Inpatient Leave Policy (M-019)

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Policies should be accessed via the Trust intranet to ensure the current version is used

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1. INTRODUCTION

Humber Teaching NHS Foundation Trust has a responsibility for preparing inpatients for a successful return to the community with periods of leave being an essential component of this preparation. The decision to grant leave of absence from hospital has to balance the contribution that leave makes to the patient's rehabilitation against considerations for the safety of both the patient and others.

For patients receiving care and treatment within mental health and learning disabilities services, periods of leave from the ward /unit area play an important part in their treatment plan, particularly in relation to discharge planning. Patients detained in hospital have the right to leave hospital lawfully only if they have leave of absence from their responsible clinician under section 17 of the MHA (Mental Health Act 1983).

For informal patients, the period of stay in hospital should be discussed and agreed with them and, where appropriate, with the patient's consent, their relatives and/or carers. In some circumstances informal patients may lack capacity to make certain decisions about their care and treatment. The Mental Capacity Act 2005 provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves. From April 2009 onwards the act also contains procedures authorising the Deprivation of Liberty (DoL) in Hospitals of some people who lack capacity to consent to being there. However the legal safeguards of the MHA rather than the MCA should always be utilised under these circumstances if the criteria is met.

Informal patients are not detained under, but are subject to, the MHA 1983. If they have the capacity to make decisions about their care and treatment then they have the right to decide whether to leave or remain in hospital.[1] This includes decisions about participating in day-to-day activities which may involve periods off the ward. They cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward. It must be recognised, however, that such periods must be consistent with the safe and effective management of the presenting problem which has required inpatient admission.

Any period(s) of leave to be taken by an informal patient must be preceded by a risk assessment of the patient's mental health. Based on that risk assessment, it is essential that any conditions of leave are clearly agreed with the patient and again, well documented in the patient's clinical notes.

Patients detained under the MHA 1983 have leave more rigorously managed, in line with the requirements of the Act. This will always require the approval of the Responsible Clinician (RC) and, in the case of restricted patients, that of the Secretary of State for Justice. It is good practice that leave is discussed and agreed by the multi-disciplinary team (MDT) prior to any leave being agreed.

It is worth bearing in mind that inpatient leave may on occasion be affected by things beyond our control (for example - pandemics) and curbs on leave may be implemented that have nothing to do with the risk the patient presents and more to do with protecting the patient. Prior to patients taking or on return from leave staff should refer to other relevant SOPs/guidance etc. in operation at that time.

[1] Please note that even though a patient may be informal they may have restrictions within their leave, for example conditions of bail. The Organisation has to allow them to leave but they would need to understand they are under other imposed conditions outside of the conduct of the Mental Health Act. Secondly there may be a Community Treatment Order in effect.

2. SCOPE

This policy applies to all Humber Teaching NHS Foundation Trust staff, contracted agency staff and supporting agencies that have a responsibility for all patients on inpatient mental health and learning disability wards/unit.

This procedure applies to all patients on inpatient mental health and learning disability wards/units. Some aspects will apply to both detained and informal patient while others will differentiate between detained patients and those who are informal.

3. POLICY STATEMENT

The aim of this policy is to ensure that all Trust Staff working in a clinical environment are aware of their responsibilities in relation to the application and administration of Section 17 of the Mental Health Act. Patients detained in hospital have the right to leave hospital lawfully only if they have leave of absence from their responsible clinician under Section 17 of the Act. The same considerations in terms of assessing risk should be applied to those informal patients wishing to spend time away from the unit. All staff have a statutory obligation to follow the standards and processes set out within the Mental Health Act (1983) Code of Practice 2015. The procedures outlined in this Policy are in line with the requirements of the Code. There must be no exceptions.

The policy aims to:

- ensure the physical and emotional safety and wellbeing of the patient when considering the benefits of granting or refusing leave
- ensure that robust risk assessments are carried out prior to any period of leave and that any necessary safeguards are put in place
- ensure that the patient receives the necessary support to facilitate their leave away from the ward with a view to promoting their recovery
- balance the benefits of granting leave against any risks that the leave may pose for the protection of other people
- ensure that the patient's wishes and those of relatives, friends, carers and others are taken into account when planning periods of leave
- set out the roles and responsibilities of staff including rigorous recording and completion of legal documents
- set requirements for recording, monitoring and reviewing the use of Section 17 leave and any follow-up action

4. DUTIES AND RESPONSIBILITIES

Chief Executive

The chief executive has overall responsibility to ensure that policies and processes are in place for the provision of leave for patients detained under the Mental Health Act and those who are admitted on an informal basis.

Trust Board

The Trust Board members have responsibility to ensure full compliance with the Act.

Executive Directors and Assistant Directors

Medical Director

The medical director as lead director has responsibility to ensure that this policy is understood and adhered to by all staff and that all the processes are in place to ensure the policy is fully implemented.

The director of nursing, Allied Health and Social Care Professionals is responsible for ensuring that this policy is understood and followed by nursing staff involved in the implementation of granting leave to patients detained under the Act and carrying out robust risk assessments for those informal patients having time away from the unit.

Chief Operating Officer
The chief operating officer is responsible for ensuring the MHA/CoP legislation/standards are followed by all staff involved in the implementation of this policy.

Clinical Director
Has responsibility for ensuring that all clinical staff within the Trust are familiar with the requirements of the policy and are able to implement them.

Divisional General Managers and Divisional Clinical Leads

- Have responsibility for ensuring that all clinical staff within the care group are familiar with the requirements of the policy and are able to implement them.
- Have responsibility for ensuring staff adhere to this policy and for monitoring their staff's compliance with the Act.

Senior Managers, Managers and Clinicians

Responsible Clinicians (RCs)

- Personally accountable for discharging duties under the Mental Health Act
- Attend regular update training
- Abide by any applicable professional Code of Conduct
- Responsible for granting leave in adherence with the Inpatient Leave Policy
- Ensure all relevant staff, including Mental Health Legislation, are aware who the on-call AC is and how to contact them during times when the RC is unavailable

Modern Matrons
The modern matrons have the responsibility to ensure that all nursing staff working within inpatient areas comply with the policy and ensure it is implemented effectively and safely.

Charge Nurses/Registered Clinical Staff/Other Clinical Staff
Must be aware of and comply with their responsibilities to implement the policy.
Risk assessment prior to each period of leave can only be completed by qualified / registered professionals with appropriate competencies. This currently excludes nursing associates.

Mental Health Legislation Committee and Steering Group

- Act within their prescribed and agreed terms of reference
- Seek assurance on behalf of the organisation for the application of the Mental Health Act
- Enact policy, procedure and guidelines
- Provide a forum for resolving of operational issues in relation to the Mental Health Act
- Provide support and guidance to all clinicians

Employees
All Humber Teaching NHS Foundation Trust staff involved in the delivery of clinical care must ensure compliance with the requirements of Trust policies, standard operating procedures and the MHA Code of Practice (2015), Chapter 27 of the Code is specific to leave of absence.

5. PROCEDURES

5.1. Granting Leave for Detained Patients – Background

Section 17 provides for a detained patient under the care of Humber Teaching NHS Foundation Trust to be granted leave of absence from the hospital for a specified period, subject to such conditions as are considered necessary. It provides the only lawful authority for a detained patient to be absent from the ward/unit where he/she is detained. The patient granted leave of absence under this Section continues to be "liable to be detained" and is therefore subject to the Consent to Treatment provision in Part IV of the Act.

