Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
ADMISSION AND RECALL OF RESTRICTED (S37/41) PATIENTS

Document Reference	SOP23-043
Version Number	1.0
Author/Lead **Job Title**	Michelle Nolan, Mental Health Act Clinical Manager Jess Slingsby, Modern Matron (MH Division) Bekki Whisker, Community Clinical Lead (Secure Services) Jon Rawling, Staff Nurse (Community Forensics) Hannah Bumford, Social Worker (Community Forensics) Lisa Clark, Unit Manager (MH Division) Drew Brace, Unit Manager (MH Division)
Instigated by: **Date Instigated:**	Dr Kwame Fofie - Medical Director
Date Last Reviewed:	18 October 2023
Date of Next Review:	October 2026
Consultation:	
Ratified and Quality Checked by: **Date Ratified:**	Mental Health Legislation Steering Group 18 October 2023
Name of Trust Strategy / Policy / Guidelines this SOP refers to:	

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*Oct 2023*	*New SOP. Approved at MHL Steering Group (18 October 2023).*

Contents

1. INTRODUCTION

After being granted a conditional discharge by either the Secretary of State for Justice or the First Tier Tribunal (Mental Health), the Secretary of State may recall a patient under section 42(3) if something has happened since the conditional discharge of sufficient significance to justify doing so (Code of Practice 22.81).

Section 42(3) of the Mental Health Act 1983 provides that:

> *The Secretary of State may at any time during the continuance in force of a restriction order in respect of a patient who has been conditionally discharged under subsection (2) above by warrant recall the patient to such hospital as may be specified in the warrant,* (Ministry of Justice - The recall of conditionally discharged patients, Feb 2009).

In order for the Justice Secretary to recall there must be evidence of mental disorder of a nature or degree warranting detention (following *Winterwerp v Netherlands* (1979) as reflected in the Mental Health Act 1983).

1.1. Guiding Principles

The following principles should be considered when making decisions about any course of action under the Mental Health Act 1983 as outlined in the Code of Practice: Mental Health Act revised 2015 (COP 1.1):

Least Restrictive option and maximising independence

- Where it is possible to treat a patient safely and lawfully without detaining them under the Act the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Empowerment and involvement

- Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professions should explain the reasons for this.

Respect and dignity

- Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness

- Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity

- Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care

services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

2. SCOPE

This SOP should be read in conjunction with relevant chapters of the Code of Practice 2015 which offers guidance on the operation of the Act. Chapter 22 focuses on patients concerned with criminal proceedings; 22.81 – 22.84 specifically covers recall to hospital. The five guiding principles set out in Chapter 1 of the Code should be considered when making decisions about any course of action under the Act. Staff should also refer to the Ministry of Justice the recall of conditionally discharged patient's guidance (Feb 2009).
This Trust-wide procedure sets out procedural requirements, where these are explicit in the Act or Code, but guidelines have been produced locally which, while complying with this procedure, provide advice on more specific matters. Where appropriate, reference should be made to other Trust policies and procedures (e.g. Bed Management SOP).
The purpose of this procedure is to ensure that there is lawful and appropriate recall of restricted patients and that the legal rights of any patient subject to a conditional discharge are upheld at all stages.

3. DUTIES AND RESPONSIBILITIES

Chief Executive
The chief executive has responsibility to ensure that systems are in place and regularly monitored to ensure that Trust staff understand their responsibilities regarding the recall of restricted patients.

Chief Operating Officer and the Executive Director of Nursing, Allied Health and Social Care Professionals
The Chief Operating Officer and the Executive Director of Nursing, Allied Health and Social Care Professionals have responsibility for ensuring the development, review/monitoring of this procedure and for the appropriate training and education to support implementation.

Medical Director and Clinical Director
The medical director and Clinical Director are responsible for ensuring that procedures are understood and carried out by medical staff involved in the recall of restricted patients.

Responsible Clinicians/Clinical Supervisors
As with any other patient admitted to a Humber inpatient unit the named RC will be the inpatient Consultant with some consultation provided by the Forensic / Community Team RC.

