STANDARD OPERATING PROCEDURE
FORENSIC – PATIENT LEAVE AND MOVEMENT

Document Reference	SOP20-029
Version Number	3.6
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Instigated by: **Date Instigated:**	Security Committee
Date Last Reviewed:	7 August 2023
Date of Next Review:	August 2026
Consultation:	Ward managers, Heads of Department
Ratified and Quality Checked by: **Date Ratified:**	Security Committee 7 August 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
2.0	*4/9/13*	*Addition of unescorted patients accompanied by staff and use of personal vehicles.*
2.1	*5-2-14*	*S17 form revised to reflect CQC recommendations (i.e. confirming receipt / otherwise)*
3.0	*13.01.16*	*Incorporate HCR20 into leave planning* *Include access to other wards* *Include S17 risk form incorporated into leave record* *Patient photograph.* *Use of handcuffs.*
3.1	*21.03.16*	*Revision of pre-leave assessment*
3.2	*Sept 2020*	*New format, update of ward names*
3.3	*20.01.21*	*Patients accessing Humber Centre*
3.4	*25.05.21*	*Clarification on staff using own vehicle to transport patients*
3.5	*19.04.23*	*Review and update with additional guidance on airlock procedure*
3.6	*07/08/2023*	*Review of SOP in regard to mobile phone use on S17 leave and issues on leave. Approved at Security Committee (7 August 2023).*

CONTENTS

1. INTRODUCTION

The effective management of patient movement and leave is central to maintaining safety and security for patients, staff and the wider public. This involves movement within service buildings, and leave outside of them.

This procedure is divided into two key sections:

- Patient leave, which outlines the process by which we manage the granting of leave
- Patient Movement, which outlines guidance on how we conduct ourselves both within and outside the building

Care Quality Commission (CQC) – from April 2015 the Care Quality Commission (CQC) guidance Essential Standards of Quality and Safety and the 28 'outcomes' that it contained was replaced in its entirety by the 'Raising Standards putting people First' Strategy 2013-2016 which asked five key questions (Key lines of enquiry known as KLOEs):-

- Are we SAFE
- Are we CARING
- Are we EFFECTIVE
- Are we WELL LED
- Are we RESPOSIVE to individual's needs.

In 2021 a new strategy 'For the changing world of health hand social care' was published using four themes (People and communities, Smarter regulations, Safety through learning, Accelerating improvement) with 12 outcomes, but the five key questions (Safe, Caring, Effective, Well Led and Responsive) are still central to the way the CQC regulates services.

2. SCOPE

This procedure is intended to guide the practice of all staff in the service.

3. PROCEDURE STATEMENT

Movement in the building and leave outside of it are part of the care pathway of all patients. As they progress through the stages of leave, there is the need for effective risk assessment and the effective management of S17 leave by staff within the service.

4. DUTIES AND RESPONSIBILITIES

All staff will be aware of this procedure and will work in accordance with it. Staff will not act as patient escorts until they have received the appropriate training, which includes a working knowledge of this procedure.

5. LEAVE

Following admission and initial assessment, the appropriate level of leave will be agreed by the Responsible Clinician, in consultation with the multidisciplinary team (MDT) as part of the clinical pathway, reviewed each week, and changed as and when appropriate. The granting of Section 17 leave should involve the MDT giving consideration of risks identified within the HCR20 and scenario planning within the risk assessment should be completed to form the basis of any leave management plan.

All requests for leave will be considered on a multidisciplinary basis and as part of the clinical pathway. Where appropriate, this consideration will be subject to Ministry of Justice agreement. For some levels of leave, a Section 17 leave form is required (in the format attached as an appendix to this procedure). If the section 17 leave form is missing, incomplete or unsigned then the leave will not take place. Copies of correspondence regarding the granting of leave (i.e. from the Ministry of Justice) should also be filed with the Section 17 leave form.

