Policy:

NP029 - Section 17 Leave Mental Health Act Authorisation of Leave

Including guidance for patients who are not detained, 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 (as amended) and the absence from the ward of patients who are not detained under the Act.

Target audience	Inpatient staff

Keywords	S17; section 17; leave; authorisation

Storage & Version Control

Version 5 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (Oct 2019). Any copies of the previous policy held separately should be destroyed and replaced with this version.

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	Nov 2016	
3.0	Review/ratification/issue	Nov 2016	• Ratified/finalised/issued

4	Scheduled review	Nov 2016	• 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.
5.0	Review and refresh	09/2022	• New Executive Lead for policy added. • New role of Authorised Member of the MDT created. • New core, minimum of what should be considered as part of Pre-Leave Risk Assessment. • Staff authorised to complete Pre-Leave Risk Assessments expanded. • Clarification provided regarding what should be considered when carrying out a Post Leave Review. • Clarification regarding leave conditions and best practice • Added importance to ensure patients whose first language is not English are not disadvantaged by any misunderstandings related to leave and leave conditions. • Staff authorised to complete Post Leave Reviews expanded. • New acronym devised to aid assessors when completing Pre-Leave Risk Assessments. • Clarification regarding when leave not being able to be facilitated becomes an incident, and how to report this should it arise.

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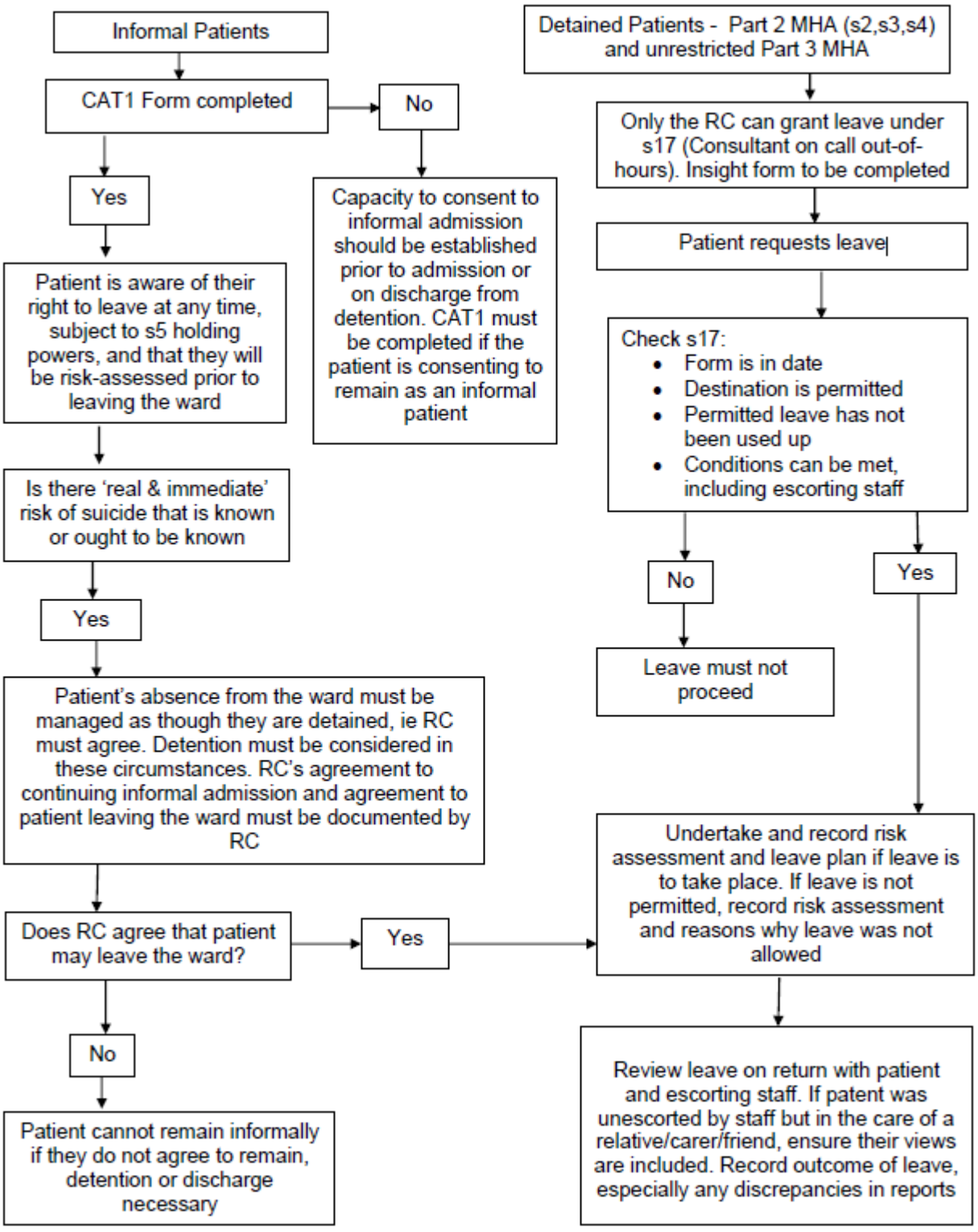
Flowchart


