Camden and Islington NHS
NHS Foundation Trust

PATIENT LEAVE POLICY – INCLUDING TRANSFER OF SERVICE USERS TO LOCAL ACUTE TRUSTS JULY 2013

This policy supersedes all previous policies for Patient Leave

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Policy title	Patient Leave Policy – Including Transfer Of Service Users To Local Acute Trusts
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Policy lead	Roz Jones, Clinical Policy Manager
Contact details	Email: roz.jones@candi.nhs.uk Telephone: 0203 317 3132
Accountable director	Claire Johnston, Head of Nursing and Performance
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Document history

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Membership of the policy development/ review team	Roz Jones, Clinical Policy Manager:
Consultation	Ward/Team Managers, Divisional Managers, Divisional Clinical Leads, Professional Leads, Matrons, Deputy Director of Nursing,

DO NOT AMEND THIS DOCUMENT

Further copies of this document can be found on the Foundation Trust intranet.

Contents

Below in separate document on intranet

1. Introduction

1.1 This policy aims to guide inpatient mental health teams in the consideration, recording, granting and management of leave for inpatients. It sets out the legal position regarding leave from hospital and follows good practice guidelines as set out by the Mental Health Act Commission, Home Office Mental Health Unit (MHU) and others. [22.1, 22.2, 22.3]

1.2 Leave from hospital is an important part of a patient's treatment plan. Allowing a patient off their unit/ward for a set period of time forms an essential aspect of their care and is generally a reflection of the patient's progress towards an improved state of health and, ultimately, discharge. As with all components of patient care, this intervention must be viewed as part of an overall therapeutic care plan and should be decided upon only after careful discussion and consideration.

1.3 This policy, therefore, sets out the steps that teams should take before granting leave, the considerations they must make and the procedure they must follow.

2. Aims and objectives

2.1 To provide guidance to inpatient mental health teams in the management of leave for all current inpatients, whether informal or detained under the Mental Health Act.

2.2 The policy sets out the legal position regarding leave from hospital and follows good practice guidelines as set out by the Mental Health Act Commission, the Home Office Mental Health Unit and the Care Programme Approach Policy.

3. Roles and responsibilities

3.1 Chief Executive - has overall responsibility to ensure that policies and procedures are in place for the processes associated with inpatients leave in line with the Mental Health Act.

3.2 Divisional Manager, Matrons and Ward Managers - are responsible for ensuring that this policy is adhered to within their area of accountability.

3.3 Responsible Clinicians – are responsible for:

- authorising S.17 leave as appropriate and document it on the S.17 leave form.
- using S.17 leave in a clinically appropriate way, balancing the therapeutic advantage against the potential risk.

3.4 Clinical Staff – are responsible for:

- monitoring episodes of leave in regard to the patient's well-being and whether conditions were kept,
- liaising with Responsible Clinicians
- reporting on use of S.17 leave in nursing reports to MHRTs and Hospital Managers hearings.

3.5 MHA Managers - are responsible for:

- obtaining details of S.17 leave episodes as necessary for MHRT appeals.
- providing /advice on legal aspects of S.17 use.

3.6 Mental Health Law Manager - is responsible for:

- providing advice and support to MHA Managers and other staff
- raising concerns as necessary about use of S.17 leave within the Trust.
- organising regular audits of S.17 leave.

4. Definitions

4.1 Approved Clinician (AC)

A mental health professional approved by the Secretary of State to act as an approved clinician for the purposes of the MHA. Some decisions under the Act can only be taken by people who are ACs.

4.2 Care Programme Approach (CPA):

The framework for multiagency working in mental health services.

4.3 Hospital Grounds:

Paragraph 21.5 of the MHA Code of Practice notes that "What constitutes a particular hospital for the purpose of leave is a matter of fact which can only be determined in the light of the particular case. Where one building, or set of buildings, includes accommodation under the management of different bodies (e.g. two different NHS Trusts), the accommodation used by each body should be treated as forming separate hospitals. Facilities and grounds shared by both can be regarded as part of both hospitals." The extent of the Hospital Grounds should be clearly understood by those staff responsible for authorising and supervising leave within the hospital grounds.

4.4 Leave from hospital:

The act of a patient leaving the hospital and its grounds either escorted or unescorted.

4.5 Responsible Clinician (RC):

Under the terms of the MHA this means the AC in charge of a patient's treatment. The role of the RC pertains only to patients who are formally detained or subject to Community Treatment Orders (CTO) under the Act. The term "Responsible Clinician" should be used in respect of informal patients, meaning a clinician with responsibility for the patient's day to day care, or a deputy acting in their place.

