PATIENT LEAVE POLICY – INCLUDING TRANSFER OF SERVICE USERS TO LOCAL ACUTE TRUSTS
SEPTEMBER 2017

This policy supersedes all previous policies for Patient Leave
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| Consultation | Consultant psychiatrists; ward/team managers; associated divisional directors; divisional clinical directors; matrons; deputy director of nursing; practice development nurses; associate director of quality and governance; mental health law manager. |

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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 for patients who are liable to be detained under the Mental Health Act 1983 (MHA) and follows good practice guidelines as set out by the Code of Practice, the Ministry of Justice and others.

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 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.

1.4 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 voluntary, subject to Deprivation of Liberty Safeguards (DoLS) 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 Care Quality Commission, the Ministry of Justice Mental Health Casework Section 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 documenting 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 Section17 leave in nursing reports to First Tier Tribunals and Hospital Managers hearings.

3.5 **MHA Officers** - are responsible for:
   - Providing/advice on legal aspects of Section17 use.
3.6 **Mental Health Law Manager** - is responsible for:

- Providing advice and support to MHA Officers and clinical staff on the implementation of Section 17.
- Raising concerns as necessary about use of Section 17 leave within the Trust.
- Organising regular audits of Section 17 leave and developing improvement plans as appropriate

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 27.7 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:**
Any agreed or authorised period of absence from the hospital which is an essential part of an individual patient’s treatment plan. It can be an escorted or unescorted absence.

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 not 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 **Community Treatment Order (CTO):**
Community based Section under which patients are discharged from detention in Hospital under the Act, but remain subject to the Act in the community.
4.9 **Informal Patients:**
Patients who are not subject to the Mental Health Act (i.e. patients who are voluntary as defined below or who lack capacity to consent to admission and are subject to Deprivation of Liberty Safeguards (DoLS) under the Mental Capacity Act 2005).

4.10 **Voluntary Patients:**
Patients who have given informed consent to admission to a mental health ward and to a care plan which may include assessment, treatment, arranged absence (which may include starting with short periods of escorted arranged absence as part of the assessment process).

5. **Voluntary patients**

5.1 “Voluntary” patients have the right to make their own decisions about whether to leave or remain in hospital. This includes decisions about day-to-day activities which may involve periods away from the ward base. Patients who are not detained under the Mental Health Act or DoLS must not be deprived of their liberty whilst they are in hospital without their informed consent. All voluntary patients must be informed of this right and the poster at Appendix 5 must be displayed on all ward doors.

5.2 It is important that nursing staff, in consultation with the multidisciplinary team, agree a care plan with the patient that includes an assessment of their clinical appropriateness to arrange absence. This must address the circumstances for arranging absence, the amount of time that may be spent off the ward, the patient's destination and any other relevant conditions dependent upon the risk assessment.

5.3 The Arranged Absence Monitoring Form (Appendix 3B) must be completed to record arranged and actual absence. Staff must make every effort to explain to voluntary patients that the form is not intended to compromise their liberty of movement, but to allow clinicians to provide care and to maintain safety.

5.4 Where a voluntary inpatient about whom the clinical team have significant concerns in relation to risk tries to take unarranged absence from 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.

5.5 Wards with controlled entry and exit, must ensure that the liberty of voluntary 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 Detained patients may only be granted leave from the hospital with the authority of the Responsible Clinician (RC) under section 17 of the MHA 1983. This power cannot be delegated. In the absence of the patient's usual RC (e.g. if they are on leave) leave can only be authorised by the approved clinician who is, for the time being, acting as the patient's RC. (See Appendix 6 “Procedure for allocating/changing a responsible clinician”)

6.2 The RC may grant leave for specific occasions or for specific periods of time. They may make leave subject to any conditions which they consider necessary in the interests of the patient or for the protection of other people.