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 (as amended) makes provision for certain patients who are detained in hospital, under its provisions, 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 and meets the requirements set out in its Code of Practice.

2 Scope

This policy applies to all staff who are involved in the care and treatment of those detained under the Mental Health Act.

It also applies to staff who provide care to those who are not detained, but have been admitted to a mental health ward on an informal, voluntary basis.

This policy applies to all services, directorates, and teams within Sheffield Health and Social Care NHS Foundation Trust regardless of location or specialism.

Whilst, in general, patients who are detained in hospital can only leave if they have been authorised to do so by their Responsible Clinician, there are certain patients who this does not apply to. Leave of absence granted by a Responsible Clinician cannot be given to those who have been detained under sections 35, 36, or 38 of the Act. Patients detained under such sections are not within the scope of this policy.

3 Purpose

The purpose of this policy is to provide guidance for all staff who are involved in the care and treatment of patients detained under the Mental Health Act, and those who have been admitted on a voluntary, informal basis.

The policy seeks to ensure that all clinical staff act in accordance with the Act and the Act's Code of Practice. It aims to set out the processes which Sheffield Health and Social Care NHS Foundation Trust has in place in relation to patient's leave and further aims to give clarity to what is expected of its staff when arranging and managing patient leave.

4 Definitions

'**Authorised Member of the MDT**' for the purposes of this policy is a registered nurse, social worker, speech and language therapist, occupational therapist, psychologist, or physiotherapist. These professional disciplines are authorised to carry out Pre-Leave Risk Assessments (subject to the conditions of the s17 leave authorisation written by the patient's Responsible Clinician).

(Please note: The Trust acknowledges that over recent years, new professional roles have been introduced; examples of such roles include the Nurse Associate and Physician Associate. Nurse Associates and Physician Associates are not included in the definition of an Authorised Member of the MDT, meaning these professional disciplines are not currently

authorised to carry out Pre-Leave Risk Assessments. This policy position will, however, be kept under routine review should these roles develop)

'The Act' means the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

Part 2 MHA means the part of the Mental Health Act regarding civil detentions (ie. those who are not detained to an MHA section by a criminal court).

Part 2 patient means a person who is detained under s2 or s3 of the Act.

Part 3 MHA means part of the Mental Health Act regarding forensic detentions (ie. those who have been detained to an MHA section by a criminal court)

Unrestricted Part 3 patient means 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 means a patient who is subject to those Ministry of Justice (MoJ) restrictions or limitations detailed above.

Informal Patient is a patient who has made a mentally capacitous decision to be admitted to a mental health ward for mental health treatment.

Approved Clinician means a person approved by The Secretary of State to act as an Approved Clinician for the purposes of the Act.

Nurse Associate means a person who has successfully completed Nurse Associate training and is registered as a Nurse Associate with the Nursing and Midwifery Council (NMC)

Responsible Clinician (RC) is the Approved Clinician with overall responsibility for a 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 has the meaning given to it by the National Health Service Act 2006, that is 'any institution for the reception and treatment of persons suffering from illness'. However, now hospitals may be divided into units and may not be coterminous with managers, a hospital, for the purpose of section 17 leave is 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.

MHA means the Act (see The Act)

Occupational Therapist, for the purposes of this policy, means an Occupational Therapist who is either employed by, or seconded to, the Trust and who has a valid professional registration with the Health and Care Professions Council (HCPC)

Physiotherapist for the purposes of this policy, means a physiotherapist who is either employed by, or seconded to, the Trust and who has a valid professional registration with the Health and Care Professions Council (HCPC)

Pre Leave Risk Assessment means the assessment which is undertaken by an Authorised Member of the MDT to determine whether it is safe and legal for the patient to have leave.

