Section 117 of the Mental Health Act (S117 MHA): Aftercare
Gloucestershire Joint Policy

Status	Final
Author	Karl Gluck
Owner	Gloucestershire County Council / NHS Gloucestershire
Signed off by	JCPE – May 2022
Implementation Date	1 October 2022

Version	Date	Author(s)	Principal Changes
1	June 2013	Karl Gluck	The previous S117 policy was reviewed by David Pugh and Karl Gluck. Despite obvious merits to the policy there were significant deficits. The decision was therefore taken to draft a completely new policy for consideration. Areas not covered or not addressed by the previous policy are as follows: • Previous policy was between Gloucestershire Health and Care NHSFT and Gloucestershire County Council. This policy is between Gloucestershire County Council and Gloucestershire ICB. • Top up payments. • Accommodation as an aftercare need. • Prescription charges and S117. • Determination of funding splits between health and Social Care. The guidance has been updated to take account amendments made to S117 MHA by s40 Health and Social Care Act 2012, the most recent responsible commissioner guidance ***(Who Pays? Determining responsibility for payments to providers, August 2016)*** and s75 Care Act 2014.
2	August 2015	Karl Gluck	S117 guidance updated based on feedback following 12-week consultation.
3	Sept 2019	S117 steering group	Update of case law and legislation, comments and feedback from consultation group Implementation of funding matrix with guidance
4	August 2022	Karl Gluck / Noor Al- Koky	Refining and aligning to new Gloucestershire position.

This policy describes the statutory framework for managing and supporting persons to whom s117 applies across Gloucestershire.
The purpose of the policy is to:

- provide a consistent approach across Gloucestershire's ICS; and
- clarify agreements for the funding of S117 between NHS Gloucestershire and the County Council.

This document is not exhaustive, and it recognises that although correct at the time of distribution there are likely to be changes to national legislation/guidance/policy developments or case law. For example, there will be changes introduced relating to the replacement of the Care Programme Approach (CPA). This document should <u>not</u> be used as a substitute for seeking further advice from Senior Managers/Executives and legal advice if required.

Contents

1. Introduction

1.1. Section 117 (s117) of the Mental Health Act 1983 as amended by the Mental Health Act 2007 (MHA) places a joint duty on local NHS and local authorities to provide or arrange for aftercare services for people that have been sectioned under the treatment. The purpose of this policy is to set out the requirements for provision of after-care services under S117 to the residents of Gloucestershire.

1.2. The primary purpose of s117 is to ensure that the ICB and Local Authority work together in partnership to:

- *Meet the needs arising from or related to the person's mental disorder; and*
- *Reduce the risk of a deterioration of the person's mental condition and,*
- *Reduce the risk of the person requiring admission to a hospital again for treatment for mental disorder)*

1.3. This policy aims to lay out a clear framework for the Health and Social Care services in Gloucestershire to utilise when delivering statutory aftercare to people who are entitled to those services under S117. In addition, staff should be familiar with the relevant sections in the Code of Practice and the Reference Guide to the MHA in respect of S117.

1.4. This document also aims to give staff an understanding of their responsibilities with respect to planning, providing, reviewing and ending aftercare services

2. Scope & Purpose of policy

2.1. This Policy should be read in conjunction with Gloucestershire's Standard Operating Procedure and the relevant legislation and guidance.

2.2. This Policy and any associated documentation applies to:

- *Gloucestershire County Council*
- *NHS Gloucestershire*
- *Gloucestershire Health and Care NHS Trust*

2.3. It applies to people of all ages including children and young people who have been detained in hospital under the MHA under sections 3, 37, 45A and 47/48 of the Act and then cease to be detained and leave hospital. This includes patients granted leave of absence under s17 and patients going on CTOs. These are outlined below:

Section 3	**Detained for treatment**
Section 37	Admitted to hospital by an order of the Court
Section 45A	Admitted to hospital by a direction of the Court
Section 47	Removal to hospital of a person serving sentence of imprisonment
Section 48	Removal to hospital of other prisoners

2.4. The S117 statutory duty arises at the point of discharge but aftercare bodies must ensure that appropriate planning takes place as soon as possible.

2.5. S117 aftercare planning meetings must be documented fully. Further practice guidance is provided in **Appendix A** (adapted from Bevan Brittan: S117 Briefing).

2.6. The aftercare **will** be provided when an individual's Responsible Clinician (RC)

authorises Section 17 leave of absence and if the individual is made subject to a Community Treatment Order upon discharge from hospital.

2.7. Individuals are not charged for services they receive relating to their mental health needs under S117 (see paragraph 17).

2.8. Ending of S117 can only be made with the agreement of both the County Council and the ICB

2.9. The duty to provide S117 aftercare is not broken by the Individual's subsequent re-admission to hospital, either informally or under Section 2 of the MHA.

2.10. Services should be provided in co-operation with the relevant agencies and professionals.

3. Assessment

3.1. The planning and implementation of Aftercare services should be completed using the existing processes of the Care Programme Approach (CPA). It should be noted that during the lifetime of this policy document there will be changes to CPA in line with the Community Mental Health Transformation Framework. This policy will be updated accordingly as and when a new framework for assessment and care management is introduced.

3.2. At the point of becoming eligible for s117 each person must have their needs assessed and clarified as part of the appropriate care planning process and receive an assessment of their care and support needs. Aftercare planning must start as soon as possible after admission and should be person focused.

3.3. It should be noted that Care Act eligibility criteria should not be used to determine s117 aftercare needs when undertaking an assessment. S117 is a distinct/separate legal duty.

3.4. Personalised care means people have choice and control over the way their care is planned and delivered. Personalised care represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to have a voice, to be heard and be connected to each other and their communities. It makes the most of the expertise, capacity and potential of people, families and communities in delivering better outcomes and experiences. People who are eligible for s117 aftercare under the Mental Health Act also have a legal right to a personal health budget.

3.5. Personalised social care should be offered in the same way as patients not eligible for S117. Legislation is not intended as a barrier to providing creative and personalised support and the direct payments, personal budgets or self-directed support policies should be considered.

3.6. Individuals who are eligible for s117 aftercare should have their health and social care needs assessed taking a person-centred approach and in line with the Gloucestershire policy and procedure "My Life, My Plan". In practice, this means supporting the person to articulate what matters to them to enable them live independently in the community, focussing on their strengths not their deficits and jointly producing a care plan. This

should involve the use of creative solutions/alternatives in addition to traditional services.

