Cambridgeshire and Peterborough NHS Foundation Trust

MENTAL HEALTH ACT 1983

SECTION 17 POLICY

LEAVE OF ABSENCE FROM HOSPITAL

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Ratified by:	Quality, Safety & Governance Committee
Consultation & approval: (Committee/Groups which signed off the policy, including date)	Mental Health Law Operational Group (by email), 28 September 2017
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Signed on behalf of the Trust: ……

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Version Control Page

Version	Date	Author	Comments
1.0	April 2009	Mick Simpson/ Nephat Chege	Approved and ratified by the MHA Committee.
1.1	August 2009	Orna Clark	S17 Leave form reviewed and updated to include dates the form was given to the patient, carer, escort, medical records and MHA Administration.
1.2	June 2011	Orna Clark	S17 Leave form reviewed and updated to include patient's signature.
2.0	March 2015	Orna Clark	Complete review and re-write of the original policy, a new Risk Assessment form, additional SOPs, a reviewed leave form and a Section 17 Leave information leaflet.
2.1	September 2017	Denise Hone/ Orna Clark	Review and re-write of section 13 to take account of the new Informal Patient Leave SOP, which has also been added to section 18 and the SOP included as Appendix 7. Additional bullet point added to section 3.9 on accompanying patients. Transferred to 2017 policy template.

Policy Circulation Information

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CONTENTS

Appendices

THE USE OF LEAVE UNDER SECTION 17 OF THE MENTAL HEALTH ACT

POLICY AND PROCEDURES

1. Assurance Statement

1.1 Introduction

This Policy aims to ensure that staff members are aware of the provisions of section 17 of the Mental Health Act 1983 (the Act/ or the MHA) and that the granting of leave under section 17 is carried out within the legal and good practice framework represented by this Policy. The Policy also aims to define the interface between section 17 Leave and section 17A – Community Treatment Order (CTO).

1.2 The policy should be read in conjunction with the MHA Code of Practice (CoP) 2015, in particular:

- Chapter 1 – The over arching Guiding Principles, which should always be considered when making decisions in relation to care, support, or treatment provided under the Act.

- Chapter 3 – Human Rights, Equality and Health Inequalities. Staff will need to consider the legislation and international convention, which provide a framework to deliver the best possible outcome to everyone who uses the Trust's services.

- Chapter 27 and 28 – Leave of absence and Absence Without Leave, which gives direct guidance to this policy.

1.3 The MHA CoP provides statutory guidance to staff working with the Act. Staff must ensure that they are familiar with its content and follow the guidance. Any deviation from the Act and the Trust policy must be explained and well documented by staff in the patient's RiO clinical notes.

2. Aims & Objectives

2.1 This Policy aims to explain the legal requirements of section 17.

2.2 The Policy aims to ensure that decisions to grant section 17 Leave are properly taken and documented.

2.3 The overall objective is to allow detained patients opportunities to go on leave, whilst ensuring that risk is carefully managed.

2.4 The Policy contains a section 17 Leave Recording form (appendix 1) a section 17 Leave risk assessment form (appendix 3) and section 17 Standard Operating Procedures (appendix 5). The aim and purpose of the SOP and the forms is to ensure consistency in the application of the Act across all Trust localities and services.

3. General Provisions

3.1 For patients subject to detention under the MHA, leave can only be authorised by their named Responsible Clinician (RC). Authorisation of leave cannot be delegated to other medical, nursing or other staff. In the absence of the patient's named RC, the delegated responsibilities will be carried out by the RC covering or the on-call RC during after hours.

3.2 The RC may grant "to any patient who is for the time being liable to be detained in a hospital under this Part of this Act to be absent from the hospital subject to such conditions (if any) as that Clinician considers necessary in the interests of the patient or for the protection of other persons". (s17(1))

3.3 Leave of absence under section 17 may be granted either for an indefinite period, or on specified occasions or for any specified period.

3.4 Except for certain restricted patients, no formal procedure is required to allow patients to move within a hospital, or its grounds. Such ground leave within a hospital may be encouraged, or where necessary, restricted, as part of each patient's care plan (CoP 27.5)

3.5 An RC cannot grant leave of absence from hospital to patients who have been remanded under sections 35, 36, or who are subject to an interim hospital order section 38 (CoP 27.4)

3.6 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. (s41(3))

3.7 Patient detained under the short term sections 4, 5(2), 5(4) are not eligible for section 17 leave, as they have not become an 'in-patient of the hospital named in the application'.

3.8 A Community Treatment Order (CTO) patient recalled under section 17E is not liable to be detained (s17D(2b)), and therefore cannot be granted section 17 leave

3.9 Leave may be granted in various ways and with conditions attached.

- **One-off Leave** where leave is granted for a particular purpose or event.

- **Short-term Leave** where for example short periods of local leave are granted on a regular basis, such as an hour a day between specified times. The taking of such leave is normally at the discretion of nursing staff who may decide (following a risk assessment) that the leave cannot be taken because the patient is too unwell or disturbed.

- **Longer term Leave** such as overnight, weekend leave or extended leave.

- **Escorted Leave "Escorted"** means that the patient will be in the legal custody of the escort who should usually therefore be a member of staff. If others undertake the role of escort, written authority is required from the 'Hospital Managers'. Information with regards to escorted leave must be included in the RC's leave conditions.

- If the intention is not to grant leave subject to an escort, but to stipulate that the patient should be accompanied by their care providers (friends, carer, or relatives) during the leave, the term **"accompanied"** should be used.

- Where a patient is to be accompanied by a friend, carer, or relative on a period of leave, and the expectation of the psychiatrist or nursing staff is that that person will remain with the patient during that period of leave, this will be made clear to the person accompanying the patient. Advice will also be given as to what the accompanying person should do in the event that the patient refuses or is reluctant to remain with them.

3.10 In all cases, authorised leave should be given only:

- Following consultation with involved professionals, including those working in the community, to ensure the patient's needs for health and social care are taken account of and addressed.

- Following the drawing up of a care plan for a longer period of leave and specifying where the patient is to reside, who is to provide any necessary support.

- Following a detailed risk assessment (which must be carried out by the RC as part of planning the leave and recorded on the patient's RiO risk assessment form). And by the Primary Nurse/Nurse in charge, on the section 17 Pre-Leave Risk Assessment form (appendix 3), before the patient leaves the ward. Leave arrangement and risks should also be documented in the patient's RiO clinical notes and care plan.

- With carefully considered contingency plans including contact telephone numbers (this may be the Community Care Co-ordinator if there is one or the Responsible Clinician).

- With clearly set down parameters including the time of return.

- With clearly set down supervision arrangements.

- For episodes of leave lasting more than seven days, there must be prior consideration of whether the patient is suitable for section 17A Community Treatment Order (CTO) as an alternative. The RC must record the reason the use of a CTO may not be appropriate in the clinical notes /care plan on RiO.

- With a copy of the section 17 Leave form (signed by the patient) and given to the patient and others as appropriate (see Appendix 1).

3.11 If friends, relatives or carers are involved in the patient's care, then, **with the agreement of the patient,** appropriate consultation should take place with them prior to leave being taken (See appendix 2). The patient consent to share the information with their Nearest Relative (NR), carer, or friends must be recorded in the RiO consent to share information form and in the clinical notes and the patient's care plan. The section 17 Leave form, in such cases, should be copied to the relative, friend or carer.

3.12 If the patient objects to an involved relative, or carer being informed about the section 17 Leave, the issues should be carefully considered. The patient has a right to confidentiality, but this has to be balanced against the possibility of risk to the patient, relative or carer. It might be a condition of leave that the relative or carer is informed. Alternatively, in a situation where the patient was refusing to allow a relative, or carer to be informed, it might not be possible to grant leave. In difficult cases advice should be sought from the Trust's MHA Legislation Manager.

4 Roles & Responsibilities

4.1 The role of the Responsible Clinician (RC)

4.1.1 To plan, risk-assess and authorise section 17 Leave as appropriate and document it on the section 17 Leave Form and in the patient's RiO clinical records/care plan.