Psychologist, for the purposes of this policy, means a psychologist who is either employed by, or seconded to, the Trust and who has a valid professional registration with the Health and Care Professions Council (HCPC)

Registered Nurse, for the purposes of this policy, means a Nurse who is either employed by, or seconded to, the Trust and who is registered with the Nursing and Midwifery Council (NMC) in the field of either mental health nursing or learning disability nursing.

Social Worker, for the purposes of this policy, means a social worker who is either employed by, or seconded to, the Trust and who has a valid professional registration with Social Work England.

Speech and Language Therapist (SALT), for the purposes of this policy, means a SALT who is either employed by, or seconded to, the Trust and who has a valid professional registration with the Health and Care Professions Council

The 'Trust' means Sheffield Health and Social Care NHS Foundation Trust

5 Detail of the policy

This policy is concerned with statutory duties under the Mental Health Act 1983 (as amended).

6 Duties

Responsible Clinicians:

The Responsible Clinician is responsible for:

- Authorising Section 17 leave requests
- Ensuring that he/she is informed of any child protection, child welfare issues, adult protection or domestic abuse issues
- Recording the decision to grant / refuse leave and rationale on the patient's electronic record
- Recording the approval of s17 leave on the s17 leave authorisation form which is available on the patient's electronic patient record
- Ensuring that any s17 leave they authorise is written in a clear, unambiguous way on the electronic s17 authorisation 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 whilst balancing 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. Public Protection Unit (PPU)
- 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
- 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

Ward Manager:

The Ward Manager is responsible for:

- Ensuring that all ward staff comply with this policy
- Ensuring that staff working on their wards are competent to carry out the tasks which this policy authorises them to undertake
- Ensuring that Section 17 leave compliance audits are completed on at least a weekly basis.
- Ensuring that any person on their ward whose first language is not English has a robust care plan in place to ensure leave and any written leave conditions are explained and understood as far as is possible.

Registered Nurses:

Registered nurses have a vital role to play in the effective implementation and facilitation of s17 leave. They often have a significant amount of knowledge of patients, their risks and protective factors and as such are authorised members of the MDT for the purposes of Pre-Leave Risk Assessments. Even if another professional discipline is conducting a Pre-Leave Risk Assessment, Registered Nurses can share their knowledge and experience of a particular patient to help inform the assessment.

Registered nurses have a role to play in assessing the competency of nursing assistants to carry out Post Leave Reviews.

All Staff:

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

Authorised members of the MDT are responsible for carrying out Pre-Leave Risk Assessments and ensuring the assessments which they carry out are documented on the

patient's electronic record. They are also responsible for ensuring the record of section 17 leave is completed when a patient they have assessed goes on leave. In most cases, the carrying out Pre-Leave Risk Assessments will be Registered Nurses on the wards where a patient receives care.

7 Procedure

7.1 Section 17 leave

Section 17 MHA makes provision for certain patients who are detained in hospital to be granted leave of absence. It provides the only lawful authority for a MHA 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 s135, s136, or those whose liberty is being deprived by means of a Deprivation of Liberty authorisation (court ordered or authorised by the Local Authority)

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. The latest guidance can be found on the Government's website:

https://www.gov.uk/government/collections/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 an eligible, detained patient has official leave from the hospital site, s17 leave is necessary. This applies to short term leave (e.g. to the local shops), longer term 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 and 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 authorisation form and record of absence from the ward will be kept for ground leave, thus being consistent with s17 practice for leave outside the hospital 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.

A Pre Leave 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 under s19 of the Act

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.

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 Responsible Clinician and should be done in a timely fashion so as not to disadvantage the patient. Section 17 leave 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 Responsible Clinician or covering Responsible Clinician and the s17 authorisation form should be completed as soon as possible.

7.3 When are other arrangements necessary?

Guidance for patients who are not detained under the Mental Health Act and are known (or ought to be known) to be at 'real and immediate' risk of suicide

Patients who have been admitted to hospital for the treatment of a mental disorder on an informal, voluntary basis have the right to leave at any time, but they can be asked to inform staff when they wish to leave the ward.

Informal, voluntary patients should always be aware, even prior to their admission, that they will be asked to inform staff should they wish to leave the ward. This would form one element of the mental capacity assessment which should have been completed prior to their admission (this form being known, in SHSC, as the 'CAT1').

However, as a State body, the Trust has a legal obligation, under Human Rights legislation, to protect life. This obligation exists in relation to both detained and informal patients.

In the case of voluntary, 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.

