Policy:

NP 029 - Section 17 Mental Health Act - Authorisation of Leave (Detained Patients)

Including guidance for patients who are not detained and but for whom there is a duty to undertake a risk assessment prior to their leaving the ward

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Summary of Policy

A policy in respect of the authorisation of S17 leave for patients detained under the Mental Health Act 1983 and the absence from the ward of patients who are not detained under the Act.

Target audience	Staff involved in the administration of the Mental Health Act and in providing care and treatment under the Mental Health Act 1983

Keywords	Section 17, Mental Health Act, authorisation, leave, detained, patients

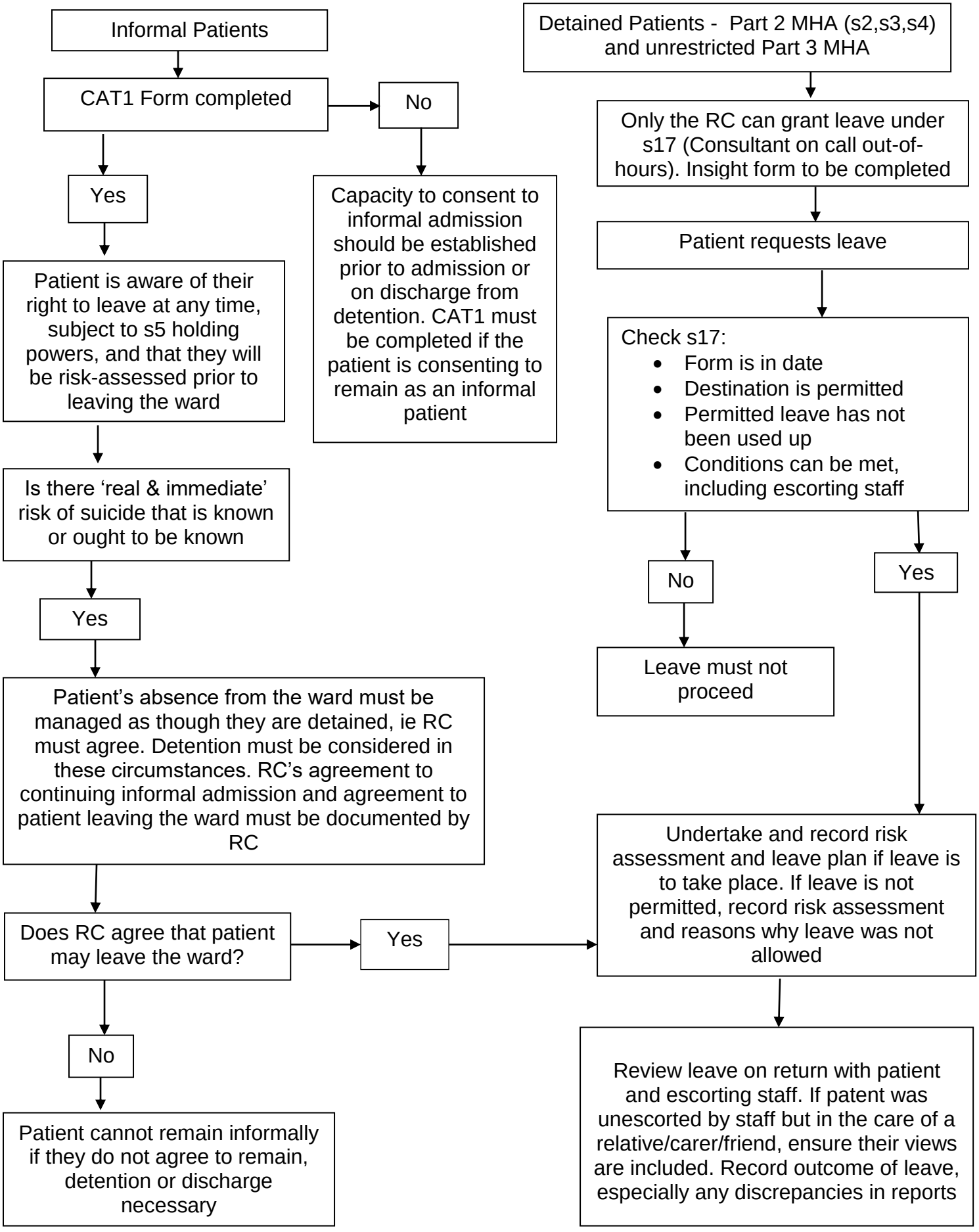
Storage
This is Version 4.1 of this policy which is stored and available through the SHSC policy governance team. This version supersedes Version 4 which superseded the previous version (V3 November 2016). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Contents