4.1.2 The RC must carry out a section 17 leave risk assessment and record the outcome on the RiO risk assessment form. The RC must also complete and record the leave conditions and details on the section 17 Leave record form (appendix 1). **The form must be signed by the patient's named RC as clear evidence of the leave being duly authorised.**

4.1.3 When considering & planning leave of absence the RC should consider - (CoP 27.10):

- 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.
- In the case of part 3 patients – (see CoP Chapters 22 and 40) 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.

4.1.4 If the RC is on leave, or absent through sickness etc., leave for the patient can be authorised by the person who is, for the time being, in charge of the patient's treatment.

4.1.5 Prior to authorising leave, the RC, in consultation with other professionals concerned, should ensure that the patient's needs for health and social care are fully assessed and that the care plan addresses them. There is a duty to provide aftercare under section 117 for those detained (or who have in the past been detained) under sections 3, 37, 45A, 47 or 48 and this applies when leave is taken.

4.1.6 The RC should review the conditions of the leave in accordance with the patient's and at any time when significant change is noted in the patient's behaviour. Any changes to the conditions or the leave arrangements must be documented appropriately in the RiO clinical notes/care plan/risk assessment and a **new leave form must be completed** and signed by the RC and the patient. How often leave is reviewed will depend upon the type of ward or unit. In an acute setting, it would be expected that leave should be reviewed each week.

4.1.7 For any leave lasting over seven days, the RC must first consider whether a section 17a Community Treatment Order (CTO) is a more suitable alternative and if so, act accordingly. The consideration should be documented in the patient's RiO clinical notes/care plan.

4.2 The Role of the Nurse

4.2.1 To risk assess and monitor episodes of Leave in regard to the patient's wellbeing and whether conditions met kept (See appendix 3 – section 17 pre leave risk assessment form)

4.2.2 To liaise with the patient's RC and document all required leave information on the section 17 Leave Form, RiO clinical records and reflect in the care plan.

4.2.3 Leave previously authorised by the RC may be over ruled by the Nurse in charge of the ward, or unit and if he / she feels that the patient's mental health has deteriorated since the authority was given and they are not now well enough to go on leave. This decision will be made after carrying out a pre leave risk assessment which will be recorded on the pre-leave risk assessment form (Appendix 3)

The Nurse may also consider that conditions imposed as part of the leave cannot, or will not be met and as a result the leave cannot be taken.

Any such instances should be recorded in the patient's RiO clinical notes and reported to the RC, who may then have to review whether further leave is appropriate.

4.2.4 To ensure that the patient and carers have a copy of the section 17 leave form and other relevant leave information (Leave information pack/crisis plan/leave leaflet).

4.2.5 In collaboration with the patient, review the leave with the patients (and carers, if applicable) when the patient returns to the ward. All relevant leave follow up information must be recorded in the patient's RiO clinical notes.

4.2.6 To report on use of section 17 Leave in nursing reports to Mental Health Tribunals (MHTs) and MHA Hospital Managers hearings.

4.3 Locality MHA Administrators

4.3.1 To obtain details of section 17 Leave episodes and compile reports with regards to the compliance with the policy.

4.4 Patient Information & Mental Health Act Legislation Manager

4.4.1 To provide advice and support to medical and nursing staff with regards the use of section 17 Leave within the Trust.

4.4.2 To provide advice on legal aspects of section 17 use

4.4.3 To oversee the monitoring of section 17 Leave and submit reports with regards to compliance to the Divisional Management, the Mental Health Legislation Group and the Safety, Quality and Governance Committee.

4.4.4 To ensure that section 17 leave is part of the mandatory e-learning and classroom based training provided to staff working with the MHA and raise staff awareness with regards to compliance with section 17 leave requirements and the Act.

5. Consent to Treatment

5.1 Because a patient on authorised leave remains "liable to be detained", he / she remains subject to the Consent to Treatment provisions set out in section 58 of the MHA. Should treatment be required whilst on leave, and the patient refuses, then a recall to hospital should be considered (see 7 below).

6. Recording of Leave

6.1 The authorisation of leave must be recorded on CPFT section 17 Leave Record form (see Appendix 1). Copies should be distributed in accordance with the guidance on the form. It is recognised that it may not always be practicable to distribute copies of the form to all parties - if for example if leave is taken very soon after authorisation is given. If this is the case, an entry must be made on the form and in the patient's RiO clinical notes to explain why the why copies were not given. The principles contained in item 3.11 above must however be followed.

6.2 The form should be signed by the RC. Exceptionally if the need to authorise leave is urgent (e.g. in cases of bereavement in the patient's family, or an urgent admission to A&E), another member of staff may sign the form on the basis of the RC's authorisation over the telephone. Details of the agreement must be recorded on the leave form and in the clinical notes on RiO. The RC must sign the form at the earliest opportunity.

6.3 The form should also be signed by the patient, to signify their acceptance of the terms and conditions of the leave. It is recognised that this may not always be possible, e.g. because the patient is not present, or refuses to sign, in which case the leave should go ahead without the patient's signature. A note of the patient's refusal to sign (or lack of capacity) must be recorded on the form.

6.4 The form must be completed with particular attention to the:-

- Address where the patient is expected to stay (if overnight / weekend or extended periods of leave are being granted).
- Start and finish times and dates or periods of leave.
- Conditions attached, for example, no alcohol, escorted regular visits by CPN.
- Contact person and telephone number for patient / carer.

6.5 Leave does not need to be authorised and documented when the patient is allowed to go off the ward but remains in the grounds of the hospital, or unit of the same 'Hospital Managers'. Patients who are detained in a ward which is based on the grounds of a hospital which is not part of the same 'Hospital Managers' authority must be under section 17 Leave to leave the ward. It is the policy of the 'Hospital

Managers' of CPFT to complete a section 17 leave and risk assessment form every time a detained patient leave the grounds of the ward.

6.6 Whenever a new Leave Record form is complete, any previous leave form must be **struck through** to indicate that it is no longer valid. This will help prevent leave mistakenly being allowed on the basis of an out of date form.

6.7 For patients needing treatment at the local general hospital, then this period of leave should be accounted for under section 17 Leave (see item 11). The name and address of the general hospital must be clearly identified on the section 17 form.

6.7.1 A copy of the leave form **must** be faxed and / or taken with the patient to the nurse in charge of the ward of the general hospital (a request should be made to the ward to place the document in their patient file).

A copy of the leave form **must** also be uploaded onto RiO (MHA Documents) and the locality MHA Administration must be informed that the detained patient has moved to the acute hospital ward.

6.7.2 The local Psychiatric Liaison Team should be notified of the planned leave- A discussion between the patient's RC and the relevant hospital Liaison Psychiatry RC must take place and a hand over details must be discussed. A copy of the leave must be emailed to the Liaison Psychiatry Team as part of the handover. **Also see CPFT procedure for Detained Patients in an Acute Hospital**

6.8 All section 17 leave forms and risk assessment must be scanned and uploaded onto RiO when they are initially completed and every time they are updated. All current original section 17 forms should be filed in a central Section 17 Leave file in the ward. When a new form is being completed, the non current leave form should be sent to the locality Mental Health Act Administrator and filed in the patient's Section File.

6.9 The outcome of leave, whether or not it went well, particular problems encountered, concerns raised or benefits achieved, should be recorded in patients' RiO clinical notes to inform future decision-making. Patients should be encouraged to contribute by giving their own views on their leave. (See CoP Chapter 27.23)

7. Revoking of Leave

7.1 The RC can revoke leave at any time if he/she considers it necessary in the interests of the patient's health or safety, or for the protection of other people.

7.2 If leave is revoked, the RC must state this in writing with an explanation of the reasons to the patient or to the person temporarily in charge of him/her. (See Appendix 4 – RC Revocation Form)

7.3 A restricted patient's leave may be revoked by the Home Secretary, as well as the RC.

7.4 It is essential that relatives and friends (especially where the patient is staying with them whilst on leave) and professional staff in the community have access to the RC if they feel that consideration should be given to revoking leave.

