Other logos to be included subject to approval

Section 117 Policy and Procedure

September 2019

Contents

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Policy Summary

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GLOSSARY OF TERMS

Term	Definition
Aftercare	Care services provided to patients who have been discharged from hospital following admission under the following Sections of the Mental Health Act 1983 s.3, s.37, s.45A, s.47 or s. 48. A patient's entitlement to after-care section 117 begins when they are detained under the above sections. The duty to provide after-care is triggered at the point of discharge.
Carer	A **carer** is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support
Care Programme Approach (CPA) Assessment. **Care co-ordinator**	CPA is a way of co-ordinating community health services for people with mental health problems. It means that once you have an assessment detailing your needs, one person will be able to co-ordinate all aspects of your care for example, this could be your medical and social care and community services available to you. This assessment will be carried out by a care co-ordinator. Care co-ordinators are also sometimes called keyworkers or case managers
Clinical Commissioning Group	Clinical commissioning groups are groups of GPs that are responsible for designing local health services in England. They will do this by commissioning or buying health and care services. Clinical commissioning groups will work with patients and healthcare professionals and in partnership with local communities and local authorities.
Immigration Status	Refers to an individual's legal position with regard to their presence in the UK
Local Authority	At a local level, the country is divided into a series of local authorities or councils. These authorities are responsible for providing local services to the community such as education, adult and children social care, regeneration, leisure, housing and environmental services
Medical Treatment	Medical treatment" is defined in paragraph 1.17 of the Mental Health Reference Guide as including nursing, psychological interventions, specialist mental health habilitation (services for people who may never have developed a particular skill or ability), rehabilitation (where a person is re-learning or re-acquiring particular skills or abilities), care, medication and other forms of treatment that might normally be considered to be medical

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Mental Health Act 1983	An act of parliament that governs the treatment and care of some individuals incapacitated through mental illness.
"Deeming provisions" of the Act	These are the sections of the Act which trigger a person's entitlement to Section 117 aftercare, if they have been detained under one of the following Sections: Section 3 Section 37 Section 41 Section 45A Section 47 Section 48
Section 3 Mental Health Act 1983	This is commonly known as a "Treatment order", and allows for people to be detained in hospital for treatment if they have a mental disorder which is to such a degree that they need to be treated in hospital, and that there is a risk to their health and safety or that of others. The treatment must be available.
Guardianship Order (Section 7 Mental Health Act 1983)	A Guardianship Order is an order which appoints a guardian to ensure that certain requirements are met by a person with a severe mental health problem. It is most commonly used to require a person to live in a certain place, but it can also require a person to attend for day care and to meet with their mental health professional workers. The Guardian is usually (but not always) the Local Authority. A person subject to Guardianship is not entitled to aftercare provided under Section 117, unless they have been previously detained under one of the deeming provisions of the Act.
Section 17 Mental Health Act 1983	This Section of the Act allows the patient's Responsible clinician to agree arrangements for the person to have a period of leave away from the ward. This may be for a short period, to allow the person to visit a relative or their own home, for example, or it may be for longer, to help a person to be introduced for a few days to their new residential care placement. The patient remains subject to their detention order and can be recalled to the hospital if problems arise.
Section 37 Mental Health Act 1983	This is known as a hospital order, and is made by the Courts. It happens when a person is convicted of a crime punishable by imprisonment, where the convicted person has a serious mental illness and is in need of treatment.
Section 41 Mental Health Act 1983	This is what is known as a "restriction order". It is applied in some cases a Section 37 order is discharged, and means that a person can live in the community but with some restrictions or conditions on them. These can include living in a certain place and accepting medical

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	treatment, and keeping appointments with a supervisor, such as a probation officer.
Section 45A Mental Health Act 1983	This is known as a "hospital direction", and is again applied by the courts, but this time after a person is convicted of an offence, the sentence for which is not fixed by law (it cannot apply to murder, for example, which has a fixed sentence). If a person has a severe mental illness, this Order can require them to receive hospital treatment, but once their mental health has improved, they can be returned to prison to serve out the remainder of their sentence.
Section 47 Mental Health Act 1983	This is an Order which allows the Ministry of Justice to approve the movement of a convicted prisoner from prison to hospital, if they have developed a severe mental illness which requires inpatient treatment. If the person's sentence ends whilst they are still in hospital, and they still need treatment, then they can be kept in hospital.
Section 48 Mental Health Act 1983	This Order applies to prisoners who are on remand. If they develop a severe mental illness, Section 48 can be used to transfer them to hospital for treatment. If their mental health improves, they can then be returned to prison.
Multi Disciplinary Team	A multidisciplinary team (MDT) is a group of professionals from diverse disciplines who come together to provide comprehensive assessment and consultation in cases.
Ordinary Residence Regulations	A term used in the Care Act to allocate responsibility for the patient's aftercare on their discharge from hospital.
Responsible Clinician (RC)	A patient's responsible clinician is defined as the approved clinician with overall responsibility for the patient's care. All patients subject to detention or Supervised Community Treatment have a responsible clinician, who may be a nurse, occupational therapist, psychiatrist, psychologist or social worker
Section 117 Register	Register of service users on section 117. This register is currently maintained by the social services administration department who should be notified of any changes e.g. discharge from section 117 or transfer.
Service User	A service user is a person receiving any health or social care services, from going to the family doctor, the pharmacist, to accessing social services such as home care or direct payments.
Supervised Community Treatment Order	Supervised community treatment is a legal framework for ensuring that certain people receive compulsory care and treatment in the community. A CTO can only

	be made if you are detained under certain sections of the Mental Health Act
Trust	For the purpose of this policy this refers to North West Boroughs NHS Trust

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All areas are required to develop a formal Section 117 policy and procedure, which then becomes a public document. The Author of Halton's policy and procedure would like to particularly acknowledge the policies of the following areas, which have been used in part to inform and improve this document:

Cheshire East

Bolton

Merseycare

Warrington

Southern Health

London

Lancashire Care

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1.0 INTRODUCTION

1.1 For some people with complex mental ill-health issues, where they may pose a risk to themselves or others, detention in hospital under the Mental Health Act may be the only way of ensuring that they get the care and treatment that they need at the time. It has long been understood that treatment and support for people in such circumstances will need to last beyond the time that the person is in hospital. This support – known as "aftercare" – may need to be provided for years, and will include a combination of treatment for the mental health condition and support with the social effects of having a severe mental health problem.

