Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title:	**Section 17 (Leave of Absence) Policy**
Version:	**10**
Reference Number:	**MHL002**
Scope:	
This policy is to ensure that all staff are aware of their responsibilities prior to the granting of leave under section 17, during periods of leave and on return from leave.	
Purpose:	
The aim of this policy is to standardise the definitions, practices and responsibilities in the use of planned section 17 leave for all detained patients within the Trust.	
Requirement for Policy	
Mental Health Legislation, Mental Health Act Code of Practice (2015)	
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Section 17 (Leave of Absence) Policy V9	
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Mental Health Law Manager – Mia Majid	
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This document has been developed in collaboration with the following interested parties: • Mental Health Law Scrutiny Group • Acute Care Forum • Local Borough wide forums	

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The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: • Mental Health Law Scrutiny Group • Acute Care Forum • Local Borough wide forums	
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Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
CL003	Care Programme Approach (CPA) Policy
CL005	Observation & Engagement Policy
MHL001	Absent without Leave (AWOL) Policy
CL032	Community Treatment Order (CTO)
CL061	Admission, Exit and Entry Policy for Mental Health Wards

CL049	Section 117 – Aftercare Policy
CL058	Policy on Treatment of Patients Subject to the Mental Health Act 1983 Part 4 and Part 4A
CL010	Child Safeguarding Policy
CL019, CL088 CL094	Risk Assessment and Management Policies
Policy Associated Documents:	
TAD_MHL002_01	Section 17 Leave Form for all adults
TAD_MHL002_02	Section 17 Leave Form for all RHSD inpatients
TAD_MHL002_03	Ministry of Justice Guidance and Form
Other external documentation/resources to which this policy relates:	
CQC Regulations **This policy supports the following CQC regulations:**	

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i. Guiding Principles

It is essential that all those undertaking the functions under the Mental Health Act 1983 (MHA) understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act.

The five overarching principles are:

- **Least restrictive option and maximising independence**
  Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.
- **Empowerment and involvement**
  Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.
- **Respect and dignity**
  Patients, their families and carers should be treated with respect and dignity and listened to by professionals.
- **Purpose and effectiveness**
  Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.
- **Efficiency and equity**
  Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Staff must apply all the principles to all decisions. All decisions must be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998 (HRA) and Equality Act 2010. All five sets of principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.

Any decision to depart from the directions of the policy and the Code of Practice must be justified and documented accordingly in the patient's case notes. Staff should be aware that there is a statutory duty for these reasons to be cogent and appropriate in individual circumstances.

1. INTRODUCTION

Leave of absence is acknowledged by the Trust as being an important part of a patient's treatment plan, care, recovery and discharge pathway but it can also be a time of risk.

The Trust recognises its responsibility placed upon its employees by the Mental Health Act 1983 (MHA) in ensuring that the practice of using leave is compliant with section 17 of the MHA, is evidence-based and safe for the patient.

2. PURPOSE.

The aim of this policy is to standardise the definitions, practices and responsibilities in the use of planned section 17 leave for all detained patients within the Trust.

This policy is to ensure that all staff are aware of their responsibilities prior to the granting of leave under section 17, during periods of leave and on return from leave.

Section 17 leave cannot be granted to patients subject to section 136, 135 5(2), 5(4), 35, 36 or 38 of the Mental Health Act 1983 and the processes for clinical leave must be followed for those patients (see Section 13 of this policy).

Patients subject to restriction orders (i.e.: Sections 41 and 49) cannot be granted leave of absence by the RC without the permission of the Secretary of State for Justice, (exceptions are when urgent medical attention is required). The Ministry of Justice paperwork for authorising leave and reporting on leave are available from the Mental Health Law Office in each borough and in also contained within TAD_MHL002_03.

3. DEFINITIONS

Leave

Leave of absence is permission to be absent from hospital for a period of time, granted under section 17 by the patient's RC.