Whenever a patient is admitted on an informal basis, the MDT should always discuss and care plan how leave will be facilitated for that individual. The professional who has overall care responsibility for the person must be involved in this discussion from the earliest stage possible.

Care should be taken however to ensure that the plan to facilitate leave does not result in the person being unlawfully deprived of their liberty. It would not be appropriate to require a patient to wait until their next ward or MDT meeting for a decision about leave to be made; nor would it be appropriate for a care plan to state that should a person wish to leave the ward then a s5 holding power must be used, as both of these steps are likely to be unlawful.

Most capacitous patients who are admitted on an informal, voluntary basis understand why mental health wards may have locked doors and why they are asked to speak with staff when they wish to leave. It is therefore essential to always ensure that there is an open, ongoing discussion with the patient about how their leave can be safely facilitated.

In formulating a plan about leave, the ward should take proactive steps to consider the views and feedback from others such as the person's relatives/carers, CMHT and other relevant organisations. Any person(s) who will be affected by the leave should similarly be consulted.

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 an eligible 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 must 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.

It is important to ensure that patients whose first language is not English are not disadvantaged by any language barrier. If a patient is not able to access leave because of a language barrier which cannot be overcome, this must be formally escalated as a mental health incident and via directorate management.

Risk assessment by authorised members of the MDT should 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 (see subsequent section re. multiple episodes of leave). 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 conditions upon the granting of leave, but any such conditions can only be what are considered necessary in the interests of the patient or for the protection of others.

Any conditions which are imposed on a patient's leave must be as clear as possible to minimise the potential for misunderstanding and misinterpretation.

Responsible Clinicians are asked to consider the following when considering the granting of conditional leave:

- If conditional leave is leave to a certain area, it should be as specific as possible. Conditions such as 'local leave' or 'local area' are open to wide interpretation and are subjective. Such conditions can be difficult to manage if neither the patient, nor staff facilitating the leave, are not from the local area.

- If conditions may have an impact upon others, such as a patient's family/carer, other professionals, or external organisations, then those affected should be consulted before the leave is granted. This is to ensure that there is clear communication between relevant parties, but to also ensure that any proposed conditions do not inadvertently 'set up' anyone to fail.

- Conditions which are stipulated by the Responsible Clinician do not impose a legal duty on others to facilitate such conditions. For example, a condition of leave allowing a person overnight leave at a relative's address does not mean the relative has to agree to the patient staying.

When granting leave:

Any conditions must be clearly detailed e.g. whether the patient is to be escorted, by whom, how often.

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.

Authorised members of the MDT may be given the authority by the RC 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 the Electronic Patient Record.

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 others.

Historically, nursing staff have been responsible for the carrying out of Pre-Leave Risk Assessments. Given that much care and support is now provided to patients on a wider multi-professional, multi-disciplinary basis, this policy and approach to carrying out Pre-Leave Risk Assessments has been amended to recognise modern day mental health practice.

Neither the Mental Health Act, nor its Code of Practice, stipulates which professional disciplines can manage the leave of patients on a day-to-day basis. Within the Trust, the following professional disciplines are deemed to be **Authorised Members of the MDT**. This means they are authorised (subject to the s17 leave conditions written by the RC) to carry out Pre-Leave Risk Assessments:

- Registered Nurse
- Occupational Therapist
- Physiotherapist
- Psychologist
- Social Worker
- Speech and Language Therapist

Reference should be made to the definitions section of this policy in relation to what these professional disciplines mean for the purposes of this policy.

Authorised members of the MDT who are carrying out a Pre-Leave Risk Assessment must ensure they check the wording of the actual s17 leave authorisation form to ensure they are authorised under the terms of the s17 leave to conduct the assessment. Whilst, from a Trust's perspective, consent is given to authorised members of the MDT to conduct Pre-Leave Risk Assessments, any leave must still comply with the individual patient's leave conditions set out within the s17 leave authorisation written by the Responsible Clinician.

This means that if the Responsible Clinician has authorised s17 leave subject to 'nursing staff discretion', 'nursing assessment' or similar wording, then only a registered nurse would be authorised to carry out that patient's Pre-Leave Risk Assessment.

Whilst it is ultimately the Responsible Clinician's professional judgment and decision whether to allow leave, and to set conditions they consider to be appropriate, Responsible Clinicians are encouraged to authorise s17 leave subject to assessment by an 'Authorised member of

the MDT'. This will allow wider members of the MDT to help facilitate a patient's leave and recognise developments in professional mental health practice.