8. Duration & Renewal of Section whilst on Leave

8.1 Leave cannot continue past the end date authorised by the leave form unless extended by the RC. The patient does not have to be present for leave to be extended.

8.2 Leave can be granted for an indefinite period, i.e. with no specified end date.

8.3 Although it is accepted that extended periods of leave away from the hospital, or unit can be combined with continued hospital in-patient treatment, it should be noted that it is unlawful to renew a section for a patient who is not receiving any medical treatment in hospital. It is also unlawful to recall a patient from leave solely in order to renew the section. In such instances consideration should be given to the use of section 17A – Community Treatment Order (CTO).

8.4 A patient who is on section 17 Leave may have their section renewed in their absence.

8.5 A 'Renewal of Section' statutory form completed by the RC for a patient on extended section 17 Leave in the community - is satisfied under section 20(4), if the treatment plan provides for a 'significant component' of medical treatment in hospital. Medical treatment in hospital does not depend upon a plan to put the patient at times into a hospital bed. It is likely to be met if the patient attends hospital for treatment. However, as stated above in 8.3, in such cases consideration should be given to the use of section 17A – Community Treatment Order (CTO).

9. Leave & General Hospitals

9.1 A patient who needs short-term treatment at a general hospital and who is likely to return the psychiatric hospital or unit should be transferred to the general hospital on section 17 Leave. Though section 19 is acceptable under the Act, section 17 is the preferred mode. This enables medical treatment to be carried out, but the overall responsibility for the patient's mental health to be retained by their RC. It also means that the patient is more likely to return to the psychiatric hospital for discharge through the CPA process. Leave should be authorised by the RC using the leave form in the normal way.

9.2 In an emergency, where the RC is not available (not even by telephone), the patient should be transferred to the general hospital under common law and the necessary documentation completed at the earliest opportunity after.

9.3 In all cases of section 17 leave of CPFT patients who are transferred to local Acute Hospital, the RC should inform the that Hospital Liaison Psychiatry Team and discuss the details of the leave. The Liaison Psychiatry should contact the consultant at the local general hospital to discuss the transfer of the patient (Also see CPFT procedure for Detained Patients in an Acute Hospital). Outside of working hours and for cases that are not thought to be complex, discussions should be had with the doctor on duty.

9.4 If a transfer of RC responsibility (i.e. to Psychiatric Liaison Service) is needed, then this is a clinical decision between the consultants and may depend upon the nature of each case.

9.5 A patient being transferred to another psychiatric hospital, or unit, would normally be transferred under section 19, even when the transfer is for a short period and the patient is due to return (i.e. section 17 Leave would not be used in this case as the psychiatric hospital is taking full responsibility for the patient's mental health and has staff qualified to act as RC).

10 Leave & Crisis Resolution and Home Treatment Team (CRHTT)

10.1 The CRHTT is a multi-disciplinary service aiming to provide safe and effective home based assessment and treatment as an alternative to in-patient care.

10.2 If the RC believes the CRHTT should be involved in a patient's period of leave, so that support and supervision are provided, then a referral should be made to the CRHTT for assessment. The assessment needs to take place and a decision reached before section 17 can go ahead.

10.3 Where the CRHTT have accepted the patient, the RC must ensure leave conditions are clearly indicated on the section 17 form and an entry made in the patient's RiO clinical notes. Where leave is conditional upon CRHTT involvement then the RC should not sign the section 17 form until they are clear that the Team have accepted the patient's care.

10.4 If the CRHTT have not accepted the patient's care, alternative plans need to be considered.

11. Section 17 Leave & Community Treatment Orders (CTO)

11.1 The MHA introduced CTOs to allow patients to be discharged from hospital and managed in the community subject to a legal framework.

11.2 RCs are required to consider the use of section 17A – CTO, whenever section 17 Leave is granted for a period of more than seven consecutive days. The reason a CTO may not be appropriate must be recorded in the clinical notes on RiO.

11.3 CTOs are for patients ready to be discharged from hospital, whilst section 17 Leave is for patients not yet ready to be discharged.

12. Failure to Return from Leave

12.1 If a patient granted leave of absence fails to return as agreed then he/she is considered 'Absent Without Leave' (AWOL) and the 'Absent Without Leave' Policy and Procedures should be followed.

12.2 It should be clear that the AWOL does not automatically require the police to be notified as soon as a patient fails to return from leave, but when their absence is confirmed and/or there is a level of concern. In the intervening time ward staff may want to contact the patient's home address, or relatives, to try and establish their whereabouts and intentions.

12.3 In all cases where a patient has failed to return from leave, the ward team and RC should review whether it is safe, or appropriate, to authorise further leave until there is a significant change in the patient's clinical state or circumstances.

12.4 Absent Without Leave reports should distinguish between episodes where the patient has absconded from the unit and episodes where the patient has failed to return from leave, so that the incidence of the latter can be monitored.

13 Leave of Absence for Informal Patients

13.1 Definition of an Informal Patient

A patient who has either entered hospital for treatment for mental disorder on an informal basis (of their own accord), or has chosen to remain in hospital on an informal basis once the authority for his or her original detention has come to an end.

13.2 Procedure

Please refer to Standard Operating Procedure 'Informal Patient Leave from Mental Health Inpatient Wards'.

14 Process for Implementation

14.1 This Policy will be placed on the Trust intranet site so that all staff members are able to access it.

14.2 The ward, unit or team managers are expected to brief staff where necessary about the key points of this Policy.

14.3 A Standard Operating Procedure on the use of section 17 Leave should be accessible/or on display in the ward.

15 Monitoring Arrangements

15.1 Issues relating to section 17 Leave will be reported and raised at the Trust MHA Legislation Group Meetings.

15.2 An audit of section 17 Leave will be organised regularly by the Mental Health Legislation Manager and the Trust's Quality & Clinical Effectiveness Team. The outcomes and action plans of the audits will be discussed and reported via the Clinical Audit Group and the MHA Legislation Group.

16 Human Rights & Equality Statement

16.1 The use of section 17 Leave/ informal patients leave - should be part of all patients' recovery process and applied equally - regardless of ethnicity, gender, age, sexual orientation, disability, or religion. CPFT will strive to ensure that this is the case and this will feature in monitoring.

17 Training

17.1 The ward, unit or team managers are expected to brief their staff about the key elements of this Policy.

17.2 Section 17 will feature in regular mandatory and refresher CPFT MHA Training which is run by the Trust.

18 Other Relevant Policies

- CPFT procedure for Detained Patients in an Acute Hospital
- MHA S17A-G – Community Treatment Orders;
- MHA S26 – The role of the Nearest Relative;
- MHA S20(3)-23 – Mental Heath Act Managers;
- MHAS69 – Applications to the First Tier (MHA) Tribunal;
- MHA S5(2) & 5(4) – Doctors and Nurses Holding Powers;
- MHA S132/132a – Reading of Rights;
- MHA S56-64 – Consent to Treatment under the MHA
- CPFT Equality and Diversity Policy
- Informal Patient Leave Standard Operating Procedure

19 References

- Mental Health Act 1983
- Code of Practice to the Mental Health Act 2015
- Care Quality Commission Guidance ‘Leave of absence and transfer under the Mental Health Act 1983’ Revised version – March 2010.
- Care Quality Commission Guidance ‘Use of the Mental Health Act 1983 in general hospitals without a psychiatric unit’
- Mental Health Casework Section – Policy On Section 17 Leave for Restricted Patients https://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/mhcs-guidance-s17-leave.pdf

Appendix 1

Cambridgeshire and Peterborough NHS
NHS Foundation Trust

Mental Health Act 1983
Section 17 Leave of Absence Authorisation Form

Full name of patient		Patient's information Label
Date of Birth		
Hospital Number		
Section		
Ward		
Responsible Clinician		

PART 1

Leave of Absence has been agreed upon, as part of the above named patient's individual care plan and is authorised as follows:

(If leave granted is for more than 7 consecutive days, consideration for using a CTO should be given. Please record in RiO Clinical Notes the reason CTO may not be appropriate).