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
V3 D0.1	Initial draft	Oct 2016	Previous version mapped onto new policy template. Content reviewed and updated.
V3 D0.2	Draft for consultation / verification	Nov 2016	
3.0	Review / ratification / issue	Nov 2016	Ratified/ finalised / issued
4	Scheduled Review	Aug 2019	Flow Chart added Mapped onto current template Job Titles & authorship updated Amended with direct quotation of the Code of Practice for increased clarity Additional information added in respect of: • Recording granting of leave & recording episodes of leave taken, including ground leave • care and treatment on leave • recall/revocation of leave • escorted vs accompanied leave and custody during leave • failure to return from leave in line with conditions or recall or revocation of leave Guidance & risk management for non-detained patients moved from appendix to body of policy and amended to remove language only relevant to detained patients & to emphasise need for consent Unnecessary repetition removed The term ‘patient’ is used throughout to reflect the Code of Practice
4.1	Admin Amendments	July 2020	Front Page – Summary of Policy amended. EIA Form inserted after an EIA audit carried out by Policy Governance.

Flowchart –


Informal Patients
CAT1 Form completed
No
Yes
Capacity to consent to informal admission should be established prior to admission or on discharge from detention. CAT1 must be completed if the patient is consenting to remain as an informal patient
Patient is aware of their right to leave at any time, subject to s5 holding powers, and that they will be risk-assessed prior to leaving the ward
Is there 'real & immediate' risk of suicide that is known or ought to be known
Yes
Patient's absence from the ward must be managed as though they are detained, ie RC must agree. Detention must be considered in these circumstances. RC's agreement to continuing informal admission and agreement to patient leaving the ward must be documented by RC
Does RC agree that patient may leave the ward?
Yes
No
Patient cannot remain informally if they do not agree to remain, detention or discharge necessary
Detained Patients - Part 2 MHA (s2,s3,s4) and unrestricted Part 3 MHA
Only the RC can grant leave under s17 (Consultant on call out-of-hours). Insight form to be completed
Patient requests leave
Check s17:
• Form is in date
• Destination is permitted
• Permitted leave has not been used up
• Conditions can be met, including escorting staff
No
Yes
Leave must not proceed
Undertake and record risk assessment and leave plan if leave is to take place. If leave is not permitted, record risk assessment and reasons why leave was not allowed
Review leave on return with patient and escorting staff. If patent was unescorted by staff but in the care of a relative/carer/friend, ensure their views are included. Record outcome of leave, especially any discrepancies in reports

1 Introduction

Section 17 Mental Health Act 1983 makes provision for certain patients who are detained in hospital under the Mental Health Act 1983 to be granted leave of absence. It provides the only lawful authority for a detained patient to be absent from the hospital.

This policy is intended to ensure the Trust complies with the Mental Health Act 1983 and meets the requirements set out in the Code of Practice to the Mental Health Act.

2 Scope

This policy applies to all who are involved in the care and treatment of those detained under the Mental Health Act and those who are not detained but for whom there is a duty to undertake a risk assessment prior to their leaving the ward, especially those who may be at risk of suicide where there is an operational duty under Article 2 of the European Convention on Human Rights to ensure their right to life is protected

3 Purpose

This policy provides guidance for nursing, medical staff and other staff who are involved in the care and treatment of patients detained under the Mental Health Act 1983 and those who are not detained but for whom there is a duty to undertake a risk assessment prior to their leaving the ward, especially those who may be at risk of suicide where there is an operational duty under Article 2 of the European Convention on Human Rights to ensure their right to life is protected

It describes who may grant leave, management of the process of the leave, systems for recording and the role of the staff within this. The purpose of this policy is to ensure that those who implement the provisions of the Act work within its boundaries and are aware of the scope of these boundaries, and the scope of their practice in respect of informal/voluntary patients.

