

Section 117 of the Mental Health Act (s117 MHA): Aftercare

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Revisions History

(Please note that revisions have only been tracked since the 2007 MHA Act. The original 1983 MHA policies were compiled by David Pugh and were stored in the former Strategic Planning and Policy Group)

Version	Date	Author(s)	Principal Changes
1	3/6/13	Karl Gluck	<p>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. After reviewing a sample of other areas policies it was decided to use the NHS Herefordshire as a broad template for consultation. Areas not covered or not addressed by the previous policy are as follows:</p> <ul style="list-style-type: none"> • Previous policy was between 2gether NHSFT and Gloucestershire County Council. This policy is between Glos County Council and Glos Clinical Commissioning Group. • Top up payments. • Accommodation as an aftercare need. • Prescription charges and S117. • Determination of funding splits between health and Social Care. <p>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 (<i>Who Pays? Determining responsibility for payments to providers, August 2013</i>) and s75 Care Act 2014.</p>
2	28/8/15	Karl Gluck	S117 guidance updated based on feedback following 12 week consultation.

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1. Policy Statement

1.1. Gloucestershire County Council and Gloucestershire Clinical Commissioning Group are committed to ensuring, through this policy, that individuals who are subject to s117 (s117) of the MHA 1983/2007 receive care in line with the principles articulated within the MHA Code of Practice. The primary purposes of S117 of the MHA 1983/2007, as defined in s117(5) , are as follows:

- **To meet the need arising from the individual's mental disorder**
- **Reduce the risk of deterioration**
- **To minimise the need for repeated admissions.**

1.2. It is the intention of this policy to articulate a clear process by which care planning in the context of S117 should be undertaken to deliver these objectives.

1.3. It is the intention of this policy to ensure that S117 status is reviewed in a timely fashion and that all decisions in respect of this are clearly documented.

1.4. Service Users, and their carers/representatives, where appropriate, are seen as equal partners through this process. Service Users will be eligible for the help and assistance of Independent Mental Health Advocates or Independent Mental Capacity Advocates as appropriate.

1.5. Disputes regarding ongoing responsibility **must** not be a reason for delaying care planning or discharge planning

2. Purpose

2.1. The objective of this procedure is to set out the policy requirements for provision of after-care services under S117 of the MHA 1983 (as amended by the MHA 2007) to the residents of Gloucestershire.

2.2. This document 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 MHA 1983.

2.3. All staff should be familiar with the relevant sections in the Code of Practice and the Reference Guide to the MHA in respect of S117.

2.4. This documents aims to give staff an understanding of their responsibilities with respect to planning, providing, reviewing and ending aftercare services and will ensure that the Local Social Services Authorities and Clinical Commissioning Groups involved, work together to discharge their responsibilities under the MHA 1983/2007.

3. Scope

3.1. The policy is relevant for all Approved Mental Health Professionals; qualified and registered staff of Gloucestershire Clinical Commissioning Group, Gloucestershire County Council, 2gether NHSFT, Gloucestershire Care Services, Gloucestershire Hospitals Trust and Gloucestershire GPs who are required to assess, plan and deliver aftercare services

4. Definitions

- **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 Social Services Authorities

(Within adult mental health services, CPA and care management are fully integrated. This is true to a lesser and varied extent where CPA applies for other care groups. Therefore both CPA and care management will be referred to where applicable throughout the policy.)

- **Clinical Commissioning Group (CCG):** Replaced Primary Care Trusts in April 2013.
- **NHS Continuing Healthcare**
- **Relevant sections of MHA 1983:**
 - **Section 3:** Order detaining an individual in hospital for treatment

- **Section 17 leave:** Period of agreed community leave for a service user 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:** Hospital 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 37/41 – conditionally discharged Service Users:** section 42 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.
- **Section 47/49:** Orders detaining an individual transferred from prison to hospital for treatment, with restrictions
- **Social services:** Various terms are used to describe the provision of social services throughout the policy:

- 'Social services' for general references
- Local Social Services Authorities (LSSA) where appropriate
- 'Gloucestershire Council Adult Social Care where it is necessary to name the relevant local social services authorities providing adult social care

5. Legal Context

5.1. Local Social Services Authorities (LSSAs) and Clinical Commissioning Groups (CCGs) have a statutory duty to provide, in cooperation with relevant voluntary organisations, aftercare services for any person to whom section 117 of the MHA (hereafter referred to as s117 MHA) applies.

