Mental Welfare Commission for Scotland

Report on unannounced visit to:
Royal Edinburgh Hospital, Divert Suite, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 20 April 2026

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

The Divert Suite was established in August 2025 as part of NHS Lothian's escalation arrangements for periods when adult mental health inpatient capacity was at "critical" status.

Its purpose was to provide a short-term diversionary inpatient facility in the Royal Edinburgh Hospital (REH) site when all other admission options in Lothian and other NHS Boards had been fully explored and exhausted, supporting the management of acute bed pressures while maintaining patient safety.

NHS Lothian developed a standard operating procedure (SOP) to govern the use of the Divert Suite. The SOP set out that the Divert Suite should only be operational when capacity was declared "critical" and all alternative options for admission, discharge, or flow management had been exhausted.

The SOP described the Divert Suite as "a short-term facility intended to operate for a maximum of 72 hours, during which individuals would receive care from an identified mental health team, including assessment, risk assessment and initial care planning, to determine ongoing needs and appropriate placement".

The SOP also outlined that the service should be rapidly mobilised, closely monitored and supported by system-wide efforts to restore inpatient capacity as quickly as possible.

The Commission had received intelligence over a period of time from individuals who were being admitted to the Divert Suite and staff working in the service, raising concerns about aspects of the care and treatment being provided.

In response to this, the Commission undertook this unannounced visit to review the care and treatment delivered in the Divert Suite and to speak with individuals and staff about their experiences of care. As part of the visit, the Commission requested and reviewed the Divert Suite SOP to support our understanding of the intended model of care.

On the day of the visit, seven individuals had been admitted to the Divert Suite, two of whom were out on pass. We wanted to review how the Divert Suite operated in practice, including care planning, risk assessment, rights and restrictions, activity provision and the overall experience of care for individuals admitted to the unit.

Who we met with

We met with three people and reviewed their care records, along with those of three other people. We did not meet or speak with any relatives however, advised the service we would be happy to contact relatives following the visit if they wished to speak with us.

We spoke with the interim clinical service manager, deputy chief nurse and clinical nurse manager. We spoke with the consultant psychiatrist, nursing staff and healthcare support workers who were based in the unit on the day of the visit.

In addition, we met with the City of Edinburgh mental health officer (MHO) manager and contacted AdvoCard who provide advocacy to individuals in REH.

Commission visitors

Kathleen Liddell, social work officer

Dr Juliet Brock, medical officer

What people told us and what we found

Comments from individuals

The individuals we met with told us that staff were “nice, friendly and approachable.” Several individuals commented that there were “lots of different staff in the unit” and described a “lack of consistency” in staffing. This was unsettling for some individuals, who felt that some staff members were unaware of their care and treatment needs.

Some individuals told us that the environment could be “more peaceful” than acute wards, although this was reported to be the case only when there were small numbers of individuals in the unit. Some individuals commented that there was very little activity in the unit, which led to periods of boredom and, at times, frustration, particularly as there were restrictions on pass time out of the unit.

We heard from individuals that they felt the environment was “too restrictive” in relation to pass time out of the unit. All the individuals we met with were in the unit on an informal basis however, restrictions had been placed on their passes out of the unit, which they told us they had not consistently consented to.

Two of the individuals we met with had previously been admitted to the Divert Suite and had subsequently been discharged home from the unit. One individual commented that the discharge had not been successful and felt that they would have benefited from being in a unit in the main hospital where there was access to a full multidisciplinary team (MDT).

We heard that individuals were unaware of their care plans and had not been involved in care planning.

Comments from staff

Most staff that we spoke with on the day of the visit had been redeployed from their usual wards on the morning of the visit to cover staffing deficits in the Divert Suite. We heard concerns from staff that they had only been informed on arrival at work that they were required to provide cover in the Divert Suite.

Staff spoken with expressed considerable empathy for the individuals in the Divert Suite and agreed that they required specialist and high-quality care however, all staff agreed that the current arrangements for staffing cover were not sufficient and that additional staffing was required.

We heard from staff that being required to leave their usual wards had negatively affected the individuals they normally worked with. One staff member told us that they had had to cancel a care plan review with an individual, which had caused disappointment for the individual concerned and left the staff member feeling that they had not been able to provide appropriate continuity of care. We also heard that,

because staff were not regularly based in the Divert Suite, they were often unfamiliar with the individuals' care needs. This led some staff to express concerns about the quality and consistency of care being provided.