3.7. Individuals have a right to request a Personal Budget (health and social care) but this does not mean that the person has to take direct control of the care themselves and may still request that this is managed by the County Council or ICB. The purpose should be to, wherever possible and within the bounds of certain legal constraints (e.g., s17A CTO), to enable the person to be in control of their own care/support.

3.8. We will ensure that through this policy and procedure that individuals are informed of this right prior to discharge and at review in the community (either vie advocacy or health/social care staff).

4. Hospital Discharge Planning

4.1. Failure to implement discharge planning arrangements within *'a reasonable time'* is in breach of Article 5 of the European Convention of Human Rights, and therefore in breach of the 1998 Human Rights Act. Health and Social Care Staff responsible for discharge planning need to ensure that the reasons for any delay are well documented and evidenced. Discharging remains a joint responsibility between the ICB and the County Council.

4.2. Patients should be the focal point of planning care service provision and should be involved in so far as possible. Their views on what will be needed to support them should be a primary concern for staff planning aftercare and they should be encouraged and supported in planning their future care arrangements. The Responsible Clinician should ensure this takes place prior to discharge from the hospital. A planning meeting should be held;

- *Prior to authorisation of Section 17 leave*
- *If a community treatment order is being considered*
- *If a Tribunal hearing or hospital managers hearing is planned*
- *If discharge from hospital is being considered and implemented*

4.3. Where possible this should be at least a week before discharge. The Code of Practice (2.29) requires us to inform the patients nearest relative of discharge from detention or CTO (where practicable) at least seven days prior to the discharge (This would include discharge from detention on to CTO. If the patient or the Nearest Relative has asked for this information not to be shared, then there is no legal authority to discuss with them.

4.4. Reasonable steps must be taken to ensure the identification of appropriate aftercare facilities and services for the patient before his/her actual discharge from hospital, and the actual cost of such service provision. This should include identification of the relevant ICB/County Council that will be responsible for aftercare.

4.5. If aftercare cannot be provided by already commissioned services and/or universal services then an application for aftercare funding may be required.

5. Review

5.1. The Care Coordinator/Care Manager will arrange an initial review of the Care Plan within an appropriate timescale (to be determined on a case-by-case basis according to need and standard practice) and thereafter at least annually.

5.2. Each review must include an explicit decision on whether the individual continues to be eligible for S117 aftercare and what services are required to support them.

5.3. All reviews must be formally documented.

5.4. All care plans must include specific detail of which services are to be provided under S117.

5.5. Any changes in S117 status of the individual must be recorded on the appropriate template and all parties should be made aware will be immediately recorded on the register (i.e. transfers/discharge).

6. Recording

6.1. It is very important to distinguish on care plans and S117 documentation those items of care and support that relate to mental health needs and are provided free of charge, and those items that relate to other care needs unrelated to the relevant mental disorder, which may be subject to an appropriate charge by the County Council. It is therefore important that the Care Co-ordinator in the S117 planning arrangements is fully aware of the legal position and any funding commitments that may result.

6.2. Within effective care co-ordination, written documentation giving full assessment details should be available to inform an individual's care plan. All the services relevant to the S117 aftercare plan must be carefully recorded and agreed with the individual and or their representative. There should be a record of which services are to be provided by each agency.

6.3. Unwillingness by the individual to receive aftercare services is not a reason to end S117, as the need for services may be present. Any such refusal should be considered and reviewed regularly.

7. Individuals entitled to s117 rights

7.1. **Right to be engaged:** The person who is subject of detention under the Mental Health Act should be engaged in the process of reaching decisions about aftercare services and should be agreed with them. Engagement involves helping the person understand relevant information, their role and the roles of others who are involved. Where a decision is made, it should be explained to the person using an appropriate form of communication. Carers and advocates should be involved where the person wishes or if the person lacks capacity to understand.

7.2. **Right to advocacy**: The person who is subject of detention under the Mental Health Act has the right to an advocate:

- ***Independent Mental Health Advocates (IMHA):*** *Mental Health service staff have a legal duty to ensure anyone who is eligible (any person detailed under the MHA) is aware of their right to speak to an advocate on discharge or at reviews. This includes people who are in a psychiatric hospital and others who are subject to either S.17A*

Community Treatment Orders or Guardianship. Anyone who is directly involved in an individual's care or treatment can refer to the IMHA Service, as can the individual themselves.

- ***Independent Mental Capacity Advocates (IMCA):*** *Under the Mental Capacity Act 2005, there has been a legal duty to refer Individuals to the IMCA Service where they have been assessed as requiring move to new residential accommodation as part of the S117 MHA aftercare package, if they are deemed to lack capacity, and have no relatives or family whom it is appropriate to consult. This referral must be made before the aftercare plan is implemented. The IMCA service may also get involved if the individual lacking mental capacity is subject to an adult safeguarding investigation or is subject to a formal assessment under the Mental Capacity Act's Deprivation of Liberty Safeguards.*

7.3. **Right to aftercare as long as needed:** The duty to provide aftercare services continues as long as the person is in need of such services.

7.4. **Right to decline aftercare services:** Eligible individuals are under no obligation to accept the aftercare services they are offered, but any decisions they may make to decline aftercare services should be fully informed.

7.5. **Right to request a personal health budget**: Individuals have a right to request a Personal Health Budget. For more information please see paragraph 3 and 14.

8. Funding Responsibility and Residency: General Statement

8.1. S117 aftercare responsibility comes into effect at the point of discharge. It is therefore essential as part of the discharge planning process to identify the relevant funding bodies prior to discharge.

8.2. No necessary assessment, care or treatment should be refused or delayed because of uncertainty or ambiguity as to which NHS commissioner or County Council is responsible for funding an individual's health or social care provision.

8.3. Unless stated otherwise in the following sections, the overriding principle is that the originating authority or body with responsibility for commissioning s117 services i.e. the authority or body where the patient is registered prior to their detention, is also the authority or body who is responsible for paying for the commissioned s117 aftercare services regardless of where the patient is treated or placed.

8.4. This policy outlines the position for anyone detained after September 2020. For any individual detained pre-September 2020, legal advice should be sought.