Responsible Clinician

The RC is the registered medical practitioner in charge of the treatment of the patient, whose responsibilities with regard to section 17 leave cannot be delegated and who is not professionally accountable for the patient's treatment to any other clinician.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

- **The Medical Director**; is responsible for ensuring the requirements of this policy are adhered to via the Mental Health Law Scrutiny Group and the Acute Care Forum
- **Team and Departmental Managers** are responsible for the distribution and implementation of policies across services.
- **MH Law Forums** are responsible for escalating issues to Mental Health Law Scrutiny Group for investigation and monitoring the use of this policy in the local boroughs
- Staff involved in the granting of leave are responsible for applying all requirements contained within this policy and other related policies.
- **MH Law Administrators** are responsible for scrutinising all Section 17 leave forms and ensuring they are compliant with this policy
- All staff have a responsibility to follow Trust policies.

5. ROLES AND RESPONSIBILITIES OF CLINICAL STAFF

Only the RC can grant leave of absence to patients formally detained under the Act. In the absence of the RC, (for example due to annual leave or sick leave), permission can only be granted by the clinician who is for the time being acting as the patient's RC[1].

The RC and those responsible for the patient's treatment and care are still responsible for providing appropriate treatment and care whilst the patient is on leave.

The RC's responsibility to grant leave cannot be delegated.

The RC must seek the approval from the Home Secretary for any leave being proposed for a patient liable to be detained under the act who has had restrictions placed upon their detention (i.e.: under Section 41 or 49).

Nursing staff have a vital role in the effective implementation, recording and evaluation of leave granted to detained patients. It should be standard practice for the nurse to record every occasion when leave is taken, the circumstances under which it is taken (e.g. whether escorted/accompanied and if so by whom) and the date and time at which the patient departs and returns. Nursing staff should assess a patient's clinical state before each and every instance of leave. They should pay particular attention to the risk which a patient poses to themselves or others. The patient's mental state should also be assessed on return from leave. If nursing staff have particular concerns they should seek the advice of the RC.

Nursing staff have the discretion to prevent leave of absence if it is felt necessary. If leave is stopped the RC should be notified and a new leave form completed as required. The decision of nursing staff to prevent patients from accessing leave should be on the basis of clinical indicators and risk assessments and reasons should be clearly communicated to the patient and documented in the notes.

[1] Mental Health Act 1983:Code of Practice, 2015;para 27.8

The staff member who accepts the section 17 form on behalf of the hospital managers is responsible for ensuring that the leave form is correctly completed by the RC and that copies of the form are given to the patient, (and where appropriate family/carers in accordance with the usual considerations regarding patient confidentiality) and the care co-ordinator involved with the patient's care. The staff member is also required to document reasons for non-compliance with this requirement on the form

6. PROCEDURE FOR AUTHORISING LEAVE OF ABSENCE

Leave should be properly planned, well in advance if possible, with consultation with community services where necessary. RC's 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 [2]. When considering and planning leave of absence, RC's 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
- consult any relevant agencies, e.g. MAPPA or the sex offender management unit (SOMU)
- undertake a risk assessment and put in place any necessary safeguards, and (in the case of mentally disordered offender patients) 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.

In addition authorisation for leave must stipulate precisely:

- How long the authorisation is valid for;
- Under what conditions leave is authorised (e.g.: where to, who with);

[2] Mental Health Act 1983:Code of Practice, 2015;para 27.9

- If authorisation is given for periods of short leave, the frequency must be stipulated (e.g.: every afternoon, once a week);
- Any period of leave outside these stipulated conditions must have a separate authorisation;
- The authorisation must be documented in their health records and the specific details recorded on a Section 17 Leave of Absence Form (TAD_MHL002_01 & 02).
- Patients (and where appropriate family/carers) are routinely given copies of their section 17 leave plans and this is recorded. It is important to document occasions where this is not done (e.g.: where patient declines a copy). The staff member who accepts the section 17 form on behalf of the hospital managers is responsible for ensuring copies are given as above and also to the care co-ordinator involved with the patient's care.
- Authorisation should include reference to nursing staff discretion in the management of leave of absence, where appropriate.