1.2 This was only recognised in law with the introduction of the Mental Health Act 1983. Section 117 of that Act imposed a duty on health and social services authorities to work together to provide aftercare for certain groups of people who received compulsory treatment under the Act. Prior to the introduction of section 117, there was no duty on these authorities to work together to provide aftercare, so the resources and services for people with complex mental health problems were patchy and depended on what local areas saw as their priority.

1.3 In 2000, central government issued two circulars to health services and social service authorities, which took this duty further. These circulars (Health Service Circular 2000/ 003 and Local Authority Circular 2000 (3)), which were compulsory for health and social services to follow, stated that:

- Social services and health authorities should establish jointly-agreed policies on providing Section 117 aftercare services
- The policies should set out clearly the criteria for deciding which services should fall under the remit of Section 117 aftercare, and how they should be financed
- The individual's Section 117 aftercare plan should indicate which service is provided as part of the plan

1.4 It is with this in mind that this document has been developed. It aims to describe

- The responsibilities and duties of local authorities and NHS organisations
- Who is eligible for Section 117 aftercare and what it is for
- What kinds of services might be provided under Section 117
- The funding implications, for individuals receiving Section 117 services, and for organisations commissioning or providing those services
- The processes that should be used in setting up and discharging Section 117 aftercare

2.0 What is Section 117 aftercare?

2.1 Section 117 Mental Health Act 1983 describes the aftercare arrangements that apply to certain categories of patients. It is important to understand the full implications of this part of the Act if it is to be applied properly.

2.2 The key elements of the Act which trigger Section 117 aftercare (known as the "deeming provisions") and some of its key subsections read as follows (some of the aspects of this Section which relate to other parts of the United Kingdom have been removed because there is little direct relevance to this policy document):

(1) This section applies to persons who are detained under Section 3, or admitted to a hospital in pursuance of a hospital order made under Section 37, or transferred to a hospital in pursuance of a hospital direction made under Section 45A or a transfer direction made under Section 47 or 48, and they cease to be detained and (whether or not immediately after so ceasing) leave hospital.

(2) It shall be the duty of the clinical commissioning group (CCG) and of the local social services authority to provide (or arrange for the provision of), in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the clinical commissioning group and the local social services authority are satisfied that the person concerned is no longer in need of such services, but they shall not be so satisfied in the case of a community patient while he remains such a patient.

(6) In this section, "after-care services" in relation to a person means services which have both of the following purposes:

(a) meeting a need arising from or related to the person's mental disorder and

(b) reducing the risk of a deterioration in the person's mental conditions (and, accordingly, reducing the risk of the person requiring hospital admission again for treatment of mental disorder).

2.3 Other subsections affirm that the term "aftercare" includes services provided under the Care Act 2014 and the National Health Service Act 2006 and describes the application of Ordinary Residence Regulations.

3.0 Who is eligible for Section 117 aftercare?

3.1 Following from the above, any person who has been treated under any of the above Sections of the Mental Health Act is entitled to receive aftercare services when they are discharged from the Section. This applies even if:

• the person remains in hospital on a voluntary basis after being discharged from any of these sections

• the person is released from prison, having spent some of their sentence in hospital under these Sections of the Act

• the person is going on to a Supervised Community Treatment Order

• the person is granted Section 17 leave under the Mental Health Act

3.2 Section 117 aftercare does not automatically apply to anyone subject to a Guardianship Order under the Mental Health Act, unless they have been previously detained under one of the qualifying Sections above.

3.3 A person continues to be entitled to Section 117 aftercare even if they are:

• returned to prison after being detained in hospital

• readmitted to hospital either informally or under another Section of the Act, such as Section 2

3.4 Immigration status: it should be stressed that Section 117 aftercare is an entitlement, irrespective of a person's circumstances. Regardless of a person's immigration status, immigration exclusions under Schedule 3 Nationality, Immigration and Asylum Act 2002 (which includes people excluded from public funding) do not apply.

4.0 What are the key elements of Section 117 aftercare?

4.1 There are therefore two key and distinct elements to the provision of aftercare under Section 117:

- the relationship between the local authority and clinical commissioning groups in an area, in their commissioning and provision of aftercare services and
- the operational delivery of aftercare.

4.2 The relationship between the local authority and CCG: as is made clear in the quote from Section 117 above, local authorities and CCGs have a joint responsibility to ensure that appropriate aftercare services are in place for someone who meets the criteria for such services. This does not mean that they have to directly provide the services; they can use their commissioning power to identify and pay for other bodies to do this for them. The implications of Subsection 2 are:

• that local authorities and CCGs should work together to deliver appropriate aftercare for individuals. This does not have to be through the development of a formal agreement, but both organisations should be clear together as to their commissioning priorities with respect to aftercare provision

• CCGs and local authorities should be working with a range of bodies and organisations, including the voluntary sector, in order to ensure that appropriate aftercare services are in place

• The provision of aftercare under Section 117 is a duty which both CCGs and local authorities must follow.