Divisional Clinical Leads, Modern Matrons, Team Leaders, and Charge Nurses
Divisional Clinical Leads, Modern Matrons, Team Leaders, and Charge Nurses are responsible for implementing operational systems within their respective areas to ensure adherence to the principles and standards of this procedure.

Social Supervisors
To understand their responsibilities in relation to recall of restricted patients and work in partnership with inpatient services to ensure the patient's journey is one of least restriction.

Community Mental Health Teams
To understand their responsibilities in relation to recall of restricted patients and work in partnership with inpatient services to ensure the patient's journey is one of least restriction.

Roles and responsibilities following admission
Community Mental Health Teams and Inpatient Units must:

- make efforts to understand each other's roles, and routes and pathways for escalation;
- ensure good engagement between services - all community services should keep in contact with the patient and inpatient team during the admission
- the community team should assist with providing a support package to enable the inpatient unit to formulate an appropriate treatment plan;
- jointly complete any Access Assessment;
- utilise escalation pathways should there be any conflicting opinion regarding the outcome of an Access Assessment that cannot be resolved so that those clinical conversations can take place at management level.

4. PROCEDURES

4.1. Criteria for recall

Contingency planning with clear indication at time of discharge on how and where people in community should be recalled at time of emergency should be visible in clinical notes to avoid any confusion. Teams should have plans in place to ensure avoidance of need for recall when someone is escalating. All professionals involved should be aware of the plan particularly if any specified hospital advised where patient should be admitted on recall (if bed available).

It is important that the patient understands the plan and that family are involved in the plan where possible.

At appropriate point teams should consider making referrals for additional support e.g. IST, Home Treatment Team, FoLS, etc. It is also important to consider use of informal or civil sections rather than recall as this is less restrictive.

A patient will be recalled where it is necessary to protect the public from the actual or potential risk posed by that patient and that the risk is linked to the patient's mental disorder. It is not possible to specify all the circumstances when recall may be appropriate and public safety will always be the most important factor. Key points include:

- the decision on whether to recall will largely depend on the degree of danger posed by the patient, the gravity of the potential or actual risk and how imminent the risk is.

- recall does not necessarily require any evidence of deterioration in the patient's mental state, but evidence is required that a 'change' has occurred since the discharge decision. This is so that the Secretary of State for Justice can be satisfied that recall is a proportionate and lawful action. Other than in an emergency, medical evidence will be required that the patient is currently mentally disordered.
- recall will not be used to deal with anti-social or offending behaviour that is unconnected with the patient's mental disorder.
- recall decisions always give precedence to public safety considerations. This may mean that the Secretary of State for Justice will decide to recall on public safety grounds even if the supervisors (see paragraphs 22.79 – 22.80) are of the view that recall would be counter-therapeutic for the patient.
- recall will be considered to protect others from harm because of a combination of the patient's mental disorder and behaviour, including potential behaviour where there is evidence that indicates the imminent likelihood of risk behaviours.
- in an emergency the Secretary of State for Justice may recall for assessment in the absence of fresh evidence as regards mental disorder.
- the support for recall from the patient's social supervisor is important but not determinative and the Secretary of State for Justice can, satisfied that recall is necessary, make the decision to recall in the absence of any recommendation.
- where however recall is recommended by at least one supervisor, then the expectation is that the patient should be recalled unless there are compelling reasons not to recall.
- admission under sections 2 or 3 – if a restricted patient requires compulsory detention in hospital under the Act then recall will almost invariably be appropriate. The only circumstances where recall may not be indicated would be where discharge was imminent (within days rather than weeks), or where the admission is solely due to self-harm or suicide issues and the admission is likely to last less than a month Code of Practice 22.82).

4.2. Use of civil sections

The Secretary of State welcomes prompt admission to hospital, either voluntarily or under civil powers, for a short period of observation or treatment. Where admission is voluntary and the patient remains co-operative with treatment in hospital, the Ministry of Justice will not normally recall if medical advice is that only a brief period of in-patient treatment is necessary for observation or stabilisation. The patient will again be subject to the formal conditions of his/her earlier discharge when he/she leaves hospital. However, it is generally inappropriate for a conditionally discharged patient to remain in hospital for more than a few weeks time voluntarily. If the use of civil powers is necessary to detain a patient or enable compulsory treatment to be given, immediate recall will almost invariably be appropriate to regularise the restricted patient's status under the Act.