Authorisation should only be given after the following criteria have been satisfied:

- Leave of absence has been agreed as part of the patient's treatment/care plan;
- Leave of absence is authorised following a recent clinical risk assessment. This should determine what risk factors there are in relation to the length of leave, location and support from carers/relatives. This should be documented in the patient's health care record and shared (where appropriate) with those involved with the care of the patient in the community;
- Child safeguarding issues must have been considered as part of all risk assessments prior to granting leave and these must be clearly documented within the patient's notes. This must be done before the initial completion of the section 17 form but also by nursing staff prior to allowing the patient to leave the ward. Issues to be considered are:
    - Is the person likely to have or resume contact with their own children or other children
    - Does the person have delusional beliefs involving the children (please provide details in notes)
    - Is there concern that the person might harm their child / un born child as part of a suicide plan
- This requirement also means staff involved in allowing patients leave from the ward must be familiar with the Child Safeguarding Policy.
- If patients do not consent to carers or other people who would normally be involved in their care being consulted about their leave, RC's should reconsider whether or not it is safe and appropriate to grant leave.
- For long term or unescorted leave there should be a clear set of indicators in the patient's health care record as to when the patient should be recalled from leave (e.g.: signs of relapse, necessary arrangements not being in place);
- Any change in circumstances whilst the patient is on leave should be reported to the RC and a review of the authorisation prompted, if necessary;

- An assessment of the patient and the risk factors whilst on leave should be undertaken by nursing staff on the ward immediately prior to the patient going on leave. Checks should be made that all the arrangements for a successful period of leave are in place.
- If appropriate, there should be an agreed process for monitoring the patient whilst on leave, which is documented in the health care records;
- Local procedures must identify any additional requirements/ responsibilities, such as those for leave of absence from secure units.
- Where there are concerns by any member of the MDT regarding the conditions of the leave granted they should be escalated immediately to the RC and this should be documented in the notes. Leave should be withheld until the advice has been given by the RC.
- The outcome of leave – whether or not it went well, particular problems encountered, concerns raised or benefits achieved – should be recorded in patients' notes to inform future decision-making. Patients should be encouraged to contribute by giving their own views on their leave. Particular note should also be made of concerns raised by any escorting staff, by the patient, or by relatives or friends. This will also enable any future discussion of leave to be fully informed.
- A clear up-to-date description of the patient's appearance should be available in the patient's notes in case they fail to return from leave. This information should appear next to the current leave form.[3] A photograph of the patient should also be included in the patient's notes, if necessary with the patients consent (or if the patient lacks capacity to decide whether to consent or not, and whether a photograph is taken in accordance with the Mental Capacity Act (MCA)).

7. CONSIDERATION OF COMMUNITY TREATMENT (CTO)

The RC must consider the use of CTO when granting leave of absence for more than seven consecutive days or extending leave so that the total period is more than seven consecutive days. However this does not mean that the RC cannot use longer term leave if that is the more suitable option[4]. The RC will need to be able to show that both options have been duly considered. The decision and the reasons for it should be recorded in the patient's notes[5].

RC's may not grant longer term leave to Part 2 patients or to unrestricted Part 3 patients without first considering whether the patient should instead become an CTO patient by means of a community treatment order.

Guidance on factors to be considered when deciding between leave of absence and CTO is given in Chapter 31 of the revised 2015 Code of Practice to the MHA.

NB:

- CTO does not apply to patients who are subject to restriction orders

[3] Mental Health Act 1983: Code of Practice, 2015 para 27.22
[4] Mental Health Act 1983: Code of Practice, 2015 para 27.11
[5] Mental Health Act 1983: Code of Practice, 2015 para 27.12

- If leave is being implemented as part of a discharge pathway and CTO is being considered the RC must ensure a referral is made to the AMHP team as soon as possible – refer to the CTO policy for further detail on this process

Section 117 Aftercare applies to all patients on section 17 leave who are detained under section 3, 37, 45A, 47 or 48 and the section 117 policy should be referred to for guidance.

8. CARE AND TREATMENT WHILE ON LEAVE

RCs 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 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 paragraphs, although recall is not a legal requirement.

