

Policy: I3

Informal Patients

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Equality & Diversity Statement

The Trust strives to ensure its policies are accessible, appropriate and inclusive for all. Therefore all relevant policies will be required to undergo an Equality Impact Assessment and will only be approved once this process has been completed

Sustainable Development Statement

The Trust aims to ensure its policies consider and minimise the sustainable development impacts of its activities. All relevant policies are therefore required to undergo a Sustainable Development Impact Assessment to ensure that the financial, environmental and social implications have been considered. Policies will only be approved once this process has been completed

Version Control Sheet

Version	Date	Title of Author	Status	Comment
I3/01	March 2007		New Policy	
I3/02	May 2007		Revised Policy	
I3/03	November 2007		Revised Policy	
I3/04	September 2007	MHA Office/ Health Records Manager	Revised Policy. Changes ratified by Broadmoor SMT	To incorporate changes made by the MHA 2007
I3/05	November 2012	Executive Director Of High Secure Services	Revised Policy	To update the policy and make it compliant with NHSLA
I3/05	April 2013	Executive Director of High Secure Services	Revised Policy	Ratified by SMT on 25 April 2013
I3/06	October 2015	Executive Director of High Secure and Forensic Services	Revised Policy	

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1. Introduction

The aim of Policy I3 is:

- 1.1. To outline the circumstances when a patient may be admitted informally or change from detained to informal status whilst in Broadmoor Hospital.
- 1.2. To outline how an informal patient should be managed in Broadmoor Hospital
- 1.3. To provide information to staff about detaining an informal patient if circumstances warrant this.

2. Scope

- 2.1 This Policy applies to all staff working clinically with patients and those staff involved in implementing the provisions of the Mental Health Act and Code of Practice within a high secure hospital.

3. Definitions

- 3.1. Detained patient is a patient who is sectioned under the Mental Health Act 1983 (revised in 2007).

4. Duties

4.1. Accountable Director

The accountable director is responsible for the development of relevant policies and to ensure they comply with NHSLA standards and criteria where applicable. They must also contain all the relevant details and processes as per P3. They are also responsible for Trust-wide implementation and compliance with the policy.

4.2. Managers

Managers are responsible for ensuring policies are communicated to their teams / staff. They are responsible for ensuring staff attend relevant training and adhere to the policy detail. They are also responsible for ensuring policies applicable to their services are implemented.

4.3. Policy Author

Policy Author is responsible for the development or review of a policy as well as ensuring the implementation and monitoring is communicated effectively throughout the Trust via CSU / Directorate leads and that monitoring arrangements are robust.

4.4. Local Policy Leads

Local policy leads are responsible for ensuring policies are communicated and implemented within their CSU / Directorate as well as co-ordinating and systematically filing monitoring reports. Areas of poor performance should be raised at the CSU / Directorate SMT meetings.

4.5. Specific Staff for Policy

Mental Health Act Office/Health Record Staff:

- To provide advice on local procedures (Section 5.2.)
- If a patient becomes informal following a discharge from section he will receive a letter from the MHA Office (see Appendix 1)
- Review the policy which will otherwise be conducted every three years by the Director of High Secure Services and the Mental Health Act/Health Records Office (Section 10.)

Responsible Clinicians [RCs]:

- Responsible for discharging patients from their Sections under the MHA and becoming informal. (Sections 5.2. and 7.8.)

Clinical Nurse Managers [CNMs]:

- Take relevant action when an informal patient wishes to leave the hospital. (Sections 7.3. and 7.5.).
- To make arrangements for the collection of patient's property and conveying the patient to hospital reception when informal patient wishes to leave. (Section 7.10.)

Site Management Staff:

- To be responsible for taking the necessary action when an informal patient on leave of absence does not wish to return. (Section 7.11.)

Social Workers:

- To assist the Clinical Team to complete the planning process and its implementation when an informal patient wishes to be discharged. (Section 8.2.)

4.6. All Staff

Staff involved in the clinical care of patients.

Staff responsible for the implementation of the Mental Health Act and Code of Practice.

5. Systems and Recording

- 5.1 When a patient is resident in the hospital on an informal basis due to lapse of detention or discharge from detention at a Mental Health Review Tribunal, the patient's rights must be re-read, the Mental Health Act office informed and the responsible CCG alerted. In addition NHS England (NHSE) should be alerted.