There are cases in which recall to hospital for a period of observation can be seen as a necessary step in continuing psychiatric treatment. There are other cases in which anti-social behaviour may be unconnected with mental disorder, so that recall to hospital is not an appropriate sanction and there may be no alternative to leaving the conditionally discharged patient to be dealt with as necessary by the normal processes under the criminal law. Each case is assessed on its merits in the Ministry of Justice and a decision

is reached after consultation with the doctor(s) concerned and with the social supervisor. However, the decision will always give precedence to public safety considerations.

4.3. Informal admissions

Where a patient has been informally admitted because of risk of self-harm/suicide and there is no evidence of risk to others, it may not be appropriate to recall.

If the medical evidence is that the patient does not meet the criteria for compulsory detention under the Mental Health Act, then recall will not normally be indicated, regardless of the likely length of admission.

If the medical evidence is that the patient, while in hospital voluntarily, does meet the criteria for compulsory detention under the Mental Health Act, then recall may be indicated if the likely length of admission is more than about a month.

Where a decision is taken not to recall but to allow the informal admission to continue then the case must be reviewed regularly. A weekly up-date will normally be appropriate, but a longer period may be indicated depending upon the circumstances of the case.
Recall must be considered where there is any admission to psychiatric hospital. As with any consideration of recall, public safety is of paramount importance. In deciding whether recall is indicated where a patient has been informally admitted to hospital, relevant factors are:

- the likely length of admission. If an admission of more than a few weeks is likely then recall is indicated, unless there are compelling reasons against recall.
- any evidence of increased risk to others will lead to recall.

regardless of the fact that the patient is in hospital voluntarily, would the supervising psychiatrist seek to detain the patient if he wished, or attempted to leave?

4.4. Process of notifying MoJ

If the clinical supervisor has reason to fear for the safety of the patient or of others, he/she may decide to take immediate local action to admit the patient to hospital for a short period either with the patient's consent or using civil powers such as those under sections 2, 3 or 4 of the Mental Health Act 1983. Whether or not such action is taken, and even if the social supervisor does not share the clinical supervisor's concern, the clinical supervisor should report to the Ministry of Justice at once so that consideration can be given to the patient's recall to hospital.

Telephone discussion in such circumstances is welcomed by staff in Mental Health Casework Section. In normal office hours an officer in the Section should be contacted at Public_enquiry.mhu@justice.gov.uk or by telephone: 07812 760248. Outside office hours the Ministry of Justice should be contacted on 0300 303 2079.

Consideration of a case for recall will take into account any steps taken locally to remove the patient from the situation in which he/she presents a danger. MHCS must be notified at once of the need to readmit a conditionally discharged patient to hospital.

In the rare circumstance that there is a consideration that the patient could be recalled to a secure bed contact should be made with the Humber and North Yorkshire Provider Collaborative Adult Secure Services Single Point of Access (NHY SPA) at the earliest opportunity:

By email: hnf-tr.hnyadultforensicreferral@nhs.net or by telephone 01482 478702. The HNY SPA aims to foster a system-wide approach by unifying referrals for secure beds and the Forensic Community Teams (FCT) across the H&NY ICS, thereby improving quality, governance, consistency, effective communication and service user experience.

It is important for all staff to acknowledge that there will naturally be an increase in forensic patients transitioning to the community due to the national and local programmes of transformation of care; these patients will have equitable access to all services.

4.5. Identification of a bed

Informal admissions or use of civil sections would follow the same process of bed identification as for all other admissions.

Should recall be indicated, the clinical team should initially discuss their concerns with MHCS and identify a suitable bed at an appropriate security level for the patient to be admitted to. Once the arrangements are confirmed, MHCS will issue a Secretary of State for Justice warrant for the recall of a patient to a named hospital or unit (MHA Code of Practice 2015, 22.83).

The clinician / professional contacting the case worker should ensure they convey the unit specification for each inpatient unit in our locality so that MoJ have a full understanding of whether the unit is locked or not.