9. ESCORTED LEAVE

- 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 (please note this authorisation is different to the authorisation for 'escorted leave' on the section 17 leave form, please contact your local MHL Office for further advice/information)**. These powers are contained within section 17(3) and effectively make available to the custodian the powers within section 137 (provisions as to custody, conveyance and detention) and section 138 (retaking of patients escaping from custody). The purpose of this provision is to provide those who are caring for the patient during a period of leave immediate power to restrain the patient should the patient make an attempt to abscond. Its effect is that the patient maybe detained in the named hospital or care home during the period of leave and maybe escorted at all times. Please note that neither section 137 and 138 gives the authority to remove someone from private premises without permission from the owner/occupier unless a section 135(2) warrant has been obtained. Please refer to the Trust policy CL031 on obtaining section 135 warrants to search and remove patients.

- If a patient who lacks capacity to understand the conditions of leave is being detained in a care home for instance, the care home must trigger the deprivation of liberty safeguards process requirements. If an authorisation is granted, the staff of the care home will be authorised to detain the patient without the need to obtain a separate written authorisation from the hospital managers of the detaining hospital. A deprivation of liberty authorisation might also be required if a mentally incapacitated patient is

granted leave of absence for treatment in hospital for a physical disorder and is detained there. For further advice please contact your local MHL Office.

10. ACCOMPANIED LEAVE

While it may often be appropriate to authorise leave subject to the condition that a patient is accompanied by a friend or relative (e.g. 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.

11. CONDITIONS OF LEAVE

There are no mandatory conditions that must be imposed by the RC. Conditions could for example, require the patient to reside as part of 'trial leave' at a particular address, to be a patient at another hospital, to maintain contact with their care co-ordinator, to abstain from substance misuse or to accept prescribed medication.

12. URGENT TREATMENT IN A GENERAL HOSPITAL

(I.e. Treatment NOT for a Mental Disorder)

In the event that a detained patient requires urgent medical treatment for a physical disorder or injury and the urgency of the situation is such that the RC has been unable to authorise leave of absence, this should not prevent the patient from receiving the necessary treatment, since leave may be granted retrospectively if necessary and it is the responsibility of all staff involved to ensure this is done in a timely manner.

Patients subject to restriction orders in need of urgent medical treatment for a physical disorder or injury and the urgency of the situation is such that the Ministry of Justice would be unable to authorise leave of absence, this should not prevent the patient from receiving the necessary treatment.

13. FAILURE TO RETURN FROM A PERIOD OF LEAVE

Times for leave to be taken between must be specified on the leave form and a return time agreed with the patient by nursing staff when allowing access. Failure to return by the agreed time will immediately result in the patient being regarded as absent without leave and the absent without leave (AWOL) policy must be implemented by staff.

The nurse in charge will consult the patient's care plan and records for information regarding contingencies already planned in the event of the patient failing to return from leave, including the implementation of the AWOL policy.

14. LEAVE TO RESIDE IN OTHER HOSPITALS

Where a patient is granted leave to reside at another hospital within England and Wales, the RC at the first hospital should remain in overall charge of the patient's case. It may be more appropriate to consider transfer of the patient in the longer term.

15. LEAVE TO OTHER AREAS

Escorted leave to Scotland, Northern Ireland or any of the Channel Islands can only be granted if the local legislation allows patients to be kept in custody while in that jurisdiction.

16. RECALLING A DETAINED PATIENT FROM LEAVE

Authorised leave of absence may be revoked if it is felt necessary in the interests of the patient's health and safety or for the protection of other persons that he/she again becomes an inpatient.

The RC must arrange for a notice in writing revoking the leave to be served on the patient or on the person for the time being in charge of the patient. [6] Hospitals should always know the address of patients 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 documented in the patient's health care record.

If the patient refuses to return to the detaining hospital, he/she becomes a patient absent without leave and may be taken into custody and returned to the hospital (see absent without leave policy).

It is essential that carers (especially where the patient is residing with them on leave) and professionals who support the patient while on leave should have easy access to the patients care team who can then liaise with the patients RC if they feel consideration should be given to return of the patient before their leave is due to end.