5.2. Section 40 of the Health and Social Care Act 2012 amended S117 MHA and allowed the Secretary of State for health to publish Regulations that changed CCG responsibility. CCG responsibility for S117 aftercare is now in line with general commissioning responsibility for healthcare (the CCG area where the person was registered with a GP or in the absence of this where they were "usually resident"). The main criteria for assessing "usually resident" is the individual's perception of where they are living. This will be explored further later on in this policy.

5.3. The Care Act 2014, which comes into effect on 1st April 2015, amended S117 and those changes are summarised below:

- *Amended s117 (3) with the effect that the term "resident" now means "ordinarily resident". This brings determination of LSSA responsibility in line with guidance issued by the Department of Health (Ordinary Residence, Guidance on the identification of the ordinary residence of people in need of community care services, England). See sections 15-17 of this policy.*
- *Introduced a dispute resolution process (S117 (4)).*
- *Introduced statutory definition of the purpose of aftercare (S117 (5)).*
- *Introduction of new subsection (s117 (A)) which introduces the statutory duty to offer choice in accommodation for individuals being.*

5.4. LAC 2000(3) requires there to be locally agreed joint agreements around S117.

5.5. S117 MHA **only** applies to the following circumstances and individuals:

- *Service Users detained in a psychiatric hospital under Section 3 MHA (compulsory admission to hospital for treatment);*
- *Service Users admitted under an order made under Section 37 MHA (detention in psychiatric hospital under a court order);*
- *Service Users transferred to a psychiatric hospital from prison or remand centre (including those on remand, detained in prison under the civil law or held under immigration legislation) in pursuance of a transfer direction under Section 45A, 47 MHA and Section 48 MHA; and Who cease to be detained; and Leave hospital (whether or not immediately after the detention has ended).*

5.6. In addition S117 MHA applies to:

- *Those Service Users subject to Guardianship where he/she has previously been detained under Section 3; 37; 45A, 47 and 48 MHA and discharged from one of these and where the Aftercare plan included a requirement of Guardianship (Section 7 MHA);*
- *Service Users, detained under Section 3; 37; 45A, 47 and 48 MHA, who are given leave of absence under Section 17 MHA, as part of the preparation of a post-discharge Aftercare plan, and where that care plan is based on jointly assessed and agreed health and social care needs;*
- *Service Users, detained under Section 3; 37; 45A, 47 and 48 MHA, who are made subject to a Supervised Community Treatment Order under Section 17A MHA;*
- *Service Users who have been assessed as requiring to live in residential accommodation or to receive other non-residential community care services as a condition of leave under Section 17 MHA and/or S117 MHA.*

5.7. Aftercare under S117 is to be provided until such time as the Local Social Services Authority and Clinical Commissioning Group are **jointly satisfied** that the person concerned is no longer in need of statutory after-care. This is achieved through Care Co-ordination with systematic, high quality assessment, review and discharge arrangements.

5.8. Health Service Circular HSC 2000/003 and Local Authority Circular LAC 2000(3) states that:

- ***‘Social services and health authorities should establish jointly agreed local policies on providing S117 MHA after-care. Policies should set out clearly the criteria for deciding which services fall under S117 MHA and which authorities should finance them. The S117 MHA Aftercare plan should indicate which service is provided as part of the plan. After-care provision under S117 MHA does not have to continue indefinitely. It is for the responsible health and social services authorities to decide in each case when after-care provided under S117 MHA should end, taking account of the patient's needs at the time. It is for the authority responsible for providing particular services to take the lead in deciding when those services are no longer required. The patient, his/her carers, and other agencies should always be consulted’.***

5.9. Within this policy we use the terms ‘will’ and ‘should’ and they are to be interpreted in the following way;

- ***Will*** – is used to indicate the requirement is a legal or overriding duty or principle. Where staff are unable to complete this requirement they must report this to a manager and request advice as to alternative ways to comply with the legislation.
- ***Should*** – is used where the duty or principle may not apply in all situations and circumstances, if there are factors outside the control of staff that may affect how they comply with the policy.