Once a decision to recall has been made, it is the responsibility of the RC or Social Supervisor to identify an appropriate bed and to make the practicable arrangements for admission to hospital (Jones, Richard – MHA Manual 25th Edition - page 319). Every effort should be made to pursue a bed placement which is least restrictive and a decision regarding placement should be made in relation to risk and treatment not on the basis of bed availability.

As soon as it is identified that the patient needs to be admitted or recalled the Community Team staff should liaise with Bed management and agree the next steps (refer to the Bed Management SOP). In the rare circumstance where recall to secure services is being considered the HNY SPA should be consulted at the earliest opportunity.

The least restrictive option should always be considered; people should not be recalled to secure services if they can be recalled to a less restrictive environment.

A secure bed can be insisted by the MOJ if the current risks are determined to be high. A gatekeeping assessment is required (even if he MOJ specify a secure bed) as the funding is from NHS E and not from DOH.

In extremis, after all efforts have failed to find a bed, MoJ can direct (order) a hospital to admit a restricted patient but would always look to voluntary agreement first. Secure bed availability information is only available from the HNY SPA.

If there is no bed instantly available dependent on capacity and clinical activity on any particular unit, this might need escalating to on call managers.

Early conversations with MHRS will be helpful so that the bed management team are aware of the potential need for admission.

4.6. Effect of recall

In urgent cases, a direction recalling a patient may be given verbally outside office hours by a duty officer of the Ministry of Justice's Mental Health Casework Section on behalf of the Secretary of State. In practice, the warrant would then normally be provided on the next working day.

If the hospital, or unit, specified in the recall warrant is not the one from which patient was conditionally discharged, the original hospital order, hospital direction or transfer direction is then treated as if it had specified the new hospital or unit (MHA Reference Guide 2015 - 27.46).

Once recalled, and until they are readmitted to hospital, patients are treated as if they were absent without leave from the hospital or unit specified in the recall warrant. The effect is that they may be taken into custody and taken to the hospital or unit in question, if necessary (MHA Reference Guide 2015 - 27.47).

There is a general duty to inform a patient, within 72 hours of his recall to hospital, of the reasons for that recall. Mental Health Casework Section should be informed as soon as a recalled patient is back in hospital or in case of any difficulty.

After recall a patient is once again detained as a restricted patient in pursuance of the order of the Court which made the restricted hospital order. Like other restricted patients, patients who have been recalled to hospital from conditional discharge can only be discharged again by or with the Secretary of State's consent, or by the Tribunal (MHA Reference Guide 2015 - 27.48). In some cases the Responsible Clinician may be able to recommend the patient's further discharge after only a short while. The Secretary of State understands this, and will be willing to consider discharge of a recalled patient as soon as the responsible clinician thinks appropriate.

Secretary of State 'direction'

In exceptional circumstances, the Secretary of State for Justice may 'direct' a restricted patient's admission into hospital, outside the NHS commissioning arrangements. This is usually where it is critical that the patient receive treatment and identifying a suitable bed is difficult Code of Practice 22.85).

In urgent cases, a direction recalling a patient may be given verbally outside office hours by a duty officer of the Ministry of Justice's Mental Health Casework Section on behalf of the

Secretary of State. In practice, the warrant would then normally be provided on the next working day (MHA Reference Guide 27.45).

If the hospital, or unit, specified in the recall warrant is not the one from which patient was conditionally discharged, the original hospital order, hospital direction or transfer direction is then treated as if it had specified the new hospital or unit (MHA Reference Guide 27.46).

Once recalled, and until they are readmitted to hospital, patients are treated as if they were absent without leave from the hospital or unit specified in the recall warrant. The effect is that they may be taken into custody and taken to the hospital or unit in question, if necessary (MHA Reference Guide 27.47).

4.7. Conveyance to hospital

A recall warrant has immediate effect. If the patient will not return to hospital willingly on being told of the recall, then the police should be asked to assist. In non-urgent cases, the police should be provided with a copy of the recall warrant. Once recalled, and until they are readmitted to hospital, patient are treated as if they were absent without leave and can therefore be taken into custody and taken to the hospital specified in the warrant. There is no power of entry attached to a recall warrant. If it is not possible to gain access to a patient who has been recalled, an application may be made to a magistrate under S135(2).