In the consideration of granting Section 17 leave the MDT must consider what items it is appropriate for the patient to carry. This might include, but is not limited to, the carrying of mobile phones (hospital owned or personal), quantities of money, cash cards or credit cards, passports, bus passes or other travel cards. The decision must be made on an individual basis, related to identified risk and guided by the relevant leave risk scenarios in the HCR20. Agreed items to be taken on leave must be included on the Section 17 leave form.

There are four general levels of leave:

Courtyard Access
On admission, each patient will as a minimum have access to the ward's secure courtyard, unless risk assessment suggests that this is not possible. This does not require a S17 leave form. Supervision of activity in the secure courtyard is described in individual Ward Security Profiles (WSP).

Access to secure courtyards that are usually "no patient access" for activities such as the horticulture group, requires agreement by the MDT and a completed Section 17 form.

Garden Leave
Is limited to the secure garden of the unit and does not require a S17 leave form. However, any decision to grant garden leave must be supported by a comprehensive record of the decision to grant that leave. This is particularly important in the case of prisoners transferred to hospital under S47 or S48 MHA 1983. An escape from within the secure perimeter by a transferred prisoner is a 'never event', and the decision to grant garden leave must be made with this in mind and with due regard to any escaping behaviours in this or any other setting.(DoH, 2011b).

All patient activity in the garden area is to be directly supervised by staff.

Any additional restrictions for garden access (times, etc.) will be justified, risk assessed and control measures described by the WSP of each ward.

Access to the secure garden is usually escorted only. However, is a specific case an MDT may grant unescorted garden access for defined periods into a cleared garden. Such a decision will be made on a case by case basis, due to specific clinical and risk related factors of an individual patient. This decision will then be discussed and ratified at the weekly risk and referral meeting.

Ground Leave
Takes place in the grounds of the Willerby Hill site (this relates to the Grounds that has been agreed with the Ministry of Justice. An illustrative map is attached as an appendix to this procedure). Any decision to grant ground leave must be supported by a comprehensive record of the decision to grant that leave AND a S17 leave form.

For patients subject to restrictions (S37/41, S47/49 or S48/49) whose original hospital order or warrant for admission stipulates "Medium Security", require MoJ approval for the granting of ground leave. For all patients who have identified on their warrants "Humber

Centre" or none restricted patients, this leave can be granted at the Responsible Clinicians discretion, subject to the above guidance on the granting of leave.

Community Leave
Takes place external to the Willerby Hill site. Any decision to grant community leave must be supported by a comprehensive record of the decision to grant that leave AND a S17 leave form.

Pine View patients accessing Humber centre

- Patients can have access to all off ward areas that allow patient access following MDT approval. All patients accessing the Humber Centre must have section 17 leave granted to attend the Humber Centre and relevant paperwork completed on each occasion.

Each of these levels of leave will attract an appropriate level of escort/supervision:

Escorted: the number of escorts should be stated on the Section 17 leave form, i.e. 2:1 means two staff escorts to one patient.

Group: the number of patients per escort should be stated on the Section 17 leave form, i.e. 1:3, means one staff escort to each three patients.

Unescorted: the patient does not require to be escorted.

Consideration must also be given to the mode of transport to be used whilst on leave (if any).Most common forms of transport would be use of secure vehicle, unit transport, or public transport. Where risk assessed and identified as clinically appropriate, Staff can utilise their own vehicles to facilitate leave, as long as this is covered in their insurance. The use of staff vehicles must be considered within the MDT and clearly stipulated within the section 17 leave. Staff vehicles can only be utilised for transportation in this circumstance. The purpose of this arrangement would be to bring greater flexibility to leave plans and to support successful pathways.

The risk assessment of the patient is integral to the process of granting of leave, and should be undertaken on a multi-disciplinary basis. When, following appropriate assessments, the need is identified to make changes in an individual's leave status, the following process will be adhered to:

Although decreases in leave can be made on a uni-disciplinary basis, good practice dictates that decreases should be made by at least two members of the team following identification of increased risk. This should be reviewed on a multidisciplinary basis at the earliest opportunity.

All increases in leave entitlement must be made on a multidisciplinary basis, including the Responsible Clinician and at least one other involved professional.