6.3 The decision to grant Section 17 leave must be based on an assessment of needs and risk and will form part of the patient's overall care plan. This must be recorded in the appropriate risk assessment and management documentation on the electronic patient record system currently RiO. Any decisions regarding section 17 leave should
be properly planned, whenever possible in advance, and should where practicable and appropriate, be the subject of multi-disciplinary discussion and fully involve the patient.

As per 27.10 Code of Practice, when considering and planning leave of absence, the RC should:

- Consider the benefits and any risks to the patient’s health and safety of granting or refusing leave;
- Consider the benefits of granting leave for facilitating the patient’s recovery;
- Balance these benefits against any risks that the leave may pose for the protection of other people (either generally or particular people);
- Consider any conditions which should be attached to the leave, e.g. requiring the patient not to visit particular places or persons;
- Be aware of any child protection and child welfare issues in granting leave;
- Take account of the patient’s wishes, and those of carers, friends and others who may be involved in any planned leave of absence;
- Consider what support the patient would require during their leave of absence and whether it can be provided;
- Ensure that any community services which will need to provide support for the patient during the leave are involved in the planning of the leave, and that they know the leave dates and times and any conditions placed on the patient during their leave;
- Ensure that the patient is aware of any contingency plans put in place for their support, including what they should do if they think they need to return to hospital early;
- Liaise with any relevant agencies, e.g. the sex offender management unit (SOMU);
- Undertake a risk assessment and put in place any necessary safeguards, and
- In the case of part 3 patients, consider whether there are any issues relating to victims which impact on whether leave should be granted and the conditions to which it should be subject.

6.4 Patients detained under section 4 or 5, remanded under sections 35 or 36, detained in hospital as a place of safety, or subject to an interim hospital order under section 38, may not be granted leave of absence.

7. **Conditions of leave**

7.1 Leave should normally be of short duration and not normally more than seven days. When considering whether to grant leave of absence for more than seven consecutive days, or extending leave so that the total period is more than seven consecutive days, responsible clinicians should also consider whether the patient should go onto a community treatment order (CTO) instead and, if required, consult any local agencies concerned with public protection. This does not apply to restricted patients, nor, in practice, to patients detained for assessment under section 2 of the Act, as they are not eligible to be placed on a CTO.(27.10 Code of Practice). Please refer to Trust Policy for guidance on the implementation of a CTO.

7.2 The option of using a CTO does not mean that the RC cannot use longer-term leave if that is the more suitable option, but the RC will need to be able to show that both options have been duly considered. Decisions should be explained to the patient and fully documented, including why the patient is not considered suitable for a CTO and also guardianship or discharge.
7.3 Leave for more than seven days may be used to assess a patient’s suitability for discharge from detention. Guidance on factors to be considered when deciding between longer-term leave of absence, guardianship and a CTO is given in the Code of Practice at Chapter 31:

7.4 Any proposal to grant leave to a restricted patient has to be approved by the Secretary of State for Justice, who should be given as much notice as possible and full details of the proposed leave. (For further information on restricted patients see the Ministry of Justice website https://www.justice.gov.uk/).

7.5 The RC may also, when granting leave under Section 17, impose certain conditions upon the patient. For example, the patient may be required to attend a specified place whilst on leave, allow visits from a Community Mental Health Nurse (CMHN) or Social Worker. In each case, the conditions must be clearly documented on the Section 17 Leave Form (see Appendix 2).

Short-term leave

7.5 Except where the agreement of the Secretary of State for Justice is required (in the case of restricted patients), responsible clinicians may decide to authorise short-term local leave, which may be managed by other staff, e.g. patients may be given leave for a shopping trip of two hours every week to a specific destination, with the decision on which particular two hours to be left to the discretion of the responsible nursing staff. This must be explicitly stated on the section 17 leave form, including any circumstances when leave should not go ahead.

7.6 The RC should regularly review any short-term leave they authorise on this basis and amend it as necessary.

7.7 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 by the Responsible Clinician. Where there are concerns regarding the patient a Responsible Consultant should be involved.