4.6 Risk Assessment:

The systematic collection of information to determine the degree to which risk is present, or is likely to pose problems at some point in the future for the patient, relative(s), carer(s) or the public.

4.7 Section 17 Leave:

Section 17 is the provision within the MHA for a Responsible Clinician (RC) to grant a detained patient leave of absence from hospital. It is the only lawful way that a detained patient can be absent from the hospital, even for a very short period of time.

4.8 Supervised Community Treatment (SCT):

Arrangements under which patients can be discharged from detention in Hospital under the Act, but remain subject to the Act in the community.

5. Informal patients

5.1 The leave of patients who are not detained under the Mental Health Act must not be restricted whilst they are in hospital. All informal patients must be informed of this right and the poster at Appendix 6 must be displayed on all ward doors. It is important that nursing staff, in consultation with the multidisciplinary team, negotiate a care plan with the patient that includes leave assessment. This must address the circumstances for negotiating leave, the amount of time that may be spent off the ward, the patient's destination and any other relevant conditions.

5.2 Compulsory detention may need to be considered by the team in the case of patients who fail to make, or comply with agreements regarding leave and its conditions. Where an informal inpatient about whom the clinical team have significant concerns in relation to risk tries to leave the ward, the team should consider the immediate assessment of the patient and the possibility of the use of compulsory powers (section $5^{(4)}$ and/or section $5^{(2)}$) to prevent this. Consideration should be given to the use of the Mental Capacity Act 2005 where a patient lacks capacity and restricting leave is in their best interest. It should be considered a least restrictive option and should not amount to a Deprivation of liberty. Safeguards should be implemented by seeking a standard or urgent authorisation via the managing authority. Under no circumstances should any patient be informed that they will be placed on a section if they attempt to leave, neither must this be documented in the patient's RiO notes.

5.3 Wards with controlled entry and exit, must ensure that the liberty of informal patients is not compromised, while maintaining safety. An appropriate local audit mechanism must also be in place to monitor this intervention.

6. Detained patients

6.1 Under Section 17 of the Mental Health Act 1983, the Responsible Clinician (RC), almost always a consultant psychiatrist, may grant leave to any patient detained in hospital under sections 2, 3, 37 or 47. Any patient subject to extended S17 leave must have documented in his/her notes the reason for using extended leave as opposed to using a Community Treatment Order under S17a. If the RC does not feel this is appropriate they must justify their reason for continued use of S17. Please refer to Trust Policy for guidance on the implementation of a CTO.

6.2 Patients must not be granted S.17 leave until the risk assessment process has been completed

6.3 Patients detained under sections 37/41, 47/49 or 48/49 may not be granted leave without the prior permission of The Secretary of State (The Home Secretary). In practice, this permission is delegated to officials within the Mental Health Unit (MHU) of the Home Office. Detailed guidance to RC's concerning leave for restricted patients, which has also been separately circulated to all wards, is contained in Appendix 4 and Annexes A to G. Details of the MHU out of hours service is contained in Appendix 5 and the MHU telephone directory is in Appendix 6.

6.4 Patients detained under sections 35, 36 or 38 may not be granted leave without the prior permission of the court that made the original detention order.

6.5 Patients detained under other sections of the Mental Health Act 1983 (4, 5(2), 5(4), 135 and 136) may not be granted leave. This is because those sections are short-term emergency detention orders.

7. The power to grant leave under section 17

7.1 Only the RC has the power to grant leave under Section 17 of the Mental Health Act 1983. The power to grant leave cannot be delegated to another person except where the RC is not available, e.g. on leave, in which case leave may be granted by the doctor who is currently in charge of the patient's treatment. Where practicable, this doctor should be another consultant psychiatrist, a locum consultant or a specialist registrar (ST4) approved under section 12(2) of the Mental Health Act.[20.4] It is essential to note that Section 17 leave needs to be planned as far in advance as is possible. It is unusual for leave to be granted/ changed out of office hours. However, should the need arise then the appropriate consultant psychiatrist on call should be contacted.

7.2 Additionally, leave granted to patients who are subject to restrictions under sections 41 or 49 of the act, must also be approved by the Home Secretary, prior to that leave being granted. See appendices 4 to 6.

7.3 During any period of Section 17 leave, the RC retains responsibility for the patient.

8. Conditions of leave

8.1 Section 17 leave (or leave of absence) can be granted either indefinitely or for a specified period and can be extended for as long as the patient remains on section. Short-term leave may be granted which is then managed by other staff. For example, the RC may decide to grant the patient two hours leave per day, with the decision regarding which particular hours at the discretion of nursing staff. It is important that, where local discretion is used, the decisions taken fall within the terms of the leave authorised by the RC.