Longer term leave in excess of seven consecutive days may not be granted to a patient unless the RC first considers whether the patient should be dealt with under Section 17A Community Treatment Order instead and document the reasons why if not appropriate. A patient can be recalled to hospital from leave by the RC in appropriate circumstances.

5.2. Who Can Grant Leave of Absence?

Only the patient's RC can authorise leave and he or she has to take full responsibility for their decision. The RC does not have power to delegate functions under this section (although the power can be exercised by another AC acting as RC in the absence of the patient's usual RC). However, in the event of an extended absence of the RC for whatever reason, a new RC must be appointed. This might be a locum psychiatrist or an in-house arrangement within Humber Teaching NHS Foundation Trust.

The RC cannot grant Section 17 leave for patients detained under part 3 of the 1983 MHA on Sections 35, 36 and 38 or for patients subject to restrictions (restricted patients) without the Secretary of States approval, a written record of that authority must be available.

Planning Leave

Please note that Adult Mental Health Inpatient Services, Forensic Inpatient Services and CAMHS inpatient unit each have their own specific S17 Leave SOP (standard operating procedure) for further guidance in the planning of leave however all staff must abide by this policy.

Engaging patients in discussions regarding the planning for leave has therapeutic benefits and allows for appropriate plans, risks and contingencies to be considered that should be recorded on the care plan. When considering and planning leave RCs should consider a number of factors and it is best practice to include and record the discussions held with members of the multi-disciplinary team, the patient and where appropriate the patient's family/carer.

Leave of absence can be an important part of a detained patient's care plan; it is a measure of treatment progression, an essential requirement of discharge planning and the patient's recovery but can also be a time of risk. When discussing and planning leave of absence, responsible clinicians and multidisciplinary teams should:

- Consider and document the **benefits and any risks** to the patients' health and safety of granting or refusing leave
- Consider and document 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 relatives, friends, carers** 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
- Consider the **support needs of carers** and ensure any relevant steps or referrals are made to address these
- Ensure that any **community services** which will need to provide support for the patient during the leave are **involved in the planning of 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**, including information on personalised signs and symptoms of relapse that have been put in place for their support, including what they should do if they need to return to hospital early
- Ensure that the **patient and/or relative, friend or carers are provided with the contact details** and telephone numbers of the services and/or people that they should contact in case of any difficulty, for both in and outside of normal working hours
- Ensure that the **patient understands the leave plan** and any special requirements e.g. limit of time, time of return, non-use of alcohol and/or drugs and what to do in case of any difficulty
- Liaise with any relevant agencies, (e.g. MAPPA prior to leave being granted)
- **Undertake a risk assessment** and put in place any necessary safeguards
- In the case of all patients consider whether there are **any issues relating to victims** that may impact on whether leave should be granted and the conditions to which it should be subject
- Ensure that the **clinical decision about leave is comprehensively documented** in the patients' medical record before any leave is taken, include who was present

Where section 17 leave results in the patient being absent from the unit over night or over a period of days, leave patients must be made aware that in their absence: the emergency requirement for an inpatient bed might on occasion, result in their empty room being used to house another person. Such an occurrence though rare would take into account the leave persons need for privacy dignity and respect and staff would ensure that any property in the room was kept and stored appropriately pending the patients return and relocation.
NB. This is not applicable to CAMHS or Forensic inpatient services.

5.3. Recording the Granting Of Leave

The Mental Health Act 1983 Code of Practice guidance must be adhered to. The details of all decisions regarding the granting of leave must be properly recorded in writing and where professionals are involved in the patient's care they must be informed about the conditions that have been attached to the leave. Humber Teaching NHS Foundation Trust has an approved form for the authorisation of leave known as Form Z03 which should be completed by the RC electronically onto EPR. This provides the means of prescribing all accompanied or unaccompanied leave.

The patient shall be given opportunity to sign the leave form as a record of their agreement to any conditions attached to the leave. Staff should clearly document reasons for patients not signing their leave forms. The form must also indicate whether relative/carer (where applicable) has been given a copy of the leave form.

The clinical records should have recorded within them reference to the risk assessment that supports the RC's decision to grant the leave and his/her granting of that leave, any multi-disciplinary teams involvement, along with evidence of the patients involvement in the decision making process and any conditions that may be attached to the leave. The RC must also record the reasons why a Community Treatment Order was not appropriate should the leave go beyond seven days.

Ground leave –
No formal procedure is legally required to allow patients to move within a hospital or its grounds, except for certain restricted patients. However, detained patients do usually need a valid S17 leave authorisation to walk in the hospital grounds of Humber units. This is because mental health

units across the Humber region often share grounds with another Trust. Where a site is shared (for example Mill View and Castle Hill) there can be issues about which bits are our hospital and which bits are the hospital of another Trust so it is safer to ensure any such leave is authorised.

A decision to allow the patient to leave the ward area, but not the hospital, is a clinical decision that should be made following a risk assessment. Every absence from the hospital, however brief, requires leave to be given under this section.

The granting of leave under Section 17 and any specific condition attached to it must be recorded in both the patient's record as well as on the Z03 Section 17 Leave of Absence Form which has to be completed electronically onto EPR by the Responsible Clinician, dated and signed with copies going to:

- The patient
- The patient's relative/friend/carer if appropriate
- Uploaded to the patient's electronic record (if for some reason completed on paper)

Information that has to be included:

- Date/s of the period of leave
- Times from and to
- Where the leave is to be taken
- Who, if anyone, is to be with the patient whilst on leave and ensure that any relatives, friends or carers who are to be involved in the period of leave for the patient are aware that they are not taking any legal responsibility for the patient as they remain under the care of the service
- If it is for recurring leave, a review date must be set
- Any conditions/restrictions for whilst the patient is on leave
- Confirmation of Ministry of Justice (MoJ) approval (where applicable)
- Who is to receive copies of the completed form

Where a patient's prescribed leave is subject to **cancellation, postponement or simply not offered**, please refer to section 6.14 of this policy.

5.4. Short-term Leave of Absence

RCs may decide to grant short-term local leave which may be managed by other staff. Once prescribed, unless otherwise stipulated, the decision to use which particular hours can be left to the discretion of nursing staff. For example, 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 qualified / registered staff. This decision would be dependent upon the risk assessment undertaken by the nurse in charge of the unit prior to any such period of leave being taken.

The Z03 leave form should clearly specify the amount of time that the patient may spend on leave, how frequently that leave might be taken and whether leave should be taken as unaccompanied leave or as escorted leave in the care of supporting staff. It should make it clear that the qualified / registered professional carrying out the risk assessment will use their discretion when allowing patients to go on leave following due care and consideration of risks before granting any episode of leave.
Please note this currently excludes nursing associates.

Leave of absence must be used to enable a patient to receive treatment for a physical disorder in a general hospital that the patient has consented to or is within their best interests in the absence of capacity. This should be done on the 'routine medical and emergency treatment section 17 leave form (Z04) on patient's EPR in conjunction with the Z03 Section 17 leave form. If a patient needs to be moved using Section 17 leave to another hospital a copy of the Section 17 leave form should

accompany them. This must remain with the health care worker who escorts them and must be carried in a secure case, as per the Safe Haven Policy.

5.5. Leave and Care Arrangements

The RCs' responsibilities for their patients remain the same while the patients are on leave. The patient who is granted leave under section 17 remains liable to be detained, and the rules in part 4 of the Act about their medical treatment continue to apply. Should it become necessary to administer treatment without the patient's consent, the RC should consider whether it would be more appropriate to revoke the leave or terminate the leave early although this is not a legal requirement.