The details of any variation in leave entitlement must supported by a comprehensive clinical entry and a new section 17 leave form, signed by the Responsible Clinician.

The appropriate level of leave will be decided by the MDT on an individual basis, as part of the clinical pathway at the multi-disciplinary team meeting or the service risk management meeting.

All service users, regardless of their leave status, should be accompanied by staff to the airlock, if taking leave outside the secure perimeter. For patients at the Humber Centre, unescorted patients will access the airlock, having been escorted there by staff and will be allowed out by the reception/control room staff.

Patients on escorted leave from the Humber Centre, will be accompanied by staff into the airlock. The staff member(s) will hand over their keys and kit to the reception control room staff, who will store them in the appropriate cabinet within the control room. The staff member will be given a corresponding key card in exchange.

On return, this card will be exchanged in the patient airlock for the same keys and kit, that were originally handed in.

Any service users visiting from another unit within the Trust, will be escorted by staff and will access the unit via the patient airlock. On arrival, the staff member will be given keys and kit in exchange for ID. This process will be reversed as the staff and patient leave the Humber Centre.

5.1. Escort

Consideration should be given, in determining the number and type of escorts, to whether the patient requires to be within sight of the escort at all times or whether the patients can be out of sight of the escort for brief periods, such as for using the toilet. This relates to the Escort Level as stated on the S17 leave form, and detailed on the reverse:

Level 1
Escorts must be aware of risk factors.

Two escorts – one of whom may be the driver.

Escort must remain within arm's length of patient at all times. Disabled toilet must be used, escort to check for other means of exit prior to allowing the patient access. Escort to remain outside the door.

Level 2
Escort must be aware of risk factors. Patient must remain within sight of escort. Use disabled toilet wherever possible.

If communal toilet is used, escort to keep in sight the cubicle door that patient is using (this will have gender implications). Consideration must be given to escort needs in relation to bladder function (Duration of leave). If it is possible that escort will need to use the toilet, two escorts must be present.

Level 3
Escort must be aware of risk factors. May be left unescorted/out of sight of escort for brief periods (such as escort or patient using the toilet).

In the case of escorted leave, appropriate escorts are any member of the multi-disciplinary clinical team who are security inducted and have undertaken escort training.

Students (from any discipline) cannot be escorts (though they may accompany escorts as part of their learning experience).

Escorting staff should be familiar with the requirements of Section 137 of the Mental Health Act 1983.

Escorts must carry a service issued radio or mobile phone when accompanying patients on leave. Escorts should not carry a personal mobile phone.

Escorts must ensure that their entire attention is on supporting the patient on S17 leave. The escort must not be given other tasks on behalf of other patients or the ward

to complete. The Escort must not complete their own personal shopping/tasks while on S17 leave.

Escorts must be familiar with the Trust's policy in relation to missing patients and their responsibilities should a patient abscond from their care.

Non Clinical staff (admin) may act as escort for individual patients who have undergone a risk assessment to address this specific issue. Such escorting may only take place within the Humber Centre building and a recovery plan must stipulate the exact purpose and location of the non-clinical escort (e.g. supervision in the hospital shop).

5.2. Patients on unescorted leave who are in the company of staff

Patients utilising unescorted leave are responsible for their own leave. However any member of staff in the company of an unescorted patient who knows the boundaries of that leave have a duty to enforce them wherever possible. Patients that are on unescorted leave and, for any reason, are transported by staff or become accompanied by staff then, by default, become patients on escorted leave for the period that they are in the company of staff. The escort then has the responsibility of escort as described by the Act and this procedure.

5.3. Assessment prior to taking leave

After requests for leave have been granted a risk assessment must be made prior to each period of leave. The shift leader will consider (in collaboration with the escorting clinician if of a different professions) the patient's presenting behaviour and mental state at the time, and make an appropriate decision. The shift leader must also consider the views of the clinical team, and any factors influencing the integrity of the wards security, prior to their decision. This should be recorded appropriately when a patient leaves the ward, under any circumstances, including garden leave. The Section 17 leave record (Appendix 3) incorporates a pre-leave risk assessment which must be completed in all cases. An up to date and recognisable photograph must be stored electronically within the clinical record system before any leave is taken outside of the secure perimeter.