We were told that staff who had been moved to the Divert Suite had the option of returning to their usual ward halfway through their shift. We heard that staff often chose to return to their own ward, as they preferred working in their permanent team. However, staff recognised that this did not support the best interests of the individuals in the Divert Suite in terms of consistency of staffing and continuity of care.

We were concerned to hear that there had been occasions when there was only one member of registered nursing staff available in the Divert Suite, and this frequently was a newly qualified nurse, despite the individuals in the unit presenting with complex needs and at times, acute levels of distress. Staff told us that, on some occasions, the needs of individuals admitted to the Divert Suite had not aligned with the admission criteria set out in the Divert Suite SOP. We were told that newly qualified staff had found managing this group of individuals challenging and had needed to request additional support, which was not always available when required. This included an episode of a staff member pulling their emergency alarm, only to find that no response was forthcoming.

We discussed these concerns with the senior management team and were advised that they had already received feedback from staff regarding the impact that covering shifts in the Divert Suite had been having on staff morale, as well as on activity in the wards from which staff had been redeployed. We heard that to improve staffing consistency, a temporary 12-week arrangement had been agreed involving a senior charge nurse and approximately six additional staff, including staff nurses and band two support staff. We were told that this arrangement would be reviewed following the initial 12-week period.

Care, treatment, support, and participation

NHS Lothian implemented a new person-centred care plan in April 2025. The new person-centred care plans reviewed on TRAKCare contained a range of headings, including mental health, stress and distress, meaningful activity, physical health, activities of daily living, discharge planning, and family or carer involvement.

We were told at the start of the visit that all individuals in the Divert Suite had care plans in place and that there was no disparity in care planning between individuals in the Divert Suite and those in the acute wards in the Royal Edinburgh Hospital. We were disappointed to find, on review of the care records, that most individuals in the Divert Suite did not have sufficiently developed care plans in place. In some records, the only documented care plan related to continuous intervention, with a single line stating that this was required due to the "physical environment."

Where care plans had been recorded, there was no evidence that individuals had been involved in their completion. There was also no evidence of input from other allied health professionals, with care plans completed solely by nursing staff. We found limited evidence of regular review, evaluation of interventions, or forward planning in relation to transition to another ward or discharge from hospital. We also found an absence of documented initial risk assessment and risk management planning to guide staff in responding to identified safety concerns.

However, for one individual, we noted that a detailed mental health core assessment had been completed on admission and contained comprehensive information regarding the circumstances of admission, diagnosis, personal history, mental state examination and an initial management plan, which included admission to the Divert Suite on an informal basis. Despite the level of detail in this assessment, it was unfortunately not consistently reflected in the person-centred care plans.

The Divert Suite SOP stated that documentation in TRAKCare should be completed to the same standard as for any inpatient admission, including shift-by-shift entries, use of mental health risk assessments to inform care planning and daily documentation of plans for transfer to an inpatient ward. We did not find evidence that these requirements had consistently been met with the records we reviewed, particularly in relation to ongoing reviews of care and transfer planning.

We were concerned that the current care planning was not sufficient for individuals receiving inpatient mental health care and treatment. While we were aware from the SOP that admission to the Divert Suite was intended to be short term and that some individuals might be transferred to another ward quickly, we would still have expected an initial care plan to be completed at the point of admission which clearly recorded the purpose of admission, immediate care needs, identified risks and the intended outcomes of the admission.

For individuals who remained in the unit for longer periods, we would have expected a more individualised approach to care planning, with care plans reflecting their ongoing care and treatment needs. We were concerned that the absence of comprehensive care plans and documented risk management plans increased the risk that care was not delivered consistently, that changes in mental state or risk were not identified promptly and that treatment, transfer, or discharge could be unnecessarily delayed.

Recommendation 1:
Managers must ensure that all individuals admitted to the Divert Suite have an initial care plan and risk assessment completed on admission, including a clear risk management plan. Where admissions extend beyond the intended short-term period, care plans should be developed further and regularly reviewed to reflect ongoing needs and support safe transfer or discharge.

The Commission has published a good practice guide on care plans[1]. 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.

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

Since the implementation of the person-centred care plans, care records have been recorded using pre-populated templates with headings aligned to the care plan headings, supporting consistency and continuity of care, treatment and support outcomes. However, as most individuals in the Divert Suite had limited care plans in place, the records reviewed were not consistently recorded using these structured headings.