5.10. For purposes of clarity the term discharge in this document applies to discharge from services (inpatient/community). Discharge of S117 status is referred to as ‘ending of section S117’.

6. Mandatory procedures

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

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

6.3. Service Users who are subject to S117 and receiving community services **will** be offered an IMHA to support them at reviews.

6.4. Decision to end S117 can only happen with the agreement of both Glos County Council and Glos Clinical Commissioning Group (see section – discharge). Any such decision **will** be recorded in writing in line with this policy.

6.5. Service Users **should not** be automatically discharged from S117 if they are discharged from specialist mental health services.

6.6. The Aftercare **will** be provided when a Service User's Responsible Clinician (RC) authorises Section 17 leave of absence, – the service user is discharged on to Supervised Community Treatment (SCT) and upon discharge from hospital.

6.7. Service Users are not charged for services they receive relating to their mental health needs under S117 (see section 35).

6.8. Discharge of S117 can only be made with the agreement of both the LSSA and the CCG.

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

7. The Purpose of Aftercare

7.1. The purpose of aftercare is to:

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

8. Scope of Aftercare

8.1. Aftercare services could include a combination of health and social care services to ensure that issues relating to an individual's mental health needs and social care needs are met through the appropriate professionals. Case law has provided the following description of services that could be included:

8.2. "After-care services are not defined in the Act of 1983. They would normally include (1) social work; (2) support in helping the ex-patient with problems of (a) employment, (b) accommodation or (c) family relationships; (3) the provision of domiciliary services; and (4) the use of day centre and residential facilities" per R (Afework) v London Borough of Camden (2013) .

8.3. Please note however that this is not a definitive list and any consideration in relation to other types of service should be subject to legal advice.

8.4. The provision of accommodation in and of itself is not considered to be an S117 aftercare need unless:

- Need for accommodation is a direct result of the reason that the patient was detained under the MHA; and
- It is enhanced specialised accommodation to meet needs directly arising from the mental condition; and
- Ex-patient is being placed in the accommodation on an involuntary (in the sense of being incapacitated) basis arising as a result of the mental condition.

8.5. Recent case law on the scope of aftercare is summarised in appendix C:

9. Carers

9.1. Carers, including young carers, should be seen as equal partners in the development and review of S117 Aftercare plans, subject to the normal rules of confidentiality.

10. Assessment

10.1. The planning and implementation of Aftercare services should be completed using the existing processes of the Care Programme Approach.

10.2. 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.

11. Hospital Discharge Planning

11.1. 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 CCG and the LSSA.

11.2. 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. It is the responsibility of the Responsible Clinician to ensure this takes place prior to discharge from the hospital. A care 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*

11.3. This meeting should be initiated by the Responsible Clinician and may include the following people:

- *The patient, if he/she wishes and/or a nominated representative or advocate;*
- *The patient's Responsible Clinician;*
- *A nurse involved in the care of the patient whilst in hospital;*
- *A Social Worker/Care Manager;*
- *A Support Worker;*
- *G.P. and Primary Care Team;*
- *A Community Psychiatric/Mental Health Nurse;*
- *Independent Mental Health Advocate or Independent Mental Capacity Advocate*
- *In the case of a restricted patient, the Probation Service / MAPPA Coordinator;*
- *Subject to the patient's consent, any informal carer who will be involved in looking after him/her outside hospital;*
- *Subject to the patient's consent, his/her nearest relative;*
- *Employment/Housing/Education as appropriate*

11.4. 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 have asked for this information not to be shared then there is no legal authority to discuss with them.

11.5. 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 CCG/LSSA that will be responsible for aftercare.

11.6. In the event that aftercare cannot be provided by already commissioned services and/or universal services then an application for aftercare funding may be required. For advice about applying for aftercare funding in these circumstances, please see paragraph 20' Funding Extra Care and s117'.

12. Review

12.1. 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 .