Where recall is considered by the Secretary of State to be necessary and a warrant is signed to that effect, the patient may be returned in the most appropriate manner to the hospital specified on the warrant. If the patient will not return to hospital willingly, on being told of his recall, then assistance may be requested from the police, to whom a copy of the warrant will have been sent. There is no statutory duty on the police to assist, but they have authority under section 137 of the 1983 Act, if their assistance is requested by a supervisor, and will normally be ready to assist in the interests of preserving public order and preventing crime.

The Secretary of State for Justice then expects full reasons to be communicated to the patient within 72 hours of re-admission (Code of Practice 22.84).

4.8. Treatment

The consent to treatment provisions contained in Part 1V MHA apply to the patient from the date of the recall (s.56(3)(c). Jones, Richard – MHA Manual 25th Edition (page 319)

4.9. Transfer

Section 19 of the Mental Health Act 1983 (MHA) and regulations made under it, enable a patient who is detained in hospital to be transferred to another hospital and to be detained in that hospital on the same basis. By virtue of section 41(3)(c) of the Act, where the patient is subject to a restriction order, the consent of the Secretary of State is needed to transfer any restricted patient between hospitals under section 19.

Where a hospital / unit is named, the Secretary of State's agreement is needed for movement out of that unit, even if the transfer is to the same level of security. In particular, the MoJ would need to have details of the level and type of security of the unit/hospital where the patient is to be transferred to. Please note that, unless the MoJ are satisfied that it

is adequate, they may refuse the transfer until agreement is reached on another suitable unit.

In urgent cases, a direction transferring a patient may be given verbally outside office hours by a duty officer of the Ministry of Justice's Mental Health Casework Section on behalf of the Secretary of State. In practice, the new warrant stating the name of the transferred unit / hospital would then normally be provided on the next working day.

Apply for trial leave or full transfer to another hospital for restricted patients - GOV.UK (www.gov.uk)).

4.10. Applications and references to the Tribunal by and in respect of recalled patients

Like other restricted patients, patients who have been recalled to hospital from conditional discharge can only be discharged again by or with the Secretary of State's consent, or by the Tribunal (MHA Reference Guide 27.48).

The Secretary of State must refer the case of all recalled conditionally discharged patients to the Tribunal within one month of their return (MHA Reference Guide 27.49).

The Secretary of State will always refer the case of a recalled patient to the Tribunal within days of recall (MoJ / HM Prison & Probation Service - Guidance for Clinical Supervisors 05 July 2019).

For most purposes, patients recalled to hospital are treated as if they were being detained for the first time. In particular, recall resets the periods during which patients may apply to the Tribunal (MHA Reference Guide 27.50).

The effect of this is that patients may not apply to the Tribunal until a further six months have passed from their return. They may then apply once during the six months following that, and once in each subsequent 12 month period. This applies to all types of restricted patients, even those who were able to make an application in the first six months of their original detention. As described above, all recalled patients will have had their cases referred to the Tribunal by the Secretary of State on their recall (MHA Reference Guide 27.51).

For the purpose of the rules on applications and references to the Tribunal, patients' 'return' means the day on which they arrive at, or are brought to, the hospital, or unit, to which they are recalled. If they are already in the hospital or unit at the time, it means the date of the recall warrant (MHA Reference Guide 27.52).

5. EQUALITY AND DIVERSITY

The core Mental Health Act policies, protocols and procedures have been impact assessed. Where individuals are being detained or receiving treatment under the terms of the Act it is vital that no community group is treated less favourably.

Where peoples' legal status is affected we have a clear duty to inform them of their rights regardless of their language or communication difficulties. DVDs in 28 languages other than English are available on the rights of detained patients. When people with physical impairments are detained clinical staff should identify this need as soon as possible to enable the Trust to access appropriate support, e.g. BSL interpreter, Independent Mental Health Advocates.

Where religious belief is important to patients this will be respected and the Trust chaplain will support access to relevant faith leaders and information. Clinical settings, wherever possible, should be able to accommodate individual prayer/meditation space with appropriate access facilities.

