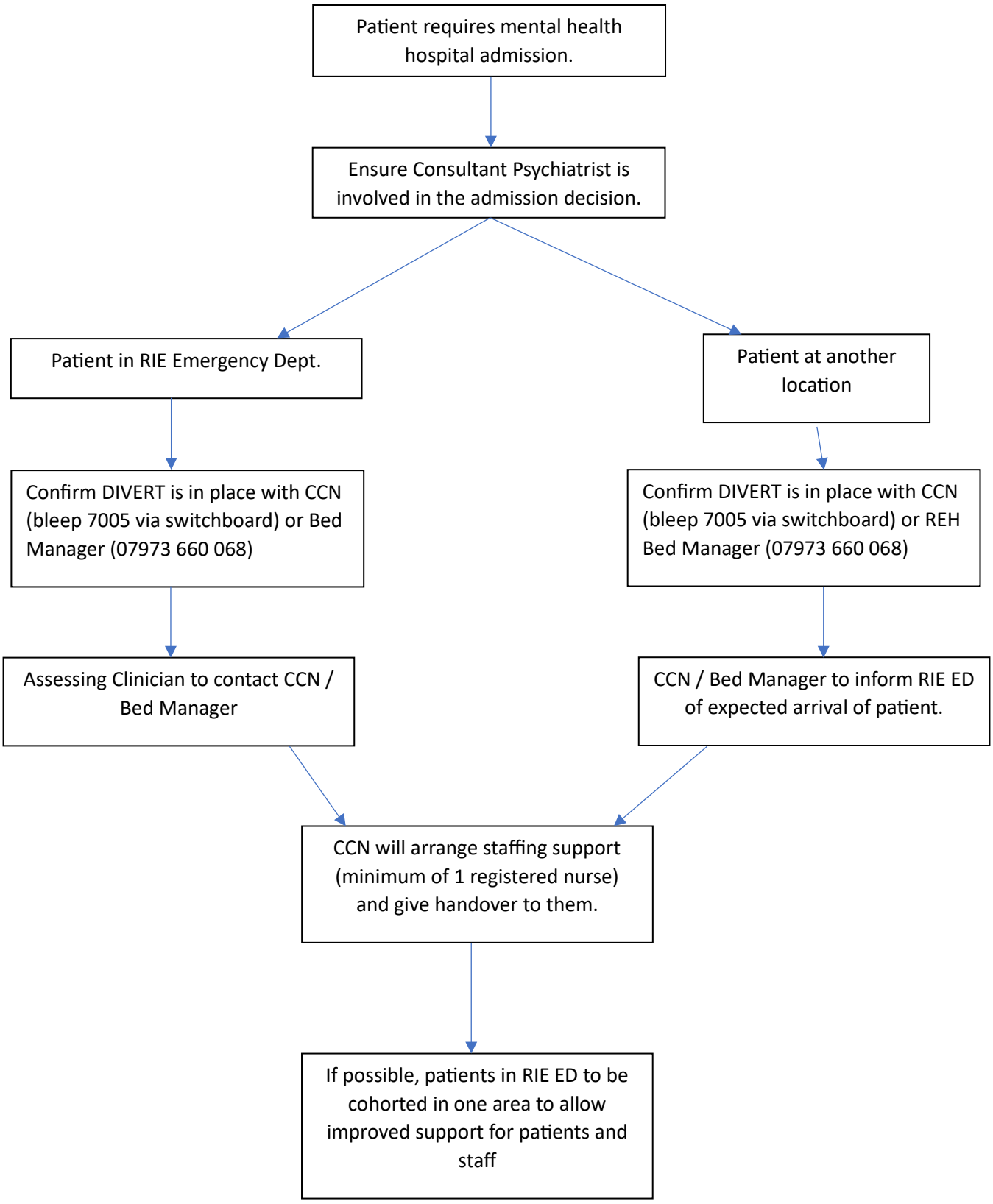
- All patients on Divert should be discussed at REH based MH system handover at 0900 Saturday and Sunday morning
- Rota C doctors to join via teams
- Consultant and CNM led MDT Handover to discuss need for reviews and allocate staff to do these at handover

APPENDIX A - REH Bed Capacity Escalation Guide

- Over Capacity > 105 Beds (or Full capacity with one or more of the following):
    - No capacity for additional admissions
    - Adult acute wards require to use contingency beds for admission
    - No appropriate patients identified for boarding/ no boarding capacity
    - No additional MH beds in NHS Lothian and/or NHS Scotland

- Actions to Mitigate Over Capacity
    - In addition to "Business as Usual" and "Risk of Full Capacity" actions (see below)
        - Carefully consider use of additional 5 contingency beds within Acute Adult (no ensuite facilities/anti-ligature measures are in place) – risk assess use.
        - Look at delays and what options for movement/flow might be
        - Look at what support IHTT can give.
        - Update Chief Officers/HSCP Joint Directors
        - Call additional flow meeting with senior staff.
        - Service Director to consider escalation to CEO, MD or Exec on call.