12.2. This meeting may include the following people:

- *The patient, if he/she wishes and/or a nominated representative or advocate;*
- *The patient's Responsible Clinician;*
- *Social Worker/Care Manager;*
- *Support Worker(s);*
- *GP and other representatives of the Primary Care Team;*
- *Community Psychiatric/Mental Health Nurse;*
- *Independent Mental Health Advocate or Independent Mental Capacity Advocate*
- *In the case of a restricted patient, the Probation Service / MAPPA Coordinator;*
- *Subject to the patient's consent, any informal carer who will be involved in looking after him/her outside hospital;*
- *Subject to the patient's consent, his/her nearest relative;*
- *Employment/Housing/Education as appropriate*

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

12.4. All reviews must be formally documented.

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

12.6. Any changes in S117 status of the service user (or patient as referred to in the Act) will be immediately recorded on the register (i.e. transfers/discharge). This information will be regularly updated and shared with the LSSA and CCG or other successive body. This Register can be used as part of the process for reviewing individual status for S117.

13. Recording

13.1. It is very important to distinguish on care plans and S117 MHA 1983 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 community care needs unrelated to the relevant mental disorder, which may be subject to an appropriate charge by the local social services authority. It is therefore important that the care co-ordinator in the S117 MHA 1983 planning arrangements is fully aware of the legal position and any funding commitments that may result.

13.2. 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 person and or their representative. There should be a record of which services are to be provided by each agency.

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

14. Departmental Records

14.1. There will be a centralised S117 database established as part of this policy. Any changes to S117 status will be recorded on this system and it will be used a repository of documents relating to S117 status.

15. Access to Advocacy (Statutory Advocacy - IMHA and IMCA)

15.1. Section 130A MHA 1983 established arrangements for statutory MHA advocacy from 2009.

The IMHA Service provides advocacy for people who have mental capacity but who are subject to compulsory powers under the MHA. 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 a person's care or treatment can refer to the IMHA Service, as can the individual themselves.

15.2. Under the Mental Capacity Act 2005, there has been a legal duty, since 2007, to refer Service Users to the Independent Mental Capacity Advocate (IMCA) Service where they have been assessed as requiring to 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.

15.3. The IMCA service may also get involved if the person 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.

16. Funding Responsibility and Residency: General Statement

16.1. 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.

16.2. As stated in paragraph 5.2 above, the responsibility of CCGs has been changed with regard to residency and is determined in new regulations. The responsibility of the LSSA was changed by the Care Act 2014 and will take effect from April 2015.. As these new regulations are not retrospective, the following provisions apply:

- Patient's residency prior to 1st April 2013 should be determined according to their residence prior to detention. Further details are provided in Paragraph 16 below.
- Patient's residency on/after 1st April 2013 should be determined according to the new regulations, Commissioning Guidance

- Patient's residency on/after 1st April 2015 should be determined in accordance with the amendments made to S117 by the Care Act.

17. Funding Responsibility and Residency: Discharge Pre 1st April 2013

17.1. The responsible Clinical Commissioning Group and Local Social Services Authority are identified by the area the patient was resident at the time they were detained under the relevant section of the MHA. If the person did not have a place of residence the area they are being sent to on discharge would assume responsibility.

17.2. Residency in the context of S117 should be interpreted as a **“settled presence in a particular place other than under compulsion”** (*R.(on the application of Mv Hammersmith and Fullham LBC [2010])*). This applies regardless of the duration of the residence. In cases of dispute the matter of residency should be determined on a case by case basis (which includes the Service Users views of where they reside), seeking legal advice if required.

17.3. Decisions regarding residence may often be complex and for this reason advice should be sought via Senior Managers, who can/will escalate issues to legal services as appropriate.

17.4. Where the responsible authorities have been identified the patient's case should be allocated to a Care Coordinator as soon as possible after implementation of the detaining section. This allows for assessments and discharge planning commencing at the earliest opportunity.

18. Funding Responsibility and Residency: Discharge on or after 1st April 2013

18.1. The new regulations determine that the CCG's responsibility in these circumstances is as follows:

- The CCG responsible for the area where the patient is registered with a GP, or where there is no GP registration;
- The CCG responsible for the geographic area where the patient is “usually resident”

18.2. For CCGs '**usually resident**' is not the same as **ordinarily resident** and the main criteria for determining is through the individual's perception as to where they are resident in the UK (currently or most recently).

18.3. In cases of dispute the matter of residency should be determined on a case by case basis (which includes the Service Users views of where they reside), seeking legal advice if required.

18.4. Decisions regarding residence, CCG responsibility and LSSA responsibility may often be complex and for this reason advice should be sought via Senior Managers, which will escalate issues to legal services as appropriate.