Longer periods of leave

7.8 Longer term leave should be planned properly and, where possible, well in advance (see also paragraph 6 above). Patients should be fully involved in the decision and the RC must be satisfied that patients are likely to be able to manage outside the hospital. Subject to patient confidentiality, carers and other relevant people should be consulted before leave is granted (especially where the patient is to reside with them). Relevant community services should also be involved in the planning.

7.10 If patients do not consent to carers or other people who would normally be involved in their care being consulted about their leave, the RC should reconsider whether or not it is safe and appropriate to grant leave.

7.11 As with short-term leave, the RC should specify any circumstances in which the leave should not go ahead, e.g. if the patient’s health has considerably deteriorated since it was authorised.

7.12 This does not apply to restricted patients.

7.13 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.
Escorted Leave

7.14 If the RC believes that it is necessary, in the interest of the patient or for the protection of other people, they can direct that the patient remains in custody during leave. This is commonly termed “escorted leave”

7.15 Patients on escorted leave may be kept in the custody of an officer on the staff of the hospital or of any other person authorised in writing. If the leave was granted on condition that they stay in another hospital, then patients can also be kept in the custody of any officer on the staff of that other hospital. Before authorising leave on this basis, the RC should consider whether it would be more appropriate to transfer the patient under section 19 of the MHA 1983 instead (see also Appendix 6 “Protocol for allocating/changing a responsible clinician”)

7.16 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 nurse accompanying the patient, whether they should be substantively employed, student nurses, 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 leave exceeding one hour, time should be allowed to enable extra staff to be obtained if necessary.

Accompanied leave

7.17 While it may often be appropriate to authorise leave subject to the condition that a patient is accompanied by a friend or relative (e.g. on a pre-arranged day out from the hospital), the RC should specify that the patient is to be in the legal custody of a friend or relative only if it is appropriate for that person to be legally responsible for the patient, and if that person understands and accepts the consequent responsibility.

Leave within the hospital grounds

7.18 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 Care Quality Commission is that ‘hospital’ refers to a building or set of buildings with attendant grounds and a boundary. 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.

7.19 Where the courts or the Secretary of State have decided that restricted patients are to be detained in a particular unit of a hospital, those patients will require the Secretary of State’s permission to take leave of absence to go to any other part of that hospital as well as outside the hospital.

7.20 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.

7.21 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?

8. Care and Treatment whilst on leave

8.1 During any period of Section 17 leave, the RC’s responsibilities for their patient remains the same.

8.2 A patient who is granted leave under section 17 remains liable to be detained, and the rules in part IV of the MHA 1983 about their medical treatment continue to apply. If it becomes necessary to administer treatment without the patient’s consent, consideration should be given to whether it would be more appropriate to recall the patient to hospital, although recall is not a legal requirement.

8.3 Patients who are detained for treatment may be entitled to after-care provided by (or for) clinical commissioning groups (CCGs) and local authorities under section 117 of the MHA 1983 while they are on leave of absence. (For further guidance see chapter 33 of the Code of Practice)

9. Emergency Medical Treatment

9.1 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.

9.2 Similarly, the RC may use their discretion if presented with an acute situation in which a restricted patient requires emergency hospital treatment. Examples of such conditions are heart attack, stroke and penetrative wounds and burns. Emergency or urgent treatment may also be needed for non-life threatening but urgent conditions such as fractures. The Ministry of Justice should be notified as soon as practicable of the circumstances of the treatment, including arrangements to manage any risk and when the patient is returned.

9.3 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.

9.4 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.

10. **Transfer to hospital for acute (medical) care**

10.1 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 factors set out below need to be taken into consideration (for further information see Appendix 4).

10.2 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 contained within the usual 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 consultant psychiatrist, or out of hours the duty doctor, will also liaise with their counterpart in the receiving unit if this is clinically indicated.

10.3 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.

10.4 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.

10.5 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.

10.6 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. (See Appendix 6 “Procedure for allocating/changing a responsible clinician”)

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

10.8 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.