Leave duration and frequency	Conditions (If escort is required, include relevant information)	Authorisation Date/Signature	Review Date/Signature

Leave may be withheld at the discretion of the Nurse in Charge. Nurse to notify RC if this happens and record the reason for withholding leave on RiO)

Address of any overnight leave: _____

Patient signature:_____ **Date:** _____

If patient has not signed the form – explain why: _____

1 **Details of leave to be completed by nursing staff**
2 **Form to be uploaded to RiO when completed/updated.**
3 **Copies given to** (Tick as appropriate)

- **Patient** ( ) **Initial & Date** _____
- **Carer/other** ( ) **Initial & Date** _____
- **Escorting (if applicable)** ( ) **Initial & Date** _____
- **Scanned & uploaded onto RiO** ( ) **Initial & Date** _____

Mental Health Act 1983

PART 2 - SECTION 17 LEAVE RECORD

Section 17 is required when a patient detained under the MHA is allowed to go beyond the hospital grounds for any reason i.e. social, therapeutic, or work and for any period of time i.e. during the day, overnight or longer. This form must be uploaded onto RiO within 24 of being updates.

RETURN

Risk reviewed by Nurse immediately prior to leave (Date/sign)	Purpose of Leave	Date/ Time of Departure	Date/Time of agreed Return	Description of Patient	Nurse's signature/ Date	Date/Time of Actual Return	Has patient failed to return (Y/N) (AWOL)	Nurse's signature/ Date

A new section 17 form must be completed when the RC agrees new conditions, or when you run out of space to record leave details on part 2 of the form

Appendix 2

Cambridgeshire and Peterborough NHS
NHS Foundation Trust

CARER DISCUSSION QUESTIONNAIRE

The aim of the questionnaire is to find out the family/carers views on the proposed leave plan as discussed in the report out meeting. The conversation can be face to face or via the telephone.
The following questions are meant to act as a guide to seek the family/carers view about leave and their role in leave.

Prior to discussing patient's information with the carer, please ask the patient if they object to you doing so - The ward team want to give your relative/friend leave in your care, before they decide would you be happy with this?
Yes: □ **No:** □

Questions to ask the carer, subject to the patients consent

1. Do you have contact numbers for the ward in case you need advice or support?
   Yes: □ **No:** □

2. Do you need any advice on your relative/friends medication?
   Yes: □ **No:** □

3. Is there anything else you need to know?
   Yes: □ **No:** □

4. Would you be happy to contact us to let us know how the leave went?
   Yes: □ **No:** □

5. Would you like us to contact you?
   Yes: □ **No:** □

ANY ADDITIONAL COMMENTS

_____

_____

_____

_____

_____

Name of relative/friend: _____

Staff Name: _____ **Signature:** _____

Date: _____

NB: Staff completing this form please ensure any additional comments are recorded on RiO Clinical Notes and that this form is scanned and uploaded to the patient's records on RiO.

Appendix 3

Cambridgeshire and Peterborough NHS
NHS Foundation Trust

Pre- Leave Nurse Risk Assessment – ESCORTED (Staff) ( )
UNESCORTED ( )

Name of the patient		**RiO Number**		**Ward**	
Date and time of Leave		**Name of the Nurse Conducting Risk Assessment**			

Assessment of the mental health state prior to leave

Mood	
Thoughts	
Behaviour	

Please answer the following questions. (Please do not be offended, they are only a guide to help staff).

Do you understand the conditions of your leave? ***Expected leaving time*** ***Expected time of return*** ***Accompanied/un-accompanied***	**Yes ( ) No ( )** **Patient comments:**	**Assessing professional comments (*including conditions discussed*):**
Do you have any thoughts, or plans of harming yourself? (*explore presentation over previous 24/48 hours and any risks noted – what has changed?)*	**Yes ( ) No ( )** **Patient comments:**	**Assessing professional comments (*include any risks noted in handovers, progress notes etc and agreed plan to manage*):**
Do you have any thoughts of ending your life? (*if this has been a risk at any time during admission, what has changed?*)	**Yes ( ) No ( )** **Patient comments:**	**Assessing professional comments (*include any risks noted in handovers, progress notes, risk assessments etc and agreed plan to manage*)**

If you were struggling to cope on leave, would you feel confident to phone the ward? (*check phone and relevant numbers available*)	**Yes ( ) No ( )** **Patient comments:**	**Assessing professional comments (*include agreed plan of contacts*)**
Do you feel safe on leave? (explore what may lead to feeling unsafe during leave, i.e. where will leave take place, who may be there) **Do you have a Safety Plan?**	**Yes ( ) No ( )** **Patient comments:**	**Assessing professional comments (has Safety Plan been discussed and given, include details of discussion):**

Patient Signature and date		**Professional Signature and date**	

ADDITIONAL QUESTION FOR FAMILY/CARERS (Where relevant)

Do you understand any conditions of the leave? **e.g. accompanied, un-accompanied, expected time of return, any medication requirements**	**Yes ( ) No ( )** **Relative/carer comments:**	**Assessing professional comments (*what conditions have been discussed*):**
Do you feel potential risks and management have been fully discussed with you? **Have you understand the Safety Plan?**	**Yes ( ) No ( )** **Relative/carer comments:**	**Assessing professional comments (*agreed plan*):**

Pre-Leave Risk Assessment and clinical record keeping

Risk assessment should be carried out by the assessing professional before leave. If there are specific concerns regarding violence, self-harm, self-neglect, substance misuse, or vulnerability to exploitation, these risks and subsequent plan should be documented within the progress notes in the format below.

For any risk identified the assessing professional must develop a risk management plan with the patient and carers/relatives wherever possible and share that plan with relevant others, i.e. the care team, care coordinator, carer/relatives.

Describe the risk (as identified during leave risk assessment discussion)
Identify options (e.g. leave time, escorted by staff, accompanied by family/carer, non-accompanied, leave not advised etc)
Choose the preferred option
Explain the rationale for choosing this option
Share the decision with the patient, relevant colleagues, carer/relatives/accommodation staff, including any conditions

Appendix 4

Cambridgeshire and Peterborough NHS
NHS Foundation Trust

RESPONSIBLE CLINICIAN'S REVOCATION OF LEAVE
Section 17(4) Mental Health Act 1983

Patient Name	
Section	
Ward	
Hospital	
Name of RC	

THIS FORM RELATES TO THE SECTION 17 LEAVE FORM COMPLETED ON:

DATE: _____

I am the Responsible Clinician for the above named patient and it is necessary to revoke leave under section 17(4) of the Mental Health Act 1983 because:

RC'S Name and signature	**Date**

Once completed, the patient must be provided with a copy of this form, the form must be scanned and uploaded onto RiO and the original must be sent to the Mental Health Act Administrator

PLEASE SCORE THROUGH OUT-OF-DATE FORMS

Appendix 5

Section 17 Leave - Standard Operating Procedure

- Patient detained under Mental Health Act (sections 3, 2, 3, 37, or 47)
- Patient requests leave of absence, RC plans leave of absence for the patient
- Leave request is reviewed by Responsible Clinician at MDT Meeting.

In assessing whether to grant Section 17 Leave, consideration must be given to any implications at the time for child or vulnerable adult safeguarding concerns. Where there are concerns, the relevant procedures must be followed.

Decision made by RC to grant Section 17 Leave. For restricted patients under Part 3 of the Mental Health Act (those subject to Section 41 or 49 restrictions) the RC can only grant discretional leave within the secure perimeter fence of the unit (leave within the secure perimeter fence is classified as 'grounds leave'). All other leave (including onto non-secure CPFT hospital grounds) is classified as 'community leave' and must be granted in advance for each individual patient by the Ministry of Justice following application by the RC.

Leave of absence conditions agreed by RC and MDT in consultation with the patient and if appropriate, relatives/carers/friends

Is leave for more than seven consecutive days and nights
(I.e. the patient will not be resident on the ward for a week or more?)

YES

RC to consider the appropriateness of using s17A CTO. If CTO is not appropriate, RC to record reasons in RiO clinical notes.