4 Definitions

The Act
Refers to the Mental Health Act 1983 as amended by the Mental Health Act 2007

Patient
Part 2 MHA:
A patient who is detained in hospital under section 2 or section 3.

Part 3 MHA: Patients Concerned in Criminal Proceedings or Under Sentence

Unrestricted Part 3 Patient
A patient who is liable to be detained in hospital on the basis of a Hospital Order (section 37) or Hospital Direction (section 45A) who never was or is no longer subject to Ministry of Justice (MoJ) restrictions or limitations (sections 41 and 49 respectively).

Restricted Part 3 Patient
A patient who is subject to those Ministry of Justice (MoJ) restrictions or limitations detailed above

Informal/voluntary Patient

Those who are not detained are included in this policy to the extent that a risk assessment will be required before they leave the ward and to ensure particular consideration is given to the risk of suicide

Approved Clinician
A person approved by The Secretary of State to act as an approved clinician for the purposes of this Act.

Responsible Clinician
The Responsible Clinician (RC) is the Approved Clinician with overall responsibility for the patient's case. The role cannot be delegated, but temporary cover is permitted. Cover arrangements must be clear in order to avoid unlawful granting of leave

Hospital
Under the Mental Health Act 1983, 'hospital' has the meaning given to it by the National Health Service Act 2006 (MHA manual, 14th ed), that is 'any institution for the reception and treatment of persons suffering from illness'. However now those hospitals may be divided into units and may not be coterminous with managers, a hospital, for the purpose of section 17, leave can be defined as 'only those buildings on a particular site that are adjacent to each other and have the same NHS Managers'. It is the responsibility of each site to ensure it has a working definition of its boundaries.

5 Detail of the Policy

This policy is concerned with statutory duties under the Mental Health Act

6 Duties

Responsible Clinician:
The Responsible Clinician is responsible for:

- Authorising Section 17 leave requests (see 7.3, 7.8)
- Ensuring that he/she is informed of any child protection, child welfare issues, adult protection or domestic abuse issues (see 7.4)
- Recording the decision to grant / refuse leave and rationale in the patient's notes and on the relevant Mental Health Act Documentation (Authorisation for leave form)
- Considering the benefits and any risks to the patient's health and safety of granting or Refusing leave
- Considering 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)
- Considering any conditions which should be attached to the leave, e.g. requiring the patient not to visit particular places or persons
- Taking account of the patient's wishes, and those of carers, friends and others who may be involved in any planned leave of absence
- Considering what support the patient would require during their leave of absence and whether it can be provided
- Ensuring that any community services which will need to provide support for the patient during the leave are involved in the planning of the leave, and that they know the leave dates and times and any conditions placed on the patient during their leave

- Ensuring that the patient is aware of any contingency plans put in place for their support, including what they should do if they think they need to return to hospital early
- Liaising with any relevant agencies, e.g. the sex offender management unit (SOMU)
- Undertaking a risk assessment and put in place any necessary safeguards, and (in the case of part 3 patients – see chapters 22 and 40 Mental Health Act 1983 Code of Practice (2015)) consider whether there are any issues relating to victims which impact on whether leave should be granted and the conditions to which it should be subject.
- Ensuring that a care plan, incorporating a contingency plan is written (see 7.7)
- Ensuring that the duty to provide aftercare under Section 117 (for those eligible) includes patients who are on leave has been met.
- Recalling a patient on leave when it is necessary in the interest of the patient's health or safety or necessary for the protection of others (see 7.11).

Ward Manager:
The Ward Manager is responsible for:

- Ensuring that all staff (within remit) comply with this policy
- Ensuring that Section 17 leave forms are completed before any applicable period of leave and that decisions and rationales for leave requests are recorded in the patient's notes and on Section 17 authorisation forms and checking compliance on at least a weekly basis.

Nursing staff:
Nursing staff have a vital role to play in the effective implementation, recording and evaluation of section 17 leave.

The granting and planning of leave should include the contributions of nursing staff as part of the MDT and be clear on the role they are to play in facilitating this i.e. risk assessment prior to each episode of leave. There must be a correlation between the Section 17 leave form and the subsequent note in the daily record, risk assessment and care plan for safety and audit purposes.