The duty on local authorities and Integrated Care board (ICB) (or, in certain circumstances, NHS Commissioning Board (NHS England)) to provide aftercare under section 117 of the Act for certain patients who have been discharged from detention also applies to those patients while they are on leave of absence and have Section 117 aftercare entitlement, for example trial leave in a residential care home.

It is important when patients are given leave of absence to ensure that a thorough and comprehensive risk assessment has taken place. In those instances where patients are taking longer periods of leave it is important that there are adequate arrangements in place to ensure that the patient's care and support will continue to be provided outside hospital.

The granting of leave, any conditions attached to it and the details of the risk assessment must be recorded in the patient's S17 leave form with copies given to the patient and any professionals in the community who need to know including the patient's GP.

Section 17 applies without modification to patients made subject to hospital or guardianship orders by a court. It applies, in a modified way to patients who are subject to special restrictions, i.e. those patients transferred from prison to hospital under section 47/49 or patients subject to section 45A directions who are not as a general rule permitted leave in the community while so detained. The presumption for many of these patients is that their care pathway will see their return to prison to continue their sentence rather than release into the community. Where this is not the case, and where leave might form part of a patient's treatment and discretion is needed the Secretary of State will consider requests for community leave on an individual basis.

Responsible clinicians must review and renew Section 17 leave forms every time patients' leave arrangements are subject to change. This applies to all patients detained under the Mental Health Act.

5.6. Restricted Patients

Where the RC wants to allow a restricted patient beyond the boundaries of the hospital or unit named on the detention authority, then Section 41(3)(c)(i) of the Mental Health Act 1983 requires the RC to obtain consent from the Secretary of State before granting section 17 leave.

Leave request forms are provided on the Ministry of Justice website which outlines the information required: https://www.justice.gov.uk/offenders/types-of-offender/mentally-disordered-offenders.

The attachment of leave plans may also be useful.

In the event that consent for leave is given, responsible clinicians should be aware that the Ministry of Justice may request additional reports on the restricted patient as considered necessary.

No restricted patient may leave the hospital or unit named on the authority for detention without such consent. The application for leave must be approved by the mental health unit at the Ministry of Justice. A record of that approval must be present in the patient's clinical notes/records before any leave is taken. The clinical notes must contain a written record of the outcome of the period of leave that details the patients conduct on leave and whether the patient was concordant with any

conditions attached to the leave. The mental health casework section at the Ministry of Justice provides a “Report on completed leave form” for RCs to submit when the next stage of leave is applied for.

The Secretary of State’s permission is also required for leave to attend routine medical appointments or treatments. In an emergency medical situation the RC may use their discretion having due regard to the emergency or urgency being presented and the management of any risks to have the patient taken to hospital. The completion of the ‘routine medical and emergency treatment section 17 leave form (Z04) on patient’s EPR would still be required however this should not delay the transfer for emergency treatment. The Secretary of State should be informed as soon as possible that the patient has been taken to hospital, what risk management arrangements are in place, be kept informed of developments and notified when the patient is returned to the secure hospital.

5.7. Restricted Patients and the Courts – Leave for Court Proceedings

When a court directs attendance, the Secretary of State will rarely refuse consent to leave under Section 17. However consent for leave must still be sought. For those patients detained under Section 48 of the Act, general permission will be provided on the assumption that legal proceedings will inevitably need to be completed. This will take the form of a formal notification, on admission, advising that the Secretary of State’s permission for the attendance at court for the purposes of legal proceedings is given.

With regard to patients detained under sections 37/41 and sentenced prisoners transferred under sections 47/49 the following details will be required:

- The date(s) when attendance is required.
- The details of the court, including location.
- The reasons for attendance.
- Whether consideration has been given to the patient attending the hearing via a video link.
- Arrangements for transporting the patient to court, including physical security, e.g. number of escorts/secure van/necessity for handcuffs.
- Details, if applicable, of whether attendance will take the patient into any exclusion zone or into the proximity of any victim.

Further information needed if there are unusual circumstances (e.g. likely to attract national media interest). An email to the Mental Health Caseworker will suffice. The expectation is that providing all the relevant information is received, permission will be granted within 48 hours.

5.8. Rehabilitation

If the discharge of a patient is under consideration, Section 17 can be used to facilitate a period of trial leave to another hospital other than the one which the patient is formally detained in order to enable the hospital and Social Services to work together towards his/her subsequent rehabilitation in the community.

5.9. The Transfer of Patients between Hospitals

Responsible Clinicians may require patients, as a condition of leave, to reside at another hospital in England and Wales, and they may then be kept in the custody of staff of that hospital. Before authorising leave on this basis Responsible Clinicians should consider whether it would be more appropriate to transfer the patient to the other hospital instead.

It is lawful to use Section 17 to grant a patient “trial leave” to a hospital other than the one in which he/she is formally detained. Such leave can be a useful step in a patient’s rehabilitation programme. In these circumstances the RC at the base hospital continues to be the patient’s RC. Although day-to-day functions relating to the care of the patient can be delegated to a RC at the second hospital, the responsibilities of the RC cannot be so delegated. If the trial leave is successful the patient could then be transferred to the second hospital under Section 19 if the receiving hospital is in another trust.

Leave under Section 17 is often used in circumstances where a patient is being transferred down the security ladder, for example from high to medium security.

The permission of the Secretary of State is required for restricted patients. The RC does not have the power to delegate his/her functions under this Section and the exercise of his/her discretion cannot be fettered by either the Hospital Managers or the Hospital Management. However, if the RC is absent due to sickness or annual leave and the patient is not subject to restrictions, the power can be exercised by another AC who is covering for the RC's short-term absence.

5.10. Leave between Trusts

Section 17 leave is required in this circumstance, "where two or more NHS trusts manage different parts of an institution" (e.g. where a mental health trust manages a unit within a district hospital site owned by another trust). In this context a detained patient who needs treatment for a physical disorder at the general facility must be sent to that facility under the authority of Section 17 leave. This situation will require an individual risk assessment to determine whether such leave will require additional conditions (see escorted leave).

5.11. Leave from Acute Trust

Humber Teaching Foundation Trust has a Service Level Agreement (SLA) with Hull University Teaching Hospitals (HUTH) to enable and assist them to implement the terms of the Mental Health Act where necessary in premises under HUTH's control.

This includes the provision by Humber Teaching NHS Foundation Trust of a named Consultant Psychiatrist to act as the Responsible Clinician (RC) for each patient in respect of whom services are provided under this Agreement. The appointed Consultant Psychiatrist will act as Responsible Clinician and have responsibility for the purposes of Part 4 of the Mental Health Act as well as that of granting S17 leave where appropriate:

- In the Adult and Older People's MH Division it has been agreed that the Hospital Liaison Consultant or the Older People's Liaison Consultant will be the RC for patients not known to services; the locality community RC if the patient is known to the community teams; and the inpatient RC if the patient is already an inpatient with the Trust but then transferred under S19 to HUTH.
- In children's services during office hours the named RC will be the consultant covering the geographical area and the consultant on call will cover out of hours.
- In Learning Disability Services the named RC will be a Consultant responsible for inpatient services at Townend Court and the consultant on call will cover out of hours.

Humber Teaching Foundation Trust also has a Service Level Agreement (SLA) with Goole and District Hospital (NLAG) to enable and assist them to implement the terms of the Mental Health Act where necessary in premises under NLAG's control.