NO

RC to complete a section 17 leave risk assessment and section 17 Leave Form - clearly outlining the leave conditions and their review date.

Copies of the section 17 Leave form and leaflet to be given to the patient, carer or relative, as appropriate.
The updated section 17 Risk Assessment and Leave forms are to be scanned and uploaded onto RiO.

At the time when the patient requests to go out on their assigned leave, the patient's Nurse completes a risk assessment and completes part 2 of the leave form. (The Nurse should exercise discretion and if leave is refused, the reasons must be documented on RiO and the RC must be informed).
Patient to be informed that if they experience any problems/or concerns - they should call the ward/return to hospital.

Section 17 Leave details must be documented in the patient's RiO clinical notes and care plan.
Updated Leave forms must be scanned and uploaded onto RiO

On return from the assigned leave, the patient's Nurse in Charge must discuss the leave's success and outcome with the patient. The details of the discussion must be documented by the Nurse in the patient's RiO clinical notes.

If a patient fails to return from leave at the specified time, the patient's Nurse must try and contact him/her. If the patient absence is confirmed, the AWOL (Absent With Out Leave) Policy & Procedure should be followed.

In cases of emergency, if the patient is in need of urgency medical treatment (for example, if an elderly patient has fallen out of bed and has a suspected fractured hip and needs to be moved to the general hospital for the medical treatment), the patient can be taken to the Acute Hospital and the section 17 Leave Form can be completed retrospectively by the RC at the earliest opportunity.
If possible, RC to authorise the urgent section 17 Leave by phone and record the details of the conversation in the patient's RiO clinical records.
Any outpatient hospital appointments, optician appointments etc. must be planned and the section 17 Leave form must be completed and signed by the RC in advance of the appointment.

Once any updates to section 17 Leave are made, the form must be scanned and uploaded onto RiO within 24-hours!

Appendix 6

Mental Health Act – Definitions

Advance Decision to Refuse Treatment (ADRT)
At a time when a patient has the capacity to make the decision they may decide that if they lack capacity at some point in the future they do not want to receive certain forms or methods of treatment. Advance Decisions can only be made by people 18 or over. If an advance decision relates to life sustaining treatment (such as resuscitation) it must be in writing and witnessed – ideally by a carer or relative or if this is not appropriate an advocate or independent third party - but not by a member of Trust staff unless there are special circumstances.

Care Quality Commission (CQC)
Took over from the Mental Health Act Commission (as well as the Health Care Commission and the Commission for Social Care Inspection) in April 2009 to look after the rights and concerns of all those who are held under the Act. Ensures the Act is being properly used and sends **SOADs** when required.

Community Treatment Order (CTO)
Power under sections 17A-17G that enables a patient to be discharged from detention in hospital but to remain subject to recall. Also referred to as **Supervised Community Treatment (SCT)**

Court Appointed Deputy
In certain situations where an individual does not have a **Lasting Power of Attorney (LPA)** but a series of decisions needs to be made the Court of Protection may appoint a deputy who then take on the same functions as an attorney either for a specified period or indefinitely.

Independent Mental Health Advocate (IMHA)
Specialist advocates who support detained patients and those on CTO, ensuring that the safeguards laid out in the legislation are followed.

Lasting Power of Attorney (LPA)
A Lasting Power of Attorney (LPA) is a formal legal document which confers on the attorney (or donee as it sometimes called) the authority to make decisions on the patient's behalf. There are 2 types of LPA: Personal Welfare and
Property & Affairs. The decisions that can be made by the attorney will depend on the type of attorney they are and what is written in the LPA. To be valid an LPA must be formally written down, signed and registered with a body known as the Office of the Public Guardian. An LPA can also be verified through this body and should be verified if a paper copy cannot be presented to staff.

Mental Health Tribunal (MHT)
Independent statutory body responsible for hearing patients' appeals against detention. Acts as a mobile court. They are now classified as 'first-tier tribunals' as per the Tribunals, Courts and Enforcement Act 2007.

Nearest Relative
Not to be confused with 'Next of Kin', a patient cannot choose their Nearest Relative. It is a term specific to the Act and the Nearest Relative has a legally defined role (see section 26 of MHA). The Nearest Relative has certain powers and is entitled to receive certain information regarding a patient who is subject to the Mental Health Act. In contrast a patient can choose their Next of Kin but the Next of Kin will have no legal standing.

Second Opinion Appointed Doctor (SOAD)
Sent by the **CQC** to ensure that when a patient does not or cannot consent to certain treatment it is only given if it is medically necessary. Also required to ratify the treatment provided to **CTO** patients irrespective of whether consent is forthcoming. In this role they are acting independently of the detaining hospital on behalf of the CQC.

Supervised Community Treatment (SCT)
Refers to the regime applied when someone is subject to a **Community Treatment Order (CTO).**

Mental Health Act – Abbreviations

AC – Approved Clinician

ADRT – Advance Decision to Refuse Treatment

AMHP – Approved Mental Health Professional

AWOL – Absent Without Leave

BIA – Best Interests Assessor

CQC - Care Quality Commission

CRHT – Crisis Resolution and Home Treatment

CTO - Community Treatment Order

ECT – Electro-Convulsive Therapy

EDT – Emergency Duty Team

HM – Hospital Managers

IMHA – Independent Mental Health Advocate

LPA – Lasting Power of Attorney

MHA – Mental Health Act

MHT – Mental Health Tribunal

MOJ – Ministry of Justice

NIC – Nurse in Charge

NR – Nearest Relative

OOH – Out of Hours

RC – Responsible Clinician

SOAD – Second Opinion Appointed Doctor

SCT – Supervised Community Treatment

Appendix 7

Informal Patient Leave from Mental Health Inpatient Wards

Standard Operating Procedure

Contents

1 Introduction

The services have a responsibility for preparing inpatients for a successful return to the community and periods of leave can form an essential component of this preparation. However any decision to agree a period of leave from a mental health unit has to balance the contribution that leave makes to the patient's recovery against considerations for the health and well-being of both the patient and others.

2 Purpose

Although informal patients have the right to leave the ward at any time, the Trust has a duty of care towards them including responsibility for their safety and well-being. The aim of this standard operating procedure is to set out the specific standards for when an informal patient takes leave from one of the Adult Mental Health Inpatient wards. Additionally it also sets out the responsibilities of clinical staff prior to any period of leave for informal patients, during periods of leave and when a patient returns from leave.

3 Scope

The contents of this standard operating procedure cover the management of leave for informal patients and apply to all clinical staff working within the Trust's Adult Acute Mental Health Services. Patients subject to a period of detention under the Mental Health Act 1983 staff are to refer to the Trust Section 17 Policy.

4 Definitions

For the purpose of this Standard Operating procedure the following definitions are used;

Informal patient: Section 131 of the MHA 1983 makes provision for patients to be admitted to hospital "informally", that is without being detained under the MHA 1983. This will include patients who have been detained in the past, even during their current admission, but have been discharged from detention and are therefore no longer subject to detention under the Act.

Care Programme Approach (CPA): A framework for multiagency working in mental health services.

Care Co-ordinator: A qualified professional from a mental health team in the community responsible for coordinating a patient's care on a day-to-day basis.

Lead Professional: Patients who are on the case load of a community team for a defined episode of treatment, and do not meet the threshold for CPA will not have an allocated care coordinator. Instead they will have an allocated lead professional who will be responsible for overseeing their episode of treatment and discharge back to primary care.

CRHT: Crisis Resolution and Home Treatment Team. In the case of some patients where there is an identified need and agreement with the CRHT they may provide support to patients whilst on a period of leave from the inpatient ward. For any patients

they are supporting the team which will be responsible for the care and treatment of the patients' mental health and risks during a period of home leave and during 48 hour follow up on discharge from hospital if part of an early facilitated discharge.

Named Professional: The inpatient professional (i.e. nurse, occupational therapist) who is responsible for collaborating with patients and carers in the development, delivery and monitoring of the care plan.

Leave from hospital: The act of a patient leaving the hospital and its grounds either escorted (with a member of staff) or accompanied (with a family or friend) or unescorted (on their own).