9. ICB Funding Responsibility and Residency (after 1 September 2020):

9.1. Where a person is detained under the relevant section of the MHA, and is not already in receipt of s117 aftercare, the responsible ICB for s117 after discharge will be the 'originating ICB' defined as:

- *Where a person is registered on the list of NHS patients of a GP practice, even if on a temporary basis, the ICB of which the GP practice is a member.*

- *Where a person is not registered with a GP practice, the ICB in whose geographic area the person is "usually resident". This includes people of 'no fixed abode'.*

9.2. Where, a person has been discharged from detention and is already receiving s117 aftercare, funded in part or whole by an ICB, that ICB will remain responsible for funding the aftercare – and any subsequent further detentions or voluntary admissions – until such point as the person is discharged from s117 aftercare.

9.3. Where a person is detained in hospital funded by an ICB, that ICB will be responsible for funding the full period of detention and any necessary NHS aftercare on discharge – and any subsequent further detentions or voluntary admissions – until such point as the person is discharged from s117 aftercare.

9.4. Where a person is detained in hospital funded by NHS England, the ICB which will be responsible for funding any further detention in a ICB-funded hospital setting and any necessary NHS aftercare (including any subsequent further detentions or voluntary admissions, until such point as the person is discharged from s117 aftercare) will be the responsibility of the ICB in whose area the person was registered, or where not registered usually resident, at the start of the period of detention in hospital funded by NHS England.

9.5. Where a child or young person aged under 18 years is placed out of area under the Children Act 1989 and is subsequently detained under the MHA and becomes s117 eligible on discharge, and is still detained on their 18th birthday, the ICB which will be responsible for funding the continued period of detention and any necessary NHS aftercare (including any subsequent further detentions or voluntary admissions, until such point as the person is discharged from s117 aftercare) will be the originating ICB at the time of the care placement.

9.6. The ICB who is responsible for s117 aftercare is not necessarily the responsible ICB for meeting other health needs. The ICB responsible for meeting other health needs (e.g., for physical health, FNC or CHC) will be the ICB in whose area the person is registered, or where not registered deemed to be usually resident.

9.7. Where a dispute takes place between ICBs about responsibility for commissioning, the commissioners must agree that (a) one of them will take responsibility for arranging for assessment and planning for the person, and for arranging appropriate aftercare services; and (b) all costs are jointly funded pending resolution of the dispute. Once the dispute is resolved, the ICB which is no longer deemed responsible will be reimbursed.

9.8. Any person who is in receipt of s117 aftercare and is subsequently detained under the MHA will remain the responsibility of the ICB who was originally responsible for s117. Subsequent periods of detention prior to discharge of s117 do not transfer commissioning responsibilities

10. County Council Responsibility

10.1. The duty on county councils' rests with the area in which the individual was ordinarily resident **immediately** before they were detained, even if the individual subsequently becomes ordinarily resident in another area after leaving hospital.

10.2. Statutory guidance has clarified that the deeming provisions set out in the Care Act **do not** apply to s117 aftercare. Therefore, the responsible County Council will be the one the person was *'ordinarily resident'* immediately prior to detention. In relation to any additional care and support needs that an individual may have (which are not part of the s117 aftercare plan), if that individual is being provided with accommodation under S117, they are to be treated as being ordinarily resident for the purposes of the Care Act, in the area of the County Council which has the duty to provide aftercare. This is to ensure that the same County Council will be responsible for both.

10.3. As the Care Act is not intended to be retrospective this only applies to cases where the individual was detained on/after 1st April 2015. For pre-existing cases residency should be determined under the old rules and case law. Ordinary residence is a complex area and legal advice should be sought where responsibility for s117 services is not clear particularly in cases where an individual subject to S117 is detained under the relevant sections of the MHA.

10.4. If the person is subsequently detained before being discharged from s117 aftercare, the responsible County Council becomes the authority in whose area the person is ordinarily resident at the time that period of detention commences. *R(Worcestershire County Council) v Secretary of State for Health and Social Care* [2021] EWHC 682 (Admin) states that " Although any change in the patient's ordinary residence after discharge will affect the County Council responsible for their social care services, it will not affect the County Council responsible for 5 commissioning the patient's s117 aftercare. Under s117, as amended by the Care Act 2014, if a person is ordinarily resident in County Council area (A) immediately before detention under the 1983 Act and moves on discharge to County Council area (B) and moves again to County Council area (C), County Council (A) will remain responsible for providing or commissioning their aftercare. However, if the patient, having become ordinarily resident after discharge in County Council area (B) or (C), is subsequently detained in hospital for treatment again, the County Council in whose area the person was ordinarily resident immediately before their subsequent admission (County Council (B) or (C)) will be responsible for their after-care when they are discharged from hospital"

10.5. Where a dispute arises between local authorities, the County Council that is meeting the needs of the person on the date that the dispute arises must continue to do so until the dispute is resolved. If no County Council is currently meeting the person's needs, then the County Council where the person is living or is physically present should accept responsibility until the dispute is resolved.

11. Funding

11.1. The majority of those subject to S117 will have their aftercare needs met through access to existing services. For those whose needs cannot be met as described, it will fall to the responsible aftercare bodies, provided that all reasonable alternatives have been explored.

11.2. It should be noted that this section relates **only to** Individuals where Gloucestershire

ICB and County Council are jointly responsible for S117 aftercare. There will be occasions where S117 responsibility is split between different ICBs and Local Authorities. In such cases funding will have to be agreed on a case-by-case basis. It is therefore essential where individuals are placed out of area and are registered with a different GP that the ICB for that area are notified as soon as is practicable.

11.3. All requests will be presented to the relevant **funding panel**. The funding split will be an automatic 50:50, shared equally between the ICB and County Council, except in certain circumstances where the request is over a certain threshold, or is particularly complex or high risk. These exceptions are outlined in the Standard Operating Procedure.

11.4. If a request meets the exception criteria, the S117 Funding Matrix Tool (see **Appendix D**) should be used **as a guide** to determine relative funding splits. The Funding Matrix Tool must be completed by a health worker and a social care worker. One or both of these individuals should have prior knowledge of the case. The purpose of jointly completing the tool should be to reach a joint conclusion on the relative balance of health/social care needs. Both workers should sign the form as agreement.

11.5. Exceptional funding splits will be agreed through a funding panel organised across the different client groups.

12. NHS Continuing Health Care and NHS Funded Nursing Care

12.1. Where a person is eligible for services under S117 these should be provided under s117 and not under NHS Continuing Healthcare. It is not, therefore, necessary to assess eligibility for NHS Continuing Healthcare if all the services in question are to be provided as after-care services under s117.