4.3 The operational delivery of Section 117 aftercare

Although the duty to ensure the appropriate provision of aftercare services falls on CCGs and local authorities together, the way this is organised and delivered depends to a large extent on the services that provide direct mental health care and treatment to people who have been detained under relevant provisions of the Act: that is, the NHS provider mental health trusts, some private mental health hospitals which are performing NHS functions, and the local authorities, in the form of their social work staff. Hence, the admission to hospital under one of the key provisions in Subsection (1), the assessment, treatment and care management process whilst they are being treated as inpatients, and the development of an appropriate aftercare plan to support the person back into the community, all require close cooperation between the relevant agencies. Outcomes need to be clearly identified and their effectiveness should be closely monitored to ensure that the aims of Subsection (6) (meeting needs arising from a person's mental disorder and aiming to reduce the chance of relapse and future readmission to hospital) are fully achieved.

4.4 Aftercare under Section 117 is therefore a combination of commissioning functions and operational delivery, and the two are inextricably linked. Indeed, CCGs and local

authorities, as service commissioners, should be closely and regularly reviewing the way front line aftercare services are delivered, and amending their own commissioning intentions accordingly. It is for this reason that this policy and procedures addresses the commissioning relationship between local authorities and CCGs, the way in which aftercare services are identified and delivered, and the relationship between the two processes.

5.0 What are Section 117 aftercare services, and what are they for?

5.1 There is no absolute definition in the Mental Health Act of what is or is not an aftercare service. The Care Act 2014 (Section 75 (5)) describes their purpose as follows (in summary):

- Meeting a need arising from or related to a person's mental health disorder
- Reducing the risk of a deterioration in the person's mental health disorder
- Reducing the risk of readmission for treatment of the mental disorder

5.2 Given that there is no specific definition of aftercare services, it follows that these services must depend on each individual's identified mental health needs. The following list cannot be exhaustive as individual needs vary: they are examples only of the types of services that might be provided under the generic term of "aftercare":

- Assistance from Community Psychiatric Nurses
- Medical supervision through outpatient appointments
- Psychiatric treatment
- Medication
- Domiciliary care or other community support
- Residential or nursing care
- Employment support

5.3 Provision of accommodation as a part of a Section 117 aftercare plan

Accommodation can be provided by a local authority as part of a Section 117 aftercare plan, but only if the need for the accommodation arises specifically from a person's mental health need. In the case of R vs London Borough of Camden (2013), relating to a person with a brain injury who was seeking specialist accommodation as a part of their Section 117 aftercare, the following judgment was made:

"As a matter of law, Section 117(2) is only engaged vis-à-vis accommodation if:

• The need for accommodation is a direct result of the reason the ex-patient was detained in the first place ("the original condition")

• The requirement is for enhanced specialised accommodation to meet the needs directly arising from the original condition and

• The ex-patient is being placed in the accommodation on an involuntary (in the sense of being incapacitated) basis arising as a result of the original condition"

To recap, therefore: there is no requirement arising from Section 117 to provide general accommodation, particularly where the need does not directly and specifically arise from the reason why the person went into hospital in the first place.

6.0 Delivering the Section 117 aftercare planning process

6.1 The Section 117 aftercare plan: the context

6.1.1 It is frequently said that aftercare planning begins at the point at which a person is admitted to hospital. In many senses, this is true, in that the aim of admission should be to ensure that the person is able to be discharged back into their community setting as quickly as possible, with the levels of support needed to sustain them once they are discharged. Clearly, though, this process can only be a starting point at the time of admission: the admitted person is likely to be in a state of considerable distress, and it could take some time until a comprehensive aftercare plan can be developed. It is essential, however, that the process should start as soon as possible.

6.1.2 The primary assessment, risk management and care management process within mental health services is the Care Programme Approach (CPA), which is used across the country as the main framework for working with people with complex mental health needs who are involved with secondary mental health services. This framework has a number of key features:

• It is a multidisciplinary approach to the identification and management of need

• Its clear focus is the individual, who should be as fully involved as possible

• It involves a detailed assessment of need and risk, which then requires a detailed outcome-focused care plan to address the identified needs and risks, and which may include a contingency plan for any potential deviations from the identified care plan

• It identifies a care co-ordinator, the person within the multidisciplinary team who is best place to ensure the delivery of the care plan

• It identifies a review frequency, to ensure that the outcomes in the care plan are being met.

6.1.3 The Section 117 aftercare planning process follows this framework. However, the key issue is that the aftercare plan must be explicit about which services and supports are provided under section 117, to achieve the purposes identified in paragraph 2.2 (6) above. These services and supports will arise from the detailed assessment, and will be specifically agreed with the person concerned or their representative.

6.2 Who should be involved in the aftercare planning?

6.2.1 It is essential that the admitted person is as involved as possible in the development and implementation of their aftercare plan, although this may on occasion not be fully

possible if there are concerns about the person's mental capacity to take part. Even if there are such concerns, every effort should be made to involve the person and to try to determine their views; these should be carefully documented in the case records and any decision to exclude the person from the planning process because of concerns about their mental capacity should be justified by a formal Best Interests decision.

6.2.2 Similarly, it is essential to involve the person's carer* in the aftercare planning process, particularly in the development of any contingency plans. Carers may have detailed and up to date information about a person's presentation and may be very familiar with any signs of relapse or changes in behaviour. It is important that the clinical team has access to this information in order to be able to formulate and implement an effective aftercare plan.

*Note 1: it is essential that the patient's permission is gained before a carer is involved in any aftercare planning.

*Note 2: a family member or friend may not always see themselves as a carer, but may instead see themselves as a partner, family member or friend. This does not matter; the important thing is that the clinical team should identify the key person (s) involved in a person's care and involve them as closely as possible in any decision making

6.2.3 The Mental Health Act Code of Practice, paragraph 34.12, provides an extensive list of those people who may be invited to attend an aftercare planning meeting. This is reproduced in full in Appendix 1.