The same above provisions by Humber Teaching NHS Foundation Trust are in place however arrangements for allocation of RC is slightly different:

- If working age patient has an open referral to Goole CMHT the named RC will be the Consultant (AC) covering Goole CMHT
- In OPMHS for patients open to the CMHT, discussion takes place between the community consultant and the CITOP consultant and an agreement is made as to who the RC will be
- If patient is not known to services in hours the named RC will default to either the Consultant (AC) in the MHCIT or Crisis Intervention Team for Older People (CITOP)
- If out of hours the RC defaults to consultant on call

For both SLAs these arrangements are open for negotiation between the relevant Consultant Psychiatrists named above.

5.12. Escorted Leave

The RC may direct that the patient must remain in custody during his/her leave if it is necessary in the interest of the patient or for the protection of other persons. The patient may be kept in the custody of an officer (officer is not defined in the Act and could include an employee who is neither a nurse nor a doctor) on the staff of the hospital, authorised in writing by the hospital managers.

These kinds of arrangements would allow detained patients to have escorted leave for outings, to attend other hospitals for treatment, or to have home visits on compassionate grounds.

The purpose of this subsection (S17(3)) is to provide those caring for the patient during a period of leave with an immediate power to restrain the patient should they make an attempt to abscond. Any patient who escapes from custody can then be immediately recaptured using the power contained in s.18 – there is no need to wait for the patient to fail to return to the "base hospital" or for the RC to revoke the leave in writing.

Detained patients who are AWOL may be taken into custody and returned by an approved mental health professional (AMHP), any member of the hospital staff, any police officer, or anyone authorised in writing by the hospital managers (CoP 28.4). Please note a S135(2) warrant – applied for by the hospital staff – will be required for the police to gain entry to the patient's property unless for the reason "of saving life or limb or preventing serious damage to property" (S17 Police and Criminal Evidence Act 1984).

If a patient is granted leave of absence on condition that they stay in another hospital, they may be kept in the custody of any officer on the staff of the other hospital.

5.13. Accompanied Leave

In order to further inform an assessment, optimise therapeutic interventions and clinical management plans or prepare for a planned transfer or discharge, it may be appropriate for the RC to authorise a period of accompanied leave. Accompanied leave would be a period of leave agreed with the condition that the patient is accompanied by a relative, friend or carer. Prior to the leave taking place, the RC or clinical staff within the wider care team, must, through effective communication, ensure the accompanying person undertaking to support the patient throughout their period of leave, understand the responsibilities in relation to the patient's care needs. This should include information pertaining to identified risks, and individualised signs and symptoms of relapse as well as contact details for day and night, should they require advice or assistance for the duration of the accompanied leave.

Where there are any care needs identified for the wider family, the MDT must ensure these are discussed with the family, and where indicated, staff should initiate referrals for any necessary support or assessments they require in order to address these needs.

This could include a carer's assessment, a referral for carers support and/or a community care assessment. The wider families care needs must be taken into consideration within any MDT discussions when the team are engaging with families to negotiate and arrange for episodes of accompanied leave. Leave may need to be postponed until assessments are initiated and associated support packages put into place.

Where relatives, friends or carers who may be involved in supporting periods of accompanied leave, are known to engage in lifestyle choices or decisions which may have a direct negative and detrimental effect on the patient, or impact on their ability to undertake the responsibilities associated with accompanied leave, consideration should also be taken in relation to the associated risks and management or mitigation of these for the patient. This may require further discussions with relatives, friends or carers to seek assurances about their ability to facilitate or

support the leave safely and where required other support mechanisms put in place for the period of proposed leave, or with their consent, referrals made to respective agencies or services to address identified issues.

The Humber Teaching NHS Foundation Trust 'Accompanied leave' leaflet may assist staff in initiating discussions about accompanied leave and the associated responsibilities, friends or family's care needs and how the team can support these by initiating relevant referrals where indicated.
In relation to restricted patients, accompanied leave is not recognised by the ministry of justice and any such leave should be considered as unescorted leave.

5.14. Revoke

An RC (or, in the case of restricted patients, the Secretary of State) may revoke their patient's leave at any time if they consider it necessary in the interests of the patient's health or safety or for the protection of other people. RCs 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 revocation, although it would almost always be a reason to consider revocation. It is unlawful to recall a patient to hospital when the intention is merely to facilitate the renewal of the patient's detention under Section 20. A patient who is on leave of absence can have his/her detention renewed under Section 20 if his/her treatment programme is reviewed by the RCs with the patient in any Trust facility.

There is a legal requirement - except for escorted leave (see 5.12) – for the RC to provide to the patient or the person with responsibility for them whilst on leave **notice in writing** that the leave is being revoked (27.33 Code of Practice). There should be robust arrangements to make sure that when the RC is on annual leave/off duty/off sick another named approved clinician is allocated responsibility for each patient's case in their absence as temporary RC.

In a truly exceptional and urgent situation where there is **imminent risk to life**, the common law could potentially be relied upon to revoke the leave without service of written notice.

A patient cannot be recalled to hospital after a period of 12 months has elapsed since the first day of leave or the authority to detain lapses, whichever is the earlier. The maximum period of leave that can be granted to a patient is the unexpired term of his current period of detention.

A restriction order patient can be recalled by his RC at any time up to 12 months from the first day of his/her absence on leave. The Secretary of State can recall such a patient at any time.

27.35 "A restricted patient's leave may be revoked either by the responsible clinician or by the Secretary of State for Justice. If a problem were to arise during a restricted patient's leave of absence the responsible clinician 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".

5.15. Inpatient leave (temporary modifications in response to the risks posed by infectious disease or other public health / safety situation).

To minimise restrictions placed on patients and their relatives, the Trust's approach to leave is responsive to the prevailing government guidelines, individualised risk assessments and the local picture (including local outbreak restrictions).

Humber Teaching NHS Trust understand that our inpatient wards and units have a responsibility to protect the safety of patients and staff, and as far as possible continue to facilitate leave, in order to support the health and wellbeing of patients. This may be particularly important in the case of patients with a learning disability and autism, where preventing or reducing leave may represent a

change in the patient's routine, potentially having detrimental effects on the individual's mental health.

Humber inpatient wards and units should ensure that the welfare of patients – mental as well as physical – underpins decisions taken to limit leave. If there is a local or national lockdown or an outbreak of infectious disease on the unit, or some other public health or safety situation, S17 leave may have to be restricted or completely banned. In very exceptional circumstances some leave may still be allowed following risk assessment and agreement within the MDT.

Patients who have the capacity to understand public health advice and any local restrictions should be assumed to be able to comply with this advice if granted leave, unless there is evidence to the contrary and this is supported by DHSC, NHS England and NHS Improvement Guidance.

Our inpatient wards and units may take additional measures to reduce risk of community transmission, where appropriate.

If leave is granted in the community, this should be carefully planned, and consideration should be given to whether an escort is needed to help ensure compliance with public health advice.

5.16.1 Leave to areas in local restrictions

For patients travelling to other areas staff should be aware of any local restrictions in those areas to ensure safe arrangements can be made. Unless there are exceptional circumstances it is unlikely that leave would be authorised to areas with increased restrictions.

5.16.2 Informal patient leave

Informal patients cannot be prevented from leaving the ward or unit without good reason to believe they would be a risk to themselves or others, in which case the MHA would need to be considered.

If informal patients wish to leave the unit during times of national or local infectious disease concern, they should be advised of the risks of the infectious disease and the government requirements in terms of social distancing and restrictions on movement.