6. Admission of an informal patient or change of legal status from a detained to an informal patient

- 6.1. With one or two exceptions all patients in High Secure Hospitals are continuously detained under the Mental Health Act 1983 (as amended by the MHA 2007) or associated Criminal Insanity legislation. Rarely, a patient may be admitted informally (not under a section of the MHA) or remain informally, having previously been detained under the MHA. Section 131 of the MHA covers Informal Patients.
- 6.2. There are a number of circumstances where it is appropriate to consider allowing an informal patient to be admitted to or remain in a High Secure Hospital:
- A detained (sectioned) patient may become informal. Principal among the reasons for this are discharge by a Mental Health Tribunal, a MHA Managers Panel or the Responsible Clinician (RC). A Nearest Relative can also order the discharge of a patient detained under Section 2 or Section 3. If specific conditions are met, the RC can bar a Nearest Relative's discharge (Section 25). If a discharge from detention occurs it may be inappropriate to require the patient to leave the hospital immediately. Provided the patient expresses a willingness to stay this can be facilitated in the short term.
 - A detained patient may become informal because the legal authority for detention unexpectedly ceases, for example, charges against a remand patient are dropped and the powers for remand rescinded. In this case the RC would need to consider using a civil section of the MHA. The MHA Office can advise the RC on local procedures.
 - A detained patient may become informal if the detention papers are found to be invalid and cannot be rectified under Section 15 of the MHA. If this happens, a patient should be informed and it is probable that a new application for detention will be made. If the patient insists on leaving immediately, the Doctor's or Nurse's (MHA Section 5) holding powers may be used if the statutory criteria are met (see paragraph 7 below).
 - In exceptional circumstances, the Hospital Admissions Panel may be asked to consider admitting a patient informally who is subject to a probation order or bail order with a condition of in-patient psychiatric treatment. If the patient refuses to co-operate and wants to leave the hospital the relevant court will be notified with the expectation that the order will be rescinded.

- Exceptionally again, a patient may be admitted informally for specialist tests needed to be undertaken in conditions of maximum security. Such an admission will be agreed by the Clinical Director and the Directorate Clinical Lead. The tests can only be undertaken with the full co-operation of the informal patient.
- 6.3. In the rare situation where an RC is considering discharging a patient from detention or not renewing the section, he/she will undertake full consultation with the patient and the clinical team. Such cases may include a patient who is elderly or frail. If no consensus is reached, the RC is strongly advised to seek an opinion from the Clinical Director, Broadmoor CSU. The form 'Discharge by Responsible Clinician of Patient Liable to be Detained in Hospital' must be completed. This can be obtained from the MHA Office.

7. Rights of an informal patient in high secure hospital

- 7.1. An informal patient is not subject to compulsory treatment under Part 4 of the MHA. Treatment cannot be given unless the patient consents to the treatment. If the patient does not have capacity to consent to a specific treatment or investigation, the Mental Capacity Act 2005 and the Trust Mental Capacity Policy (M9) must be followed. A patient is presumed to have capacity unless it can be shown otherwise.
- 7.2. It should be exceptional for patients to become informal whilst in a High Secure Hospital. Informal patients have no right to apply to a Mental Health Tribunal. They are not monitored by the Care Quality Commission although the Commission can investigate any matter pertaining to when the patient was detained.
- 7.3. An informal patient has the right to leave the hospital on request. In some cases, other agencies such as the police or prison service will need to be notified of the patient's request to leave. In certain circumstances, he may be taken back into custody.
- 7.4. Whether a patient is admitted informally or becomes informal he should be promptly notified of this in writing and understand what other lawful powers exist, if any, to prevent him moving freely from the hospital to the community.
- 7.5. If a patient becomes informal following a discharge from section he will receive a letter from the MHA Office (see Appendix 1) notifying him when and by whom the section was discharged. The letter will outline the continuing need for compliance with hospital policies and procedures.
- 7.5.1 If a patient is admitted as an informal patient, he will be given a similar letter, explaining the reasons for admission and the requirement to be subject to all relevant safety and security processes such as mail monitoring, telephone monitoring, searches and visiting (particularly child visits). The Safety and Security Directions for High Secure Hospitals apply to all patients in the hospital, not just patients detained under the MHA. The letter must be in a language and format that the patient can understand and members of the clinical team should

provide help to the patient so that he fully understands the implications of being an informal patient.

- 7.6. If a detained patient is discharged from section, unless the patient objects, the Nearest Relative should be informed (MHA Section 133). This will be done by the MHA Office.
- 7.7. An informal patient remains subject to the Care Programme Approach (CPA). Steps should be taken by the clinical team to seek an alternative placement. Planning should be undertaken in the event that the patient decides to leave the hospital without notice. This must be clearly documented in the care plans. The care plan should also address what medication the patient will be given to take with him on discharge and what money will be available, either from the patient's hospital account or through the Social Work emergency float. If the patient exercises his right to leave he must be escorted to the hospital reception. The letter given to informal patients makes it clear that departure at night time is not likely to be possible due to the requirement for escorting and sorting out of property and monetary matters.