6.3 What should go in to a Section 117 aftercare plan?

6.3.1 The Mental Health Act Code of Practice (paragraph 34.17) follows the national guidance on the Care Programme approach, and stresses that aftercare planning should start as soon as possible after admission to hospital. This will follow a detailed assessment of the person's needs.

6.3.2 The Code of Practice (paragraph 34.3) stresses that a CPA care plan (which will therefore act as a Section 117 aftercare plan) "aims to ensure a transparent, accountable and coordinated approach to meeting wide-ranging physical, psychological, emotional and social needs which are associated with a person's mental disorder".

6.3.3 The aftercare plan should include

- a treatment plan, detailing medical, nursing, psychological, and other therapeutic support for the purpose of meeting individual needs, promoting recovery and/ or preventing deterioration
- details of any prescribed medications
- details of any actions to address physical health problems or reduce the likelihood of health inequalities
- details of how the person will be supported to achieve their personal goals
- support in relation to social needs, such as (but not limited to) housing, occupation and finances
- support for carers
- actions to take if a person's mental health deteriorates

- guidance on actions to take if a crisis arises.

6.3.4 The assessment, risk management and care planning process must be demonstrably focused on the individual. It should include detail about their own wishes and feelings, and describe clearly their wishes for their future live; where possible and appropriate, the care plan should strongly reflect these aspirations.

6.3.5 It should be stressed again that it is essential that the elements of the care plan which fall within the provisions of section 117 aftercare are specifically identified, with clear outcomes, measures of success and (where possible) timescales for delivery. These will then form the baseline for the multidisciplinary team to assess the effectiveness of the interventions and will allow for effective and dynamic reviews. They will also clearly identify whether a situation has been reached which could permit the ending of the Section 117 aftercare because all identified aims have been met.

6.4 Who should be the care co-ordinator?

6.4.1 In most circumstances, the care co-ordinator will be drawn from the multidisciplinary team within the secondary mental health services. This person should be the team member who is best placed to ensure that the aftercare plan is delivered appropriately. It is not their job to deliver the plan themselves (although they may have key elements of the plan which are their responsibility); rather, they should be able to work with all the multidisciplinary team members to ensure the plan's delivery.

6.4.2 The care co-ordinator will have the authority to recall the multidisciplinary team if the plan needs to be revised, say in the event of a deterioration in the person's mental health. They are also responsible for ensuring that reviews of the care plan take place, at least on an annual basis but more frequently if needed.

6.4.3 On very rare occasions, the care co-ordinator will not be drawn from the multidisciplinary team within the secondary mental health services. This will be the case if the person's mental health has improved so much that they no longer need input from secondary mental health services and can appropriately be discharged from that care.

6.4.4 However, there may be a need for the services provided under Section 117 to continue even though they have been discharged from secondary mental health services. Under these circumstances, the responsibility for managing the aftercare reverts to primary care services. This raises some complicated practical questions, particularly in terms of the availability of a multidisciplinary team for review purposes, and for consultation if there is a deterioration in the person's mental health.

6.4.5 Under these circumstances, it is for the CCG, in consultation with the local authority, to manage the aftercare. In practice, this will most likely involve the GP managing the medication and ongoing treatment elements of the aftercare plan, whilst a CCG lead takes responsibility for ensuring that reviews take place as needed. It may be necessary to develop a protocol between the CCG and the Secondary Mental Health Trust for a fast-track process back into secondary care if there is evidence of a significant deterioration in the person's mental health.

6.5 Consideration of parenting responsibilities and the needs of children

6.5.1 It is clearly understood that the presence of a severe mental illness in a parent or other caregiver for a child is a potential indicator of risk of child abuse. It should be stressed that the vast majority of families with severe adult mental illness are competent and successful parents, but there is nonetheless a clear correlation with risk to children in some cases (along with other factors such as drugs/ alcohol abuse or domestic violence).

6.5.2 Additionally, there are considerable stresses and pressures on children and young people if there is an adult in the household with a severe or complex mental illness. The child/ young person is potentially more likely to face bullying, they are less likely to have friends to visit at times, their family lives may be very disrupted and at times chaotic, and they may take on inappropriate caring responsibilities for their age.

6.5.3 The Borough Council and CCG regard it as essential that any assessment and aftercare plan should take explicit account of the needs of any children under the age of 18 in the household. The Code of Practice hints at this when it says that consideration of the psychological needs of carers and family should be taken into account. However, the requirement is more than that: multidisciplinary teams should consider the impact of the parent's mental ill-health on the children, and have a duty to take steps to refer to children's services for support if they consider that the parent's mental ill-health could compromise their parenting and have an adverse impact on the child or young person.

6.6 Reviews of Section 117

6.6.1 Reviews of Section 117 should take place within the requirements of the local CPA policy, that is:

- Within three months of the start of the care plan
- Annually thereafter
- More frequently as the patient's needs dictate.

It is the responsibility of the care co-ordinator to ensure that the reviews take place and that all key people are invited to the meeting. They should also ensure that all meetings are minuted and that any changes to the care plan are circulated to all members of the multidisciplinary team.

6.6.2 In those rare occasions where the responsibility for care co-ordination has been transferred to primary care, then the Section 117 lead officer will take responsibility for organising all necessary reviews.

6.7 Section 17 leave

6.7.1 As a part of the process of recovery, it can be essential for a detained patient to have periods of leave from the ward. This can be for a variety of reasons: short visits to the person's home to prepare for discharge, visits to community resources and activities, or familiarisation with a new service or support, such as a residential care home. This leave is granted for detained patients under Section 17 of the Mental Health Act, and is therefore known as "Section 17 leave".