8.2 When nursing staff have used their discretionary powers under Section 17, to stop a patient's leave, this can only be reinstated following a mental state examination. Where there are concerns regarding the patient a Responsible Consultant should be involved.

8.3 Longer-term leave, such as overnight leave or indefinite leave must be carefully planned and recorded. The patient should be fully involved with the decision to grant leave and should be able to demonstrate an ability to cope outside the hospital. Subject to the patient's consent, there should also be detailed consultation with the care coordinator (if allocated), other community services and any relatives, carers or friends, especially with those with whom the patient may be expected to reside. Leave should not be granted to a patient who refuses to consent to such consultation. Those patients on long leave should be reviewed at each ward round and, in addition, they should also be reviewed on the ward at specified times.

8.4 All patients on longer-term leave must be clearly identified as such and regularly reviewed by the multi-disciplinary team in conjunction with the care coordinator.

8.5 The RC may also, when granting leave under Section 17, impose certain conditions upon the patient. For example, the patient may be required to live at a specified address or with a particular person, attend a specified place whilst on leave, allow visits from a Community Mental Health Nurse (CMHN) or Social Worker or remain in the custody of a member of staff (an escort). In each case, the conditions must be clearly documented on the Section 17 Leave Form (see Appendix 2).

9. Escorted leave

9.1 In determining whether an escort is required, the purpose of the leave must be fully considered. The rationale for the escort also needs to be clearly recorded e.g. supporting the patient, assessment of the patient in a social setting or boundary setting. Consideration also needs to be given to the grade and experience of the escorting nurse, whether they should be substantively employed, student nurses (in what stage of training) bank or agency staff. When making these decisions, teams need to consider the destination and purpose of the leave and the role and purpose of the escort. When the purpose of the escort is more complex e.g. giving or receiving a clinical handover, assessing social skills, transferring section papers, or escorting a patient to an acute hospital, it is more appropriate to use a trained member of staff. Due to its nature, escorted leave should not routinely be granted for periods exceeding one hour. For escorted leave exceeding one hour, time should be allowed to enable extra staff to be obtained if necessary.

10. Communication

10.1 Details of the patient's leave must be recorded in their RiO notes and on the Section 17 form. In addition others involved in their care such as care coordinators and carers must be informed prior to the leave commencing. CPA crisis and contingency plans must address issues around leave.

10.3 The conditions of leave must be fully communicated to the patient, particularly in terms of time limits, destination and the consequences of non-compliance with leave. The allocated nurse must also ensure that the patient understands the terms of the leave and agrees to comply with these prior to the taking of any leave.

10.4 Written information must be given regarding the use of leave beds as per the Bed Management Policy and, especially around practical issues such as patient's property if the bed is used. This again may be subject to local audit.

10.5 For all leave over a one week period, the care co-ordinator and general practitioner must be informed. This is especially important if any direct or indirect intervention may be required, for example, administration of medication or assessment of mental state.

11. Documentation

11.1 Any and all leave granted, as well as any conditions attached to that leave, must be recorded both in the patient's RiO notes and on the Section 17 Leave Form (Appendix 2). The RC must be as explicit as possible when documenting Section 17 leave, particularly when recording times and dates when the leave can be taken and will expire, destination, duration and whether an escort is required. This may be subject to audit.

11.2 All leave taken, whether Section 17 or other leave, must also be recorded on the Leave Monitoring Form (Appendix 3). Staff should record the patients name, the amount of leave they are entitled to, the time they left the ward, the time they are due back and the time of their actual return. In this way, teams can keep an accurate and up to date record of leave entitlements and leave taken. This may be subject to audit.

11.3 A record should be kept in the RiO notes of every occasion when leave is taken and the circumstances under which it was taken (the conditions). Nursing staff should also assess the patient's clinical state before and after every period of leave and

make a note of this. The patient's RiO notes should therefore contain an ongoing record of the outcome of each leave period and its success or otherwise.

11.4 Teams may also use the Leave Entitlement Form (Appendix 4) to record each patients entitlement to leave on a daily basis. Though optional, this form provides a useful, at a glance, record of each patient's entitlement without having to locate that patient's Section 17 Leave Form.

12. The section 17 leave form

12.1 All patients subject to sections 2, 3, 35, 36, 37, 38, 47 or 48 must have a Section 17 Leave Form, either in their paper notes file or in a file held specifically for this purpose. Original Section 17 Leave Forms are pink to distinguish them from photocopies. Any leave granted must be detailed on the form, which must be signed and dated by the RC. If the RC is not available on site, the Section 17 Leave Form may be faxed to the RC, who will then sign it and fax it back to the ward. The fax should then be kept with the original Section 17 Leave Form until the RC is able to sign and date the original form, at which time the faxed form may be removed and destroyed/filed. Section 17 leave must not be recorded on a form other than the original Section 17 Leave Form.