It is acknowledged that different services and MDTs may work differently and the level of involvement by authorised members of the MDT with individual patients will vary (especially those who are not registered nurses). There is therefore a recognition that despite being an authorised member of the MDT for the purposes of this policy, this does not mean that professional is always best placed to carry out the Pre-Leave Risk Assessment.

An element of professional judgement will therefore always still be needed when determining which authorised members of the MDT should conduct a particular Pre-Leave Risk Assessment.

7.10 Risk assessment considerations

The Trust adopts a position where all in-patients, regardless of diagnosis, service, or directorate are required to have a Core Pre-Leave Risk Assessment.

However, the Trust provides a range of in-patient services to an equally diverse range of patients. The risks posed by certain patients are likely to differ, and the environments in which patients are cared for will also differ. This means there may be times when a particular ward or service needs to consider certain risks which may, or may not, be relevant elsewhere.

Given that some services may need to consider risk factors which are not contained within the Core Pre-Leave Risk Assessment, local services may wish to create a local Standard Operating Procedure (SOP) which sets out what additional risk factors need to be included in their Pre-Leave Risk Assessments.

Adopting this approach therefore allows some flexibility to meet local service needs.

It is important to stress however that any SOPs produced in relation to Pre-Leave Risk Assessments must not seek to remove any of the risk factors contained within the Core Pre-Leave Risk Assessment. In other words, a SOP is to complement a Core Pre-Leave Risk Assessment and not to replace it.

Should local services wish to add to the Core Pre-Leave Risk Assessment by creating a SOP, the SOP should be presented to the Mental Health Legislation Operational Group (MHLOG) for comment.

7.11 Core Pre-Leave Risk Assessments – Minimum standards required

All patients to which this policy applies must have a Pre-Leave Risk Assessment undertaken by an authorised member of the MDT prior to every episode of leave.

As a minimum, a Core Pre-Leave Risk Assessment must consist of the following:

- Checking the s17 leave authorisation form to make sure the professional carrying out the assessment is allowed to do so
- Ensuring that s17 leave is actually allowed and in date.
- Staff need to be satisfied that if the patient is a restricted patient then permission from the Secretary of State must be evident.

- Checking whether leave is escorted, or unescorted, and checking that the right escorts (as per the s17 leave authorisation form) carry out the escorting
- Assessment of the risks associated with leaving with the ward; assessors should always ensure they feel able to account for their assessment and decision which they make
- Assessors should consider whether anyone needs to be alerted or informed that a person is about to have leave
- Assessing staff should consider whether there are any child or adult safeguarding issues which exist and if so whether such risks can be safely managed and mitigated against.
- An up-to-date description of the patient should be documented and a photograph taken as a safeguard in case the patient does not return and is missing
- A plan should be agreed with the patient (and relevant others eg. family) should a problem arise whilst out on leave.
- A copy of the s17 leave authorisation form should always be given to the patient, and to relevant others (eg. family)

Some authorised members of the MDT may find the 'LEAVING' acronym to be a helpful prompt and reminder about what each Core Pre-Leave Risk Assessment should contain as a minimum.

A copy of the LEAVING acronym can be found at Appendix XX.

Every Pre-Leave Risk Assessment must be recorded on the patient's electronic record.

If the Pre-Leave Risk Assessment is undertaken by an authorised member of the MDT who is not a registered nurse based on the ward where the patient is, then the staff member carrying out the assessment must always speak with a registered nurse who is on-shift about their intention on assessing leave. This is to ensure that any potentially relevant risk information which has not yet been documented on the patient's electronic record, or other relevant information which was shared during a shift handover, is not missed.

Whenever a Pre-Leave Risk Assessment has been undertaken and a patient granted permission for leave to take place, this decision should always be communicated to the nurse in charge. This is to ensure the nurse in charge is always appraised of a patient's whereabouts.

Subject to any conditions stipulated by the Responsible Clinician on a patient's section 17 leave authorisation form, the authorised member of the MDT is professionally responsible and accountable for their assessment and decision regarding whether leave is safe and appropriate to go ahead at a given point in time. Staff are authorised to not allow any proposed leave to go ahead if they assess it not to be safe.

Whilst all Pre-Leave Risk Assessments are important and need to be fully documented, this is even more critical if the risks of allowing leave versus not allowing leave are finely balanced, or when allowing leave is authorised under circumstances which may suggest leave should not be allowed (eg. if the team believe a period of time off the ward, after a period of disturbed behaviour, would be beneficial).