6.7.2 The leave can only be granted by the doctor or clinician who is responsible for the patient's care (known as the "responsible clinician"). Conditions may be attached to the leave and the patient can be recalled to the hospital if problems arise. Whilst the patient is on leave, they are still liable to be detained and there is still a bed available for them in the hospital. The CCG is therefore responsible for the funding and provision of any care and support that the person may need whilst they are on leave (such as a placement in a residential care home). Once the person has been discharged from hospital, of course, and is no longer therefore subject to Section 17 leave, then the locally-agreed funding arrangements for care and support will apply.

6.8 Discharge of Section 117 arrangements

6.8.1 Section 117 aftercare arrangements are put in place for very explicit reasons, as described in paragraph 2.2 (6) of this document. The services and supports are not intended to be in place indefinitely, but should remain in place whilst the person needs them and whilst they are still needed to achieve the goals of the aftercare plan. This is reinforced by paragraph 27.3 of the Mental Health Act Code of Practice: "the duty to provide aftercare services continues as long as the patient is in need of such services". Additionally, the Code confirms (in paragraph 27.19) that "the duty to provide aftercare services exists until both the primary care trust [CCG] and the local social services authority are satisfied that the patient no longer needs them".

6.8.2 This position has been confirmed by a number of court cases and Ombudsman's judgments. Essentially these stress that:

- The decision as to whether to discharge Section 117 aftercare is the responsibility jointly of the CCG and the local authority, but with advice from mental health services
- Aftercare under Section 117 does not have to continue indefinitely
- Any decision to discharge Section 117 should not be taken arbitrarily, but should be made on the merits of each case

6.8.3 The decision to discharge Section 117 aftercare should therefore be taken as part of the multidisciplinary review process, organised by the care co-ordinator, and should always involve decision-making representatives of the local authority and the CCG.

6.8.4 There are three circumstances, therefore, when Section 117 aftercare can be discharged:

• When a multidisciplinary review has determined that all aspects of the aftercare plan have been delivered and that the plan is no longer needed to prevent a deterioration in the person's mental health or reduce the risk of readmission; this still has to be formally agreed by the CCG and local authority

• On the death of the patient

• When the patient moves away and becomes the responsibility of a different CCG and local authority

6.8.5 Section 117 aftercare cannot be discharged solely on the grounds that:

• The patient refuses the services

• The care need is now being successfully met and the patient is settled in the community

• The patient has been discharged from the care of a consultant or specialist mental health services

• An arbitrary period of time has passed since the patient was discharged from hospital

• The patient is deprived of their liberty under the Mental Capacity Act

• The patient has returned to hospital informally or has been detained under Section 2 Mental Health Act

• The patient is no longer on Section 17 leave or subject to a Community Treatment Order

6.8.6 Section 117 guidance produced by the Association of Directors of adult Social Services on behalf of the pan-London CCGs, local authorities and specialist mental health Trusts suggests that the following factors can be considered to establish whether discharge from Section 117 may be appropriate:

- What are the individual's current assessed mental health needs?
- Have the individual's needs changed since their discharge from hospital under S117?
- What are the risks of return to hospital/relapse?
- Has the provision of after-care services to date served to minimise the risk of the individual being re-admitted to hospital for treatment for mental disorder/experiencing relapse of their mental illness?
- Are those services still serving the purpose of reducing the prospect of the individual's re-admission to hospital for treatment for mental disorder/experiencing relapse or has that purpose now been fulfilled?
- What services are now required for the individual's current mental health needs?

- Does the individual still require medication for mental disorder?
- Is there any ongoing need for care under the supervision of a consultant psychiatrist or any ongoing need for involvement of specialist mental health services such as a community mental health team?

6.8.7. This guidance goes on to suggest that indicators that S117 could be discharged may include any of the following:

- Stabilised mental health which no longer requires the level of care that has been provided under S117 in order to be maintained
- Services no longer needed for the purpose of reducing the risk of return to hospital or relapse

However, any decision should be taken with reference to the individual circumstances of each case and none of the indicators above should be used solely as grounds for discharge.

6.8.8 It should be stressed once more that there is a pressing need for all aftercare plans to be explicit about the needs which are to be met as part of a Section 117 aftercare plan, the outcomes which are intended to be achieved and the timescales in which the plans should be delivered. Without this, it is impossible to know whether the interventions are suitable for the person and are achieving

6.8.9 If there is any doubt as to whether it is appropriate or not to discharge an individual's Section 117 aftercare plan, then legal advice should always be sought.

6.9 Section 117 register

6.9.1 A register of all Halton residents subject to Section 117 aftercare will be held and maintained by the local authority. The reason for this to be held and managed by the local authority is that not all Halton residents subject to this provision are known to the local specialist mental health trust (the North West Boroughs) ; some may have been detained in specialist hospitals elsewhere in the country and not have had any contact with the North West Boroughs.

7.0 Commissioning and funding arrangements:

7.1 Identifying the responsible CCG:

7.1.1 For those people who have been detained in a hospital in their local area, the responsible CCG will generally be well known to the Trust in which they have been detained, and there will be close working relationships between the two organisations. However, many people are detained in settings which are far from their home area (in a secure hospital, for example, or a prison), and it is important that the CCG responsible for the aftercare is identified at the earliest possible stage.

7.1.2 The CCG which holds the responsibility for the aftercare of any qualifying patient is determined by the national "Who Pays" guidance, published by NHS England in August 2013, and revised in April 2016. In essence, the position is as follows:

- For people detained before 1st April 2013 or after 31st March 2016, the responsible CCG is the one where the patient was registered with a GP before their hospital admission

- For people detained after 1st April 2013 but before 31st March 2016, then wherever the person has been moved to (or has been placed) and is registered in their new area with a GP, then the new area becomes the responsible CCG if the person is again detained under a qualifying Section

- If a person is not registered with a GP, and is of no fixed abode, then a "usual residence" test applies, as described in Section B of the 2013 guidance. This is different from the term "Ordinary Residence", and refers to the person's own perceptions of whether they are resident in the UK, and if so where they see themselves as living. The latter area effectively determines which CCG would be responsible

7.2 Identifying the responsible local authority:

7.2.1 The determination of which local authority is responsible for meeting the Section 117 duties for an individual patient is to be found in Section 75 of the Care Act (and also Sections 19.14 – 19.22). The test for this depends on where the person was "ordinarily resident" at the time that they were detained.