5 Duties

Consultant Psychiatrist
The Consultant Psychiatrist is the clinician in charge of the patient's episode of inpatient care and has responsibility for prescribing and overseeing the delivery of treatment for informal patients admitted under their care. This should include negotiating of ward activities and home leave with informal patients in consultation with the MDT and the patients' carers/relatives.

Admitting Clinician.
On admission, consideration should be given to the potential risks to the patient and/or others of any off ward activities including leave to their home as part of a comprehensive risk assessment. This assessment should also take into consideration:

- The clinical presentation and nature of the disorder;
- Risk factors;
- Information from relevant others (carers, other professionals e.g. GP, Care Co-ordinator, supported accommodation staff);
- The social circumstances of the patient.

Named Professional.
In liaison with the Community Care Coordinator/Lead Professional the allocated Named Professional (e.g. Nurse, OT) plays a central role in coordinating patient care and in relation to the planning of leave the Named Professional must:

- Where appropriate, in conjunction with the multi-disciplinary team encourage the patient to utilise periods of home leave in order to assess their readiness for discharge.
- Ensure the patient has been provided with a copy of leaflet "Admission as an Informal Patient" (Appendix 1).
- With the patient's consent liaise with their relatives/ carers/accommodation staff about any plans for leave.
- Take steps to ascertain that the accommodation at which the patient is taking their leave is accessible and that they have the finances to support themselves whilst on leave
- Review the patient's clinical risk assessment and risk management plan to take account of any new or increased risks once the patient leaves the ward.

- Have in place appropriate care plans for any planned periods of leave from the ward.
- Ensure that any required support is in place prior to the patient going on leave, and that the patient and where appropriate relatives/carers/accommodation staff are aware of the safety plan and support arrangements.
- Ensure discussion has taken place with carer/relative/accommodation staff and understanding of leave requirements in relation to maintaining safety are understood
- Ensure the patient has a copy of their Safety Plan and that carers/relatives/accommodation staff also have contact details which can be used in the event of an emergency/crisis arising.
- Make sure the patient has supplies of all their required medication and knows how to administer it.
- When the patient returns from a period of leave :

    - Gain and record in the clinical records the patient's perspective on the quality of the leave.
    - Gain feedback from the patient's relatives/carers/accommodation staff as to the quality of the period of leave, and ensure that this is documented in the clinical record. Staff need to be aware that gaining this information from relatives or carers and listening to any concerns they may have **does not breach** patient confidentiality.

Care Coordinator
It is the responsibility of the patient's allocated care coordinator to:

- Be involved where practical in the planning of leave for patients they are working with; ward staff to ensure that the Care coordinator or their team is aware that the person is on leave .
- Support patients whilst on leave from the wards;
- Report back to inpatient staff as to the progress of the patient or concerns expressed to them by the patient's relative/carer/accommodation staff following any contact whilst leave is taking place.

Multi-Disciplinary Team
The risk management plan including the provisions for off ward activities such as leave should be reviewed and revised at the first Care Programme Approach (CPA) multi-disciplinary team (MDT) meeting and at each MDT meeting thereafter with changes to the plan being discussed with the patient, carers (with the consent of the patient) and other professionals. The outcome of these reviews will be clearly documented in the patient's clinical record.

6 The Planning of Leave

Leave should be agreed as part of the patient's treatment plan and discussed by the MDT with the involvement of carers (to discuss progress and ascertain their views), accommodation staff where involved, other professionals and / or the Home Treatment Team.

Any MDT support for a patient to have a period of leave from the ward will:

- Be informed by the on-going assessment of clinical risk, taking account of the fact that a patient's risk profile will change once they are off the ward and no longer under the supervision and care of clinical staff. As part of the risk assessment the following should also be considered:

    - Any issues with treatment adherence;
    - The risk of the patient absconding from the local area;
    - The risk of the patient refusing to return to the ward;
    - Any child or adult safeguarding concerns once the patient returns home.

A leave care plan must be developed which takes account of any identified risks, and the management of these risks, and includes any specific community based support which is needed to safely facilitate the leave.

7 Action Immediately Prior to a Period of Leave

Prior to leave each patient will be seen on a 1:1 basis by their named professional or other allocated staff member who will carry out an assessment of the patient's mental health presentation and clinical risk profile.

As part of this assessment the named professional/staff member should obtain information from the patient as to how they feel about the planed leave and that they clearly understand the arrangements including what to do in the event of them needing advice or assistance.

This discussion will also provide an opportunity to explore with the patient their perception of any identified clinical risk issues and what coping strategies they can utilise.

For any home leave staff should make every effort to contact the patient's carers /relative/accommodation staff to confirm:

- That there has been no change in circumstances which have a direct impact on the planned leave.
- The address to which leave is to be taken and a contact number for use should the need arise for the ward to contact the patient.
- Any support which is to be provided by the services during the period of leave.
- That they are aware of action to take in the event that they have any concerns during the period of leave.

Where the patient is going on home leave, the inpatient team should also be satisfied:

- That the patient has access to the premises.
- That the patient has (or will have) enough food and beverages for the period of leave.
- That there are no immediate risks which could compromise the safety of the patient.

Any medication required by the patient during leave will be issued immediately prior to the patient leaving the ward. The named nurse /staff member should ensure that the patient understands how and when to take their medication, including any “as required” (PRN) medication if issued. The patient should be reminded of the purpose of the medication and of any side effects they might encounter.

All patients who are having a period of leave from the ward will be provided with a copy of the relevant Adult/OPMH/CAMH Mental Health Leave leaflet.

Prior to the patient leaving the ward staff will provide a verbal handover to anyone who arrives to accompany the patient. Where a patient is to be accompanied by a relative, friend or other carer on a period of leave and the expectation of the psychiatrist or nursing staff is that that person will remain with the patient during that period of leave, this will be made clear to the person accompanying the patient. Advice will also be given as to what the accompanying person should do in the event that the patient refuses or is reluctant to remain with them.

All of the above must be recorded in the electronic patient record.

8 Action if a period of leave has been agreed but there is a change in the patient’s clinical presentation/risk profile

In the event that staff have any concerns in relation to a patient’s clinical presentation/risk profile they are to suspend the professional support for planned leave subject to either a review by the patients Consultant or the MDT.

A full explanation is to be provided to the patient and where relevant their carers/relatives/accommodation staff as to why this decision has been made and that arrangements are being made for a review to take place.

Should the patient insist on the leave taking place but it is clear that the risk of harm has increased, the patient should in the first instance be asked to remain on the ward until seen by one of the medical team. In the event that the patient refuses to wait, then a nurse should consider their powers under section 5(4) and a doctor must be contacted urgently to carry out an assessment under Section 5(2). It is not permissible to deny informal patients the right to go out without conducting an assessment to decide if detention under the MHA is appropriate.

An informal patient found in the grounds of the hospital is still an inpatient for the purpose of using ‘Holding Powers’ (The patient still occupies a bed and has not been formally discharged from the ward). In this case, it is essential that staff facilitate a MHA Assessment immediately).

If the patient does not meet the criteria for detention under the Act and has not had any previous episodes of leave it is essential that a full risk assessment is undertaken before they leave the ward. In these circumstances adequate communication with families/carers/accommodation staff is key and there is to be a detailed record made in the patient’s clinical record of all action taken.

9 Action if an informal patient requests to leave the ward at short notice

Although patients who are not subject to detention under the Mental Health Act 1983 are able to leave the ward area it is not unreasonable for them to be asked to inform a member of staff if they wish to go out for a short period and to give at least an approximate time of return. Any such request should then be considered in relation to the patient's risk assessment, level of capacity and current presentation.

Any staff approached by an informal patient who wishes to leave the ward but is unwilling to provide full relevant details of the leave, or the professional has concerns in relation to their clinical presentation should request that the patient remains on the ward until seen by a member of the medical team. In the event that the patient refuses to wait staff should consider the use of section 5 'Holding Powers' to assess if the criteria for detention under the Mental Health Act 1983 are met (as per item 8).