17. RESTRICTED PATIENTS

- Patients subject to restrictions orders cannot be granted leave by the RC alone. The Mental Health Unit at the Ministry of Justice must approve all periods of leave for this patient group.
- The RC must complete an application form (TAD_MHL002_03) detailing the leave proposal. This must be sent to the MHU at the Ministry of Justice.
- Once leave has been approved it will remain in operation unless the patient's circumstances change. Careful risk assessments must be undertaken before each

[6] Mental Health Act 1983:Code of Practice, 2015 para 27.32

period of leave. This may be carried out by the RC or a member of the nursing team. If there are any changes the Ministry of Justice must be immediately informed.

- Leave should be planned in advance for restricted patients to allow time to request the approval of the Ministry of Justice. Where this is not possible for emergency reasons (see 7.2 of this document) the Ministry of Justice should be informed as a matter of urgency. Where leave is required for compassionate reasons the caseworker at the Ministry of Justice should be contacted by telephone to agree the arrangements.
- If a decision is made to revoke or suspend leave the RC should ensure the Ministry of Justice is informed immediately.
- Reports on completed leave need (TAD_MHL002_03) to be sent by the responsible clinician to the Ministry of Justice no later than three months after the date of consent.
- Where the courts or Secretary of State has specified a particular unit within Pennine Care rather than a hospital name, those patients would require an approved leave of absence to access any other part of the hospital site as well as outside the hospital.

18. LEAVE NOT COVERED BY SECTION 17

- Informal patients are not covered by section 17 leave and staff MUST refer to the CL019 Clinical Risk Assessment and Management Policy and any other related policies for guidance. Practitioners need to be aware the Trusts duty of care also applies to informal patients. There is a responsibility for ensuring that the current whereabouts of patients is known at all times and that their safety and those of others is maintained. The fact that the patient is not detained under the Mental Health Act does not necessarily imply that they are well enough to leave the in-patient area without the knowledge of the staff charged with providing their care. It may also be necessary to assess an informal patient for detention under the MHA should concerns be raised as to their risk to self, others or from others. Staff MUST follow the correct procedures contained within the AWOL Policy for informal patients who are missing or absent from the ward.
- Section 17 leave only applies to patients subject to a long term detention (such as section 2 or 3 for example) so does not include short term detentions such as section 5(4), 5(2) or 135, 136. However there may be occasions where the patient needs to access the grounds whilst awaiting further assessments subject to risk assessments.
- As the patient is detained to the hospital, grounds access[7] is possible and would be a clinical decision that is only made following a risk assessment[8].

[7] Code of Practice para 27.7: What constitutes a particular hospital for the purpose of leave is a matter of fact which can be determined only in the light of the particular case. Where one building, or set of buildings, includes accommodation under the management of different bodies (e.g. two different NHS Trusts), the accommodation used by each body should be treated as forming separate hospitals. Facilities and grounds shared by both can be regarded as part of both hospitals.

[8] Code of Practice para 27.5: Except for certain restricted patients, no formal procedure is required to allow patients to move within a hospital or its grounds. Such “ground leave” within a hospital may be encouraged or, where necessary, restricted, as part of each patient’s care plan.

- Patients remanded to hospital under sections 35, 36 and 38 may not be granted leave of absence from the hospital without the express agreement of the court[9]. As stated above grounds access may be possible as a clinical decision following risk assessments although this should only be escorted access for this category of patient.
- Local protocols must be adopted through the Mental Health Law forums to agree the criteria for grounds access.

19. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure

20. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

21. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

22. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

[9] Reference Guide to the MHA 2015 25.11

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

23. MONITORING

The Mental Health Law Scrutiny Group will monitor this policy and will be responsible for ensuring the processes and principles of this policy where applicable are included in clinical audits where this is considered appropriate.

As part of the review and monitoring of this policy the Mental Health Law Scrutiny Group will consider how any learning requirements will be addressed with staff.

The effective application of this policy / guideline, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

24. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

25. REFERENCES

- Mental Health Act 1983
- Mental Health Act Code of Practice 2015
- Mental Health Act Reference Guide 2015
- Ministry of Justice Guidance 2017