7.2.2 Ordinary Residence is not specifically defined in the Care Act. However, the Statutory Guidance which accompanies the legislation refers to the case of Shah v. London Borough of Barnet as the source for the test. In that case, Lord Scarman said "ordinarily resident refers to a man's abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration"

7.2.3 The Statutory Guidance advises that "the concept of ordinary residence involves questions of both fact and degree. Factors such as time, intentions and continuity (each of which may be given different weight according to the context) have to be taken into account."

7.2.4 The above test involves the place of abode to be voluntarily adopted which requires the individual to have the mental capacity to do so. For individuals who do not have the mental capacity to decide where to live one would look at all the circumstances of the case to decide where they are ordinarily resident, including whether they can be considered to remain ordinarily resident with their parents even after they have left home.

7.2.5 Where a person's ordinary residence cannot be determined, then it will usually be the place to which the patient will be discharged from hospital.

7.2.6 If there is a dispute between local authorities as to which should be responsible for a person's aftercare, and this cannot be resolved at a local level, then the matter can be referred to the Secretary of State for a final decision. Halton Borough Council's approach is that the funding and responsibility for the aftercare planning will be retained without prejudice by Halton until the Secretary of State reaches a decision, to ensure that continuity of care remains uninterrupted for the person concerned.

7.3 Local Authority Protocol for the application of Section 117

7.3.1 Across the four local authorities which cover the Cheshire County footprint Halton, Warrington, Cheshire West and Chester, Chester East and also including Wirral Borough Council), a protocol has been agreed which prevents the transfer of the commissioning responsibility for Section 117 to another signatory local authority, even if the person concerned is no longer ordinarily resident in the first local authority. This is designed to ensure that high cost social care packages are not transferred to an authority which had not budgeted for this contingency in the first place.

7.3.2 This is a voluntary agreement so does not have the force of law behind it. However, it has been agreed at the most senior levels of each council and the protocol is expected to apply to all such situations. This protocol is being rolled out more widely across the North West Region.

7.4 Funding of services provided under Section 117 aftercare

7.4.1 The commissioning and funding of services to meet individual needs identified in a Section 117 aftercare plan is the joint responsibility of the person's CCG and local authority. In simplistic terms, this would mean that the CCG would fund all identified health needs, whilst the local authority would fund social care services. However, when providing support to someone with complex mental health needs, it is not easy to separate out what is a social care need from that of a health need, as the two issues are often very closely intertwined.

7.4.2 In addition, there are legal restrictions as to the types of service that local authorities and CCGs can commission. Local authorities cannot, for example, routinely fund services that would be seen as specifically health services (although there are some exceptions to this if the NHS service – such as the provision of general nursing care in a care home – is merely incidental or ancillary to the provision of the accommodation), and the same applies in reverse for the NHS. Across the country, various attempts have been made to devise formulae to apportion funding between CCGs and local authorities, but these have generally been cumbersome, difficult to apply in practice, and have generally failed as a result.

7.4.3 Under most circumstances, the local agreement between Halton Borough Council and NHS Halton CCG takes a purely pragmatic approach: that all new Section 117 aftercare services (as from the date of implementation of this policy) will be funded on a 50/ 50 basis between Halton Borough Council and NHS Halton CCG. The funding of existing aftercare services will be unaffected by this policy, unless the aftercare plan changes and effectively becomes a new plan.

7.5 The Process in Halton for obtaining Section 117 aftercare services funding

7.5.1 In order for both the CCG and the local authority to be able to make the decisions on funding care and support packages provided under the Section 117 aftercare arrangements, sufficient detail must be provided by the multidisciplinary teams working

with the individual. Without this detail, delays in commissioning an appropriate service may occur if the information is lacking.

7.5.2 If a funding decision is required in order to secure aftercare, then the following documents, attached as Appendices, provide the detail about the process to be used and the information to be provided:

- Appendix 2: Mental Health Funding Process for Section 117 aftercare arrangements
- Appendix 3: Funding Process Diagram

7.6 NHS Continuing Healthcare (including NHS Continuing Care for Children) and Funded Nursing Care

7.6.1 If all the required aftercare services relate specifically to a person's mental health condition, then it will not be necessary to assess for eligibility for NHS Continuing Healthcare (CHC). However, a person who is receiving Section 117 aftercare services may also have additional needs which do not fall within the scope of Section 117, but relate instead to their physical health. This is explained in the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (July 2009):

> *"a person in receipt of aftercare services under S117, may also have needs for continuing care that are not related to their mental health disorder, and that may therefore, not fall within the scope of Section 117… it may be necessary to carry out an assessment for NHS continuing healthcare that looks at whether the individual has a primary health need on the basis of the needs arising from their physical problems."*

7.6.2 People who have, or develop, physical health needs as well as their mental health needs may need to be assessed under the NHS Continuing Care or Continuing Healthcare Frameworks for funding to support their physical health needs. This, and any subsequent reviews of their eligibility, will be done as part of the Care Programme Approach process, and any CHC or CC requirements will be recorded in the care plan.

7.7 Direct Payments (DPs) and Personal Health Budgets (PHBs)

7.7.1 Under the Care Act 2014, all people with assessed eligible needs in social care have the right to a personal budget to meet those needs, and this includes a direct payment. Local authorities have a discretionary power (not a duty) to make DPs to people who are receiving Section 117 aftercare services: this gives greater flexibility to local authorities in those situations where there may be risks in making DPs for services which the person may prefer not to receive.