10.9 The staff at the mental health inpatient unit are responsible for informing the patient’s family before the end of the shift in which the patient is transferred. Any
communication is dependent upon the patient’s consent. The general practitioner and the community care coordinator must be informed within 72 hours of the transfer taking place.

11.0 Evacuation

In case of an evacuation, 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 the evacuation and after alternative plans have been made for the patient’s stay and treatment so that the necessary leave and/or transfer arrangements can be made. Additionally, it is not necessary to contact the Ministry of Justice prior to the evacuation of a restricted patient. In this case, the Ministry of Justice must be contacted as soon as possible after the event and informed of the new arrangements which might include transfer or leave.

12. Recalling a patient from leave

12.1 The RC can, at any time, recall a patient who has been granted Section 17 leave. In doing so, the RC must feel it is necessary in the interests of the patient’s health and safety or for the protection of others. The RC must be satisfied that these criteria are met and should consider what effect being recalled may have on the patient. A refusal to take medication would not, on its own, be a reason for recall, although it would almost always be a reason to consider recall.

12.2 A patient can only be recalled if, in the opinion of the RC, the patient’s condition makes it necessary for the patient to become an in-patient again. Except in an emergency, patients should not be recalled from leave of absence without up-to-date clinical evidence that they remain mentally disordered.

12.3 To recall a patient, the RC must issue a notice in writing of the recall to be given to the patient or to the person, if there is one, in charge of the patient during their leave. The reasons for recall should be fully explained to the patient and a record of the explanation included in the patient’s notes. A record should always be kept of the address of patients who are on leave of absence and of anyone with responsibility for them whilst on leave (27.33 Code of Practice).

12.4 A restricted patient may be recalled to hospital either by the RC or by the Secretary of State for Justice. If a problem were to arise during a restricted patient’s leave of absence, the RC should immediately suspend the use of that leave and notify the Ministry of Justice who would then consider whether to revoke or rescind the leave or let the permission stand.

12.5 Patients cannot be recalled after they have been discharged from section or after the authority for their detention has expired. It is possible to renew a patient’s detention whilst they are on leave, if the criteria in section 20 of the MHA 1983 are met.

12.6 It is essential that carers (especially where the patient is residing with them whilst on leave) and professionals who support the patient whilst on leave should have easy access to the patient’s RC if they feel consideration should be given to returning the patient before their leave is due to end.

13. Patients who abscond whilst on leave
13.1 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 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: Absent Without Leave Policy).

14. Communication

14.1 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.

14.2 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.

14.3 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.

14.4 Copies of the Section 17 leave specifying the conditions attached to it should be given to the patient and to any carers, professionals and other people in the community who need to know (27.22 Code of Practice).

15. Documentation

15.1 Any and all leave granted, as well as any conditions attached to that leave, must be recorded both in the patient’s EPR 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 is subject to audit.

15.2 All leave and absence must be recorded on the Leave / Absence Monitoring Forms (Appendix 3A&B). Staff must complete all details requested on the forms to ensure that teams can keep an accurate and up to date record of leave / absence. This is subject to audit.

15.3 A record should be kept in the EPR 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 EPR notes should therefore contain an ongoing record of the outcome of each leave period - whether or not it went well, particular problems encountered, concerns raised or benefits achieved – to inform future decision-making. Patients should be encouraged to contribute by giving their own views on their leave. (27.23 Code of Practice).

16. Section 17 Leave Form

16.1 All patients subject to sections 2, 3, 35, 36, 37, 38, 47 or 48 must have their leave authorised by the RC and documented on the Trust’s Section 17 Leave Form
16.2 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 scanned and sent to the RC, who will then sign it and send it back to the ward. The scanned copy 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 scanned 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.

16.3 Information and guidance about additional information to be provided and documentation to be completed for restricted patients can be found on the Ministry of Justice website (https://www.justice.gov.uk)

16.4 When Section 17 leave has expired or has been cancelled, a line must be placed through the form which must also be signed and dated by the RC or Nurse – in-Change. 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 scanning procedures should be followed.