12.2. Only needs that are not section117 should be considered for NHS continuing healthcare eligibility.

12.3. A person eligible for s117 aftercare should only be considered for NHS continuing healthcare or NHS continuing care where they have physical health needs which are not related to their mental health aftercare needs. However, for adults, not meeting the criteria for full CHC funding does not preclude the ICB from having a joint funding arrangement with the Council to meet specific physical health care needs which do not fall within the eligibility of the Care Act. It is not, therefore, necessary to assess eligibility for NHS Continuing Healthcare if all the services in question are to be provided as aftercare services under s117. However, a person in receipt of s117 aftercare services may also have, or later develop ongoing primary health care needs which may then trigger the need to consider NHS Continuing Healthcare or NHS Continuing Care for Children in addition to any s117 support.

12.4. Where an individual in receipt of s117 services develops physical care needs resulting in a rapidly deteriorating condition which may be entering a terminal phase, consideration should be given to the use of the Continuing Healthcare Fast Track Pathway Tool.

12.5. Arrangements under the Mental Health Act are separate and different from NHS

Continuing Healthcare and the two should not be confused. The above guidance particularly deals with S117, however the same principle (regarding the need to determine whether the services are provided under the Mental Health Act or under NHS continuing healthcare) applies where an individual is subject to Section 17 leave or to a Section17A Supervised Community Treatment Order.

12.6. **Funded Nursing Care** (FNC) is the funding provided by the NHS to care homes delivering nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible. If the individual has such a need and it is determined that the individual's overall needs would be most appropriately met in a care home providing nursing care, then this would consequently lead to eligibility for NHS-funded nursing care. Once the need for such care is agreed, the ICB's responsibility to pay a flat rate contribution to the care home towards registered nursing care costs arises.

13. Top Up Payments and Risks

13.1. Individuals who are entitled to S117 and for whom Gloucestershire County Council are providing or arranging accommodation under S117 are entitled to choose their preferred accommodation provided that the conditions are met which are set out in the Care and Support and Aftercare (Choice of Accommodation) Regulations 2014.

13.2. An individual subject to S117 is entitled to purchase additional services over and above those identified to meet their assessed care needs.

13.3. In relation to the top ups for accommodation then this will be subject to Regulation 4.

13.4. There is no need to undertake a financial assessment, but risks must be clearly explained and recorded.

13.5. If an individual's S117 has ended and the individual meets the eligibility criteria for social care services, the usual financial arrangements will apply. An assessment will be made on the cost effectiveness of the placement and the risks to the individual of a move to a more cost-effective placement.

13.6. Any 'top up' payment arrangement for S117 must be agreed by the relevant manager and Panel because of the risks involved.

14. Direct Payments and Personal Health Budgets

14.1. Local authorities are obliged to offer a person the option of direct payments in place of the services currently received, subject to the conditions set out in section 31 of the Care Act 2014 and The Care and Support (Direct Payments) Regulations 2014. There are some limited circumstances where a person may not be given this choice and direct payments cannot be used to pay for permanent residential accommodation. Local Authorities have a duty to offer direct payments to people who are subject to mental health legislation. This is with the principal exception of people who are on *conditional discharge* from hospital under Part III of the MHA where there is now a power (but not a duty) to offer direct payments. County Councils also have a power (but not a duty) to offer direct payment arrangements for conditions attached to a Guardianship Order.

14.2. Where the person does not have capacity to request direct payments then an

authorised third party may do so on their behalf subject to section 32 of the Care Act 2014. The County Council must consider that making direct payments to the authorised third party to be an appropriate way to discharge their s117 duty and be satisfied that the authorised party will act in the best interests of the person when arranging the aftercare.

14.3. People eligible for aftercare services under s117, and who are funded by an ICB, have a right to have a Personal Health Budget (PHB). The PHB may be taken as a direct payment (under The National Health Service (Direct Payment Regulations) 2013), a Third Party PHB or a Notional PHB, dependent upon prescribed criteria being met

14.4. It is important to note that a Personal Health Budget is not a Direct Payment. A Personal Health Budget is a source of funding, whereas a Direct Payment is a method of payment. Individuals can receive a Personal Health Budget as a direct payment via a payment card.

15. Ending S117

15.1. S117 (2) imposes the duty to provide services until such time as the ICB and County Council are **jointly** satisfied that the individual concerned is no longer in need of statutory after-care.

15.2. Aftercare under s117 may be terminated for the following reasons:

- Death of an individual
- *A review has determined that aftercare is no longer required*

15.3. The authority responsible for the particular services should consider whether ending s117 is appropriate. S117 obligations end only at the point when both the ICB and County Council have come to a decision that the person no longer needs any after-care service for their mental health needs. There needs to be positive evidence that a person no longer needs s117 after-care services otherwise their discharge from s117 is considered unlawful. Prior to ending S117 it should be demonstrated that there has been active engagement with the Individual/their representatives. This must be clearly documented at review (see **Appendix A**).

15.4. Services should not therefore be withdrawn on the basis that:

- *The individual has been discharged from the care of specialist mental health services*
- *an arbitrary period has passed since the care was first provided;*
- *The individual is deprived of their liberty under the Mental Capacity Act 2005;*
- *The individual has returned to hospital informally or under Section 2 MHA;*
- *The individual is no longer subject to arrangements under either Sections 17 or 17A MHA.*

15.5. Indicators that S117 could be discharged may include any of the following:

- *Stabilised mental health no longer requires the level of care that has been provided*
- *Services no longer needed to reduce risk of return to hospital or relapse*
- *No ongoing need for involvement of a consultant psychiatrist or specialist mental health services or for medication.*

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.

15.6. S117 cannot be ended if the individual is also subject to section 17A or if they are a conditionally discharged Section 37/41 individual, or on section 17 leave from section 3, 37, 45A, 47, or 48.

15.7. Any recommendation to discharge, resulting from consideration of the above factors, must be agreed by:

- For Integrated Teams (Adults with Mental Health) the relevant Team Manager/Social Care Specialist **and** the Responsible Clinician (Consultant Psychiatrist) on behalf of the ICB.
- For non-integrated services (Learning Disabilities, Older People, Children) then this should be by the relevant Senior Team Manager on behalf of the County Council **and** the Responsible Clinician on behalf of the ICB.

15.8. If there is a difference of opinion between ICB and County Council regarding the decision to end S117, which cannot be resolved at operational level, this will need to be escalated to Senior Management within the ICB and County Council.