Nursing staff are responsible in particular for:

- Contributing to the granting, planning and facilitation of leave
- Ensuring that Section 17 leave authorisation forms have been completed and that these are recorded in the patient's record, with a copy given to the patient
- Assess the patient's clinical state and conduct a risk assessment prior to each period of leave (see 7.9)
- Withholding leave if required
- Ensuring that appropriate escort and support arrangements are in place
- Meeting the information needs of patients, relatives and carers.
- Recording details and outcomes of each period of leave
- Ensuring that an up to date description of the patient and a photograph are available in the notes. NB photos are taken with informed consent, or – in the absence of capacity - as part of a best interests decision under the Mental Capacity Act 2005.

All Staff:
All staff implementing the provisions of the Mental Health Act must be aware of their duties and responsibilities under the Mental Health Act and the guidance of the Code of Practice; and must comply with this policy.

7 Procedure

7.1 Section 17 leave

Section 17 makes provision for certain patients who are detained in hospital under the Mental Health Act 1983 to be granted leave of absence. It provides the only lawful authority for a detained patient to be absent from the hospital.

Section 17 leave applies to patients detained under sections 2, 3, 37 and 'notional 37'.

Section 17 does not apply to those patients detained under Sections 4,5 or subject to s136, o

Section 17 applies to sections 47 and 48 if unrestricted, but in practice such transferred prisoners will normally be subject to restrictions.

Section 17 applies to those patients detained and restricted or subject to limitations under Sections 37/41 and 45A; however approval must first be sought from the Secretary of State for Justice. Please refer to the guidance published by the Ministry of Justice, which includes information in respect of medical leave.

https://www.gov.uk/government/collections/mentally-disordered-offenders#guidance:-working-with-restricted-patients

Section 17 does not apply to those patients who have been remanded in hospital under Sections 35 & 36 or admitted under Section 38 (interim hospital order). Absence from the ward for urgent medical reasons may be undertaken with due consideration for risk management and the court's opinion (where safe and practicable to seek it).

7.2 When is formally authorised Section 17 leave necessary?

Whenever a detained patient has official leave from the hospital site Section 17 leave is necessary, this applies to short leave (e.g. to the local shops), longer leave, escorted leave, unescorted leave and periods of stay in another hospital where transfer under Section 19 would not be appropriate (e.g. general hospital)

For part 2 & unrestricted part 3 patients, Section 17 leave is not required for the patient to leave the ward and remain within the hospital grounds, but in order to ensure comprehensive records are kept, a section 17 form and record of absence from the ward will be kept for ground leave, in line with s17 practice for leave beyond the grounds. However if two or more hospitals are located within the same grounds but managed by different Trusts, leave must be given to move from the detaining hospital to another.

Risk assessment is always necessary when a patient is leaving the ward on which s/he is detained.

Section 17 leave authorisation is required for the patient to attend a different site belonging to the same Trust. If this includes an overnight stay the patient should be transferred.

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

For part 2 & unrestricted part 3 patients, longer term leave may be granted but when considering authorising a period of leave which would be more than 7 consecutive days the Responsible Clinician must first consider whether a Community Treatment Order would be the better option. If, after consideration, the Responsible Clinician still feels that longer term leave is the better option, the Responsible Clinician will need to show that both options have been considered. The decision and reasons should be recorded in the care records, which should include a record of the MDT discussion.

Community Treatment Orders (CTO) cannot be considered for patients detained under restriction orders. CTO does not apply to restricted patients.

If a patient who is detained under one section is granted leave but subsequently becomes detained under another section a new authorisation of leave should be completed as soon as possible, but is not strictly necessary.

If a patient transfers wards then a new authorisation of leave must be completed by the New RC and should be done in a timely fashion so as not to disadvantage the patient and therefore should form part of the transfer discussions.

Where Emergency leave is required (e.g. to hospital for physical healthcare) leave is to be permitted following a risk assessment and verbal authorisation by the RC or covering RC and the authorisation form completed as soon as possible.