6. OPERATIONALISING THE LEAVE PROCEDURE

6.1. All Patients – Action on Admission

On admission, the admitting doctor and nurse should give consideration to the potential risks to the patient and/or others for off the ward activities including leave to their home as part of a comprehensive risk assessment. This assessment should take into consideration:

- The clinical presentation and nature of the disorder
- Risk factors
- Information from relevant others (carers, other professionals, e.g. social worker, Crisis Service, GP)
- Care coordinator
- The social circumstances of the patient (conditions at home/available support)
- Any safeguarding issues

The risk assessment must be completed and include clear advice on the appropriateness of off ward activities/leave. The nurse in charge should discuss this suggested plan with the patient in the context of the therapeutic aims of the admission.

Physical screening will also provide details of the patient's height, weight, build and any distinguishing features. This, and other information, will be used to complete the Missing Patient Information form (Appendix 2), to include where possible, for all patients, but particularly for

detained patients, a current photograph of the patient (Ref: MHA Code of Practice 27.22). This document will serve to inform the police in the event of the patient going missing.

The risk management plan including the provisions (and contingencies) for off ward activities including leave should be reviewed and revised at the first MDT meeting and at each MDT meeting thereafter with changes to the plan being discussed and agreed with the patient (in so far as the agreement is judged compatible with safe and effective treatment of the patient) and where appropriate relatives and other professionals. The outcome of these reviews should be clearly documented in the patient record.

Wherever possible leave requests should be considered as an MDT prior to any decision about leave being made, consultation will take place with the patient; appropriate relatives/carers (with the patient's consent, if the patient is able to give consent) to ascertain their views. The nurse (or other relevant clinician) must ensure that these views are communicated to the MDT to inform the decision-making process and documented.

Where considered clinically appropriate by the MDT, the patient's community support network, e.g. GP, care coordinator, social worker etc. should be advised/consulted regarding the patient's leave. The notification of appropriate professionals should be clearly documented in the multi-disciplinary notes. Any clinical decision regarding the appropriateness of leave of absence will be fully discussed with the patient, and any appropriate others and documented.

6.2. All Patients – Assessment prior to the Patient Leaving the Ward

Once the patient has informed the ward staff of their wish or intention to take leave from the ward, a qualified / registered professional will make a clinical risk assessment of the patient's current presentation, to include:
Risk assessment prior to each period of leave can only be completed by qualified / registered professionals with appropriate competencies. This currently excludes nursing associates.

- A face-to-face conversation with the patient, to allow for an immediate risk assessment Planned purpose of leave, destination and anticipated time of return
- An awareness of current formal assessment (and consequent strategies)
- Reference to notes recording presentation over the last 48 hours (particular consideration of any recorded significant events, conversations, etc.) and to any current clinical discussions concerning time away from the ward
- Any requirement for additional medication over the last 48 hours, or of refusal of any prescribed medication over a similar period
- Any available expressed views of any others who may hold relevant information (to include professionals or carers/relatives)
- Any plan to accompany the patient – ward staff or otherwise (relative, friend, carer)
- Any contact arrangements – it will be helpful to know contact telephone numbers (ward and patient)
- All of the above to be documented in the patient's clinical notes in the 'Leave – Risk Assessment Prior' note in the Communication tab in clinical charts.
- A full description of what the patient is wearing at time of taking leave must be recorded in the leave- Risk Assessment; in Forensic Services this is recorded in a separate document that is taken to reception as the patient is leaving the building.

Where possible this assessment will be undertaken with (or in consultation with) other available clinical staff (see Leave Flowchart Appendix 3). The risk assessment prior to leave will be recorded on EPR in the communication tab in clinical charts ('leave-risk assessment prior' note).

6.3. Informal Patients

Patients who are not legally detained in hospital have the right to leave at any time. They cannot be required to ask permission to do so but may be asked to inform staff when they wish to leave the ward. However, if an informal patient is deemed to be at risk to themselves or others or are

vulnerable to risk from others and risk assessment agreement with the MDT has confirmed that observations are required to maintain their safety and manage the risk, a discussion must take place with the patient to understand their capacity and consent to this intervention.

Please see Appendix 4: Practice Note (Observations – Informal Patient).

The assessment described above (6.2) must be completed prior to any leave being undertaken and will guide the qualified / registered professional in either supporting the patient's expressed wish to leave the ward, or considering other options if it is felt that the patient may be at risk should they leave the ward. Any risk assessment undertaken must be documented in the patient's clinical notes with a clear rationale as to the decisions made. These options may include:

- Offering an escort
- Obtaining the patients agreement to defer their intent to leave as part of a collaborative risk reducing/management strategy
- Immediate detention under the Mental Health Act 1983 under S5(2) or S5(4) MHA 1983
- If a patient lacks capacity deprivation of liberty safeguards could also be considered but if there is any objection to stay by the patient, they must be detained using the Mental Health Act 1983 if the criteria are met.

In the case of Savage v South Essex Partnership NHS Foundation Trust (10/12/08) confirmed that hospitals owe a duty to patients detained under the MHA to prevent them from taking their own lives. The Supreme Court's decision in Rabone v Pennine Care NHS Foundation Trust (08/02/2012) has extended this principle, so that the law now applies whether or not a patient has been formally detained.

The judgment means that hospitals **must** ensure they take reasonable steps to safeguard the right to life of mental health patients in their care – regardless of whether they are detained or not – in circumstances where the authorities know or ought to know that there is a "real and immediate risk" to their life. As a result, decisions made by healthcare practitioners will be subject to greater scrutiny.

6.4. Detained Patients

The RC may set a condition on the S17 leave form that registered staff can decide not to implement any authorised leave at their discretion should they believe that the patient is too unwell or poses a significant risk of harm to self or others. Qualified / registered staff may withhold the leave under these circumstances however the RC must be informed immediately in order for them to make a decision whether the current period of leave should be revoked.

The assessment described above will guide the qualified / registered professional in either supporting the patient's expressed wish to leave the ward, or to decline the request. Any decision not to grant S17 leave will be supported by an entry in the patient's notes. If the leave is to be granted:

- Ensure that the leave is in accordance with the S17 form, which must be complete, up to date, and allow for the planned period of leave
- Ensure that the leave is in accordance with any planned programme of leave
- There should be a current photograph of the patient on file (MHA Code of Practice 27.22)
- Up to date Missing Person Information and Patient alert form (Appendix 2)

6.5. During Leave

If the patient is on unescorted leave of any duration, there must be a description of the planned contact arrangements in the patient's notes.

Any subsequent contacts or attempts at contact will be recorded in the patient's notes.

6.6. Escorted Leave

- Escorting staff will support the patient throughout the period of leave, with the aim of optimising the therapeutic benefit of that period of leave
- Escorting staff will carry their ID card (should it be needed), but ensure that neither that nor any other equipment is worn in such a way as to identify themselves as clinical staff
- In the event of patients engaging in risk behaviours (including absconding) whilst on leave, escorting staff will engage verbally with the patient in an attempt to encourage safety for all. There is no expectation of physical intervention, unless the escort has been arranged to allow for such contingencies (including sufficient suitably trained staff who can effectively apply physical interventions if necessary)
- Should the patient abscond from their escort, the escort should:
  - Make a note of the patient's presentation, appearance and direction of travel
  - Inform the ward immediately
  - Attempt to follow the patient at a safe distance
  - Refer to the S18 AWOL and Missing Patient SOP and contact the police where necessary.

6.7. On Return from Leave – all Patients' Clinical Records

Upon the patient's return to the ward they will be met by a member of the ward team to discuss and review the period of time away from the ward. A record will thereafter be made in the patient's notes on EPR in the communication tab in clinical charts ('leave-evaluation with patient on return' note).