12.2 Patients detained under sections 35, 36, 37, 38, 47, 48 are subject to restrictions (under 41 or 49) that are set by the home office and not the RC – see additional information on permission that must be sought and paperwork to complete which is on the intranet.

12.3 When Section 17 leave has expired or has been cancelled, a line should be placed through the leave in question and the form signed and dated by the RC or nurse in charge. Only the RC may cancel leave that is not at the discretion of other staff. If the RC is not available on site, the above faxing procedures should be followed.

12.4 The boxes on the Section 17 Leave Form should be used consecutively until the form is full. At that time a new blank form should be started and the expired original filed in the patient's notes.

12.5 In each box, the RC must indicate whether Home Office approval for the leave has been approved, if appropriate. If not appropriate, this must also be indicated. If Home Office approval is necessary and not obtained, the leave must not go ahead.

12.6 Also, in each box, the RC must indicate that the risk assessment process for that patient has been completed. If the risk assessment process has not been completed, the leave must not go ahead.

12.7 The Section 17 Leave Form should be copied (on plain white paper) and circulated following any and all additions, deletions or corrections. Current copies must (at the very least) be given to the patient and kept in the notes, though individual teams should identify all those who need copies.

13. The leave monitoring form

13.1 The Leave Monitoring Form (Appendix 3) is provided to ensure that all leave taken in accordance with Section 17 is recorded accurately. Accurate recording of leave is essential to ensure that:

- patients receive the leave to which they are entitled; a record is kept of leave taken and not taken;
- staff are aware which detained patients are off the ward and when they are due back;
- that necessary action can be taken quickly when patients fail to return at the expected time.

13.2 Each day, ward staff should complete a new Leave Monitoring Form when patients subject to Section 17 leave the ward. The patient's name should be entered, along with their leave entitlement, the time they left the ward and the time they are due to return.

13.3 When a patient subject to Section 17 returns to the ward, staff should record the time returned and calculate any unused leave, if appropriate.

13.4 The allocated nurse for each patient on Section 17 leave must be aware of the time that patient is due back. If the patient fails to return at the agreed time, they must be regarded as being absent without leave (AWOL) and the relevant AWOL procedures should be commenced. Similarly, if a patient on leave fails to adhere to any of the conditions of that leave, including being accompanied by an escort, they must be regarded as being absent without leave (reference: AWOL Policy).

13.5 Where a patient is unable to take their leave, for any reason, the reason should be recorded in the appropriate column. This is essential, for example, when patients on escorted leave are not able to take their leave due to staff shortages.

14. The leave entitlement form

14.1 The Leave Entitlement Form (Appendix 4) is provided as an option for ward staff to record, on a daily basis, which patient is entitled to what leave. The form provides an 'at-a-glance' view of all patients' leave entitlements (including informal patients) on one form. This form is essential in areas with lots of beds or where many patients are detained on section and have leave under Section 17.

14.2 Each morning, a member of staff should be allocated to translate the information contained on ward notice boards (detained patients and informal patients) and Section 17 Leave Forms (entitlements). All patients should be placed on the list, in the appropriate section.

14.3 Detained patients who do not have any Section 17 leave should be put in the first column. Detained patients with Section 17 leave should be placed in columns two or three as appropriate, while informal patients should be listed in the section for informal patients at the bottom of the Leave Entitlement Form.

14.4 The Leave Entitlement Form must be updated whenever a patient's leave entitlement changes during the day. A new form should be used every day.

15. Leave within the hospital grounds

15.1 Section 17 of the Mental Health Act applies to leave from hospital. Since grounds leave is still within the grounds of the hospital, there is no legal requirement for this type of leave to be authorised under Section 17. The view of the Mental Health Act Commission is that 'hospital' refers to a building or set of buildings with attendant grounds and a boundary[22.5]. However, the managers of each unit/site/hospital should be clear as to the identification of the boundaries of each 'hospital', taking legal advice where necessary.

15.2 Occasionally, the courts or the Home Secretary directs that a patient be detained in a specific unit or part of a hospital (usually a secure unit). In this case, as the place of detention is specifically identified, Section 17 leave will be required for the patient to leave the specified area.

15.3 In any case, the same guiding principles need to be applied to leave within the grounds as for other types of leave. For all patients, especially those detained under section, multidisciplinary discussion, consultation and accurate documentation is essential. Local discussion also needs to be undertaken between wards and other departments within hospitals regarding the way leave is granted. This is particularly important in relation to patients who are on a level of enhanced observation. In considering leave within the grounds of the hospital – the ward team need to consider:

- degree of risk;
- should leave be escorted or unescorted?
- time limits;
- negotiating a plan of the patient's movements and activity.