16.5 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 crossed through and filed in the patient’s notes.

16.6 In each box, the RC must indicate whether Secretary of State approval for the leave is necessary and whether obtained. If approval is required and has not been obtained, then the leave must not go ahead.

16.7 The RC must also indicate, in each box, 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.

16.8 The Section 17 Leave Form should be copied (on plain white paper) and circulated following any and all additions, deletions or corrections. Copies must be given to the patient and to any carers, professionals and other people in the community who need to know (27.22 Code of Practice).

17. The leave monitoring forms

17.1 The Leave Monitoring Form (Appendix 3A) 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.

17.2 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.
17.3 When a patient subject to Section 17 returns to the ward, staff should record the time returned and calculate any unused leave, if appropriate.

17.4 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. Patients are treated as absent without leave (AWOL) under the MHA 1983, when:

- they are absent from hospital without having been given leave to be absent;
- do not go to, or absent themselves without permission from, any place at which they are required to reside as a condition of leave, or
- fail to return from leave either at the end of a period of leave or when recalled.

The same applies to patients detained under the “holding powers” in section 5 who go absent from hospital.

17.5 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.

17.6 There is also an Arranged Absence Monitoring Form for voluntary patients (Appendix 3B) and it must be completed when patients’ absences are arranged. Staff must make every effort to explain to voluntary patients that the form is not intended to compromise their liberty of movement, but to allow clinicians to provide care and to maintain safety.

18. Dissemination and implementation arrangements

This policy 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 must 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 Trust Policy Manager

19. Training requirements

Training on the use of this policy is the responsibility of Ward/Team Managers for all new permanent and temporary ward staff during their induction. Training will be provided in accordance with the Mental Health Law Training Plan. Attendance at training must be recorded on the Learning & Development Database.

20. 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.

See Table below
### Elements to be monitored

<table>
<thead>
<tr>
<th>Documentation of Section17 leave:</th>
<th>Lead</th>
<th>How trust will monitor compliance</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations and Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>- care planning,</td>
<td>Mental Health Law Manager</td>
<td>Audit</td>
<td>Annually</td>
<td>Mental Health Law Committee</td>
<td>Required actions will be identified and completed in a specified timeframe</td>
<td>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</td>
</tr>
<tr>
<td>- risk assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- being cancelled (date, signature, line across form)</td>
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<tr>
<td>- recording on EPR</td>
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</table>

<table>
<thead>
<tr>
<th>Episodes of escorted leave cancelled due to shortage of staff</th>
<th>Lead</th>
<th>How trust will monitor compliance</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations and Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
</tr>
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</table>

### Review of the policy

This policy will be reviewed in September 2018 or earlier should a significant change be identified.
21. References


22.4 R v Hallstrom ex parte W, 1986.

22. Associated documents

22.1 AWOL Policy

22.2 Care Programme Approach Policy

22.3 Mental Capacity Act and Deprivation of Liberty Safeguards Policy

22.4 Protocol for allocating/changing a responsible clinician.

22.5 Patient Property Policy

22.6 Search Policy
## Appendix 1

### Equality Impact Assessment Tool

<table>
<thead>
<tr>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Does the policy/guidance affect one group less or more favourably than another on the basis of:</strong></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
</tr>
<tr>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
</tr>
<tr>
<td>Nationality</td>
<td>No</td>
</tr>
<tr>
<td>Gender</td>
<td>No</td>
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<tr>
<td>Culture</td>
<td>No</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
</tr>
<tr>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
</tr>
<tr>
<td>2. <strong>Is there any evidence that some groups are affected differently?</strong></td>
<td>No</td>
</tr>
<tr>
<td>3. <strong>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</strong></td>
<td>N/A</td>
</tr>
<tr>
<td>4. <strong>Is the impact of the policy/guidance likely to be negative?</strong></td>
<td>No</td>
</tr>
<tr>
<td>5. <strong>If so can the impact be avoided?</strong></td>
<td>N/A</td>
</tr>
<tr>
<td>6. <strong>What alternatives are there to achieving the policy/guidance without the impact?</strong></td>
<td>N/A</td>
</tr>
<tr>
<td>7. <strong>Can we reduce the impact by taking different action?</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Appendix 2
#### Section 17 Leave Form