Upon return the actual time should be recorded and compared to expected time of return. Late returns will be treated seriously and reviewed by the multidisciplinary team. See Absent without Leave (AWOL) standard operating procedure.

6. PATIENT MOVEMENT

There are seven aspects of patient movement which are covered by this procedure:

1. Patient movement within the service buildings
2. Patient movement within the community
3. Patient movement on official visits
4. Patient movement after dark
5. Patients conveyed in the unit vehicles
6. Self-managed leave at South West Lodge
7. Patients conveyed in staff vehicles (personally owned or leased)

6.1. Patient movement within the service buildings

Patient movement within the building is guided by the Multidisciplinary team process and is decided via the clinical pathway. This decision making process comes as a result of multidisciplinary risk assessment. As the service comes to know the patient and identifies risk, reduces risk or formalises risk management plans more of the internal areas of the building will be made accessible to the patient. Accompanying the opening of access to areas of the service to patients will be the ever present regard for observation status (see

Trust policy for supportive engagement). Access by patient to off ward areas must be supervised at all times due to ligature risks.

Access to certain areas within the Humber Centre must be decided on an individual basis within the MDT. This will include access to the Oaks Therapy corridor, social area, gymnasium, sports hall, library and hospital shop. There should be an assumption that most patients will have access to these areas unless risk assessment highlights specific concerns or contra-indications.

In some circumstances it might be appropriate for patients to access other wards. This might be related to therapeutic activities, occupational activities or social activities. Such access will require discussion at both relevant MDTs and close liaison between the clinical teams to fully understand any risk related issues that might arise.

6.2. Patient movement in the community

Before patients are given access to the community, with or without restrictions, a leave plan will be formulated. The leave plan should clearly state where, what for and for how long, it will also clearly outline action in case of untoward incident. Leave in the community will be to venues which have previously been evaluated for risks and this evaluation will be available to escorting staff in order to pre-plan the visit.

6.3. Patient movement on official visits

When escorting patients for medical appointments the accompanying staff will liaise with the area to which they are due to attend, stating an expected time of arrival. The formulated leave plan will give guidance on escorting numbers. A thorough risk assessment must have been undertaken to the satisfaction of the multidisciplinary team. Escorting staff will be aware of the need to carefully negotiate all obstacles where risk assessment has identified a risk of absconding, obstacles such as: revolving doors, lifts, and unsupervised vehicles will require preplanning and escorts should either refer to their control and restraint training or discuss contingencies with qualified trainers before the official visit is undertaken. Where possible the area to be visited should have been pre-screened by the service and an awareness of layout communicated to escorting staff for use in formulating the leave plan.

When escorting patients to court consideration to confidentiality should be given, where the appearance is potentially high profile or sensitive arrangements must be made with the court officials. The escorts are representing the Humber Teaching NHS Foundation Trust and the service and must be appropriately dressed and conduct themselves professionally at all times.

HM Prison Service is responsible for the conveying of a transferred prisoner to and from hospital in suitable transport and with the appropriate number of escorts (DH, 2011). The service should liaise with the transferring/receiving prison to arrange this.

For some patients it might be appropriate for staff to carry handcuffs or for handcuffs to be worn. This should be guided by risk assessment and if required to do so by the ministry of justice. In the event of handcuffs being used, at least one escorting staff member must be handcuff trained and a handcuff use form completed. See handcuff SOP.

6.4. Patient movement after dark

It is the policy of the service that patients do not have leave after the hours of darkness, other than in exceptional circumstances (emergency hospital treatment, etc.). However, there are legitimate therapeutic activities that may require leave after dark.

The decision to grant planned leave after dark will be made at a multi-disciplinary level, as part of the clinical pathway, and take into account all reasonably identifiable risks.

Any patient to be allowed leave after the hours of darkness is to have this leave clearly

stipulated on their Section 17 leave form.

The reason for leave after dark will be stipulated in the Section 17 leave form (e.g. 'to attend the Patient's Committee meeting/ to attend education etc.').