APPENDIX B Process when MHAS Divert is in operation.



Appendix C - Adult Mental Health Inpatient Bed Capacity Management Actions

Business As Usual **REH <100 Beds & SJH <30 Beds**	**Risk of Full Capacity (Local huddle)** **REH 100 – 105 Beds & SJH 30 – 33 Beds**	**Full Capacity (REAS escalation meetings)** **REH 105 - 110 Beds & SJH <33 Beds**	**Critical Status (NHS L &HSCP escalation)** **REH 110 acute, 66 rehab, 62 Old age, St Johns < 33**
Daily and weekly bed, admission, and discharge reports sent to REAS and HSCP leads to inform how many patients are in hospital. 10am site huddle for REH takes place (CCNs, SCNs Patient Flow Coordinator, CNMs, CSMs) to discuss discharges and patient safety. 1pm REAS wide safety huddle (similar to site huddle with addition to other REAS services, i.e., MBU, CAMHS etc.) to discuss staffing concerns and potential agency use. 4pm Flow Meetings to review discharges and explore possibility of bringing discharges forward. 5.30/5pm report submitted by CCN + ACAST to on-call manager advising of the current position and plan for any emergency admissions overnight. **REAS and HSCPs to consider areas such as-** • Delays- both health and social and moves to increase discharges. • Last 24-hour admissions to acute and those tracked from huddle. Discharge Framework explored to ensure all opportunities for discharge are considered. • Acute Discharge Facilitators asked to follow up on list of actions. • Prompt acute re options for referring community capacity. D2A, H@H • RAG status of all care at home and housing requests outstanding both hospital and community.	**Business as usual mitigations and;** Increase all monitoring of flow noting daily email and bed status. Engage with consultants to support in rapid rundowns review of patients to appropriately facilitate discharge. HSCP leads invited to join daily huddles to ensure a collaborative approach to appropriate discharge. Involve HSCPs in 4pm REAS meetings to facilitate urgent discharges and address any barriers. Review with HSCPs their escalation actions: • HSCP Increase communication with partners- independent, third sector based on queue demand including options for commissioned partners to add additional package of care capacity. • Risk assess all delays for further discharges. • Evidence all capacity levels within our services are optimised e.g., community services- community nursing, hospital at home, discharge to assess, care at home. REAS Senior Managers to consider other appropriate NHS Lothian Beds Engage with IHTT / ACAST leads and consultants to review patients suitable for discharge with support in community. Consultants involved in requests for admission in hours Review Scottish position	**Business as usual and Risk of Full Capacity mitigations and;** Careful consideration to be made on use of additional 5 contingency beds within Adult Acute (there are no en-suite/anti-ligature measures in place). REAS / West Lothian Senior Managers to consider other appropriate out of area beds. Increase frequency of engagement with consultants to support in rapid rundowns to review patients to appropriately facilitate discharge. Look at delays and what options for movement/flow might be. Review with HSCPs their escalation actions: • To review Community Hospitals beds and potential for risk enabled discharges and potential to fill against criteria of bed (HBCCC etc.) • Work with Partners to identify whether care home/supported accommodation moves can take place earlier than planned. • POC Ragged Green and Amber risk assessed with potential to be discharged immediately. Look at what support IHTT / ACAST can provide to prevent admissions and support patients in the community. Update Chief Officers/HSCP joint Directors on situation and actions to be taken. HSCPs to consider communication to Primary and Secondary Care to consider alternative pathways of community care for relevant patients.	**Business as usual, Risk of Full Capacity, and Full Capacity mitigations and;** Service Director / WL Joint Director to liaise directly with Chief Executive Office. Evidence of need for MI protocol. Reallocation of workforce resource to maintain essential services. Consider annual leave restrictions in line with NHSL and Local Authority HR/Trade Union decisions. Initiate emergency call out procedures to increase workforce. Step-up REAS Control Room (Site Director, Hospital Medical Coordinator, Senior Manager, Site & Capacity Coordinator, and Loggist) and Site Director to attend NHSL escalation meeting as required. All actions managed on risk assessed basis. Increased oversight and situational management by REAS and WL HSCP leadership teams, ensure staff wellbeing is being maintained and supported. Service Director REAS to liaise with Chief Officer Acute Services around moving place of safety Out of Hours senior manager on call should liaise with Acute Director on call

	Escalate to Chief Officers/HSCP Directors for increased oversight and situational management by Locality Manager. REAS and HSCP Senior Management to ensure staff wellbeing is being maintained and supported across all affected services.	Consider boarding options in Rehab, Ritson Clinic, and OPMH. Potentially take OPMH and REH Rehab to +2 Bed Occupancy. Call additional flow meetings with senior staff. Service Director/Joint Directors to consider escalation to Chief Executive Office and Medical Director/Exec on call	