15.4 If a patient is on enhanced observations the following leave issues will need to be considered:

- are two escorts required?
- can family members, carers or friends be involved?

16. Emergencies

16.1 In an emergency situation, for example if an ambulance had to be called for a patient who needed urgent medical attention, the patient can leave the ward/unit without the appropriate Section 17 authorisation. However, it is essential that the RC is contacted as soon possible after this occurs to authorise the necessary leave.

16.2 Additionally, it is not necessary to contact the Home Office prior to the emergency removal, to a general hospital for example, of a restricted patient. In this case, the Home Office must be contacted as soon as possible after the event and informed of the leave. Further guidance on restricted patients is given in appendices 4 and 5.

16.3 If a patient has to leave a ward as a medical emergency, a qualified member of nursing staff must escort the patient. This nurse must be able to give a full and accurate verbal handover to staff at accident and emergency. This must include the patient's present condition and any associated risk factors, for example, self-harm, absconding risk, etc.

16.4 The qualified nurse, in collaboration with colleagues in the accident and emergency department and the ward team will determine the level of observation required for the safety of the patient and others. They will liaise regularly with the nurse in charge of the referring ward and plan suitable relief/cover arrangements. They will not leave the escorted patient until a clear plan has been agreed with the nurse in charge in accident and emergency and the referring ward/duty nurse. At the very minimum a verbal medical referral must be made to accident and emergency and, where possible, the relevant notes and other documents should accompany the patient. The relevant liaison team should always be informed and requested to attend the patient in the accident and emergency department.

17. Transfer to acute (medical) care

17.1 Occasionally patients may need to be treated in an acute hospital. Where possible, transfer to these hospitals should occur in a planned way, but there will be occasions when this will not be possible. However, the following factors need to be taken into consideration (for further information see Appendix 5).

17.2 Prior to transfer, an assessment of the level of risk the patient may present in a non-mental health setting needs to be undertaken. The risk assessment must then be communicated to the nurse in charge of the general ward by the nurse in charge of the mental health ward, along with a written summary of the current admission, which is usually contained within the normal doctor's referral letter. This would also include details of mental state, capacity to consent to treatment, potential complications, current management and care needs. All appropriate documentation must also accompany the patient and this would normally include the risk assessment. The psychiatric duty nurse/shift coordinator will also be involved in communication of these details to the nurse in charge of the receiving unit. The psychiatric ward ST1-3 or out of hours the duty doctor will also liaise with their counterpart in the receiving unit.

17.3 Particular attention must also be given to the level of observation that will be required, with the level of observation required being determined prior to transfer.

17.4 Whenever a patient is in an acute hospital, the appropriate psychiatric liaison service (out of hours the duty psychiatrist), including any services not directly managed by the Foundation Trust, will need to be immediately informed about the transfer, with the expectation that they may be able to assess and assist in the management of the patient if necessary.

17.5 Patients detained under the Mental Health Act who are transferred to an acute hospital for medical care should be granted Section 17 leave for this purpose, which states the conditions of that leave as being a patient in that hospital, if their expected stay in the general hospital is for a few days only. Patients moved to medical care in this way remain the responsibility of the original RC and staff of the general hospital cannot therefore grant leave.

When patients are expected to need a longer admission to an acute hospital their care should be transferred to the acute hospital, with the liaison psychiatrist taking on the role of RC for detained patients. There will then be shared care between the liaison psychiatrist for the patient's mental health and the acute hospital consultant for their physical care.

The same arrangements apply to informal patients, with the liaison team consultant taking responsibility for their mental health care.

17.6 The accompanying member of staff should have adequate knowledge about the patient's mental state and care needs to enable them to provide a full handover to the receiving nurse. The nurse in charge of the transferring ward should ensure that the escorting nurse has specific instructions prior to departure, including agreed arrangements for when to leave the transferred patient and to return to the psychiatric ward.

17.7 The staff of the mental health inpatient unit are responsible for informing the patient's family of their transfer, if this is agreed upon; and then the general practitioner and the community care coordinator.

18. Recalling or cancelling leave

18.1 The RC can, at any time, recall a patient who has been granted Section 17 leave. In doing so, the RC must feel it necessary in the interests of the patient's health and safety or for the protection of others. In this instance the RC must provide written notification to the patient to this effect.

18.2 A patient cannot be recalled to hospital solely for the purposes of renewing their detention.[20.6]

18.3 A restricted patient may be recalled to hospital either by the RC or by the Home Secretary.

18.4 Any and all cancelled leave must be indicated on the Section 17 Leave Form by striking through the relevant entry and signing in the appropriate place. A record must also be made in the notes indicating the reasons for recalling the patient or cancelling their leave.