It will be helpful to note:

- The patient's described experience. They may wish to make an entry in their own notes in line with any local practices
- Is there any available feedback from family members/carers/other?
- Did the patient undertake the activities discussed prior to the leave?
- Did the patient experience feelings/emotions during the leave (positive as well as negative)?
- Did the patient make any purchases? Is there any requirement to manage any purchases in line with local procedures or individualised risk assessments?

6.8. Early Return from Leave

The patient who returns early from leave may have done so because of concerns, anxieties or other difficulties interpersonal or otherwise it is important that the staff nurse should meet with the patient and their carer at the earliest opportunity to discuss how the leave went. The outcome should be summarised in the nursing notes, feedback given to the care coordinator, a discussion held within the MDT and the care plan reviewed and updated as necessary.

Where there is evidence of distress and/or increased risk staff will carefully manage the patients immediate care needs within the framework of the Humber Teaching NHS Foundation Trust supportive engagement policy. Where staff has cause to believe that the patient may have items that could be harmful in their possession then they must consider whether there is a requirement for personal search.

6.9. Detained Patients Return from Leave and Personal Search

It may be necessary to undertake a personal search and/or search of belongings in line with any person specific risk management requirements (see Inpatient Search Policy). Staff should remain vigilant of patients returning to the unit from leave with items which may cause harm (intentional or unintentional) to themselves or others.

6.10. Return from Leave under the Suspected Influence of Drugs and/or Alcohol

Alcohol and/or drug testing may be a condition of some patients' section 17 leave. Any patient returning from leave that is, or appears to be under the influence of drugs and/or alcohol requires

assessment where possible of what they have used to inform staff of the patients immediate and continuing care needs.

Where there is confirmation that alcohol and/or drugs have or could have been misused while on leave then staff will carefully manage the patients immediate care needs within the framework of the Humber Teaching NHS Foundation Trust Supportive Engagement Policy, with diligent attention paid to physical health monitoring using NEWS. A medical review should be undertaken immediately or at the earliest opportunity to inform the patient's interim care needs and medication management requirements.

6.11. Abscond or Failure to Return

During leave a patient may abscond from an escort or fail to return at the agreed time from unaccompanied leave. In either case, refer to the Section 18 AWOL and Missing Patient SOP.

6.12. Review of Leave

The effective recording of episodes of leave will inform regular and ongoing review of the patient's care and progress, as described in section 5.4 and 6.7 (above).

6.13. Documentation

If needed, escorting staff will take copies of any documentation as required. Any patient identifiable documentation must be carried in a secure case as per Safe Haven Policy.

6.14. Recording the Cancellation of Section 17 Leave

Where patients prescribed leave is subject to cancellation, postponement or simply not offered and that occurrence is attributable to staffing shortages (for example as a result of unprecedented sickness, unplanned and increased clinical activity, or as the direct result of an emergency) then **the event must be reported by recording it in the MHA and Legal tab in clinical charts in the EPR (choose filter option 'Forms' then 'Section 17 Leave Cancelled/Postponed'), unless the leave can be facilitated on the same day as originally planned**. However, any cancelled/postponed leave that results in a missed medical appointment must be reported on all occasions.
Clinicians must ensure that any reporting identifies severity of harm on the patient as a consequence of cancelled/postponed leave as per safer staffing – escalation policies. The occurrence of the above must be recorded in the patient clinical notes stating the reasons why leave was cancelled/postponed or not offered.

(For definitions of cancellation/postponement please see Appendix 1.)

7. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

8. IMPLEMENTATION

This policy will be disseminated by the method described in the Document Control Policy.

Section 17 leave is included in the basic MHA training which is available via Teams on a monthly basis.

This policy is to be implemented within existing resources and does not require additional financial resource.

9. MONITORING AND AUDIT

The Mental Health Legislation Committee receive a quarterly report including data pertaining to the adherence of the Mental Health Act, and an assurance report, which meets the monitoring requirements of the Mental Health Act Code of practice (2015). The Mental Health Legislation Committee will identify additional actions/scrutiny as required to achieve satisfactory assurance on behalf of the organisation.

The Mental Health legislation team receive implementation and audit information for the following areas relevant to this policy:

- Section 17 leave
- Section 18 AWOL (absent without leave)
- Any exceptions, non-compliance in respect of cancelled/postponed leave due to staffing shortages will be reported via the MHA and Legal tab in clinical charts in EPR and also reported through the Mental Health Legislation Steering group and the Committee.

Regular MHA audits within the My Assurance app are conducted by the unit staff and also mental health legislation team in order to monitor and authenticate that everything is working according to this element from the policy.

Part of the MHA audit content focuses on adherence to the Inpatient Leave Policy in accordance with the Mental Health Act Code of Practice (2015) in the following areas:

- Granting of leave
- Engaging patients and carers
- Risk assessment
- Informal patients
- Recording
- Returning from leave

The Mental Health Legislation Team will feed back any subsequent recommendations through the Mental Health Legislation Steering Group in order for action plans to be implemented and disseminated through the care groups.

Divisional managers and divisional clinical leads will be responsible for ensuring that any system or practice changes are implemented and for lessons learnt to be shared to all clinicians working to this policy.

10. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

National Institute for Clinical Excellence (NICE) (2011) Clinical Guidance 136 - Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services.

Department of Health (2015) Mental Health Act Code of Practice. London TSO

Jones. R. (2022) Mental Health Act Manual (25th Edition). London. Sweet & Maxwell

Mental Health Casework Section 17 – Leave of Absence: National Offender Management Service (NOMS) 2015: http://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/mhcs-guidance-s17-leave.pdf

Guidance and forms for those working with mentally disordered offenders (restricted patients): https://www.justice.gov.uk/offenders/types-of-offender/mentally-disordered-offenders

Savage v South Essex Partnership NHS Foundation Trust:
http://www.publications.parliament.uk/pa/ld200809/ldjudgmt/jd081210/savage-1.htm

Rabone v Pennine Care NHS Foundation Trust: https://www.supremecourt.uk/cases/docs/uksc-2010-0140-judgment.pdf

11. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Mental Health Act Legislation Policy
Section 18 AWOL, and Missing Patient SOP
Inpatient Search Policy
Consent to assessment, examination and treatment policy and procedure

14. APPENDICES and HYPERLINKS

- Appendix 1: Definitions of Cancellation, Postponement and Revoke
- Appendix 2: Missing Person Information and Patient alert form
- Appendix 3: Section 17 Therapeutic Leave Flowchart
- Appendix 4: Practice Note (Observations – Informal Patient)
- Appendix 5: Document Control Sheet
- Appendix 6: Equality Impact Assessment

Hyperlinks
MoJ Report on Completed Leave Form
Accompanied Leave Leaflet

Appendix 1: Definitions of Cancellation, Postponement and Revoke

Cancellation: (cancel, cancels, cancelling, cancelled)
To decide or announce that (a planned event) will not take place: i.e. *he was forced to cancel his leave.*

Where it is decided by the nurse in charge of the ward that a patient is not able to take a period of prescribed leave and there is no alternative arrangement for that leave to be taken at a different time on that same day, then that leave has been cancelled.

Where leave has been cancelled because of a change in the patient's mental state or in response to a behavioural presentation that is indicative of risk that would be difficult to control in a leave situation then that leave has been withheld and the leave plan should be reviewed at the earliest opportunity by the RC to make a decision whether the current period of leave should be revoked.

To Revoke: only the RC can revoke S17 leave.