15.9. The decision to end S117 **must** be recorded using the proforma in **Appendix B**. This should be sent to:

- *Health Records (Gloucestershire Health and Care NHSFT or equivalent).*
- *Relevant ICB.*
- *Relevant Local Authority Department.*

15.10. The Individual/their representatives **must** be informed of this decision in writing, which should include the relevant factors/reasoning. The FAB team should be advised in writing.

15.11. The criterion for agreement is that the individual no longer requires aftercare. It is essential that good and robust care planning can be demonstrated in all statutory aftercare cases.

16. Procedure ending s117 entitlement

16.1. In summary, the entitlement to s117 services only ends when it is discharged in the following way:

- *The initial recommendation to end s117 is made at a multi-disciplinary CPA / s117 review. The patient and carer should be present or represented and kept informed. Representatives of the County Council, and the Trust (on behalf of the ICB) must be present in order to formulate the recommendation.*
- *Any recommendation to discharge must be agreed by the relevant Social Care manager and the Responsible Clinician (Consultant Psychiatrist) on behalf of the ICB.*
- *If there is a difference of opinion between the Trust and County Council regarding the decision to discharge from s117, which cannot be resolved at operational level, this will need to be escalated to Senior Management within the ICB and the relevant Adult Social Care & Health department with the County Council*
- *Only when representatives from the two separate organisations agree, can s117 be discharged.*

- *The decision to end s117 must be recorded using the proforma in **Appendix B** and uploaded on the databases of the relevant organisations. This proforma should also be forwarded to the MHA office by the person completing it and the Panel. The patient/their representatives must be informed of this decision in writing, which should include the relevant factors/reasoning.*
- *Aftercare services may be reinstated if it becomes obvious that they have been withdrawn prematurely. For example, where a patient begins to deteriorate immediately after services are withdrawn.*

17. Charging

17.1. GCC is unable to charge Individuals for a contribution to any after-care services (including residential care) that are provided under S117. When someone who is subject to S117 is in receipt of services they would normally be charged for, the care co-ordinator/care manager is responsible for ensuring that the County Council Financial Assessments and Benefits (FAB) Team is informed of the date of the commencement of the period of aftercare by telephone and or email to ensure the team are aware of their legal status and that no charges for after-care can be made

17.2. Individuals may have at the same time or may develop other needs for service provision, which are not connected to their mental health aftercare needs, for example, a physical disability or age-related illness or condition. The social consequences of such a need may amount to a care need under the Care Act or other legislation. When this is the case, and whilst the individual remains subject to S117, community care services to meet their "physical" social care needs, which are clearly independent of their community care services to meet their needs from a mental disorder**, may** be subject to a financial assessment, with a view to charging the individual for those services. This is likely to be a rare occurrence and whenever it arises the care co-ordinator must always:

- Send the details of the assessment, proposed care plan and any other associated documents to the County Council's legal services so that they can give a legal view on the lawfulness of such an approach. Only once legal services confirm that, in this case, it is possible to charge the individual for a community care service will the care co-ordinator then make the necessary arrangements with the FAB team.
- The care co-ordinator will explicitly define for the individual and their representative those services which will continue to be provided under S117 and those which will be provided under the Care Act and subject to a financial assessment.
- The individual and their representative should always be offered independent advocacy during this process.

17.3. Where the need for S117 no longer applies and has been properly ended with the full agreement of both the ICB and of the County Council, but there exists a continuing need for community care services to meet a physical disability, an age related condition or any other condition not linked to the individual's mental disorder, then such a service would then be eligible to the normal charging regime.

17.4. There can exist a close inter-relationship between the presence of a mental disorder

and a physical disability/illness. The decision to end S117 aftercare, in the presence of an ongoing, long term physical disability must take into careful account both psychiatric and medical assessments and consider the individual's circumstances in the round.

17.5. The Care Co-ordinator should always consider seeking legal advice where the presenting circumstances are complex, ambiguous or where there is a dispute over any element of the review of community care needs, prior to a potential decision to end S117. Similarly, the individual and or their representative should always be offered access to independent advocacy.

18. Complaints and Disputes

18.1. No necessary assessment, care or treatment should be refused or delayed because of a complaint or dispute as to which ICB or County Council is responsible for funding an individual's health or social care provision

18.2. Any complaint regarding the operation of this policy should in the first instance be addressed with a Care Co-ordinator/care Manager and/or the relevant team manager. Where this is not successfully resolved then the complaint should be handled in line with the complaints procedures of the lead agency.

18.3. Any complaint by a person or their carer or representative with the quality and standard of the provision commissioned will be managed under the complaints procedure of the providing organisation in the first instance. Where the provider is distinct from the commissioning body, the complaint may subsequently be managed by the commissioning body. Once statutory complaints procedures have been concluded, any person has the right to complain to the Local Government and Social Care Ombudsman or the Health Service Ombudsman.

18.4. Local disputes as to S117 responsibility and funding will be addressed through the local dispute resolution process for joint funded packages.

18.5. If two or more local authorities fall into dispute about where an individual is ordinarily resident, or about an individual's continuity of care and support, and cannot resolve the question locally, the local authorities involved may request a determination of ordinary residence to be made by the Secretary of State or an individual appointed by the Secretary of State. Details specifying the dispute resolution process will be set out in regulations and statutory guidance. Where there is a dispute between local authorities regarding where the person was 'ordinarily resident' before being detained, this will be determined by the process set out by the Care and Support (Disputes Between Local Authorities) Regulations 2014 (SI 2014/2820).

18.6. Where there is a dispute between separate ICBs regarding s117 responsibility the updated NHS 'Who Pays Guidance (June 2022) should be referred to. In summary this requires:

- Local resolution at Director level;
- ICB/ ICS resolution at Director/Executive level; and
- Arbitration by NHS England.

18.7. Where a dispute takes place between ICBs about responsibility for funding or

commissioning, the commissioners must agree that:

- One of them will take responsibility for arranging for assessment and planning for the person, and for arranging appropriate aftercare services; and
- All costs are jointly funded pending resolution of the dispute. Once the dispute is resolved, the ICB which is no longer deemed responsible will be reimbursed.

19. Implementation and Review

19.1. This policy will be issued to all relevant staff to ensure employees have access to and are able to comply with the processes within.