18.5 The reason(s) for recalling a patient to hospital or for cancelling leave already granted must be fully explained to the patient and a record of the discussion made in the patient's notes.

19. Patients who abscond whilst on leave

19.1 The allocated nurse for each patient on Section 17 leave must be aware of the time that patient is due back. If the patient fails to return at the agreed time, they must be regarding as being absent without leave (AWOL) and the relevant AWOL procedures should be commenced. Similarly, if a patient on leave fails to adhere to any of the conditions of that leave, including being accompanied by an escort, they must be regarded as being absent without leave (Reference: Absent Without Leave Policy).

20. Dissemination and implementation arrangements

This document will be circulated to all managers who will be required to cascade the information to members of their teams. It will be available to all staff via the Foundation Trust intranet. Managers will ensure that all staff are briefed on its contents and on what it means for them.

Any enquiries regarding the implementation of this policy should be directed to the Clinical Policy Officer

21. Training requirements

Training on the use of this policy is the responsibility of Ward/Team Managers for all new permanent and temporary staff during their induction. Attendance at training must be recorded on the Learning & Development Database.

22. Monitoring and audit arrangements

A sample of the inpatient wards across the trust will be audited every six months to measure compliance with this policy. The audits will cover aspects of documentation, relating to documentation of Section 17 leave, care planning, risk assessment and the recording of leave. Action plans will be drawn up as a result of the audits for all wards to follow.

Elements to be monitored	Lead	How trust will monitor compliance	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Documentation of S.17 leave: - care planning, - risk assessment - recording on RiO	Mental Health Act Manager	audit	6 monthly	Mental Health Law Group	Required actions will be identified and completed in a specified timeframe	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

23. Review of the policy

This policy will be reviewed in April 2015.

24. References

22.1 Department of Health (2008) *Mental Health Act 1983 Code of Practice.* London, The Stationery Office.

22.2 Department of Health and Welsh Office (1998) *Mental Health Act 1983 Memorandum on Parts I to VI, VIII and X.* London; The Stationery Office.

22.3 Bethlem and Maudsley NHS Trust (1999); *The Maze. Mental Health Act 1983 Guidelines*. London, Bethlem and Maudsley NHS Trust.

22.4 Department of Health and Welsh Office. *Section 34(1)(a), Mental Health Act 1983*.

22.5 Mental Health Act Commission (1999) Guidance Note 1/99 – Issues Surrounding Sections 17, 18 and 19 of the Mental Health Act 1983. Nottingham, Mental Health Act Commission.

22.6 R v Hallstrom ex parte W, 1986.

25. Associated documents

23.1 AWOL Policy (October 2012).

23.2 Care Programme Approach Policy (October 2012).

Appendix 1

Equality Impact Assessment Tool

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

Appendix 2

Camden and Islington NHS
NHS Foundation Trust

Section 17 Leave Form

(Patient Leave Policy Appendix 1)

Name:	Ward:
Date of Birth:	Date of Admission:
AC/RC:	Section:

1. Use each box consecutively.
2. Be as specific as possible with conditions of leave (dates, times, escorts, etc).
3. RC only to authorise section 17 leave.
4. When leave is cancelled or has expired, cross it out and sign.
5. Leave which is at the discretion of nursing staff should state this as a condition.
6. **If Patient is going on extended leave (i.e. 7 consecutive days or over) please consider use of Supervised Community Treatment (SCT)**

When to use Supervised Community Treatment:

SCT should always be considered for detained patients who are allowed "extended" section 17 leave (i.e. 7 or more days at a time)

SCT is likely to be more appropriate if there are good reasons to expect that the patient will not need further treatment as a detained client for the immediate/medium term and that treatment back in the community no longer requires testing on a "trial" basis.

Conditions of Leave (be specific)	Home Office approval obtained? Yes/no/n/a
	Risk Assessment process complete? Yes/no
	Supervised Community Treatment considered inappropriate as patient does not meet clinical &/or legal criteria? Yes/No
	AC/RC Signature: Date:
	Cancelling Signature: Date:

Conditions of Leave (be specific)	Home Office approval obtained? Yes/no/n/a
	Risk Assessment process complete? Yes/no
	Supervised Community Treatment considered inappropriate as patient does not meet clinical &/or legal criteria? Yes/No
	AC/RC Signature: Date:
	Cancelling Signature: Date:

Conditions of Leave (be specific)	Home Office approval obtained? Yes/no/n/a
	Risk Assessment process complete? Yes/no
	Supervised Community Treatment considered inappropriate as patient does not meet clinical &/or legal criteria? Yes/No
	AC/RC Signature: Date:
	Cancelling Signature: Date:

Conditions of Leave (be specific)	Home Office approval obtained? Yes/no/n/a
	Risk Assessment process complete? Yes/no
	Supervised Community Treatment considered inappropriate as patient does not meet clinical &/or legal criteria? Yes/No
	AC/RC Signature: Date:
	Cancelling Signature: Date:

Appendix 3

LEAVE MONITORING FORM

Ward:	Date:

1. All patients taking section 17 leave to be placed on this list.
2. Patient's name, entitlement, time left and time due back to be recorded when patient leaves.
3. Allocated nurse to be made aware of time patient is due back.
4. Time returned and time left over to be recorded when patient returns.
5. Reasons for leave not used must also be recorded.

Patient's Name	Time allowed	Time out	Time Due	Time returned	Time left over	State reason if not all time used

Appendix 4

LEAVE ENTITLEMENT FORM

Ward:	Date:

1. All patients on the ward to be placed on this list.
2. This list is not a substitute for reading the patients' notes, Section 17 Leave Forms or care plans.
3. Information held on this list is CONFIDENTIAL and **must** match Section 17 Leave Forms.
4. Complete a new form daily and update as required.

Detained Patients

(see Section 17 Leave Form)

Patients NOT allowed off the ward	Patients allowed off the ward only with an escort (enter duration)	Patients allowed off the ward unescorted (enter duration)

Informal Patients

(these patients must not be stopped form leaving the ward)

Appendix 5

ACUTE HOSPITAL CARE FOR INPATIENTS (MENTAL HEALTH) WHO REQUIRE CARE IN A LOCAL ACUTE HOSPITAL SETTING[1]

1. Introduction

1.1 On occasion, service users receiving inpatient care from the Foundation Trust may need to be treated in an acute hospital. This protocol sets out the action to be taken should such a situation arise and covers guidelines for liaison between Trusts, including how such transfers should be conducted with regard to the Mental Health Act 1983.

1.2 This protocol expands on section 15 of the Trust's Patient Leave Policy (April 2013).

2. Aims and Objectives

- To provide guidance to inpatient mental health teams and acute hospital teams in the management of transfers of service users from Camden and Islington Mental Health and Social Foundation Trust inpatient sites to local acute hospital settings.
- To cover both planned and emergency transfers.
- To set out the legal position regarding such transfers under the Mental Health Act.

3. Basic Principles

3.1 Planned admissions will have a fully updated CPA Care Plan to address mental health/learning disability needs and risks and should be reviewed regularly. The frequency will be determined on an individual basis, in liaison between the mental health inpatient team and the acute hospital team. Responsibility for managing each element of the care plan will be documented.

Staff from both the acute and mental health Foundation Trust should be involved in the care planning process. Mental health care staff should be involved in the delivery of care appropriate to their skills and competence.

Acute staff will be responsible for all clinical care delivery in the acute setting, particularly following surgery, ICU admissions, multiple medical interventions, i.e. epidurals, CVP lines, syringe drivers.

3.2 Prior to transfer, an assessment of the level of risk the patient may present in a non-mental health setting needs to be undertaken. The risk assessment must then be communicated to the nurse in charge of the general ward by the nurse in charge of the mental health ward, along with a written summary of the current admission, which is usually contained within the normal doctor's referral letter. This would also include details of mental state, capacity to consent to treatment, potential complications, current management and care needs, current Mental Health Act status and leave of absence status. All appropriate documentation must also accompany the patient and this would normally include the risk assessment. The psychiatric duty nurse will also

[1] Adapted from Nottinghamshire Healthcare NHS Trust's policy 'Acute Hospital Care for In Patients (Mental Health) who Require Care in a Local Acute Hospital Setting' – Draft 4.

be involved in communication of these details to the nurse in charge of the receiving unit. The psychiatric ward SHO or out of hours the duty doctor will also liaise with their counterpart in the receiving unit.

3.3 Particular attention must also be given to the level of observation that will be required. Prior to transfer the level of observation required should be determined.

The mental health inpatient team will ensure that, when required, the patient has appropriately qualified escorting staff.

The accompanying member of staff should have adequate knowledge about the patient's mental state and care needs to enable them to provide a full handover to the receiving nurse. The nurse in charge of the transferring ward should ensure that the escorting nurse has specific instructions prior to departure, including agreed arrangements for when to leave the transferred patient and to return to the psychiatric ward.

3.4 Whenever a patient is in an acute hospital, the appropriate psychiatric liaison service (out of hours the duty psychiatrist), including any services not directly managed by the Foundation Trust, will need to be immediately informed about the transfer, with the expectation that they may be able to assess and assist in the management of the patient if necessary.