Most care records reviewed contained limited detail regarding individuals' presentation. In care records we would expect to see a clear and contemporaneous account of the individual's mental state presentation, risk status, interventions provided, response to care and treatment and any changes in care or risk management plans.

We were unable to consistently evidence regular one-to-one interventions in the records reviewed. However, we did see some documentation of discussions with individuals that recorded their views.

We were able to see that a number of different nursing staff were contributing to care records, with limited continuity of documentation from more consistent staff. This reflected feedback from both individuals and staff regarding a lack of staffing consistency in the unit.

We were pleased to observe that physical health needs were being appropriately addressed and followed up by the advanced nurse practitioner (ANP). All individuals reviewed had a physical health screening assessment completed on admission. The ANP records were detailed and provided clear information on physical health concerns, along with follow-up actions and monitoring requirements where required.

We were unable to see evidence of regular documented contact with relatives or other professionals in the care records reviewed.

Recommendation 2:
Managers must ensure that care records contain detailed information on an individual's clinical presentation, risk status, interventions provided and response to care and treatment.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Multidisciplinary team (MDT)
The Divert Suite did not have a dedicated multidisciplinary team or routine MDT meeting system, as admissions were intended to be short term and not exceed 72 hours. Instead, the Divert Suite SOP stated that nursing handover should take place at each shift change and that individuals admitted to the unit should be included in the established medical handover processes across the Royal Edinburgh Hospital site. The SOP also required daily resident medical input and senior psychiatric review within 24 hours of admission.

In practice, we were told that the medical model had included a resident doctor (core trainee grade) and access to specialty medical input. However, there had been ongoing challenges in securing Section 22 approval arrangements which had contributed to variability in consultant-level oversight. A section 22 approved medical officer is a psychiatrist who has been formally approved under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) by an NHS Board as having special expertise in the diagnosis and treatment of a mental disorder and is therefore permitted to perform duties under the Mental Health Act. At the time of the visit, a new specialty doctor locum had recently commenced, with previous locum cover in post between January and April 2025. In addition, a consultant psychiatrist had taken on responsibility for the Divert Suite in an expanded capacity alongside existing duties.

We were also advised that input was available from an older adult consultant psychiatrist, when required; however, admissions for this age group were infrequent. For people from Mid and East Lothian, consultant responsibility remained aligned to their respective locality arrangements.

Staff that we spoke with told us that they were not always involved in the handovers when moved to work in the Divert Suite, resulting in some staff feeling insufficiently informed about individuals' care and treatment needs at the start of their shift.

We found evidence that senior medical reviews were generally completed in 24 hours of admission. However, ongoing senior psychiatric review was dependent on the individual's area of residence and the consultant responsible for that locality.

From our review of the care records, we found that some individuals remained in the Divert Suite for period longer than set out in the SOP and would have benefited from a more coordinated multidisciplinary approach to support ongoing care, discharge planning, and future treatment. For example, in one record, an occupational therapy assessment had been identified as required however, there was no documentation to show whether this had been progressed or who was responsible for taking this forward.

We also heard from individuals who had remained in the unit for more than a week that they preferred the MDT meeting system used in other wards, as this supported them to feel involved in discussions and decision-making and gave them a clearer understanding of their care and treatment and what they needed to achieve to support discharge planning.

We made contact with the City of Edinburgh MHO management team. Feedback from MHOs who had attended the Divert Suite raised concerns about continuity of care, clinical oversight and safety. We heard that because some individuals remained in the unit beyond the intended 72-hour period with limited senior medical ownership and inconsistent psychiatric review; this resulted in a lack of clear direction for care and treatment.

MHOs also reported that nursing staff were often redeployed from other wards and were not always familiar with the individuals in the Divert Suite, affecting continuity of care and the follow-through of agreed actions. Concerns were also raised about the suitability of the environment for individuals who were unknown to services or presented with higher levels of risk, as the layout and staffing model could make observation and effective management of acute situations more difficult.

We would hope that the previously mentioned interim 12-week staffing arrangement improves consistency of care within the Divert Suite.

MHOs welcomed the provision of additional mental health beds, recognising that at times, individuals in the community required admission when no beds were available. Some considered that the Divert Suite offered a more appropriate alternative to individuals remaining in the Royal Infirmary emergency department because specialist mental health nursing staff were available.

Use of mental health and incapacity legislation

On the day of the visit, one individual was detained under the Mental Health Act.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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 for the authorisation of medications prescribed beyond two months, when the individual does not consent to the treatment or is incapable of doing so. Treatment must be authorised by an appropriate T3 certificate, or a T2 certificate if the individual is consenting.