19.2. S117 training will be delivered to all health and social care staff in three stages covering:

- The legal position with relevant case law, legislation, and reference to the latest Who Pays Guidance
- How the policy and associated documents, including the Standard Operating Procedure, is implemented in Gloucestershire; **and**
- How to function it in practice, with an emphasis on personalisation and personal health budgets

19.3. There will regular financial monitoring via Joint Commissioning Partnership Executive (JCPE) of s117 cases.

19.4. An audit of S117 policy will be undertaken within the first 6 months of implementation and will form the basis of the review.

19.5. There will be an evaluation of this policy after 12 months of implementation with a view to taking an annual report to the Joint Commissioning Partnership Executive.

Key Words and Phrases used in this Policy

• **Care programme approach (CPA):**	Framework of assessment, care planning and review for people who receive mental health services.
• **Care management:**	Framework of assessment, care planning, provision of care packages and review for people who receive services via Local Authorities
• **Extra Care:**	Care that is purchased to meet an individuals needs that cannot be provided through locally commissioned/universal services.
• **FAB:**	Financial Assessment and Benefits team based within Gloucestershire County Council.

Relevant Sections of the MHA

• **Section 3:**	Order detaining an individual in hospital for treatment
• **Section 17 leave:**	Period of agreed community leave for an individual currently liable to detention in hospital.
• **Section 17A (Community Treatment Order):**	Order providing a legal framework around the care plan of an individual who has been detained under section 3 (or section 37 hospital order), when they are discharged from hospital, although they remain liable for recall or revocation from the Community Treatment Order
• **Section 37:**	Order detaining an individual who has been transferred by the Courts to hospital for treatment. Note: Guardianship under section 37 does **not** confer S117 status
• **Section 37/41:**	Order detaining an individual who has been transferred by the Courts to hospital for treatment, with restrictions
• **Section 42 – conditionally discharged Individuals:**	Allows the Secretary of State to direct that someone under a restriction order should be discharged from hospital but subject to conditions e.g. place of residence, supervision by psychiatrist and social supervisor
• **Section 45A:**	When imposing a prison sentence for an offence other than when the sentence is fixed by law, the Crown Court can give a direction for immediate admission to and detention in a specified hospital, with a limitation direction under Section 41. The directions form part of the sentence and have the same effect as a hospital order. The Home Secretary can approve transfer back to prison at any time.
• **Section 47 or 48:**	Orders detaining an individual transferred from prison to hospital for treatment.

Appendix A

S.117 BRIEFING

AFTERCARE REVIEWS

The following guidance is a template document setting out a series of recommendations that will need to be adapted depending upon the circumstances of each individual patient; for some patients, this will be the bare minimum that is required. Conversely, for some patients the review will not need to be as comprehensive and only parts of this template may assist.

It is not intended to be prescriptive or mandatory, but more a guide as to the essential legal and practical issues that could be considered. It is based upon our experience of difficulties that staff encounter when having to justify the decisions that they have made with regards to aftercare.

PREPARATION FOR REVIEW MEETING

In advance of the meeting, we would recommend that the professionals give consideration to (and write down) their preliminary views on the following issues:

1. What "needs" does the patient have? These include health, social care and "common" needs.

2. Which of the identified "needs" arise as a result of (i.e. are caused by) the patient's mental disorder?

3. Conversely, which of the identified "needs" do not arise from the patient's mental disorder? Importantly, consider the reasons why they are not.

4. What services could be offered to the patient to meet their identified "needs"; arising both from the patient's mental disorder and other general needs.

5. Which of the identified services relating solely to needs arising from the patient's mental disorder, are important to prevent deterioration in their mental disorder leading to readmission to hospital?

6. Equally, which of the identified services are not required to prevent a relapse in the patient's mental disorder leading to an admission to hospital? Consider the reasons why they are not so required.

It is useful for the professionals to have given some thought to this prior to meeting and before discussing with the patient and/or Nearest Relative.

The approach which the team should take when reviewing and discussing their views on the above issues are clarified in more detail below.

REVIEW MEETING

Timing of Review and Participants

A s.117 review meeting should be convened prior to discharge with sufficient time for any services to be put in place before the discharge takes place. It is an essential part of the

Care Programme Approach. A review should then take place approximately once every 6 months post discharge, unless and until the duty under s.117 is jointly discharged by both the ICB and County Council.

The key professionals that should attend the meeting are:

- Consultant Psychiatrist;
- All other appropriate members of the MDT, including, for example:
    - Clinical Psychologist;
    - Occupational Therapist;
    - Speech and Language Therapist
    - Physiotherapist
    - Named Nurse
    - Ward Manager/Deputy
- Representative from the ICB
- Representative from the County Council

Other people that should be invited to the meeting include:

- Patient
- Nearest Relative
- Legal Representative of Patient and/or Nearest Relative
- Employment / Education ./ Probation (where appropriate)

We would recommend that a formal minute taker is also present.

Process for the Review

We recommend that any review meeting follows the format set out below (almost as an agenda) – and that the conclusions from each step are recorded.

Step One – Identify Needs

What "needs" does the patient have? These should include health (physical and mental health), social care and "common" needs (please see below).

NB – a need that is being met is still a need even if the manifestations are not active as a result of the need currently being met: consider what would happen if the service meeting the need ceased.

We would recommend that all of the needs are listed.

The clinical team may wish to consider the following needs which are commonly considered (please note that this list of needs is by no means exhaustive and is for illustrative purposes):

- Activities of daily living
- Provision of medication
- Ordering, collecting and delivering medication
- Monitoring medication compliance
- Support with regards accessing the community whilst ensuring social inclusion
- Outpatient reviews
- Psychology
- Accommodation and physical environment
- Exercise
- Transport
- Meaningful activity/occupation/interests

- Contact with family/friends
- Confirming, cancelling, rearranging and thereafter assisting the patient in attending for medical appointments
- Payment of utility bills
- Monitoring of general health, individual hygiene, food and fluid intake

Step Two – Determine which are Aftercare Needs

Which of the identified "needs" arise (i.e. are caused by) as a result of the patient's mental disorder (i.e. learning disability and/or personality disorder)? Needs "caused by" may include symptoms and manifestations of the mental disorder as well as the mental disorder itself.

We would recommend setting out the header "aftercare needs" and listing any aftercare needs along with the reasons why they are such needs.

Conversely, which of the identified "needs" do not arise from the patient's mental disorder (and importantly, the reasons why they do not)? A need, which if addressed would improve the patient's state or prevent a deterioration is not necessarily an aftercare need. The test is not whether any particular service, if not provided, will lead to an exacerbation of someone's mental disorder. The test is whether the need arises directly from the mental and if not provided for, is likely to lead to re-admission to hospital for that disorder.