The staff of the mental health inpatient unit are responsible for informing the patient's family of their transfer, if this is agreed upon; and then the general practitioner and the community care coordinator.

4. Mental Health Act 1983

4.1 Patients detained under the Mental Health Act 1983 who are transferred to an acute hospital for medical care should be granted Section 17 leave for this purpose, which states the conditions of that leave as being a patient in that hospital, if their expected stay in the general hospital is for a few days only. Patients moved to medical care in this way remain the responsibility of the original RC and staff of the general hospital cannot therefore grant leave.

4.2 When patients are expected to need a longer admission to an acute hospital their care should be transferred to the acute hospital, with the liaison psychiatrist taking on the role of RC for detained patients. There will then be shared care between the liaison psychiatrist for the patient's mental health and the general consultant for their physical care.

4.3 The same arrangements can apply to informal patients, although it is more likely that a sector consultant would retain responsibility for their mental health care.

Note: Please refer to the Camden and Islington Mental Health Foundation Trust *Patient Leave Policy* (December 2005) for guidance on service users detained under the Home Office restrictions of sections 37/41, 47/49 or 48/49.

5. Emergencies

5.1 Where possible, transfers of service users from Mental Health inpatient sites to acute hospital settings should occur in a planned way but there will be occasions when this will not be possible.

5.2 In an emergency situation, for example if an ambulance had to be called for a patient who needed urgent medical attention, the patient can leave the ward/unit without the appropriate Section 17 authorisation. However, it is essential that the RC is contacted as soon possible after this occurs to authorise the necessary leave.

5.3 Additionally, it is not necessary to contact the Home Office prior to the emergency removal, to a general hospital for example, of a restricted patient. In this case, the Home Office must be contacted as soon as possible after the event and informed of the leave. Further guidance on restricted patients is given in Appendices 4 and 5.

5.4 If a patient has to leave a ward as a medical emergency, a qualified member of nursing staff must escort the patient. This nurse must be able to give a full and accurate verbal handover to staff at accident and emergency. This must include the patient's present condition and any associated risk factors, for example, self-harm, absconding risk, etc.

5.5 The qualified nurse, in collaboration with colleagues in the accident and emergency department and the ward team, will determine the level of observation required for the safety of the patient and others. They will liaise regularly with the nurse in charge of the referring ward and plan suitable relief/cover arrangements. They will not leave the escorted patient until a clear plan has been agreed with the nurse in charge in accident and emergency and the referring ward/duty nurse. At the very minimum a verbal medical referral must be made to accident and emergency and, where possible, the relevant notes and other documents should accompany the patient. Wherever possible, a written referral letter should be made to the accident and emergency department, and a copy kept in the mental health notes (it is recognised that this may not always be possible due to the urgency of the situation). The relevant liaison team should always be informed and requested to attend the patient in the accident and emergency department.

5.6 If the patient is to return from accident and emergency to the Foundation Trust, the escorting nurse must have a full handover, and a written record of all the action taken in accident and emergency. It is preferable for there to be a copy of the accident and emergency records and a written handover from accident and emergency staff regarding any findings, interventions and any follow up required on return to the Foundation Trust.

6. Documentation

Handover of escorting staff should be recorded in the patient's notes. Effective frequent communication should take place between the acute trust staff and mental health staff regarding the patient's management.

7. User involvement

7.1 Acute Hospital staff should involve the service user in their care plan unless there are competence issues, e.g. consent/lack of understanding/capacity to consent. Where a patient lacks the capacity to consent to treatment consideration should be given to any Advance Decision , Advance Statement or whether the patient has appointed a donee or deputy from the court of protection with Lasting Power of Attorney. Mental Capacity Act 2005.

7.2 The medical/nursing staff at the acute hospital trust will be made aware of and have documented information when possible from the mental health trust of the service user's level of understanding for capacity issues surrounding consent.

7.3 When the service user is unable/unwilling to consent, legal views will be obtained from the acute mental health Foundation trust and the acute trust will be informed of outcomes. Legal advice will be sought by the Mental Health and Social Foundation Trust regarding consent. The responsible clinicians will be involved at all times.

8. Discharge Arrangements

Discharge planning arrangements will be made with the multi-disciplinary team both at the Acute Trust and the Mental Health inpatient team in a timely manner.

9. Take Home Drugs

The acute trust will dispense any required medications and liaise with the mental health trust when necessary.

10. Audit and Review

This protocol will be audited and reviewed as part of the Patient Leave Policy.

Appendix 6

Camden and Islington NHS
NHS Foundation Trust

LEAVE & INFORMAL PATIENTS

Patients who are not legally detained in hospital have the right to leave at any time. They cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward (*Code of Practice;* Mental health Act 1983).

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