<table>
<thead>
<tr>
<th>Name:</th>
<th>Ward:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Date of Admission:</td>
</tr>
<tr>
<td>RC:</td>
<td>Section:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conditions of Leave (be specific)</th>
<th>Home Office approval obtained? Yes/no/n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Risk Assessment process complete? Yes/no</td>
</tr>
<tr>
<td><strong>AWOL risk assessment/action plan:</strong></td>
<td>Has patient compliance with leave boundaries been considered? Yes/no</td>
</tr>
<tr>
<td><strong>PLS CIRCLE RISK STATUS AND STATE DETAILED ACTION PLAN BELOW</strong></td>
<td></td>
</tr>
<tr>
<td>a/ Low risk/mental state concerns.</td>
<td></td>
</tr>
<tr>
<td>b/ Moderate risk/mental state concerns</td>
<td></td>
</tr>
<tr>
<td>c/ High risk/mental state concerns</td>
<td></td>
</tr>
<tr>
<td><strong>Action plan:</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Supervised Community Treatment decision necessary? Yes/No (Give detailed reasoning on leave form)**

<table>
<thead>
<tr>
<th>If Cancelled, please give short explanation why</th>
<th>RC Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date:</td>
</tr>
<tr>
<td></td>
<td>Patient Signature:</td>
</tr>
<tr>
<td></td>
<td>Date:</td>
</tr>
<tr>
<td></td>
<td>Cancelling Signature:</td>
</tr>
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<td></td>
<td>Date:</td>
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</tbody>
</table>

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. **Ensure that a clear action plan is stated for patients who go AWOL when on leave**
7. **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 future and that treatment back in the community no longer requires testing on a "trial" basis.
# Appendix 3A

## Leave Monitoring Form

**For Patients on Section of the MHA**

<table>
<thead>
<tr>
<th>Ward:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Date:</td>
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</table>

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.
6. Description of patient’s clothing at time of leaving (Upper garment including coat/jacket and lower garment)

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Time allowed</th>
<th>Time out</th>
<th>Description of patient’s clothing when leaving the Ward</th>
<th>Time Due</th>
<th>Time returned</th>
<th>Time left over</th>
<th>State reason if not all time used</th>
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PATIENT LEAVE POLICY_CL08_SEPTEMBER 2017
Appendix 3B

“VOLUNTARY PATIENTS” ABSENCE MONITORING FORM
(This form is not intended to compromise patient’s liberty of movement – See Section 5.3 & 16.6 of the Patient Leave Policy)

<table>
<thead>
<tr>
<th>Ward:</th>
<th>Date:</th>
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</table>

1. All informal patients leaving the ward should be placed on this list.
2. The Patient’s name, time out and time back should be recorded when the patient leaves and returns.

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Time out</th>
<th>Time back</th>
<th>Risk assessed Y/N</th>
<th>Description of patient’s clothing when leaving the Ward (Upper garment including coat/jacket and lower garment)</th>
<th>Name and Signature</th>
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Appendix 4

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

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 9 and 10 of the Trust’s Patient Leave Policy (May 2015).

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 NHS 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 1983.

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 trust 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

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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.
this would normally include the risk assessment. The psychiatric duty nurse will also 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 psychiatric duty nurse will also 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.

3.4 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 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.

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 (May 2015) for guidance on service users detained under the Ministry of Justice 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 Ministry of Justice 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 8 and 9.

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.