Similarly, set out the reasons as to why each is not an aftercare need.

Step Three – Identify Services

What services could be offered to the patient to meet their identified "needs" (both those arising from their mental disorder and other general needs)?

Which of the identified services relating **solely** to needs arising from the patient's mental disorder, are important to prevent deterioration in the patient's mental disorder which could lead to a readmission to hospital?

Conversely, which of the identified services are **not** required to prevent a relapse in the patient's mental disorder leading to an admission to hospital (again, with reasons)?

When considering what the appropriate services would meet the patient's assessed needs, the clinical team should consider both primary and secondary health services, third sector services (such as citizens advice bureau, job centre and charities) and County Council services. The source of the service to meet the assessed need **does not** impact upon/determine whether an assessed need is an aftercare need or a general need. An assessed s.117 aftercare need could have a service provided by a primary healthcare organisation. Equally, a general/common need could be addressed by a secondary mental health service.

The Courts have been very clear that the nature and extent of services required to meet assessed aftercare needs must, to a degree, fall within the discretion of the authorities. This means that as long as the ICB and County Council are reasonable in their approach to the services that are identified to meet any assessed s.117 aftercare needs, the Courts will be reluctant to interfere with the exercise of professional discretion.

Overall, does the patient have any s.117 aftercare needs (i.e. those which meet **both** limbs of the test – (1) a need arising from the patient's mental disorder and (2) requiring a service to prevent readmission to hospital), as opposed to general health, social care or common needs?

Step 4 – Trust Services

Once the aftercare services have been identified, the clinical team needs to set out *which* of the aftercare services could be met by the Trust (and how) and which aftercare services require bespoke commissioning.

Consultation

The professionals should take the lead in any s.117 aftercare reviews. That being said, it is imperative that the clinical team consult with and take account of the patient's, Nearest Relative's and any other family's views. To this end, it is not for the clinical team to dictate to patient, but in the same vein it is not for the patient to dictate to the clinical team.

The minutes of the s.117 review meeting must demonstrate this consultation; to do this effectively, we would suggest that at each stage of the review meeting the clinical team (1) sets out its professional views on the aspects covered in that stage, (2) invites the views of the patient etc (and records them) and (3) acknowledges any views of the patient etc which are appropriate and also providing reasons where the views differ.

RECORD

To ensure clarity, we would recommend that the clinical team set out their views in a stepwise fashion. The simplest way to do this might be to make a record of the conclusions of each step as set out above. It is imperative that full reasons are set out for every conclusion that is drawn.

We cannot emphasise strongly enough the pressing need for full and robust documentation of the s.117 aftercare review meeting. Any minutes produced are likely to be dissected by the patient's legal advisors. The minutes should accurately record all of the discussions around identifying the "needs" which the patient has, differentiating between s.117 aftercare needs and general health/social care/common needs and identifying appropriate services to meet assessed needs.

Appendix B

Discharge from S117 Mental Health Act 1983			
Name		**DOB**	
NHS Number		**PRN**	
S117 Review Meeting Date			
People present at the review meeting			
We are satisfied that the patient is no longer in need of S117 services as specified below. The patient was therefore discharged from those aftercare services (s.117 of the MHA)			
This form must be signed by representatives from both organisations. If you are uncertain if you are able to sign this form please consult with a Senior Manager prior to doing so.			

Signed		**Name**		**Date**	
On behalf of Gloucestershire ICB		**Title**			
Signed		**Name**		**Date**	
On behalf of Gloucestershire County Council		**Title**			

Appendix C

Joint Funding Matrix - S117

Guidance Notes for completing Needs Assessment

CARE DOMAIN		LEVEL OF NEED			
		A	B	C	D
BEHAVIOUR	Risk to self, e.g. self harm, self neglect/exploitation by others and risk to others	Able to assess and make safe decisions; may require some guidance. No risk of self-harm	Requires supervision and guidance to be enabled to make safe decisions and take appropriate actions to maintain safety of self and reduce risk of harm to self	Unable to make safe decisions without regular support OR able to make decisions if given limited options, guidance and reassurance. Needs appropriate health professional input to reduce injurious behaviour which may result in harm to self or neglect. Requires regular input/ observation from skilled staff	Unable to assess situations for themselves. Will persistently expose themselves to risk of harm/ neglect unless prevented from doing so. Needs substantial input/ observation by skilled staff to eliminate or reduce harm
	Risk to others. Consider the potential risks due to mental state and support required to maintain the safety of others	Able to assess and make safe decisions; may require some guidance. No risk to others	Requires supervision and guidance to be enabled to make safe decisions and take appropriate actions to maintain safety of others	Unable to make safe decisions without regular support. Needs appropriate health professional input to reduce potential harm towards others? Requires regular input/ observation from skilled staff	Needs substantial input/ observation by skilled staff to eliminate or reduce danger/injurious behaviour towards to others. Will persistently expose others to danger unless prevented from doing so

CARE DOMAIN		LEVEL OF NEED			
		A	B	C	D
PSYCHOLOGICAL	Emotional state Include mood, visual / auditory hallucination/paranoia, levels of distress affecting daily routine	Alert, able to express feelings; has insight	Difficulty expressing emotions. Concentration span may be affected. Anxiety or distress that responds to reassurance Hallucinations' which do not have a marked effect on daily living but affects compliance	Inappropriate mood swings or inappropriate in mood most or all of the time. Anxiety or distress that does not readily respond to reassurance. Hallucinations' or paranoia which are having an effect on daily living	No insight, out of touch with reality. Marked hallucinations' or paranoia which prevent some activities of daily living Extremes of mood and consistently oblivious to life events. Anxiety or distress that has a severe impact on health and well being
COGNITION	Mental State; Consider ability to process information and concentrate on tasks required.	Oriented in time, person and place. No loss of memory or cognitive functioning	Mild, but definite problems of memory or comprehension. May lose way in a familiar environment. Confused or disorientated some of the time. Requires cues and prompts to process information and follow instructions	Marked disorientation of time, person and place. Confused by everyday events. Has a limited ability to follow and process information even with cues and prompts	Severe disorientation, e.g. inability to recognise people or communicate coherently. Unable to reliably process information or follow instructions.