We reviewed the prescribed medication for all individuals in the Divert Suite. At the time of the visit, no individual had reached the two-month threshold for treatment

requiring a T2 or T3 certificate, and therefore no statutory treatment authorisations were required.

We found that prescribing practices were appropriate, with no concerns identified in relation to medication management or the use of as required (PRN) psychotropic medication. Two of the six individuals reviewed had no PRN psychotropic medication prescribed.

Nicotine replacement therapy was appropriately offered to some individuals where indicated.

Rights and restrictions

The Divert Suite operated a locked door. There was no locked door policy displayed on the day of the visit. We raised with senior managers during the visit that a locked door policy should be clearly displayed at the entrance to the unit.

Of the six out of seven individuals that we either met with or reviewed the care of, they were receiving care on an informal basis. We found that most had a limited understanding of their rights around receiving informal care and treatment. We heard from several individuals that they were unhappy with the level of restrictions placed upon them, particularly in relation to time out with the unit. We raised this concern with staff on the day of the visit however, we were unable to understand why some individuals were subject to restrictions on their pass. We were unable to find pass plans documenting the rationale for these restrictions or when they would be reviewed.

The Mental Health Act is clear that individuals receiving care on an informal basis are not subject to detention and should be cared for in a manner that reflects the principle of the least restrictive alternative. Any restriction on a person's liberty should be clearly justified, proportionate to the identified risk and subject to regular review. In the absence of clear documentation and discussion, we were concerned that some individuals may not have fully understood the basis for the restrictions placed upon them. This raised concern that some individuals may have been at risk of experiencing restrictions amounting to de facto detention without the appropriate legal safeguards.

Staff told us that individuals had consented to restrictions in place however, we were unable to find clear documentation of this in the care records. We were also concerned that there was limited evidence that individuals' capacity to consent to these arrangements had been assessed where appropriate, particularly as the presentation of some individuals suggested that their ability to provide informed consent may have been impaired. We were unable to identify evidence that these restrictions had been subject to regular review to ensure they remained necessary and proportionate.

We were told that all individuals admitted to the Divert Suite were initially placed on continuous intervention because of environmental factors in the unit, including concerns about ligature risk. We noted that senior medical review took place within 24 hours of admission and that, following review, most individuals were assessed as no longer requiring this level of observation. However, we did not find robust continuous intervention care plans in place. Where continuous intervention care plans had been completed, these recorded the reason for the intervention but did not clearly describe the nursing interventions to be provided, the therapeutic purpose of the observation, or the arrangements for ongoing review. We would have expected continuous intervention to be supported by an individualised care plan that clearly recorded the rationale for the restriction, the care to be delivered during the intervention, and the criteria for reducing or ending the restriction.

Recommendation 3:
Managers must ensure that when continuous intervention is being utilised, corresponding care plans detail the rationale for the continuous intervention, the care to be delivered during the intervention, the criteria for reducing the intervention, and that these and the need for the interventions are regularly reviewed.

We found limited information available in the unit to support individuals to understand their rights, and we were unable to identify evidence in the care records that discussions had routinely taken place with individuals about their rights or the restrictions placed upon them. We would have expected accessible information about rights to be readily available in the unit, and we raised this with senior managers during the visit.

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 find any copies of advance statements.

Advocacy support in the Divert Suite was provided by AdvoCard. None of the individuals we met with or reviewed were involved with advocacy at the time of our visit. Following the visit, we contacted AdvoCard and were told that referrals had been received from the Divert Suite for individuals who were detained under the Mental Health Act, as well as some people receiving care and treatment informally.

We heard from AdvoCard that feedback from the individuals they had supported included concerns about the level of restrictions in place, environmental issues such as lack of privacy, staffing levels, inconsistency of staff, needs not being met, and not always feeling safe. These concerns mirrored the feedback the Commission heard from individuals during the visit.

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

Recommendation 4:
Managers must ensure that clear information about individuals' rights is readily available in the Divert Suite and that any restrictions placed on individuals who are receiving care informally are clearly documented, appropriately evidenced, subject to regular review and have been consented to.

Activity and occupation

Activity in the Divert Suite was provided by nursing staff. We were told, and observed, that there was no designated activity coordinator for the unit. There was a lack of structured or organised activity in the unit.