3. 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. (Reference: 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. Where required, legal advice will be sought by the Mental Health NHS 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.
Voluntary Patients’ Ward Information

Ward doors are normally kept locked for the safety and security of both patients and staff.

If you wish to leave the ward for a short period please ask to speak to a member of the nursing staff.

Normally staff will let you leave however - if they feel that you are not well enough to go out on your own - they may want to discuss other options with you.
MHA 1983 ALLOCATING OR CHANGING A RESPONSIBLE CLINICIAN – PROTOCOL FLOWCHART

**INITIAL ALLOCATION**

The responsible clinician (RC) for a patient admitted to hospital under the Act will be the consultant psychiatrist for the ward to which the patient is admitted.

- The responsible clinician for a patient in a community team will be the consultant for that team.

Where there is more than one consultant psychiatrist allocated to the ward or community team, they will agree who would be the most appropriate for the needs of the individual patient.

This information must be documented on RIO.

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**ANNUAL LEAVE & SICKNESS ABSENCE**

When taking annual leave the RC is responsible for ensuring there is a Consultant colleague to provide RC cover. They should follow the leave cover arrangements agreed in their division.

Cover arrangements should be provided by an authorised clinician in the following level of priority:
1. Working in the same team
2. Working in the same division and on the same site
3. Working in a different division but on the same site
4. Working in the same division but on different sites
5. An emergency cover duty rota (HMHC and SPH sites)
6. The Clinical Director or Lead Consultant
7. The Medical Director

The RC must advise the team and the MHA Administrator's office of the cover arrangements via his/her e-mail account and document on RIO.

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**ANNUAL LEAVE / SICKNESS ABSENCE / AFTERHOURS**

- **AFTERHOURS**
  - After hours, RC responsibility for all patients in a borough falls to the consultant on call for that borough. Should one of the consultants be unavailable for any reason, the RC’s responsibility will fall on the other consultant on duty.

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**TRANSFERS**

**BETWEEN INPATIENT WARDS**

Patients should not be transferred between wards for non-clinical reasons. Where exceptionally there is a requirement for a “sleep-over”, the RC responsibility remains with the original ward consultant.

Where patients are transferred for clinical reasons, there is a transfer of care and RC responsibility. This must be planned with the patient and their family, a clear plan of care agreed and a transfer/acceptance of consultant and RC responsibility.

**TO AN ACUTE HOSPITAL FOR TREATMENT**

Where a patient is transferred under Section 17 leave when it is envisaged that the treatment will be short the ward RC remains the responsible RC for that patient. Review after 3 days on a case by case basis and either transfer (S19) or the inpatient medical team reviews the patient in the acute setting and sets an appropriate time limit for retaining RC responsibility.

Where a longer period of stay is anticipated (eg further investigations or major complications), a section 19 transfer is effected and the RC responsibility is transferred to the acute hospital consultant. In these circumstances, it is usual for the liaison consultant to adopt lead responsibility for monitoring the patient’s psychiatric care in the acute hospital. There should be clear communication/negotiation in each individual case between the psychiatric ward and the liaison consultant as to when this transfer of care should occur.

**SUPERVISED COMMUNITY TREATMENT**

When a patient is discharged under a Community Treatment Order, the RC must liaise with the Community team and the consultant psychiatrist who will act as the Community RC at an early stage.

The MHA Administration Office must be advised before the patient is discharged and the change of RC documented on RIO.

**CTO PATIENT PRESENTING OUT OF HOURS**

Where a CTO patient presents "out of borough" and out of hours, the consultant on-call for that borough will take responsibility, ie Camden presentations go to Camden on-call and Islington likewise.

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**Responsible Clinician definition:** The responsible clinician is the approved clinician who will have overall responsibility for patients being assessed and treated under the Act. It is important to note that there can never be more than one RC at any one time. Therefore, for section 17 leave to crisis team/crisis house etc, the ward RC remains the responsible RC.
Appendix 7 PROTOCOL FOR SECTION 17 LEAVE

AUTHORISING SECTION 17 LEAVE FLOW CHART

Patient is an inpatient? → NO → Not entitled to s17 leave

YES → Inpatient status?