	disorders		or requires some assistance / prompting with feeding, but no nutritional concerns	encouragement and assistance by skilled staff	
CARE DOMAIN		LEVEL OF NEED			
		A	B	C	D
COMMUNICATION	Communication. Consider how MH affects ability to clearly make needs known	Can understand and communicate needs without any assistance	Able to understand and communicate needs reliably with minimal assistance	Difficulty in understanding and responding to communication. Requires assistance to aid everyday communication	Unable to understand or communicate effectively; requires skilled input to assist
MOBILITY	Mobility/getting out and about. Consider how MH affects the ability to physically mobilise independently	Independent with or without aids. Safe and confident in and outside home	Sometimes needs assistance to achieve mobility in or outside home, e.g. to maintain safety	Mental state affects mobility and independence. Support required on regular basis	Mental state means little or no mobility and independence without skilled input at all times
NUTRITION	Eating and drinking: Adequate dietary and fluid intake; eating	Can achieve independently	Poor ability to provide for self. When encouraged, can achieve independently	Ability fluctuates due to changing mental state. Needs regular prompting,	Needs skilled supervision to maintain appropriate intake

CARE DOMAIN		LEVEL OF NEED			
		A	B	C	D
PERSONAL CARE	Personal hygiene; washing, dressing and continence	Independent with all areas of personal care	Able to attend to personal care when prompted. Some supervision may be required	Needs prompting and supervision to undertake any personal care activities. At risk of self neglect if this is not provided	Unable to undertake any personal care without intervention of skilled staff
MEDICATION	Medication; Symptom control and fluctuations of MH condition	Independent	Requires prompting or supervision to take medication without which it is unlikely medication will be taken	Unable to adhere to medication programme or occasionally non-compliant. Requires assistance and monitoring. May require drugs to be administered.	Non compliant or unable to maintain medication regime without input from trained staff. May require PRN or medication administered by invasive routes
SLEEP	Sleep/night care needs e.g. safety supervision	Independent and safe	May require staff input during the day and occasionally at night due to mental health state	Regularly requires staff input during the day and regularly at night due to mental health state	Frequently requires staff input during the day and during the night due to mental health state

CARE DOMAIN		LEVEL OF NEED			
		A	B	C	D
SOCIAL NETWORKS SOCIAL NETWORKS	Relationships/daily activities	Able to establish and maintain social network and external activities	Maintains social network/ relationships and activities with support from informal/ formal network	Mental state leads to inability to maintain relationships and social networks without input. Could isolate and withdraw if this is not provided by skilled staff	No capacity to establish and maintain appropriate social networks/ relationships without full support from skilled staff

Appendix D

Joint Funding Matrix – S117

Needs Assessment for:

Name		**D.O.B**	
Date of relevant Section (MH Act 1983)		**Client Group:** **AMH** **LD** **OPMH** **ASC** (Please circle one)	

CARE DOMAIN	**NEED** Describe the actual needs of the individual including any episodic / fluctuating needs. Provide evidence that informs the decision entered on the right as to the level of need. The information provided must be completed and agreed by a social care professional and health professional together.	**LEVEL OF NEED** Using the guidance notes, assess the level of need for the individual for each care domain (enter A, B, C or D)
BEHAVIOUR – Risk to Self		**Enter A, B,C or D**
BEHAVIOUR – Risk to Others		

PSYCHOLOGICAL		
COGNITION		
COMMUNICATION		
MOBILITY		

NUTRITION		

INDIVIDUAL CARE		
MEDICATION		
SLEEP		

SOCIAL NETWORKS		
ANY OTHER RELEVANT NEEDS		There is no need to enter a score for this section

ADDITIONAL INFORMATION REQUIRED

MEDICAL DIAGNOSIS IF KNOWN:

How long has the individual been in this current placement?		
Why was this placement identified as best meeting the individual's needs?		
Has there been any improvement or rehabilitation for this individual since being in this placement?		
What is the medium term plan for this individual?		
Other needs relating to mental health if not captured in domains (please do not include carers needs)		
Please provide details of the individuals address and the name and address of the GP prior to the need for residential care/placement	*Individual's address & post code*	*G.P name, address & post code*

The information provided must have been completed and agreed by a social care professional and health professional together

Social Care Practitioner		
Name	Signature	Date
Work base address Contact telephone no:		
Health Practitioner		
Name	Signature	Date
Work base address Contact telephone no:		

Appendix E: Policy on a Page

Eligibility: Applies to all ages/across wide spectrum of mental disorders as defined by the Mental Health Act. Specifically relates to individuals who have been detained under section 3, section 37, section 45A, section 47 and section 48

Purpose of Aftercare services: Meet a need arising from or related to the person's mental disorder **AND** reducing the risk of deterioration of a person's mental condition (and accordingly, reduces the risk of the person requiring admission to a hospital again for treatment for the disorder)

Scope: Purposefully broad to meet the above purpose. Can include:

- Healthcare;
- Social care;
- Employment services;
- Supported accommodation;
- Services to meet the person's wider social, cultural and spiritual needs
- Services that support a person in regaining or enhancing their skills, or learning new skills, in order to cope with life outside the hospital.

Discharge Planning: Should take place under the framework of the Care Programme Approach. Prior to discharge a meeting should take place where all relevant parties are involved. Issues relating to commissioning and funding responsibility should be explored at this meeting if unclear. Jointly agreed plan should clearly identify s117 needs versus general needs and who is responsible for meeting those needs (including commissioning/funding responsibility). This should be shared with all relevant parties subject to usual rules regarding capacity/consent and data protection.

Responsible Commissioners: Joint duty between ICB and County Council. Responsibility is broadly determined by GP registration (ICB) and where the person was living immediately prior to detention under a relevant section of the MHA. However this can be complicated especially if the person has moved areas and or depending what legislation/case law/guidance was in in effect at the time of a qualifying detention. It is recommended that if in doubt seek advice from Senior managers.

Assessing Need: It should be noted that eligibility criteria related to the Care Act **do not** apply unless assessing for other needs that do not arise from or relate to the individual's mental disorder.

Joint funding: Funding is automatically 50:50 except in specific circumstances as outlined in the Standard Operating Procedure. Whereby completion of a joint funding matrix will be required.

Review: Usually under the framework of the Care programme Approach and at least annually. Consideration should be given as to whether s117 still applies and the decision should be recorded.

Ending s117: Can only end if jointly agreed by the County Council and ICB (or agencies with delegated responsibility). Must be recorded using the relevant form, forwarded to Health Records and uploaded to all relevant health/social care record systems (e.g. RIO, ERIC,)