7.3 When are other arrangements necessary?

Guidance for patients who are not legally detained and for those who are known (or ought to be known) to be at 'real and immediate' risk of suicide

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 In the case of voluntary or informal patients where there is a 'real and immediate' risk of suicide, the Supreme Court has ruled (February 2012) that the NHS has a positive duty (the operational duty) to protect life under Article 2 of the European Convention on Human Rights. In effect, this ruling requires absence from the ward for informal or voluntary patients at risk of suicide to be managed as is if they were detained. Detention under the MHA must be considered in these circumstances which include Section 5(4) nurses holding power and Section 5 (2).

All other patients in an acute inpatient setting, must be seen as having risks or being vulnerable, and these needs ought to be considered as part of the Trust's duty of care.

If an informal/voluntary patient wishes to leave the ward careful planning and risk assessment should take place. Their leaving the ward should be discussed and agreed in the MDT where appropriate and should involve the patient, carers and the CMHT / other community services where appropriate. Absence from the ward should be balanced

against any risks that this may pose to the protection of themselves and others. Consideration must also be given to what support the patient would require and whether – with their consent - it can be provided. Any discussion and decision should be recorded in the patient's notes and as part of care planning.

If a carer or relative is involved in or affected by the absence, they should be consulted and this conversation then documented in the patient's notes.

Risk assessment should also take place immediately prior to the patient going out. The shift co-ordinator (RMN) and contact nurse with input from the ward team and the Consultant, if required, should ensure that absence from the ward is appropriate and safe based on the current health and presentation of the patient. Prior to every episode of absence from the ward, a record should be made of what the patient is wearing particularly if there is an increased risk of their not returning.

Every period of absence from the ward must be recorded in the care record. This should include dates and time of departure and return. The outcome of each period of absence from the ward along with an assessment of success or difficulties should also be recorded.

Patients should be encouraged to contribute by giving their views and particular note should be made of any benefits or concerns raised by the patient or any accompanying staff, relatives, carers or friends.

Nursing staff may be given the authority to negotiate actual times when absence from the ward occurs. This must be recorded as part of the MDT decision making and planning, but the patient MUST consent to any restrictions on their leaving. The Collaborative Care Plan should be used to support absence from the ward, planning and risk assessment.

7.4 Power to grant leave (Code of Practice 27.8-27.9)

Part 2 patients & unrestricted part 3 patients
Only the patient's responsible clinician can grant leave of absence to a patient detained under the Act. Responsible clinicians cannot delegate the decision to grant leave of absence to anyone else. In the absence of the usual responsible clinician (eg if they are on leave), permission can be granted only by the approved clinician who is for the time being acting as the patient's responsible clinician.

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

In the absence of the RC in the out of hours period and during weekends and bank holidays, the Trust provides that the duty consultant would take over the over the role RC. Additional information is available in the Allocation of a Responsible Clinician Policy.

Restricted patients (Code of Practice 27.6)
Any proposal to grant leave to a restricted patient has to be approved by the Secretary of State for Justice, who should be given as much notice as possible and full details of the proposed leave. For further information on restricted patients, see paragraphs 27.39 – 27.42, 27.53 – 27.60, of the Code of Practice and the Ministry of Justice website.

7.5 Planning the granting of leave

The RC retains overall responsibility for granting or refusing leave.

Leave should only be granted after careful planning and risk assessment. The decision for leave to be granted should be discussed and agreed in the MDT available at the time and should involve the patient, family, carers and the CMHT / other community services where appropriate. The benefits of granting leave need to be balanced against any risks that leave may pose to the protection of the patient and others. The Responsible Clinician must also be aware of any child protection, child welfare issues, adult protection or domestic abuse issues. Consideration must also be given to what support the patient would require and whether this can be reasonably provided. The decision to grant leave and rationale should be recorded in the patient's notes and on the relevant Mental Health Act Documentation (Authorisation for leave form).

The patient should be involved in the decision to grant leave and should be asked to consent to any consultation with others that is thought necessary. It is the Responsible Clinician's responsibility to undertake any appropriate consultation. If a carer or relative is involved in or affected by the leave they should be consulted and if they are taking the patient out under their care/accompany them then their responsibilities should be explained and this conversation then documented in the patient's notes.