- *To a*nnul or revoke: to officially cancel a formal arrangement (a decree, decision, or promise):
- The patient's mental health presentation changed and section 17 leave was revoked.
- There was evidence of a risk of harm to self and/or others and section 17 leave was revoked.

Where prescribed leave has not been able to be taken at the agreed time but where an alternative arrangement has been offered to the patient then that leave has been postponed or deferred.

To Postpone: Cause or arrange for (something) to take place at a time later than that first scheduled:

- The leave had to be postponed until the following day as transport was unavailable.
- The leave was deferred until later that day as unexpected events had resulted in a reduction of staff availability to serve as accompanying escort

Where section 17 leave requires the patient to be accompanied by nursing staff (either therapeutic or via mechanical restraint) and that leave has either been cancelled, not offered, or deferred /postponed simply because there is no staff available to facilitate that leave then the event must be **reported by recording it in the MHA and Legal tab in clinical charts in EPR (choose filter option 'Forms' then 'Section 17 Leave Cancelled/Postponed'), unless the leave can be facilitated on the same day as originally planned**. However, any cancelled/postponed leave that results in a missed medical appointment must be reported on all occasions.

Appendix 2: Missing Person Information and Patient Alert Form

Humber Teaching NHS Foundation Trust

Missing Person Information and Patient alert form

(This information will be required by Humberside Police)

Mental health act status (please circle): informal detained		**Section:**
Registered to MAPPA? Yes - No **(Details)**		
NHS No:	**Date of birth:**	
Name:	**Alias:**	
Ethnicity:	**Build:**	
Height:	**Weight:**	
Hair (colour, length)	**Dental (false teeth/bridge):**	
Eyes (colour)	**Spectacles:**	
Spoken language:		
Barriers to communication:		
Marks / scars / tattoos (attach body-map)		
Notable characteristics:		
Probation/other professional:		
Home Address:	**Telephone number:** **Mobile number:**	
General practitioner:	**Next of kin/Nearest relative & address:**	
Any other info.		

Insert photograph (face)

Insert photograph (profile)

Unit:

Unit telephone No:

Name:

Date of birth: Affix pre-printed personal details label here

NHS Number:

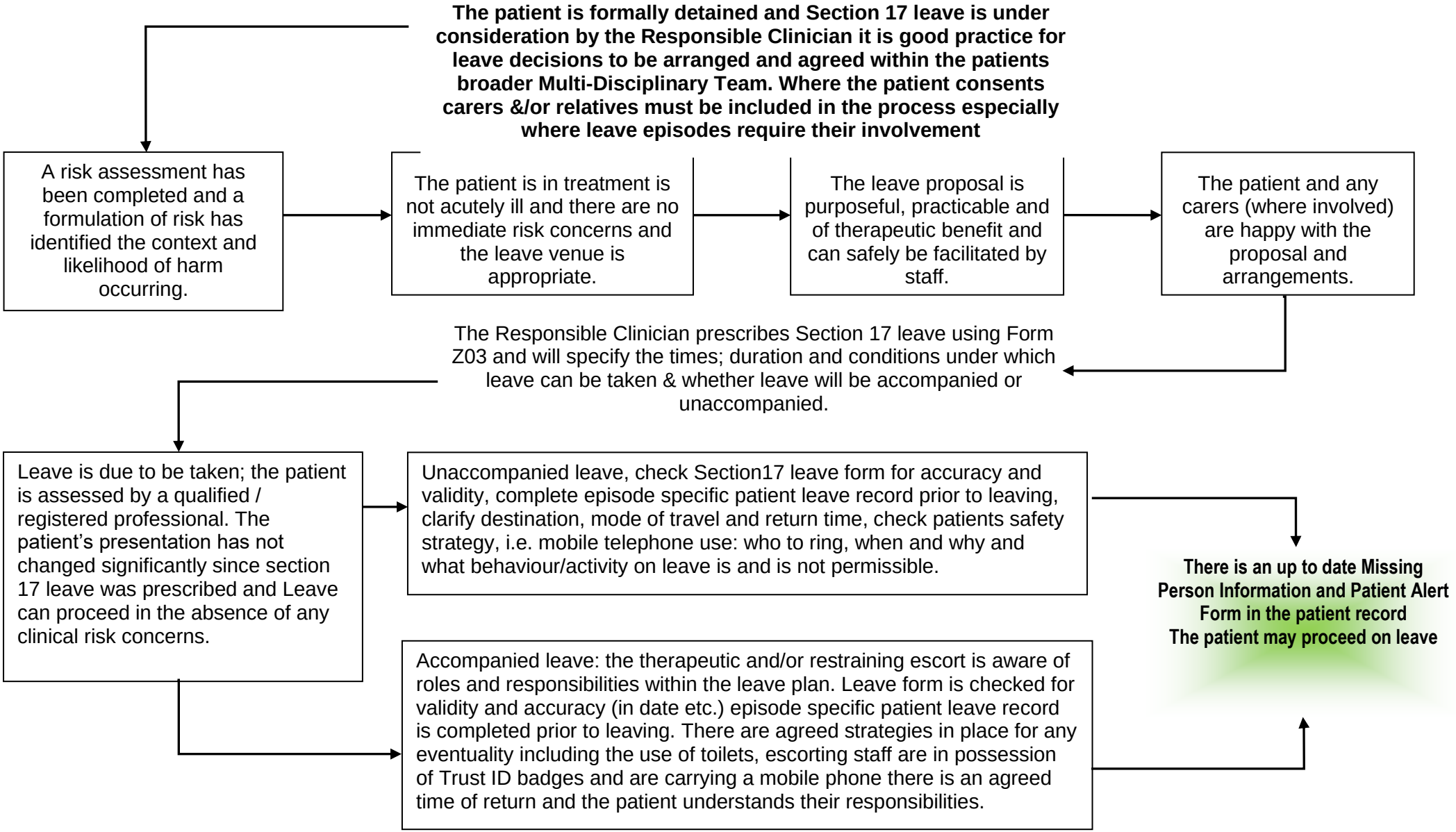
Any known allergies to prescribed medications & drug sensitivities:
Any other known allergies (nuts, perfumes, etc.):
Known medical conditions (epilepsy, diabetes, etc.):
Previous history of absence without leave/escape: Yes - No
Details of previous abscond/absence without leave/escape (dates, circumstances, where found, etc.):
Is the patient a danger to any particular individual/s? Yes - No **Name;** **Contact No**: **Address:**
Is there a history of violence? Yes - No **Is there a history of weapon use?** Yes - No **(Details)**
Does the patient have a history of self-harm/suicide attempt? Yes - No **(Details)** **Is there a history of Substance/alcohol misuse?** Yes - No **(Details)**
Details of any other significant known risk?
Ensure that this information accompanies the patient on all external transfers and hospital visits (and similar – dentist, etc.)

Form Completed by (Print name): Signature:

Designation: Band:

Date: Time:

Appendix 3: Section 17 Therapeutic Leave Flowchart



Appendix 4: Practice Note (Observations – Informal Patient)

Practice Note

Humber Teaching NHS Foundation Trust

TO: All inpatient staff working in mental health and learning disability services

FROM: Clinical Risk Management Group (**01482 301737**)

DATE SENT: 23/12/2016 **DATE RECEIVED**:

Ref: PN 2016-36 **AUTHORISED BY:** Clinical Risk Management Group

NATURE OF CONCERN:
An informal patient being placed on 15-minute intermittent observations taking leave.