If the patient does not meet the criteria for detention under the Act and is insisting on leaving the ward a detailed record is to be made in the patient's
clinical record of all action taken.

10 Support to Patients During Leave

Any patients on leave are still subject to an episode of inpatient care and if ward staff receive communication from either the patient or their carer /relative/accommodation staff expressing any concern they should in the first instance ascertain what the concern is and see if there is any advice /practical steps that can be taken to alleviate the concern.

If the call has been made by someone other than the patient, staff should also try to make direct contact with the patient to try and ascertain their perspective as to how they feel the leave is progressing. Following this discussion:

- If it is not felt that the patient needs to immediately return to the ward, the Named Professional or other allocated professional should contact the relevant community team and request that the patients care co-ordinator undertakes a visit. For patients not under the care of a care co-ordinator the ward staff or CRHTT could be asked to do an urgent visit to assess.

- If it is felt that the patient needs to return to the ward and they agree, the Named Professional or other allocated professional should make sure that they have the means to return safely.

In the event that the patient refuses to speak with staff and the situation is felt to warrant the patient returning to the ward staff must:

- Ascertain the patients' location.
- Assess the level of risk pose to either the patient, and/or others.
- Establish if the patient is willing to return to the ward, and if yes make any necessary arrangements to facilitate their safe return.

- In the event of the patient refusing to return, liaise with the patient's ward Consultant Psychiatrist in relation to the need for organising an assessment under the Mental Health Act 1983.

11 Return from Leave

Adequate feedback of progress whilst on leave is crucial for informing future clinical decision making, review of clinical risk, and timing of discharge. In view of this staff on duty at the time of any patient returning to the ward following a period of leave must obtain feedback from the patient and where possible all other relevant individuals including carers/relatives/accommodation staff. All feedback and the source of the information is to be fully documented in the patient's clinical record and the feedback will then be used to determine:

- Any required changes to the patient's risk assessment and risk
- management plan.
- The arrangements for any future periods of leave.
- Any additional support which may be required to facilitate any future
- periods of leave.

There will also be a review of the patient's mental health presentation on their return to the ward this will also include:

- A review of their adherence with medication.
- A discussion in relation to any side effects they may be experiencing and what action can be taken to manage these.
- Exploration of any issues in relation to the misuse of alcohol or illicit substances.

In addition to this:

- All leave will be reviewed regularly in multi-disciplinary team discussions with the outcome and decisions arising from this review being clearly recorded in the clinical record.
- The Named Professional or other allocated nurse will contact the carers and any relevant others to invite them to the MDTs to discuss leave and arrangements for any further leave periods.

12 Action if a patient goes missing whilst on a period of leave from the ward

For full guidance staff are to refer to the Trust Policy for Patients who are Missing or Absent without Leave (AWOL) but in brief for an informal patient who fails to return from an episode of planned leave:

- If the patient has capacity and their whereabouts are known, but they are refusing to return to the ward and there is no immediate risk to themselves or others, then they are not missing. In these circumstances staff should arrange a Multi-Disciplinary Team (MDT) review to agree if discharge is appropriate.

- If the patients whereabouts are known but there has been a reported deterioration in the patient's mental state an urgent meeting is to be convened to agree what further action is required. This may include a Mental Health Act assessment.
- If the patients whereabouts are not known:

    - If the patient has a mobile phone an attempt should be made to contact the patient and ascertain where they are and request that they return to the ward.
    - A request is to be made to the care coordinator or the CRHTT for home visits to be undertaken at different times of the day to see if there is any evidence that the patient has been back to their home address.
    - Contact is to be made with the patient's carer/relative/accommodation staff to see if they have had any contact. A request is to also be made that in the event of the patient establishing contact the ward is informed.
    - If the patient is not located, inform the Consultant Psychiatrist.
    - Inform the Police if there are significant concerns for the patient's wellbeing and safety to either themselves or others. The legal status of the patients must be fully explained along with the risk rag rating and reason for the concerns.

Staff should complete a Datix to reflect that a patient is missing.

13 Patients Subject to a Community Treatment Order (CTO)

If a patient on a CTO is admitted to hospital informally, either directly from the community, or subsequent to their recall, they are for most purposes an informal patient. As such, they cannot be prevented from leaving the hospital, nor can they be made to have medication or other treatment they do not consent to.

CTO patients who are admitted informally are different from other informal patients in certain respects, their detained status is only 'suspended' and not 'discharged' they cannot be made subject to 'holding powers' under Section 5 of the MHA. If they want to leave, but their mental state is such that this may lead to harm then a CTO recall should be considered. If the Responsible Clinician (RC) to complete CTO 3 and effect recall is not immediately available the MCA and best interest consideration can be invoked.

When a detained patient is made subject to an application for CTO the form CTO1 gives a date and time when the CTO takes effect. When this date/time is met the patient's detained status is suspended, the CTO takes effect and the patient is free to leave the hospital. As with an informal patient it is not lawful to prevent them from leaving, unless they are recalled

14 Clinical Record Keeping

For full guidance staff should refer to the following Trust policy documents:

- Record Keeping Policy

But specific to this Standard Operating Procedure:

- Staff must maintain contemporaneous records of all observations, actions and discussions in relation the planning of and feedback from periods of leave.
- As this information will be used to inform future decision making it is important that all records are factually accurate.
- Any records in relation to leave must include the following:

    - The involvement of any carers /relatives/accommodation staff in the planning of leave.
    - Details of 1:1 the conversations with service users.
    - Details of any support to be provided during the period of leave. Including agreed dates and times of any visits.
    - The date, time and location of leave.
    - Details of any contact made by the patient and /or their relative/carer/accommodation staff during the leave.
    - Details of any action taken by ward staff in response to any concerns raised by the patient and/or their relative/carer/accommodation staff during an episode of leave.
    - The agreed contact number for the patient whilst they are on leave.
    - Date and time of return from leave.

15 Involvement of Carers/Relatives

As highlighted throughout this document any carers/relatives who are supporting the patient should be involved in the care planning process throughout the episode of inpatient care, including leave planning. Agreement for this involvement should be sought from the patient at the time of their admission to the ward, and revisited at regular intervals throughout their stay.

In the event that a patient refuses to give consent for any information in relation to their care and treatment to be shared with their relatives/carers/accommodation staff, staff must explain this to the relative/carer/accommodation staff, but need to be mindful of the fact that seeking information from the carer/relative/accommodation staff and listening to any concerns they may have **does not breach** patient confidentiality. The relative/carer should also be provided with a copy of the *"Commonsense and Confidentiality – a Guide for carers, family and friends."*

However in circumstances where a failure to disclose information to the relative/carer/accommodation staff may put them at serious risk of harm they should be involved at the appropriate level in any decision making in relation to leave even though this does not have the patient's consent.

Staff are to refer to the *"Information Sharing and Confidentiality Guidance"* or contact the Trust Information Governance Team for detailed guidance and advice. The Caldicott Guardian (the Medical Director) can also be contacted for senior advice, usually by the Consultant Psychiatrist.

16 Links to Other Documents

- Record Keeping Policy

- Clinical Risk Assessment Policy
- Nurses and Doctors ‘Holding Powers’ – s5(4) and 5(2)
- AWOL and Missing Patients Policy
- Section 132 Patients Rights Policy (Rights of Informal Patients Item)
- Community Treatment Orders (CTO) Policy

Appendix 1

PATIENT INFORMATION Informal

ADMISSION AS AN INFORMAL PATIENT

(Section 131 of the Mental Health Act 1983)

1. Patient's name	
2. Name of the person in charge of your care	
3. Name of hospital and ward	

Why am I in hospital?

You have voluntarily agreed to be admitted to hospital for assessment and treatment of your mental health problem. While in hospital you will be an informal patient and have the same rights during your stay on the ward as any person staying in an acute general hospital. Equally, you have some responsibilities as well. The purpose of this leaflet is to provide you with information about the rights and responsibilities of informal patients.