Risk assessment should also take place immediately prior to the patient going out on the planned leave (as it may be a few days since the leave was discussed and agreed) i.e. prior to each episode of leave. The shift co-ordinator (RMN) and contact nurse with input from the ward team and the Consultant, if required, should ensure that the leave remains appropriate and safe to do so based on the current health of the patient. Prior to every episode of leave a record should be made of what the patient is wearing particularly if there is an increased risk of AWOL.

Leave of absence can be an important part of a detained patient's care plan, but can also be a time of risk. When considering and planning leave of absence, **responsible clinicians** should:

- Consider the benefits and any risks to the patient's health and safety of granting or Refusing leave
- Consider the benefits of granting leave for facilitating the patient's recovery balance these benefits against any risks that the leave may pose for the protection of other people (either generally or particular people)
- Consider any conditions which should be attached to the leave, e.g. requiring the patient not to visit particular places or persons
- Be aware of any child protection and child welfare issues in granting leave
- Take account of the patient's wishes, and those of carers, friends and others who may be involved in any planned leave of absence
- Consider what support the patient would require during their leave of absence and whether it can be provided
- Ensure that any community services which will need to provide support for the patient during the leave are involved in the planning of the leave, and that they know the leave dates and times and any conditions placed on the patient during their leave

- Ensure that the patient is aware of any contingency plans put in place for their support, including what they should do if they think they need to return to hospital early
- Liaise with any relevant agencies, e.g. SOMU (Sex Offender Management Unit) and MAPPA (Multi-Agency Public Protection Arrangements)
- Undertake a risk assessment and put in place any necessary safeguards, and (in the case of part 3 patients – see chapters 22 and 40 Mental Health Act 1983 Code of Practice (2015)) consider whether there are any issues relating to victims which impact on whether leave should be granted and the conditions to which it should be subject.

Paragraph 27.10, Mental Health Act 1983 Code of Practice (2015)

The Inpatient Care Plan should be used to support the leave granting, planning and risk assessment. Leave will be written in the collaborative care plan as a goal with relevant steps.

7.6 Conditions

The Responsible Clinician may place any condition upon the granting of leave considered to be in the interest of the patient or for the protection of other persons.

The information about conditions must be clearly detailed e.g. whether the patient is to be escorted and by whom, how often the patient may leave the hospital.

Day leave must state the times during which leave can be taken and the maximum time which may be spent away from the hospital. Overnight leave should state the time and date leave can commence and the date and time leave ends. Phrases such as 'as per care plan' are insufficient.

Nursing staff may be given the authority to negotiate actual times when leave is taken. This must be recorded as part of the MDT decision making and planning.

Details of escorts or other means of accompanying the patient must be clearly defined.

It may be appropriate to authorise leave subject to the condition that a patient is accompanied by a friend or relative. If that is so the Responsible Clinician should specify that the patient is to be escorted/accompanied by the friend or relative only if it is appropriate for that person to be legally responsible for the patient and that person understands and accepts the consequent responsibility.

Escort by hospital staff should include consideration as to who is best placed and qualified to do this and whether this is within their scope of practice and job description. This should be discussed and recorded at both the planning MDT and as part of the arrangements for each episode of leave.

7.7 Escorted Leave & Accompanied Leave

Escorted leave – Code of Practice 27.27
A responsible clinician may direct that their patient remains in custody while on leave of absence, either in the patient's own interests or for the protection of other people. Patients

may be kept in the custody of any officer on the staff of the hospital or any person authorised in writing by the hospital managers.

Escort by hospital staff should include consideration as to who is best placed/qualified to do this and whether this is within their scope of practice and job description If staff are escorting the patient they should have a mobile phone with them in case of emergency and be clear what action to take in case of an emergency.

Accompanied leave - Code of Practice 27.29
While it may often be appropriate to authorise leave subject to the condition that a patient is accompanied by a friend or relative (eg on a pre-arranged day out from the hospital), responsible clinicians should specify that the patient is to be in the legal custody of a friend or relative only if it is appropriate for that person to be legally responsible for the patient, and if that person understands and accepts the consequent responsibility.

When relatives, carers, friends etc are taking a patient on leave they should be made aware of what to do in the event of an emergency: they should be given the ward contact details and asked to alert the ward as soon as possible if anything untoward arises.