8. Action to be taken when an informal patient wants to leave

- 8.1. When an informal patient tells a member of staff that he wishes to leave the hospital, this must be reported to the person in charge of the ward/area.
- 8.2. If the patient is not already on the ward, he should be returned to the ward.
- 8.3. The nurse in charge of the ward should check whether the patient actually wishes to be discharged or simply wishes to leave the hospital for a while and exactly what his plans are. He should be advised that re-admission to the hospital would not be automatic.
- 8.4. If the patient is determined to leave, the care plan will address what actions and contingency measures need to be implemented.
- 8.5. Within the MHA there is provision for a Registered Mental Health nurse to detain an informal patient using the Nurse's holding powers, s.5(4). This power lasts up to 6 hours. The statutory form is replicated in Appendix 3. Refer also to the guidance in the MHA Code of Practice (2008), paragraph 12.22
- 8.6. The patient's RC or duty Consultant should be contacted immediately by ward staff. If the RC is not a doctor, the Approved Clinician in charge of the patient's treatment should be contacted.
- 8.7. The patient should be interviewed by the doctor or approved clinician in charge of treatment (or their nominated deputy) before leaving the hospital.

(see Code of Practice 12.11 to 12.17 in respect of nominated deputies).
- 8.8. When the doctor arrives on the ward, he/she should assess the situation, contact the RC if possible and make a decision as to whether the patient needs

to be detained under s.5(2), be discharged from the hospital or be allowed to go out for a period of leave if that is what the patient is requesting. Section 5(2) gives authority to detain the patient up to 72 hours to allow a doctor to make an application for admission under Section 2 or 3.

- 8.9. In the case of an informal patient who wishes to leave and who is not detained, the doctor/AC in charge of treatment/nominated deputy must notify the Site Manager, the Social Work Department and the MHA Office (out of office hours a message can be left on voicemail for a member of the MHA Office, extn 4060/4185 or the Social Work Department extn 4522).
- 8.10. In the event of a patient leaving the hospital the nurse in charge of the ward will be responsible for the collection of the patient's property and thereafter, to convey the patient to the hospital reception.
- 8.11. A particularly problematic situation might occur where an informal patient in a High Secure Hospital is outside the perimeter wall and then does not wish to re-enter the hospital. This event should be considered by the clinical team as part of the care plan. The Hospital Site Manager should be informed immediately. He/she will notify the RC/Duty Consultant, the on-call Senior Manager and the MHA Office.
- 8.12. If the patient is refusing to return to the hospital and is disturbed, the nurse escort (if there is one) can restrain the patient under common law powers in order to prevent the patient from harming himself or others. It may be necessary to request help from the local police.
- 8.13. The common law power to restrain a patient may also be used for a patient on the ward. The degree of force used to restrain a patient should be the minimum necessary to accomplish the objective for which it is required (i.e. to prevent harm occurring to the patient or others).

9. Aftercare

- 9.1. Section 117 planning should be undertaken in advance of Tribunals, MHA Managers Hearings or a planned discharge by the RC. Patients who have previously been detained for treatment under the Act are entitled to services provided by health and social services.
- 9.2. Before an informal patient is discharged, the care plan should be agreed and documented and Section 117 arrangements enacted (see MHA Code of Practice para 27.6). If the patient leaves before plans are finalised, every endeavour should be made by the RC and clinical team Forensic Social Worker to complete the planning process and its implementation and to notify the receiving health and social service agencies, the General Practitioner (if known) and the local Multi-Agency Public Protection Arrangements Co-ordinator (if relevant) of clinical and risk issues. It may be necessary to try and make contact out of office hours.

Victim liaison will also need to be considered in line with the statutory provisions in the MHA 2007 and the Trust's policy on Provision of Information to Victims which is not yet approved.

- 9.3. The patient should be offered assistance to reach the discharge address and may be accompanied by the ward social worker and/or nursing staff.

10. Training

- 10.1 Due to the situation being so rare, no formal training is offered by the Trust for the management of informal patients within the High Security setting. If, and when, this circumstance arises, the Hospital will ensure that the relevant staff are briefed on managing the patient in accordance with Policy I.3.

11. Monitoring

- 11.1 It is rare that a patient in Broadmoor Hospital is admitted informally, or changes status from detained to informal and there are no routine arrangements for monitoring in place. However, each occasion where the policy is enacted will be used as an opportunity to review the policy which will otherwise be conducted every three years by the Director of High Secure Services and the Mental Health Act/Health Records Office.

12. Fraud statement

Not applicable.