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

7.12 Pre-Leave Risk Assessments When A Patient Is Having Multiple Episodes Of Leave In One Day Or Short Period Of Time

All patients must have a Pre-Leave Risk Assessment before leave is granted. However, it is also recognised that some patients may have multiple episodes of leave within a short period of time/in one day.

Given this, if a patient is having multiple episodes of leave within a short period of time/same day, a pragmatic and proportionate approach is being taken. A balance needs to be struck between making Pre Leave Risk Assessments robust but not making the process overly demanding that they become a barrier for patients accessing leave. .

In these situations, a Pre Leave Risk Review should – as a minimum – always take place and be undertaken by an authorised member of the MDT. Some teams within the Trust are familiar with these types of reviews but they refer to them being 'top up' assessments.

A Pre-Leave Risk Review is intended to be a proportionate risk review, and to establish whether there have been:

- Any changes to the patient's mental health since the previous leave
- Any new risk incidents involving the patient since the previous leave
- Any new reasons to either facilitate or doubt for a further period of leave to be given.

If the answer is yes to answer of these, then the authorised member of the MDT should undertake a Core (ie. full) Pre-Leave Risk Assessment to inform their decision making.

It should be noted that no policy can always cover how certain individual patients may present, nor cover every feasible situation which may arise in relation to leave. It is therefore important to emphasise that should an authorised member of the MDT have any doubts about whether a period of leave should go ahead, then they should carry out a Core Pre-Leave Risk Assessment.

This means that if an authorised member of the MDT wishes to undertake a Core Pre-Leave Risk Assessment even if policy allows for only a Pre-Leave Risk Review, then that is a professional judgement made by that individual and should be respected.

Situations may arise when a clinical team's knowledge of an individual patient concludes that a Core Pre-Leave Risk Assessment should always be undertaken regardless of them having multiple episodes of leave within a short time. If this is the case, this should be entered into the patient's care plan and kept under review.

7.13 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. This should be done by an authorised member of the MDT.

Every period of leave and its risk assessment must be recorded in the patient records under a daily progress note headed '**Pre-Leave Risk Assessment (PRLA)'**. 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 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.

8. Post Leave Reviews

The MHA Code of Practice states that the outcome of a patient's leave should be recorded so it can help inform future decision making.

This review should not only consider what may have gone wrong or caused concern, but should also consider what went well.

Therefore, after every period of leave, a Post Leave Review must always take place and be documented on the patient's electronic record.

As a minimum, each Post Leave Review should consider three elements:

- What went well
- What, if anything, did not go well
- Any achievements reached as part of the patient's recovery

The review should consider the feedback from not only patients but any escorting members of staff or others who may have valuable information to contribute eg. relative/carer.

Any member of staff from the patient's care team can complete the Post Leave Review. Nursing assistants can complete the Post Leave Reviews subject to having been deemed competent to do so by a registered nurse.

All Post Leave Reviews must be documented as a progress note on the patient's electronic record. The progress note should start by writing, in capitals: **POST LEAVE REVIEW (PLR)**. This will assist others being able to find the review.

8.1 Post Leave Reviews when there are multiple episodes of leave in a day

If a patient has multiple episodes of leave from a unit in a day, a balance needs to be struck between reviewing how each leave episode has gone and the practicalities of recording these on the patient's electronic record.

To avoid a situation where members of the patient's clinical team could end up being taken away from direct patient work and their time being dominated by solely writing on patient records, a pragmatic position has been taken. This position is that if a person is having multiple episodes of leave in a day, a formal post leave review only needs to be documented on the patient's electronic record at least once a day.

This means that when a patient has multiple episodes of leave in the same day, the Post Leave Review is to reflect upon all the leave episodes a patient had that day.

It is therefore recommended that in these situations, the formal Post Leave Review should be carried out after the last leave of the day.

The content of the Post Leave Review when there have been multiple episodes of leave in a day remains the same – ie. what went well, what did not go well, what achievements were reached in terms of the patient's recovery

The review should consider the feedback from not only patients but any escorting members of staff or others who may have valuable information to contribute eg. relative/carer.

Any member of staff from the patient's care team can complete the Post Leave Review. Nursing assistants can complete the Post Leave Reviews subject to having been deemed competent to do so by a registered nurse.

All Post Leave Reviews must be documented as a progress note on the patient's electronic record. The progress note should start by writing, in capitals: **POST LEAVE REVIEW (PLR).** This will assist others being able to find the review.