7.7.2 The NHS Mandate in April 2015 set out the expectation that CCGs would develop their plans to offer Personal Health Budgets to people with long-term conditions who may benefit from them. As from Monday 2nd December 2019, this is now in effect.

7.7.3 A PHB for Section 117 aftercare should be considered:

- Whenever planning is taking place for Section 117 during an admission to hospital or

- At any assessment held to review the person's Section 117 aftercare package of support in the community, which may be managed either by the local authority or the NHS. This will include Care and Treatment Reviews for adults, or Care, Education and Treatment Reviews for children and young people, who have a learning disability and/ or autistic spectrum condition and are section 117 eligible.

7.7.4 Aftercare planning for all patients admitted to hospital for treatment for a mental health condition should be planned within the framework of the Care Programme Approach. However, if an eligible person's care is not being managed under this framework, this should not impact on their right to a PHB, as this right is not based on how services are locally delivered, but on their eligibility for Section 117 aftercare.

7.8 Disputes

7.8 1 Where a dispute as to the funding arrangements is identified, this will be managed by using the agreed Disputes Procedure between the local authority and the CCG.

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APPENDIX 1

Who should be involved in the Section 117 aftercare planning process (paragraph 34.12, Mental Health Act Code of Practice)?

In order to ensure that the after-care plan reflects the needs of each patient, it is important to consider who needs to be involved, in addition to patients themselves. Subject to the patient's views, this may include:

- the patient's responsible clinician
- nurses and other professionals involved in caring for the patient in hospital
- a practitioner psychologist registered with the Health and Care Professions Council, community mental health nurse and other members of the community team
- the patient's general practitioner (GP) and primary care team (if there is one). (It is particularly important that the patient's GP should be aware if the patient is to go onto a community treatment order (CTO), (see chapter 29). A patient who does not have a GP should be encouraged and helped to register with a practice
- any carer who will be involved in looking after them outside hospital (including, in the case of children and young people, those with parental responsibility)
- the patient's nearest relative (if there is one) or other carers
- a representative of any relevant voluntary organisations
- in the case of a restricted patient, multi-agency public protection arrangements (MAPPA)[1] co-ordinator
- in the case of a transferred prisoner, the probation service
- a representative of housing authorities, if accommodation is an issue
- an employment expert, if employment is an issue
- the clinical commissioning group's appointed clinical representative (if appropriate)
- an independent mental health advocate, if the patient has one
- an independent mental capacity advocate, if the patient has one
- the patient's attorney or deputy, if the patient has one
- a person to whom the local authority is considering making direct payments for the patient
- any another representative nominated by the patient, including anyone with authority under the Mental Capacity Act 2005 (MCA) to act on the patient's behalf

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Mental Health Funding Process for Section 117 aftercare arrangements

Stage 1 – Preparation for funding application

Prior to making a referral for funding for 117 aftercare, please ensure the following have been completed within the last 8 weeks and reports are available to support funding application:

1. **Nursing report** from named nurse if in patient/ CPN for community patients - Detailed clinical assessment including baseline assessment of Mental Health, Physical Health and social needs with clear treatment needs identified which are generated from the assessment process. **Health Needs Profile/ Commissioning Care Plan.**


Health needs profile March 2018.doc


Commissioning Care plan Feb 2018.docx

2. **Medical report** from Responsible Clinician - detail of diagnosis, medical opinion and summary of symptomology with recommendations for treatment needs.
3. **Social Circumstance report** from Social Worker – detailed social assessment including relevant historical information with recommendations of treatment needs generated from assessment process /Summary support Plan
4. Other relevant reports if available – **Psychology, Occupational Therapist** – detailed reports of assessments completed and clinical opinion with recommendations of treatment needs
5. **Risk assessment, formulation and management plans** - detailed risk assessment, formulation and management plans indicating anticipated changes to risk on transfer of care to new provider with rationale for changes in risk. Detailed risk management plan, including proactive and reactive strategies to manage risk effectively

Stage 2 – Multi-disciplinary Meeting – Treatment Options Appraisal – 117 Pre-discharge meeting

The MDT to meet and discuss care and treatment options based on report recommendations to identify types of services/care packages to be explored to support discharge, ensuring least restrictive options and local services are explored and exhausted first.

*if a specialist service is required the care co-ordinator to contact the Specialist Mental Health Nurse at Halton CCG for additional support and guidance in identifying potential providers.

The named nurse/care co-ordinator to Complete the 117 aftercare Discharge Planning Document for provision to potential care providers

Relevant parties to attend MDT are:

- Patient and/or patient representative (carer/family member)
- Advocacy

- Responsible Clinician
- Named Nurse (if in-patient)
- Care Co-ordinator
- Social Worker
- CCG Mental Health Nurse – if complex case
- Occupational Therapist – if applicable
- Psychologist – if applicable

Completion of 117 aftercare plan. Signed and agreed by Registered Clinician and Halton Borough Council Representative.

117 aftercare plan Feb 2018.docx

Stage 3a – Referral to Providers

Referrals to be completed to potential care provider by the care co-ordinator, via the 117 Aftercare Discharge Planning document. Where high cost specialist placements are being sought (such as specialist rehabilitation or hospital care), a minimum of three services to be explored from different services for the purposes of care options appraisal. Safety checks to be completed whilst awaiting outcomes of assessments.

Stage 3b – Safety Checks

Care Co-ordinator/ Social Worker to:

- Complete a service visit (if possible/necessary)
- Source the most recent CQC inspection report and scrutinise report
- Discuss with Contracts to enable checks to be completed
- Liaise with host CCG (if out of area) to check if there are any concerns regarding placing individuals in the service that we need to be aware of and expression of intention to place an individual in the service

If concerns are highlighted, further referrals to alternative care providers may need to be completed to ensure robust appraisal of options is completed.