Your responsibilities

Agreeing to these responsibilities will ensure that your time on the ward or unit is well spent and to enable you to return to your own private life as soon as possible.
On admission, everyone is encouraged to participate fully with their named nurse and other members of the clinical team in the development of their own treatment plan, leading to a planned discharge**.**

Your rights

As an informal patient you are not subject to any restrictions on leaving the ward or unit. We are responsible for the safety and care of all patients in our hospital, so it is important that you always tell a member of staff that you wish to leave the ward. As an informal patient you are not subject to statutory powers and cannot be held on the ward or unit against your will. However, there are some important related issues:

Where ward or unit exit doors are locked there may be a number of reasons for this. However, it is certainly not to prevent you from leaving and you have a right to request them to be opened to allow you to leave. Please discuss this with a member of staff, such as your named nurse or your doctor.

Clinical staff members are responsible for ensuring that the whereabouts of all current inpatients are known at all times, (for example to comply with Fire Safety and Health and Safety Regulations).

If you decide to leave, this may be on a short term basis (a few hours during the day), long term (including a stay away from the ward overnight) or you may be permanently discharged).

What treatment will I be given?

Your doctor will talk to you about the treatment they think you need. If you agree you can accept this treatment. The treatment is likely to involve taking medication, talking and answering questions. There is also the possibility that you may be asked to be involved in group work with other people. Please think about whether or not you are prepared to do all of these things. Ensure that you understand what is being offered before accepting any treatment. Ask questions about anything that concerns you.

You have a right not to be treated and this is protected by the Human Rights Act (1998).

As an informal patient you can refuse the treatment that is being offered to you. If the doctor believes that treatment is necessary and in your best interests, he/she may consider using the powers of the Mental Health Act 1983, and he/she will discuss this with you. You cannot be given any treatment against your will, except in an emergency or under the Mental Health Act 1983

Discharge from hospital

If you are discharging yourself then, following any further discussion with you on the merits of self discharge, you will be asked to sign a self-discharge form. On discharge, you may be offered follow up care in the community. Your discharge plan will be given to you and a copy sent to your General Practitioner. You also need to be aware that your family and carers might have a need to be informed that you are leaving so they can ensure support arrangements are in place. Medication for you to take home may need to be organised.

Concerns about you leaving hospital

If clinical staff have concerns regarding your health or safety or the safety of others if you decide to leave hospital they will explain their concerns so that you may take these into account. If you still insist on leaving the nurse or doctor has the power under Section 5 of the Mental Health Act 1983 to prevent you from leaving the ward if there are serious concerns about your health and safety or for the protection of other persons. Section 5 will allow a period of time between 6 hours and 72 hours to allow time for a Mental Health Act Assessment to be completed. If these powers are implemented there are systems under the Mental Health Act which are used to protect you. There are separate rights leaflets describing your rights if you are detained under the Mental Health Act 1983.

Mental Capacity Act

Some people who are not detained under the Mental Health Act but have difficulty making decisions may be subject to the provisions of the Mental Capacity Act 2005 (MCA).

Having Mental Capacity means being able to make your own decision about something at the time it needs to be made. If staff think you are unable to make a decision and the result of the decision might cause you harm then the MCA allows them to take steps in your best interest to prevent this. If the MCA applies then in certain circumstances staff may be able to prevent you from doing some of the things described above. Staff are trained in issues of mental capacity and have information they will be happy to share with you and/or your family.

Contact with your family and friends

You can speak to your family and friends by telephone or they can visit you during visiting hours. It would be helpful ~~to~~ for staff if you could inform any visitors of the visiting times. If these times are inconvenient it may be possible to make alternative arrangements. It would also be helpful to know if children are going to visit you so that arrangements can be made for you to see them within the designated family visiting area. In exceptional circumstances it may be necessary to curtail or deny visits if it may be detrimental to your care and welfare.

Other patients

We care for people with a range of different needs. Some of these people are acutely unwell and this may make them say or do something that makes you feel frightened or feel uncomfortable. Please discuss any concerns you may have with a member of staff. Some of the other patients may be under a section of the Mental Health Act. This means they do not have the same rights as you to leave hospital when they wish or to refuse treatment the doctor thinks they should have. This may mean they are prevented from leaving by staff or made to take medication they do not want. If this concerns or upsets you, again discuss it with the staff.

Confidentiality

Trust staff comply with the Department of Health's Guidance on Confidentiality and information about you should not be disclosed without your consent. Occasionally it may be necessary to discuss or pass on particular information to other professionals on a 'need to know' basis. Any such disclosure should be in accordance with the principles set out in the guidelines.

How do I complain?

If you want to complain about anything to do with your care and treatment in hospital, please speak to a member of staff. They may be able to sort the matter out. They can also give you information about the hospital's complaints procedure, which you can use to try to sort out your complaint through what is called local resolution. They can also tell you about any other people who can help you make a complaint.

Further help and information

If there is anything you do not understand about your care and treatment, a member of staff will try to help you. Please ask a member of staff to explain if there is anything in this leaflet you do not understand or if you have other questions that this leaflet has not answered.

Appendix 2

Pre- Leave Nurse Risk Assessment – ESCORTED (Staff) ( ) UNESCORTED ( ) ACCOMPANIED (Carer/family) ( )

Name of the patient		**RiO Number**		**Ward**	
Date and time of Leave		**Name of the Nurse Conducting Risk Assessment**			

Assessment of the mental health state prior to leave

Mood	
Thoughts	
Behaviour	

Please answer the following questions. (Please do not be offended, they are only a guide to help staff).

Do you understand the conditions of your leave? ***Expected leaving time*** ***Expected time of return*** ***Accompanied/un-accompanied***	**Yes ( ) No ( )** **Patient comments:**	**Assessing professional comments (*including conditions discussed*):**
Do you have any thoughts, or plans of harming yourself? (*explore presentation over previous 24/48 hours and any risks noted – what has changed?)*	**Yes ( ) No ( )** **Patient comments:**	**Assessing professional comments (*include any risks noted in handovers, progress notes etc and agreed plan to manage*):**
Do you have any thoughts of ending your life? (*if this has been a risk at any time during admission, what has changed?*)	**Yes ( ) No ( )** **Patient comments:**	**Assessing professional comments (*include any risks noted in handovers, progress notes, risk assessments etc and agreed plan to manage*)**

If you were struggling to cope on leave, would you feel confident to phone the ward? (*check phone and relevant numbers available*)	**Yes ( ) No ( )** **Patient comments:**	**Assessing professional comments (*include agreed plan of contacts*)**
Do you feel safe on leave? (explore what may lead to feeling unsafe during leave, i.e. where will leave take place, who may be there) **Do you have a Safety Plan?**	**Yes ( ) No ( )** **Patient comments:**	**Assessing professional comments (has Safety Plan been discussed and given, include details of discussion):**

Patient Signature and date		**Professional Signature and date**	

ADDITIONAL QUESTION FOR FAMILY/CARERS (Where relevant)

Do you understand any conditions of the leave? **e.g. accompanied, un-accompanied, expected time of return, any medication requirements**	**Yes ( ) No ( )** **Relative/carer comments:**	**Assessing professional comments (*what conditions have been discussed*):**
Do you feel potential risks and management have been fully discussed with you? **Have you understand the Safety Plan?**	**Yes ( ) No ( )** **Relative/carer comments:**	**Assessing professional comments (*agreed plan*):**

Pre-Leave Risk Assessment and clinical record keeping

Risk assessment should be carried out by the assessing professional before leave. If there are specific concerns regarding violence, self-harm, self-neglect, substance misuse, or vulnerability to exploitation, these risks and subsequent plan should be documented within the progress notes in the format below.

For any risk identified the assessing professional must develop a risk management plan with the patient and carers/relatives wherever possible and share that plan with relevant others, i.e. the care team, care coordinator, carer/relatives.

Describe the risk (as identified during leave risk assessment discussion)
Identify options (e.g. leave time, escorted by staff, accompanied by family/carer, non-accompanied, leave not advised etc)
Choose the preferred option
Explain the rationale for choosing this option
Share the decision with the patient, relevant colleagues, carer/relatives/accommodation staff, including any conditions