7.8 Recording the decision to grant leave

The Trust has a standardised system by which responsible clinicians can record the leave they authorise and specify the conditions attached to it.

The decision to grant leave must be recorded in the patient's care records together with details and condition of leave. A section 17 leave form must be used for this purpose – this is available on Insight.

Copies of the authorisation should be given to the patient and to any carers, professionals and other people in the community who need to know details of the leave arrangements.

Any request to amend the leave plan to an alternative venue or for an increased length of time should be considered by the RC in light of a full risk assessment which should consider the risks to the patient and others and involve other professionals as necessary.

7.9 Risk assessment

Although only the Responsible Clinician and in the case of restricted patients the Secretary of State for Justice can authorise leave, it may be managed by nursing staff.

The nurse in charge/shift coordinator must ensure that a Section 17 leave form has been completed before the patient is allowed to leave hospital. This task can be delegated to another registered nurse. This form is accessible to staff at all times on Insight.

Nursing staff must assess a patient's clinical state and conduct a risk assessment prior to each period of leave, even if the taking of leave is not contingent upon the approval of nursing staff.

Particular attention should be paid to the risk posed to the patient or to others. There must be an awareness of any child protection, child welfare issues, adult protection or domestic abuse issues. Consideration must also be given to what support the patient will require on leave and whether this can be reasonably provided.

The risk assessment is to be recorded in the locally agreed format, and take into account the recent history, e.g. use of ‘as required’ medication and the reason for it, incidents on the ward, events outside, bad/good news, anniversaries of significant events, incongruence between plans and affect/behaviour etc.

Nursing staff always have the discretion to withhold leave if they have any doubts about the patient’s fitness to take it. Reasons for refusal should be documented in the notes

Any decision to grant leave under circumstances that might be taken to be reasons to refuse it (such as the clinical opinion that time away from the ward after a period of disturbed behaviour would be beneficial) must be carefully documented and the reasons for leave being deemed safe explained in the record.

Consideration should always be given to who should escort the patient formally, or to accompany them informally e.g. staff or relative / carer. See for esc

Copies of the section 17 form should be handed to the patient and copies given to any relatives, friends or carers who may require the information or who are accompanying the patient in order that they understand the parameters of leave and their responsibilities.

Patient consent is not required to share this information with any person who is involved in the period of leave.

7.10 Recording episodes of leave taken

The date and time that a patient goes on Section 17 leave and the date and time of the patient’s return to the ward must be documented. A qualified member of staff should record this information.

Every period of leave and it risk assessment must be recorded in the patient records under a daily progress note headed ‘leave risk assessment’ and tagged as ‘Leave’. This should include dates and time of departure and return,

A record of the date and time of departure and return must also be maintained within the overall recording and safety system of the ward (which allows staff to see who is on and off the ward). A ‘record of leave taken document’ is available for this purpose.

The Ward Manager is responsible for undertaking a weekly check on the correct completion of the record of leave taken, ensuring that the date and time of the patient leaving and returning to the ward is recorded on each occasion.

The outcome of each period of leave along with an assessment of its relative success should also be recorded. Patients should be encouraged to contribute by giving their views and particular note should be made of any benefits or concerns raised by the patient or any escorting staff, relatives or friends.

7.11 Care and treatment while on leave - Code of Practice 27.24 - 27.26

Responsible clinicians’ responsibilities for their patients remain the same while the patients are on leave.

A 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 (see Code of Practice chapter 24). If it becomes necessary to administer treatment without the patient's consent, consideration should be given to whether it would be more appropriate to recall the patient to hospital (see Code of Practice paragraphs 27.32 – 27.36 and 7.13 below), although recall is not a legal requirement.

The duty on local authorities and clinical commissioning groups (or, in certain circumstances, NHS Commissioning Board (NHS England)) to provide after-care 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.

7.12 Leave to reside in another hospital

Leave can be given to authorise the patient to reside in another hospital but consideration should first be given to whether it would be more appropriate to transfer the patient under section 19.

When a patient is given leave to reside in another hospital the overall responsibility of the patient's care remains with the Responsible Clinician granting the leave.