Certain MHA forms must continue to be served to the patient in hard copy. However electronic communication can be used as an additional means of providing the patient with the information, if that is their preference.

6. MENTAL CAPACITY

The Mental Capacity Act (2005) came into force in April 2007; therefore you must take into account these principles within the implementation of this policy.
The principles:

- A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- The right for individuals to be supported to make their own decisions – people must be given all appropriate held before anyone concludes that they cannot make their own decisions
- That individuals must retain the right to make what might be seen as eccentric or unwise decisions.
- Best interests – anything done for or on behalf of people without capacity must be in their best interests; and
- Least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

Human Rights Act

The Human Rights Act came into effect in October 2000 which means that the Trust and its staff, along with its supporting agencies, are seen as a public authority and have an obligation to respect the Convention rights. This means that you must understand those rights and take them into account when carrying out the requirements of this SOP.

7. IMPLEMENTATION

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

The SOP will be approved via the MHL Steering Group. It will also be discussed within the Reducing Restrictive Interventions Meeting.

All other stake holders, partners and services to be made aware of the SOP via Mental Health Legislation Steering Group members and distributed via their internal systems.

8. MONITORING AND AUDIT

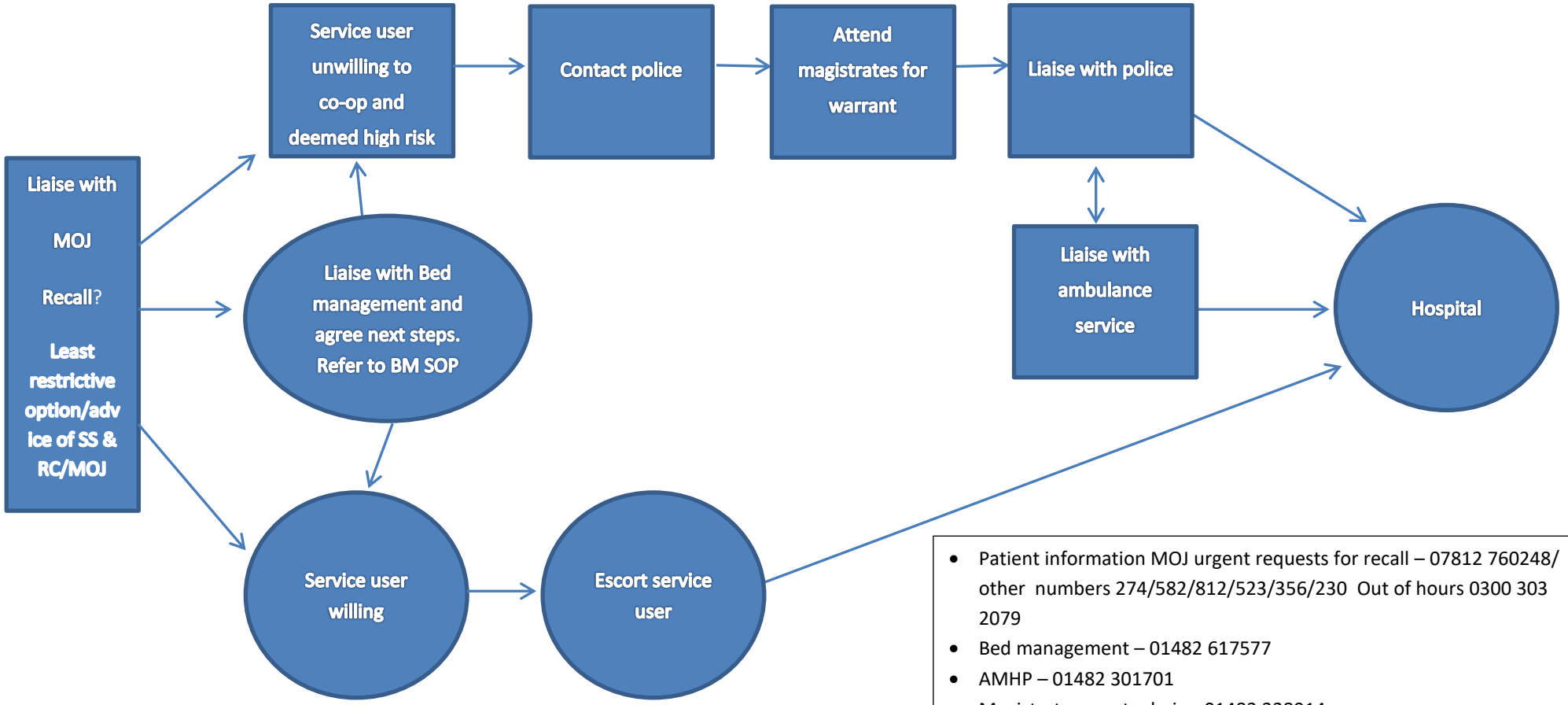
This SOP will be monitored via untoward incidents or PALS/complaints that arise as a result of the use of the SOP and reported to Humber NHS Foundation Trust which will then be processed at the Operation Risk Management Group and dealt with.