Note: Although Post Leave Reviews when there are multiple episodes of leave in a day/short period of time only need to be documented at least once a day, this does not mean that staff should not check in with patients each time they come back to the ward. Depending on how a patient presents on return may mean more than one Post Leave Review is needed to allow a more in-depth discussion with the patient.

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

Responsible clinicians' responsibilities for their patients remain the same while 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 Integrated Care Broads (ICBs) (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.

10. 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.

11. 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.

12. Leave not being able to go ahead

Situations may arise when a patient is unable to take their leave.

One such a situation is when staff, having completed a Pre-Leave Risk Assessment, deem it not to be safe for the leave to go ahead.

There may also be times when leave cannot proceed as hoped because of other demands placed on staff. How these situations should be dealt with will depend upon the circumstances.

If the s17 authorisation leave form states a patient is to have leave *at specific times and/or on specific days*, but this cannot happen because of there being insufficient staffing levels, then two incident forms are required: one to report insufficient staffing levels, and a second to report not being able to facilitate leave. To report the breach in respect of leave using the Trust's Ulysses system, select the following incident type and incident category:

Clinical Other → Diagnosis/Treatment → S17 Leave – Unable to Facilitate

If, however, a patient's s17 authorisation of leave form gives leave but not at specific times or days, if the leave cannot go ahead at a time which is the patient's choice or preference because of insufficient staffing levels, then this would not constitute being unable to facilitate leave – so long as the patient's leave is ultimately provided at a more convenient time. In these situations, only an incident related to staffing levels is needed.

Example:

- Your patient has a s17 authorisation of leave form which says they can have escorted leave three times a week for an hour each time. The patient wants to take the leave now but because of clinical activity levels it cannot be facilitated at this point in time, but can be facilitated later. So long as the patient is able to have leave in accordance with the s17 authorisation (in this case being escorted leave three times a week for an hour each time) then this would not be deemed as a breach.

- If, however, you are working with a patient and their section 17 authorisation form allows escorted leave every Tuesday morning for up to two hours, but when this time arrives it cannot be facilitated because of insufficient staffing then this would be deemed to be a breach and would need an incident report submitting in relation to a breach of mental health legislation.

If leave is not allowed to go ahead, the reasons and rationale must be clearly documented on the patient's record.

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

If a patient is recalled from their s7 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 leave 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.

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

In case a patient fails to return from leave, an up-to-date description of the patient should be readily 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.

15 Development, Consultation and Approval

This policy was developed with the involvement of clinical staff. A Task and Finish Group was established where clinical staff were able to attend, give feedback n the policy that was already in place, and highlight where challenges to policy compliance were being experienced. Suggestions to improve practice were made and considered. The Head of Mental Health Legislation met with ward and nurse managers, and individual discussions with some staff took place where they had particular issues or queries to raise.

Details of the proposed changes were circulated to nurse managers, responsible clinicians, and relevant professional leads, and online feedback forms were made available for feedback to be captured. A copy of the final draft policy was again circulated to relevant clinical managers, and also to the Mental Health Legislation Operational Group.

This policy will require formal review in 3 years-time, but it may be reviewed prior to this date should any areas of learning be identified, or in the event of legislation being amended.

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16 Audit, Monitoring and Review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Monitoring instances when s17 did not take place owing to	Incident reporting	Clinical staff to alert; Incidents reported to Mental Health Legislation Operational Group (MHLOG)	Ongoing	Monthly at MHLOG via Head of Mental Health Legislation (HoMHL)	MHLOG, via HoMHL	MHLOG via HoMHL
Compliance with Pre Leave Risk Assessment guidance	Monthly audit of random sample	Initially Head of Mental Health Legislation, subsequent to be done by ward managers	Monthly sample	Monthly at MHLOG	MHLOG, via HoMHL	MHLOG, via HoMHL
Undertaking of Post Leave Reviews	Monthly audit of random sample	Initially Head of Mental Health Legislation, subsequent to be done by ward managers	Monthly sample	Monthly at MHLOG	MHLOG, via HoMHL	MHLOG, via HoMHL

The policy review date will be September 2025.

17 Implementation Plan

This policy will not be implemented immediately upon it being approved by the Policy Governance Group. This is because training will need to be finalised (and consider any amendments by PGG) and delivered.

The training will be designed by the Head of Mental Health Legislation and made available online for staff to access. Staff will be required to confirm via MS Forms that they have undertaken the training. There are no financial implications identified in relation to the training.