7.13 Review of leave granted

Responsible clinicians should regularly review any short-term leave they authorise on this basis and amend it as necessary (paragraph 27.17, MHA 1983 Code of Practice, 2015). The S17 forms must have a clear review date.

7.14 Cancellation of leave

Should escorted leave have to be cancelled due to lack of staff escort an incident form must be completed, giving the rationale for the decision and a record should be made in the patient's notes. If leave is cancelled for other reasons this should be assessed as to whether this is incident reportable but at the very least a note made in the patient record.

7.15 Recall from leave – Code of Practice 27.32 – 27.36

The responsible clinician (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.

Responsible clinicians 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.

The responsible clinician must arrange for a notice in writing revoking the leave to be served on the patient or on the person who is for the time being in charge of the patient.

NB - record must be kept of the address of patients who are on leave of absence and of anyone with responsibility for them whilst on leave.

The reasons for recall should be fully explained to the patient and a record of the explanation included in the patient's notes.

A 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.

It is essential that carers (especially where the patient is residing with them while on leave) and professionals who support the patient while on leave should have easy access to the patient's responsible clinician if they feel consideration should be given to return of the patient before their leave is due to end.

Patients may not be recalled from leave once they have ceased to be liable to be detained.

7.16 Absence without leave (AWOL) – Code of Practice 28.3-28.6

In case they fail to return from leave, an up-to-date description of the patient should be available in their notes. A photograph of the patient should also be included in their notes, if necessary with the patient's consent (or if the patient lacks capacity to decide whether to consent, a photograph is taken in accordance with the Mental Capacity Act (MCA)).

Paragraph 27.22, Mental Health Act 1983 Code of Practice (2015)

Under section 18 of the Act, patients are considered to be AWOL in respect of s17 leave when they:

- have failed to return to the hospital at the time required to do so under the conditions of leave under section 17
- are absent without permission from a place where they are required to reside as a condition of leave under section 17
- have failed to return to the hospital if their leave under section 17 has been revoked

Detained patients

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.

A patient who has been required to reside in another hospital as a condition of leave of absence can also be taken into custody by any member of that hospital's staff or by any person authorised by that hospital's managers.

Otherwise, responsibility for the safe return of patients rests with the detaining hospital.

If a patient fails to return from section 17 leave in line with its conditions or having had their leave revoked, the date and time and action taken must be recorded and the Absent Without Leave and Missing Patients Policy should be followed**.**

NB – A warrant under s135(2) may be necessary if the patient refuses to return and police assistance is required to gain access to the premises.

8 Development, consultation and approval

This guidance was developed by the Mental Health Legislation Committee (MHLC) in line with the requirements of the Mental Health Act 1983 and its Code of Practice (2015). This review has updated job titles and Executive responsibility.

It has been reviewed by Nurse Consultants and via the ward managers meeting on 19.6.2019.

It has been approved by the MHLC for submission to the Executive Directors' Group for approval.

9 Audit, monitoring and review

Audit & monitoring of this policy will be through the Mental Health Legislation Committee and the Crisis and Emergency Care Network.

This guidance will be reviewed on a 3-yearly basis.

10 Implementation plan

None necessary, no significant change

11 Dissemination, storage and archiving (Control)

This guidance replaces the previous version (v3) on SHSC Intranet and Intranet.

The previous policy will be removed from the Trust website by the Policy Governance Team/Communications team.

12 Training and other resource implications

The Trust delivers training on the Mental Health Act on a mandatory basis

13 Links to other policies, standards (associated documents)

Mental Health Act 1983
Mental Health Act Code of Practice
All Mental Health Act policies.

14 Contact details

Title	***Name***	***Phone***	***Email***
Executive Director: Nursing & (Executive Lead for Mental Health Act)	Liz Lightbown	16395	liz.lightbown@shsc.nhs.uk
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Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date:	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**No**		
Disability	**No**		
Gender Reassignment	**No**		
Pregnancy and Maternity	**No**		

Race	**No**		
Religion or Belief	**No**		
Sex	**No**		
Sexual Orientation	**No**		
Marriage or Civil Partnership	**No**		

Impact Assessment Completed by: Anne Cook
Name /Date 23/04/2020