NO → INFORMAL

YES → DETAINED

Detained under what section?

Ss 2,3,37,47 or 48 → Responsible Clinician (RC) can grant leave

Ss 37/41, 45A, 47/49, 49/49 → Any attempt to allow patient to leave hospital without RC authorisation would be unlawful

Ss 4, 5(2), 5(4), 35, 36, 38, 135, 136 → Not entitled to S17 leave

RC must apply for approval from the Secretary of State for Justice

Only RC can authorise s17 leave

Has s17 leave from been signed by RC? → NO

YES → Are s17 leave parameters specific and defined by RC (start date, type, frequency, location, duration)

NO → Risk of s17 leave being invalidated

YES → Have all out of date leave forms been crossed through

NO → Section 17 leave validated and may be taken

YES → Has a copy of the s17 leave form been given to the patient, carer and significant other? (indicated on the leave form)

NO → Non – compliant with the MHA Code of Practice

YES → Compliant with the MHA Code of Practice
Appendix 8

Leave application for restricted patients
Mental Health Casework Section

Please send the completed form to the Mental Health Casework Section at
MHCSTeam1@noms.gsi.gov.uk (case letters A-Gile); MHCSTeam2@noms.gsi.gov.uk (case letters Gill-Nev); MHCSTeam3@noms.gsi.gov.uk (case letters New-Z) or fax on 0300 047 4387 (case letters A – GEO) or 0300 047 4395 (GEP – NEAL and NEAM – Z)

Patient’s basic details
Full name of patient
Date of birth
MHCS reference
Location of index offence

Responsible clinician’s details
Responsible clinician
Address
Telephone number
Fax number
Email address

Leave proposal
Please note that any leave taking place outside the designated security perimeter of the named unit, hospital or ward requires Secretary of State approval unless the hospital has a current agreement with the Mental Health Casework Section specifically devolving agreement to the Responsible Clinician.

Type of leave proposed
- Compassionate
- Escorted community
- Overnight
- Unescorted community

Other (please specify)

Previous types of leave taken
- Compassionate
- Escorted community
- Overnight
- Unescorted community

Other (please specify)

Report on current leave (frequency, duration, destination, purpose and conduct)
Please give details of the leave proposal, including:

- the purpose of the leave
- if escorted, the number of escorts
- future leave plans, if proposal agreed
- full address of the leave destination
- means of transport, if any
- views of care team, if different

Patient’s condition

Mental state – please describe the patient’s mental state, including:

- how long the patient has been stable
- what insight, if any, the patient has into his or her illness

Behaviour – please describe the patient’s behaviour, including any incidents of:

- aggression
- self-harm
- substance abuse

State what effect these have had on the patient and how they will be addressed.

Compliance – to what extent does the patient:

- accept the treatment programme?
- comply with medication?
Risk

Risk to victims and others – what is your assessment of the risk (including further offending, or a possible encounter) that the patient would present to:
- past victims?
- any specific group?
- the public in general?

How do you propose to address these risks?

Risk of absconding – what is your assessment of the patient’s current risk of absconding?

How do you propose to address this risk?

Responsible clinician’s signature

Date
Appendix 9

MINISTRY OF JUSTICE GUIDANCE TO RESPONSIBLE CLINICIANS

LEAVE OF ABSENCE FOR PATIENTS SUBJECT TO RESTRICTIONS UNDER SECTIONS 41, 45A AND 49 OF THE MENTAL HEALTH ACT 1983 AND UNDER THE CRIMINAL PROCEDURE (INSANITY) ACTS

THIS GUIDANCE IS A SUPPLEMENTARY DOCUMENT BECAUSE OF ITS VOLUME
Can be accessed on the Intranet (Pathway: Clinical >> Clinical Policies OR search for Patient Leave Policy)