There are robust scrutiny processes in place with regards to recall of restricted patients via the Ministry of Justice. All MHA exceptions are reported via datix and then through the MHL Steering Group with a clear escalation process, where required, to the MHL Committee.

9. REFERENCES

HTFT, Lone Working Policy
Jones, Richard – MHA Manual 25th Edition
Mental Health Act 1983
MHA Code of Practice 2015
MHA Reference Guide 2015
Ministry of Justice - The recall of conditionally discharged patients, Feb 2009
MoJ / HM Prison & Probation Service - Guidance for Clinical Supervisors 05 July 2019

Appendix 1 - Conditional Recall Pathway to Hospital



- Patient information MOJ urgent requests for recall – 07812 760248/ other numbers 274/582/812/523/356/230 Out of hours 0300 303 2079
- Bed management – 01482 617577
- AMHP – 01482 301701
- Magistrates court admin - 01482 328914
- Police - 101
- Ambulance non-emergency - 0300 3300 295 – 4 hour response
- John Thirkettle, Mental Health Police Liaison - 101

Appendix 2 - Community Forensic Mental Health Conditional Recall Pathway

Name:	DOB:	NHS No:

Procedure	*Date*	*Staff*	*Other Info*
Discuss as part of MDT/consider risk/informal admission/and liklehood of willingness to recall			
Liaise with MOJ for advice & decision making in relation to recall – least restrictve option			
Contact bed management – least restriction option, esuring protection of others			
Bed identified contact MOJ to receive warrant papers with named hospital			
Consider risk – make contact with the police for assistance if required clairify their postion in relation to their attendance; *ie mental health service attendance with MOJ warrant or PACE Section 17 (1) Power of entry for saving life and limb or preventing serious damage to property applies when there is no time to obtain a warrant under section 135 (2)* *to authorise a police officer to enter premises* *NB – police may attend with a member of the team if in possession of recall warrant and 135(2) may not be required, dependent risk and willingness of patient.*			

If required a power of entry ring Magistrates Court for a Section 135(2) make appointment to attend court, complete section paperwork, include all details and cost code.Copies required x3 Present case to the court, receive authorisation from magistrate			
Liasie with police,keep updated.			
Liaise with ambulance service – non emergency is upto 4 hours wait			
Liaise with hospital – keep updated			
Ensure patient is informed at the earliest opportunity reasons for recall			
Utilise out of hours service should this fall beyond remit/working time, ensure all paperwork is on IT systems and paperwork is handed over to the service with full explaination.			
Follow up with hospital/patient/out of hours service. Magistrates court to receive to a copy. Update MOJ			

Appendix 3 - Unit descriptors within Humber Teaching NHS Foundation Trust

Adult Mental Health Unplanned:

Miranda House (Hull) has 2 mixed sex wards within it (Avondale and PICU) and a Section 136 suite. In addition Miranda House accommodates the Mental Health Response Team.

Avondale assessment unit – is an open assessment unit (not a secure ward) and admits people who have acute mental illness and are requiring an emergency admission. Average length of stay is between 3 and 7 days. Following a period of assessment the person is either discharged back into the community or transferred to one of HTFT's treatment units.