Action / Task	Responsible Person	Deadline	Prog
Policy Governance Group	Head of Mental Health Legislation	26.9.22	
Training material to be finalised	Head of Mental Health Legislation	WC 3.10.22	
Training material goes live	Head of Mental Health Legislation; relevant clinical staff to complete	WC 10.10.22	
Policy goes live	Clinical staff	24.10.22	

11 Dissemination, Storage and Archiving (Control)

This policy will be made available on the Trust's intranet and internet site. It being approved will also be included in a Trustwide routine communication of information. Nurse managers and clinical directors will be updated, and the Mental Health Legislation Operational Group will be similarly updated.

Training links will be sent by the Head of Mental Health Legislation to nurse managers and clinical directors for dissemination.

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0				
2.0				
3.2				
4.0				
5.0	October 2022	October 2022	October 2022	

12 Training and Other Resource Implications

Training material will be devised to accompany this policy. The training will be by means of online, e-learning. Training will be provided prior to the actual implementation date of this policy.

13 Links to Other Policies, Standards (Associated Documents)

Mental Health Act 1983 (as amended)
Mental Health Act 1983 (as amended) Code of Practice, 2015

14 Contact Details

Title	***Name***	***Phone***	***Email***
Head of Mental Health Legislation	Jamie Middleton	271 8110	jamie.middleton@shsc.nhs.uk

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	N/A	N/A
Disability	Additional support may be needed for some with disabilities to access leave. This may not be as readily available if additional resources and staffing are needed.	Policy changes alone unlikely to reduce barriers but reporting and escalation processes will assist in identifying if there is a problem and for further escalation if necessary. Routine care planning is expected to address any such issues.	No
Gender Reassignment	No	N/A	N/A

Pregnancy and Maternity	No	N/A	N/A
Race	There is a potential for those whose first language is not English to be at a disadvantage as they may not understand the parameters of leave which is being given (if this is not appropriately translated)	Yes. It has been emphasised in policy that those whose first language is not English may be at higher risk of inadvertent discrimination and that wards must ensure they plan in advance for any language needs.	N/A
Religion or Belief	No	N/A	N/A
Sex	No	N/A	N/A
Sexual Orientation	No	N/A	N/A
Marriage or Civil Partnership	No		

Please delete as appropriate: - Policy Amended

Impact Assessment Completed by: Jamie S Middleton
Name /Date 20.9.22

APPENDIX B

Pre-Leave Risk Assessments
Core Structure

All patients who are to have leave must have a Pre-Leave Risk Assessment undertaken and documented.

SHSC has the following core structure which must be used for all Pre-Leave Risk Assessments. This core structure contains elements of a Pre Leave Risk Assessment which need to be considered for all patients, regardless of what ward they are on, or which service they are in.

Look at the **L**eave authorisation and **L**egal status. Look if it is still in date; if patient is 'restricted' is there also Ministry of Justice approval in place?
Ensure there is an understanding of the leave conditions to patient and relevant others. Do conditions require leave to be **E**scorted and if so have the right **E**scorts been allocated. If leave goes ahead, remember to **E**nter the time the patient leaves and to **E**nter the time the patient returns.
Assess risks associated with the person leaving the ward; do you feel **A**ble to **A**ccount for your **A**ssessment. **A**lerts – you need to **A**lert **A**nyone that leave is taking place eg. victim, relative, carer
Vulnerable adults and **V**ulnerable children: consider if there are any safeguarding issues in respect of adults and children. If none identified, state it has been considered.
Identification: ensure there is an up-to-date description documented and photograph taken
Not going well: ensure the patients, and relevant others, are aware of what to do, and who to contact, should leave not being going well or a problem arise
Give copy of s17 form to patient and relevant others eg. family. Give an account of what you have done and why – ie. document your risk assessment on the electronic record

Appendix C

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	
2.	Is the local Policy Champion member sighted on the development/review of the policy?	
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	
5.	Has the policy been discussed and agreed by the local governance groups?	
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	
	Template Compliance	
7.	Has the version control/storage section been updated?	
8.	Is the policy title clear and unambiguous?	
9.	Is the policy in Arial font 12?	
10.	Have page numbers been inserted?	
11.	Has the policy been quality checked for spelling errors, links, accuracy?	
	Policy Content	
12.	Is the purpose of the policy clear?	
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	
15.	Where appropriate, does the policy contain a list of definitions of terms used?	
16.	Does the policy include any references to other associated policies and key documents?	
17.	Has the EIA Form been completed (Appendix 1)?	
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	
20.	Is there a plan to i. review ii. audit compliance with the document?	
21.	Is the review date identified, and is it appropriate and justifiable?	