13. References (external documents)

This policy should be read in conjunction with

- *The Mental Health Act*
- *Mental Health Code of Practice*

14. Supporting documents (trust documents)

- *C2 Care Programme Approach*
- *H8 Health Records Policy*
- *M9 Mental Capacity Act Policy*

15. Glossary of terms / acronyms

MHA	Mental Health Act
NHSLA	NHS Litigation Authority
CSU	Clinical Service Unit
RC	Responsible Clinician
AC	Approved Clinician
CPA	Care Programme Approach

16. Appendices

Appendix 1 – Letter from MHA Office to informal patient.

Appendix 2 – Form H1 Regulation 4(1) (g) Report on Hospital In-patient.

Appendix 3 – Form H2 Regulation 4(1) Record of Hospital In-Patient

Dear

You will be aware that on you were made an informal patient by .

This means that you are no longer subject to the conditions of the Mental Health Act 1983 but, as a patient in a high secure hospital, you will still be subject to hospital policy and procedures and the safety and security regulations issued by the Department of Health. When you were detained under a section of the Mental Health Act you could apply or be referred to a Mental Health Tribunal. This procedure is no longer open to you.

Although it is now your right to leave the hospital at any time, should you suddenly decide during the night that you wish to leave, you will be escorted to the Main Reception as soon as it is reasonably practicable to do so (that is, early the following morning when sufficient staff are available for this purpose). It would also be advisable to give some notice of your intentions so that the Patients' Cash Office, which operates from 08.30am until 5.30pm Monday to Friday, can make arrangements for any money held in your account to be paid to you.

If you decide to leave unexpectedly and the person in charge of your immediate care is concerned about your mental state, a doctor may be called to undertake an assessment.

With your agreement, the hospital will write to make your nearest relative aware of your informal status and its implications. If there are plans in place for you to reside with someone other than your nearest relative, that person will also be informed.

If you have any questions about the plans for your future I would suggest you discuss these with your Responsible Clinician or Social Worker.

Yours sincerely

MHA OFFICE/HEALTH RECORDS

cc: Responsible Clinician
 Forensic Social Worker
 Site Manager

Form H1 Regulation 4(1)(g)**Mental Health Act 1983 section 5(2)—report on hospital in-patient****PART 1**

(To be completed by a medical practitioner or an approved clinician qualified to do so under section 5(2) of the Act)

To the managers of	

[name and address of hospital]

I am	

[PRINT full name]

and I am *<Delete (a) or (b) as appropriate>*

(a) the registered medical practitioner/the approved clinician (who is not a registered medical practitioner) *<delete the phrase which does not apply>*

(b) a registered medical practitioner/an approved clinician (who is not a registered medical practitioner)* who is the nominee of the registered medical practitioner or approved clinician (who is not a registered medical practitioner)

*<*delete the phrase which does not apply>*

in charge of the treatment of

--

[PRINT full name of patient]

who is an in-patient in this hospital and not at present liable to be detained under the Mental Health Act 1983.

It appears to me that an application ought to be made under Part 2 of the Act for this patient's admission to hospital for the following reasons—

[The full reasons why informal treatment is no longer appropriate must be given. If you need to continue on a separate sheet please indicate here [] and attach that sheet to this form.]

I am furnishing this report by: *<Delete the phrase which does not apply>*

consigning it to the hospital managers' internal mail system today at [time]

--

delivering it (or having it delivered) by hand to a person authorised by the hospital managers to receive it.

Signed:	
Date:	

PART 2

(To be completed on behalf of the hospital managers)

This report was *<Delete the phrase which does not apply>*

furnished to the hospital managers through their internal mail system

delivered to me in person as someone authorised by the hospital managers to receive this report at			
Date:		Time	

Signed:	on behalf of the hospital managers
Print Name	
Date:	

Form H2 Regulation 4(1)(h)**Mental Health Act 1983 section 5(4)—record of hospital in-patient**

To the managers of	

[name and address of hospital]

[PRINT full name of the patient]

It appears to me that

(a) this patient, who is receiving treatment for mental disorder as an in-patient of this hospital, is suffering from mental disorder to such a degree that it is necessary for the patient's health or safety or for the protection of others for this patient to be immediately restrained from leaving the hospital; **AND**

(b) it is not practicable to secure the immediate attendance of a registered medical practitioner or an approved clinician (who is not a registered medical practitioner) for the purpose of furnishing a report under section 5(2) of the Mental Health Act 1983.

I am

--

[PRINT full name]

a nurse registered—

<Delete whichever do not apply>

(a) in Sub-Part 1 of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing;

(b) in Sub-Part 2 of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing;

(c) in Sub-Part 1 of the register, whose entry includes an entry to indicate the nurse's field of practice is learning disabilities nursing;

(d) in Sub-Part 2 of the register, whose entry includes an entry to indicate the nurse's field of practice is learning disabilities nursing.

Signed:			
Date:		Time	