We were advised that some board games, puzzles, and arts and crafts materials were available however, what we heard from individuals and what we found in the care records indicated that these were rarely used and that there was limited provision of meaningful or planned activity. We saw information displayed about activities available at the HIVE activity centre in the grounds of the Royal Edinburgh Hospital although there was little evidence that individuals from the Divert Suite attended.

We heard from individuals that the lack of activity contributed to periods of boredom and frustration. We were concerned that the absence of structured occupational or therapeutic activity reduced opportunities for engagement and meaningful occupation during admission. Given that the average length of stay in the Divert Suite could extend beyond the 72-hour timeframe set out in the SOP, we considered that the provision of more structured activity would be beneficial for individuals, supporting engagement and providing greater access to therapeutic activity during admission.

The physical environment

The Divert Suite was located in the grounds of the REH, in a unit previously used as a Young People's Unit. Individuals admitted to the Divert Suite did not have access to the full building, as the community child and adolescent mental health service (CAMHS) continued to operate in other parts of the site.

The unit was mixed-sex, with individuals accommodated in single rooms arranged in four pod areas, each containing three rooms. We were told that males and females were allocated to separate pods to support privacy and reduce potential risks. There was no access to ensuite facilities and we heard feedback from advocacy services

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

that some female individuals had experienced privacy concerns in relation to the environment.

The unit had access to outdoor space, including a garden area directly attached to the unit, which we observed individuals using during the visit.

The unit had a communal area adjacent to bedroom accommodation and a small lounge with seating and a television. The environment was clean but clinical in appearance and would benefit from additional soft furnishings and improvements to create a more welcoming, warm, and therapeutic setting.

We were advised that ligature risks had been identified in the environment and that a ligature risk assessment had been completed. We also heard from the senior management team that these risks were recorded on the risk register, regularly reviewed and that actions had been taken to reduce risk, including ensuring that only individuals assessed as appropriate for admission to the Divert Suite were placed there, to mitigate some of the identified environmental risks. However, we noted that mental health presentations fluctuated, and risk levels may change or escalate during admission, which may impact on the ongoing suitability of the environment.

Any other comments

On the day of our visit, the Divert Suite, which was introduced as a temporary measure to address acute bed pressures has, nine months on, issues in allocating a consistent and regular nursing team. After the visit, we were advised that oversight of the Divert Suite sits with the operational management team who meet weekly and there are monthly reviews with the executive team to maintain an overview of the funding and resources for the unit.

We recognise that there are significant operational pressures facing acute mental health services and following on from our visit, we have heard that the appropriate governance, resourcing and oversight to ensure that standards of care, treatment and individuals' rights are maintained with what we understand to be a temporary arrangement.

We did find that staff working in the Divert Suite were empathetic towards the individuals in their care and committed to providing safe and compassionate support. However, they also described pressures associated with being redeployed at short notice and working in an environment where they were not always familiar with individuals' needs. This contributed to a sense among some staff that they were not always able to deliver the level of care they would expect in a dedicated ward setting.

We noted a lack of parity in care provision between the Divert Suite and inpatient wards in the main hospital building, particularly in relation to multidisciplinary input,

continuity of care and access to structured therapeutic input. This raised concerns that individuals in the Divert Suite were not consistently receiving the same standard of care and treatment as those admitted to core inpatient wards.

We were advised on the day of the visit, and subsequently in a follow up meeting with senior management that interim measures have been implemented, including a more consistent staffing arrangement, to improve the continuity of care.

We will continue to follow up about the service provided by the Divert Suite with senior managers, to be assured that sufficient governance, review, and strategic oversight remains place and that the Divert Suite operates in line with its intended short-term purpose and that consistent standards of care and treatment are being maintained.

Summary of recommendations

Recommendation 1:
Managers must ensure that all individuals admitted to the Divert Suite have an initial care plan and risk assessment completed on admission, including a clear risk management plan. Where admissions extend beyond the intended short-term period, care plans should be developed further and regularly reviewed to reflect ongoing needs and support safe transfer or discharge

Recommendation 2:
Managers must ensure that care records contain detailed information on an individual's clinical presentation, risk status, interventions provided and response to care and treatment.

Recommendation 3:
Managers must ensure that when continuous intervention is being utilised, corresponding care plans detail the rationale for the continuous intervention, the care to be delivered during the intervention, the criteria for reducing the intervention, and that these and the need for the interventions are regularly reviewed.

Recommendation 4:
Managers must ensure that clear information about individuals' rights is readily available in the Divert Suite and that any restrictions on informal patients are clearly documented, appropriately evidenced and subject to regular review.

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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