Miranda PICU – is HTFT's Psychiatric Intensive Care Unit. It admits people directly and also receives transfers from HTFT's assessment or treatment wards. The PICU manages people who can't be safely managed on HTFT's open wards, due to an increased risk to self or others. At times the PICU may need to operate as a single sex unit.

New Bridges treatment unit in Hull (male), Westlands treatment unit in Hull (female) and Mill View Court treatment unit in the East Riding (mixed) – are all open units (not secure units) for people who require a long stay in hospital due to their mental health. Westlands and New Bridges have access to a seclusion suite on site. Average length of stay is 4 to 6 weeks and people are discharged back into the community.

All beds are gate-kept by Mental Health Response Service.

Older People Mental Health Unplanned:

Maister Lodge Admission / treatment unit in Hull – Open unit for patients requiring assessment and treatment of organic mental health needs. The unit offers 7 male and 7 female beds with an average length of stay of 16 weeks

Mill View Lodge admission and Treatment unit in the East riding – Open unit for patients requiring assessment and treatment of functional mental illness. The unit is mixed sex unit with 9 beds in total. Average length of stay is 9 weeks.

Learning Disability:

Townend Court Assessment and Treatment Units - an inpatient provision for adults (aged 18 or above) with a learning disability. There are two separate units: Willow is a 5 bedded open assessment unit and Lilac is an 7 bedded open treatment unit. Admission into the service is considered when:

- A person is displaying abnormally aggressive or harmful behaviour of such frequency, severity or duration as to place the person or others at serious risk of harm.
- A person assessment and formulation cannot be provided in the community under conditions of lesser restriction, even with the introduction of additional resources such as are Intensive Support Team,
- A person display signs consistent with a diagnosable mental illness, amenable to treatment in an inpatient mental health service (liable and effective treatment could not be safely provided in a community setting

- A person has had a community (pre-admission) Care and Treatment Review (CTR), which has determined that inpatient admission is the right option for them

The aim of acute learning disability inpatient services is to provide the following three core functions of support:

1. Assessment (including for potential mental illness) of the causes of challenging behaviour, where it cannot be safely carried out in the community
2. Treatment of mental illness where this is the cause of challenging behaviour (complemented by other interventions as appropriate), where it cannot be safely carried out in the community
3. Reintegration of the individual back into the community after hospital treatment including provision of support/guidance to families and support providers

Admissions are within the Hull & East Riding population, and the unit also accepts admissions from other Clinical Commissioning Groups.

Appendix 4 - Equality Impact Assessment

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

1. Document or Process or Service Name: **Admission and Recall of restricted (S37/41) patients Standard Operating Procedure**
2. EIA Reviewer (name, job title, base and contact details): **Michelle Nolan, MHA Clinical Manager**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **SOP**

Main Aims of the Document, Process or Service
The purpose of this procedure is to ensure that there is lawful and appropriate recall of restricted patients and that the legal rights of any patient subject to a conditional discharge are upheld at all stages.
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	This Procedure 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 (including cancer, HIV, multiple sclerosis)	Low	This Procedure is consistent in its approach regardless 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	This Protocol is consistent in its approach regardless of gender.
Marriage/Civil Partnership		Low	The Procedure applies to all irrespective of relationship status.
Pregnancy/ Maternity		Low	This Procedure is consistent in its approach regardless of pregnancy/maternity status however consideration would be given to an appropriate hospital in the event of the need to recall.

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Race	Colour Nationality Ethnic/national origins	Low	The Procedure applies to all irrespective of race. Services must ensure where translator services are provided to ensure 'all practicable steps' are taken to ensure understanding in line with the five key principles of the MCA.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The Procedure applies to all irrespective of religion or believes
Sexual Orientation	Lesbian Gay men Bisexual	Low	The Procedure applies to all irrespective of 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	This Procedure is consistent in its approach regardless of the gender the individual wishes to be identified as. 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. No actions identified – this Procedure is specifically aimed at the protection of all service users subject to a Conditional Discharge under the Mental Health Act. Significant attention has been paid to ensure that no groups are discriminated against either directly or indirectly.
EIA Reviewer: Michelle Nolan, MHA Clinical Manager
Date completed: 13 October 2023 | Signature: Michelle Nolan