All leave after the hours of darkness will, as a rule, be escorted: level of escort to be stipulated in the Section 17 leave form. Exceptions to this will only occur when this has been agreed by the multidisciplinary team and stipulated in the leave plan.

Personal radios and/or mobile phones will always be carried by escorting staff.

The most direct, well-lit route will be taken between locations.

If going between sites of the Humber Centre service, prior to embarking on leave, the escort will contact the destination reception control room in order to establish an arrival time. Failure to arrive on time will prompt immediate implementation of the AWOL policy.

South West Lodge patients are issued with their own access keys for the building. These are issued from Pine View reception and their issue is only agreed following ongoing assessment by the patient's multi-disciplinary team. All leave is planned and the appropriate reception will always be visited before external leave for agreement and returning of key. Any external leave without agreement with staff and the MDT will be treated as a serious breach of trust and the patient will be viewed as absent without leave and the leave policy and procedure will be enacted.

6.5. Patients conveyed in unit vehicles

When using the unit vehicles to convey patients, the following basic safety measures should be applied:

- The patient will sit in the back of the vehicle in the seat on the nearside of the vehicle
- Escorts will sit in the back of the vehicle with the patient
- The child locks will be employed so that the back doors of the vehicle cannot be opened whilst the vehicle is in use
- The vehicle airlock at the Humber Centre may be used in order to minimise exposure of the patient to opportunities to abscond

6.6. Patients conveyed in staff vehicles (personally owned or leased)

Except in an emergency, patients will not be conveyed in vehicles owned or leased by staff. If, for any reason, this is necessary, it will be explicitly described in a section 17 leave form. In such circumstances, staff must ensure that they have appropriate insurance cover for the conveyance of patients.

6.7. Self-managed leave at South West Lodge

South West Lodge is a secure community preparation unit designed to continue the rehabilitation of patients who have been in secure mental health units. The ethos is to encourage the continuing acquisition of skills for independent living and to allow for an eventual safe transition to an appropriate community placement.

The use of Section 17 leave, both escorted and unescorted, is of great importance in this reintegration to the community. Patients admitted to South West Lodge will have immediate access, by the use of a keycard, to their own room and the communal areas of the building, including the secure garden. Freedom of access and egress via the front door will be dependent upon the individual patient and will be an MDT decision. Thereafter, again by MDT approval, the patient will move through a staged process of self-management of their leave, as set out in appendix one, in accordance with the parameters set out in the patient's

valid Section 17 leave form.

By the nature of South West Lodge, the patients' programmes may vary and there will be elements of flexibility necessary. For this reason, on a case by case basis, there may be additions to each patient's card authorisation of access and egress. These will be agreed by the MDT.

7. IMPLEMENTATION

All staff will be required to read the service procedures as part of their service security induction. This procedure will be central to in-service escort training.

8. MONITORING AND AUDIT

This procedure will be monitored by the Security Group.

9. REFERENCES / BIBLIOGRAPHY

Absent Without Leave – Definitions of Escape and Abscond
(Department of Health, 2009)

Good Practice Procedure Guide – The transfer and remission of adult prisoners under S47 & 48 of the Mental Health Act
(Department of Health, 2011a)

The 'Never Events" list 2011/12
(Department of Health, 2011b)

Appendix 1: Self-managed Leave at South West Lodge

Stage one

Keycard: programmed for bedroom garden door and the front door for daylight hours.
Departing on leave: the patient will complete a leave form and leave plan and report to the originating unit (Humber Centre or Pine View) on each occasion that leave is taken. Forms will be signed by the nurse in charge if the patient assessment shows leave to be appropriate. The keycard is handed in to reception.
Returning from leave: patient will report to the originating unit, retrieve the leave form, complete and submit the leave plan for checking and filing, and collects keycard. The patient will ask reception to inform the ward he has returned from leave
This stage will normally last for a minimum of three months, will be subject to the monitoring detailed below, and the patient can only progress to the next stage following MDT agreement.