An informal patient who is under assessment or receiving treatment is free to leave at any time. However, if an informal patient is deemed to be at risk to themselves or others and risk assessment agreement with the MDT has confirmed that observations are required to maintain their safety and manage the risk, a discussion must take place with the patient to understand their capacity and consent to this intervention. If the patient has capacity and gives their consent to the enhanced observations, this must be clearly documented. If the patient declines, or lacks the capacity to consent to the observations, then a review of their legal status should be considered with the use of the Mental Health Act or Deprivation of Liberty Safeguards.

Staff are reminded that when an informal patient makes a request to leave the unit, they must make an immediate risk assessment. This must be fully documented within the records. This should include an assessment of the patients' capacity to make the decision, a review of any recent events and outcomes from discussions within the multi-disciplinary meeting and any current leave decisions.

If the nurse has any concerns about the patient taking leave at that time, they should ask the patient if they are willing to have an escort or wait for a rapid medical review. If the patient is unwilling to have an escort or wait for a medical review, the nurse must make a decision in relation to use of holding powers under section 5 (4) of the Mental Health Act or to allow the patient to leave.

It is important that all decisions made, take into account the individual needs of the patient at the time, including their capacity and consent. An informal patient who has been identified to be at immediate and or significant risk to self or others, and has consented to the implementation of constant or intermittent observations would not normally be granted unescorted leave. The assessing clinician must ensure that their decision making process and outcome is documented.

ACTIONS TO BE TAKEN:

1. Informal patients must be free to leave the unit at any time.
2. Consent is sought from the individual to undertake observations to maintain their safety.
3. If the patient declines, a review of their legal status should be considered.
4. An immediate risk assessment is undertaken when a patient asks to take leave. This should include their capacity to make the decision, recent presenting history,

outcomes from discussions within the multi-disciplinary meeting and any current leave decisions.

5. The nurse or medic should consider the use of holding powers if they have any concerns about the patient.
6. All decisions made must be documented.

Signature of Ward / Team Manager

……

(To be signed only when satisfied that action is completed)

Block capitals……...Date……..

Appendix 5: Document Control Sheet

This document control sheet must be completed in full to provide assurance to the approving committee.

Document Type	Inpatient Leave Policy M-019		
Document Purpose	Humber Teaching NHS Foundation Trust has a responsibility for preparing inpatients for a successful return to the community with periods of leave being an essential component of this preparation. The decision to grant leave of absence from hospital has to balance the contribution that leave makes to the patient's rehabilitation against considerations for the safety of both the patient and others.		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates	23 September 2020	Mental Health Legislation Steering Group	
	15 June 2022	Mental Health Legislation Steering Group	
	21 June 2023	Mental Health Legislation Steering Group	
	20 March 2024	Mental Health Legislation Steering Group	
Approving Committee:	Mental Health Legislation committee	Date of Approval:	5 November 2020
Ratified at:	Trust Board	Date of Ratification:	November 2020
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	This policy is to be implemented within existing resources and does not require additional financial resource.		
Monitoring and Compliance:	The Mental Health Legislation Committee receive a quarterly report including data pertaining to the adherence of the Mental Health Act, and an assurance report, which meets the monitoring requirements of the Mental Health Act Code of practice (2015). The Mental Health Legislation Committee will identify additional actions/scrutiny as required to achieve satisfactory assurance on behalf of the organisation.		

Document Change History: (please copy from the current version of the document and update with the changes from your latest version)			
Version number/name of procedural document this supersedes	*Type of change, e.g. review/legislation*	*Date*	*Details of change and approving group or executive lead (if done outside of the formal revision process)*
Draft	New policy	November 2016	New policy
1.00	Amendments	30 December 2016	To include issues re observations and informal patients
1.01	Review	1 March 2017	Minor amendments following observations from MHLC
1.02	Review	25 July 2018	Following an incident (Datix Web25827), amendments made to 5.12 Escorted leave, 5.14 Revoke, 6.4 Detained patients. Reference made to the Adult Mental Health Inpatient Leave SOP at 5.2.1, and amendment to Appendix 1 Definitions of cancellation, postponement and revoke.
1.03	Review	11 September	Changes made to the reporting process when S17

		2018	leave is cancelled or postponed due to staff shortage.
1.04	Review	7 August 2019	Reviewed in preparation for the opening of the CAMHS unit
2	Full review	August 2020	Full Review
2.1	Amends / Addition	June 2022	Incorporation of the “Inpatient leave (temporary modifications in response to the risks posed by Covid-19) guidance” and considerations for S17 leave authorisation in the context of any infectious disease outbreak (page 14/15). Approved by Director sign off (MHL Steering Group) 15-June-22
2.2	Full review	June 2023	Minor amends including clarification of ground leave (page 8), informed about SLA with NLAG re RC responsibility when patient detianed to Goole and District Hospital (page 12), description of clothing (page 16). Approved by Director sign off (MHL Steering Group) 21-June-23
2.3	Review - minor amends	March 2024	Minor amends - Risk assessment prior to each period of leave can only be completed by qualified / registered professionals with appropriate competencies; this currently excludes nursing associates. Also clarified legalities around ground leave on page 7. Approved by director sign-off (Kwame Opoku-Fofie – 17 April 2024).

Appendix 6: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Inpatient Leave Policy
2. EIA Reviewer (name, job title, base and contact details): Michelle Nolan, Mental Health Act Clinical Manager
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service

Effective communication is essential in ensuring accurate risk assessment, appropriate care, and respect for patients' rights. Staff responsible for caring for patients should identify any communication difficulties (language barriers, learning disability, difficulty in reading or writing, visual or hearing impairment, and cultural barriers) and seek to address them.

Appendix 2 – missing person information and patient alert form – prompts consideration of barriers to communication. This policy should be adhered to with embedded consideration of how patient involvement and equality can be maximised.

Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	The MHA specifies who the Law relates to and the legal age thresholds where they exist. This Policy is consistent in its approach regardless of age.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (and including cancer, HIV, multiple sclerosis)	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the Act as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any special needs or requirements relating to any form of disability. For patients who have a communication need or have English as their second language consideration must be given to providing information in an accessible format.
Sex	Men/Male Women/Female	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any gender

			related preferences, needs or requirements.
Marriage/Civil Partnership		Low	This Policy is consistent in its approach regardless of partnership status.
Pregnancy/ Maternity		Low	This Policy is consistent in its approach regardless of pregnancy status. Staff should always ensure that any use of force is used only after having due regard to the individual's maternity status and having taken full account of their physical, emotional and psychological wellbeing.
Race	Colour Nationality Ethnic/national origins	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to race or ethnicity. It is acknowledged that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**Low**	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to religious or other belief systems.
Sexual Orientation	Lesbian Gay men Bisexual	**Low**	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to sexual orientation.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**Low**	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any gender identity related preferences, needs or requirements. We recognise the gender that people choose to live in hence why the terms gender identity and gender expression ensure we are covering the full spectrum of LGBT+ and not excluding trans, gender fluid or asexual people.

Summary

Please describe the main points/actions arising from your assessment that supports your decision above
There are statutory requirements and obligations built into existing related legislation (MHA 1983) and its supplementary Code of Practice as well as local systems in place for assurance of the monitoring of compliance with these requirements and reporting through related committees. It is felt that this policy and any associated documentation would seek to uphold principles of individualised planning and arrangements for ongoing care needs. The policy takes significant consideration of the protection of all service users and their carers under the Equalities Act 2010 and the Human Rights Act. Significant attention has been paid to ensure that no groups are discriminated against either directly or indirectly.
EIA Reviewer: Michelle Nolan
Date completed: 20.03.24 | Signature: M Nolan