Stage 4 –Multi-Disciplinary Team meeting - Care Options appraisal

On completion of safety checks and receipt of outcomes of referral (assessments), the MDT to reconvene to examine and consider any packages of care offered and identify the preferred provider based on the treatment plan offered.

Stage 5– Funding Application Pack

Care co-ordinator / Social Worker to complete and submit 117 Funding Application pack which includes:

- Reports and risk assessment from Stage 1
- Minutes of MDT – treatment options
- Referral reports and package of care offers – minimum of three
- Evidence of safety checks completed – CQC reports, any other detail available
- Minutes of MDT – care options appraisal
- Complete Halton CCG 117aftercare document
- Funding Request Form for all fully-funded CCG forms; otherwise the Support Plan Summary should be used
- Best Interests decisions if the person lacks the mental capacity to make key and specific decisions about the arrangements for their care, support, treatment or accommodation

CCG Mental Health Nurse to complete Complex Case Quality Assurance Document and book case in for review at MH Panel/ Complex Care Panel for 117 funding applications.

Stage 6 – Panel/ Funding approval

117 funded cases will be presented at MH Panel by the care co-ordinator / social worker which will convene monthly fortnightly. This only applies to full CCG funded packages, packages over £1000/ week, or complex cases or those with unusual deviations from the usual rates.

Panel will consist of representation from both the Local Authority and the CCG who are authorised to agree funding.

The following procedures to be considered:

Complex care panel process HBC/HCCG

Enhanced Care policy/procedures HBC/HCCG

Stage 7 – Outcome of Funding Application

117 cases will be agreed at panel by the Local Authority and CCG

On agreement of funding the care co-ordinator will:

- Arrange discharge meeting with MDT including new care provider to identify and plan safe transfer of care / discharge which includes:
    - Identification of admission date to service, including transportation, legal framework (MHA, CTO, DOL)
    - arrange 72 hour follow up on admission
    - Arrange 4 week review

Care package to be inputted on Care First system by social worker to support payment

Stage 8 – monitoring of placement

- Care co-ordinator will maintain regular visits to ensure care delivered is in line with the 117 aftercare arrangements and the individuals on going needs are met.
- Responsible Clinician to maintain oversight of mental health in line with 117 aftercare requirements. If 117 is no longer required, the RC will take necessary steps to remove 117 arrangements and instruct application for alternative funding streams (CHC/FNC/LA funding)

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APPENDIX 3

FUNDING PROCESS DIAGRAM

STEP 1:

Ward arrange 117 planning meeting
Invites: care co-ordinator, social worker, CCG, advocate and family
*any other professionals involved as necessary

MEETING TO IDENTIFY PATHWAY ON DISCHARGE – COMMUNITY/117 OR EXTENDED HOSPITAL STAY
REPORTS TO BE PROVIDED/DISCUSSED AT MEETING AS FOLLOWS:

WARD TEAM	CONSULTANT	SOCIAL WORKER	OTHER PROFESSIONALS*
• Nursing report OR Health Needs Profile • Risk Assessment	• Medical Report	• Social Circumstances report • Social needs assessment	• Psychology report • OT report • SALT report • Physiotherapist report

STEP 2:

follow pathway below

COMMUNITY/117		EXTENDED HOSPITAL STAY	
SOCIAL WORKER / CARE CO-ORDINATOR	WARD TEAM	CARE CO-ORDINATOR/CCG	WARD TEAM
• Complete referrals to relevant providers • Complete provider checks via contracts • Check CQC reports • Complete 117 aftercare plan	• Facilitate assessments from providers • Contribute to the 117 aftercare plan	• Complete referrals to relevant providers • Complete provider checks • Set up contract via CCG • Check CQC reports • Complete commissioning care plan	• Facilitate assessments from providers • Contribute to the commissioning care plan

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STEP 3:
OPTIONS APPRAISAL

Once assessments received from providers MDT to reconvene to review assessments and select most appropriate package of care offered.

*If no appropriate package is identified repeat step 2

PACKAGE OF CARE IDENTIFIED

- Panel will be weekly (Tuesday morning) for packages under £1000 per week
- Panel will be fortnightly (day tbc) for packages over £1000 per week

COMMUNITY / 117		EXTENDED HOSPITAL STAY	
SOCIAL WORKER / CARE CO-ORDINATOR	CCG	CARE CO-ORDINATOR	CCG
• Complete SPS • Prepare bundle for panel • Submit for quality check to manager • Submit to panel*	• On receiving bundle, complete quality check and submit to panel	• Complete OAT funding form • Prepare bundle for panel • Submit for quality check to manager • Submit to CCG via CHC duty desk inbox** Continuinghealthcare.halton.gov.uk	• On receiving bundle, complete quality check and submit to panel for authorisation

STEP 4: FUNDING APPROVED

COMMUNITY PLACEMENT		EXTENDED HOSPITAL STAY	
SOCIAL WORKER / CARE CO-ORDINATOR	WARD STAFF	SOCIAL WORKER / CARE CO-ORDINATOR	WARD STAFF
• Inform ward of outcome of funding application • Inform provider of award of contract • Attend CTO / discharge 117 meeting • Agree follow up – 72 hour, 4 week, 12 week then in line with CPA processes	• Arrange CTO/discharge 117 meeting – invite all relevant parties including provider • Identify discharge date within 117 meeting • Support transfer to new placement	• Inform ward of outcome of funding application • Inform provider of award of contract • Attend discharge meeting • Agree follow up – 72 hour, 4 week, 12 week then in line with CPA processes	• Arrange discharge meeting – invite all relevant parties including provider • Identify discharge date within meeting • Arrange transfer of care – section transfer • Support transfer to new placement

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