Stage two

Keycard: as for stage one.
Each morning: When the patient leaves SWL for the day, he will complete the in/out board to inform staff completing checks of his whereabouts. The patient will report to the nurse in charge at the originating unit and hand in a daily leave/activity plan. The patient retains their keycard.
Any deviations from the plan will be reported to the originating unit. The 'in/out' board will indicate general whereabouts and he does not have to return to his originating unit every time he goes on leave.
End of the day: patient will report back to the nurse in charge at the originating unit and hand in the completed leave plan for checking and filing. The patient will then return to SWL
This stage will normally last for at least one month, will be subject to the monitoring detailed below and the patient can only progress to the next stage following MDT agreement.

Stage three

Keycard: as for stages one and two.
Each Monday: the patient will report to the nurse in charge at the originating unit at the beginning of the week with a whole week's worth of daily leave/activity plans. The patient retains the keycard. Any deviations from the plan will be reported to the originating unit by the patient. Each time the patient leaves SWL the 'in/out' board will indicate whereabouts and timings.
Each Sunday: the patient will attend the originating unit to hand in the week's completed leave plans, for checking and filing.
This stage will normally last for at least one month, will be subject to the monitoring detailed below and the patient can only progress to the next stage following MDT agreement.

Stage Four

As for stage three except:
Keycard: programmed for up to 24 hour access and egress via the front door, depending upon the individual patient's needs, goals and risks.
This is the final stage which is intended to be maintained until discharge and will be subject to the monitoring detailed below and will be reviewed on a monthly basis by the MDT.

Monitoring

There will be an 'in/out' board by the door of South West Lodge that patients will change according to their whereabouts. All leave forms will be handed in at the reception of the originating unit. Staff will check, randomly, that the patient's clothing matches that detailed on the leave form. During the regular checks each day, staff will check that the number of patients present is in accordance with the leave plans and the 'in/out' board. A printed report will be produced from the door card system for each keycard and the front door once per week and at other random intervals for both a day and a night period and compared to the CCTV footage. Any patient who is of concern in respect of leave and/or access and egress may have their self-managed leave suspended or they may be regressed by a stage by any qualified professional, until full discussion can take place at the next MDT.

Appendix 2: South West Lodge Leave Plan and Record (Stage 1)

HUMBER CENTRE FOR FORENSIC PSYCHIATRY
SOUTH WEST LODGE
LEAVE PLAN AND RECORD
Self-managed leave stage 1 only

Name:	**NHS No:**	**Date:**

Destination:		Activity:		
Aim:		Escort:		
		Time out:		
		Time due back:		
Finance:		Lighter No		Returned
Swipe card handed in		Swipe card returned to patient		

Clothing

Coat:	Jumper:
Shirt:	Trousers/skirt:
Shoes:	Socks:
Hat:	Glasses:

Patient assessed as appropriate and section 17 form checked by:

Signature:_____ Print name:_____
Position:_____

Patient's evaluation of leave taken

Date & time	**Outcome of leave taken**	**Signature**

The patient's evaluation should be countersigned by the nurse in charge as having been read

Appendix 3: South West Lodge Daily Leave Plan and Record (Stages 2, 3 and 4)

HUMBER CENTRE FOR FORENSIC PSYCHIATRY
SOUTH WEST LODGE
DAILY LEAVE PLAN AND RECORD
Self-managed leave stages 2, 3 and 4

Name:	**NHS No:**	**Date:**

Destination:	Activity:
Aim:	Escort:
	Time out:
	Time due back:

Destination:	Activity:
Aim:	Escort:
	Time out:
	Time due back:

Destination:	Activity:
Aim:	Escort:
	Time out:
	Time due back:

Destination:	Activity:
Aim:	Escort:
	Time out:
	Time due back:

Clothing

Coat:	Jumper:
Shirt:	Trousers/skirt:
Shoes:	Socks:
Hat:	Glasses:

Finance

I will have £_____with me for today's leave and activities

Signed:_____(Patient)

Patient assessed as appropriate and section 17 form checked by:

Appendix 4: Non Secure Hospital Grounds of the Willerby Hill Site – As agreed by MoJ