18.5. Where the responsible authorities have been identified the patient's case should be allocated to a Care Coordinator as soon as possible after implementation of the detaining section. This allows for assessments and discharge planning commencing at the earliest opportunity.

19. Out of Area Placements (Discharge Pre 1st April 2013)

19.1. Out of Area placements are those services which are located outside the catchment areas of the CCG and LSSA and to which patients have moved in accordance with their aftercare needs.

19.2. For Service Users entitled to S117 who were discharged from hospital before 1st April 2013 the responsible CCG and LSSA is determined by the place they were living before they were detained.

19.3. A Care Coordinator/Care Manager will monitor the placement at arm's length and attend the CPA/S117 reviews, to ensure that the issue of whether after-care provided under S117 continues to be appropriate and is actively considered at each review.

19.4. If someone with S117 is subsequently detained under an eligible section of the MHA 1983/2007, the Clinical Commissioning Group and Local Social Services Authority will be determined in line with the guidance in paragraph 17 above.

19.5. Disputes regarding residency should not delay or prevent the provision of aftercare services.

20. Out of Area Placements (Discharge Post 1st April 2013)

20.1. For Service Users under S117 who moved, or will move, to another area and were discharged after 1st April 2013 it will be the CCG where they are registered with a GP or are usually resident that is responsible for them, until such time that they register with a GP in the new area. At that point in time the CCG which the GP practice is registered with will be responsible for ongoing S117 Health needs. Since this may mean that the current CCG will change immediately on placement it is important that the receiving CCG is involved in the aftercare planning process.

20.2. A Care Coordinator/Care Manager will monitor the placement at arms length and attend the CPA/S117 reviews, to ensure that the issue of whether after-care provided under S117 continues to be appropriate and is actively considered at each review.

20.3. If someone with S117 entitlement moves to another area and is subsequently detained under an eligible section of the MHA 1983/2007, the Clinical Commissioning Group and Local Social Services Authority where the service user is resident at that time will be responsible for aftercare provision under S117.

Table 1

Situation	CCG A	CCG B	Responsible Commissioner
Patient not yet moved	Registered and resident	-	CCG A
Patient who has moved to area of CCG B	Registered	Resident	CCG A
Patient moved	De-registered	Resident but not yet registered	CCG B
Patient moved	-	Registered and resident	CCG B

21. LSSA Responsibility following the introduction of the Care Act 2014

21.1. Section 75 of the Care Act 2014 has amended s117 (3) to the effect that from 1 April 2015 the term resident will mean ordinarily resident. Therefore the regulations regarding ordinary residence will apply. The duty on Local Authorities rests with the area in which the person was ordinarily resident **immediately** before they were detained, even if the person subsequently becomes ordinarily resident in another area after leaving hospital.

21.2. 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/caselaw.

22. Funding Responsibility: Children and Young People

22.1. LSSA S117 aftercare responsibility for children and young people is determined through the usual means as detailed in section 15 above.

22.2. CCG responsibility is determined through the usual means (as outlined above and in the responsible commissioner guidance) except in the following circumstances where the duty will be imposed on a different CCG. **The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012** outline the circumstances in which the duty (s117) may be imposed on another CCG or on the NHS Commissioning Board. Regulation 14(2)(b) refers to schedule 1 and sub –paragraphs (c) and (g) outline the circumstances, for specific groups of children, where s117 responsibility remains with the placing CCG even after they have registered with a GP in the CCG area to which they have been placed. With regards to children those groups are:

- *Any child with regard to whom (1) a local authority has made an arrangement before 1 April 2013 by virtue of which the child is provided with accommodation at a school in the area of another CCG, to which the child is admitted in accordance with a statement of special educational needs, (2) immediately before the child was so accommodated, the child was either provided with primary medical services by a person who is now a member of the 'placing' CCG or usually resident in the area of the 'placing' CCG and not provided with GP services by a person who is now a member of the 'placing' CCG and (3) the 'placing' CCG would not otherwise be responsible under s3(1A)(a) of the 2006 Act (because the child has now been registered with a GP practice in the area of the 'receiving CCG').*

- *Any child who is:*
 - *a “looked after child” within the meaning of s22 Children Act 1989 (but excluding a child accommodated in a secure children’s home for whom the Commissioning Board has commissioning responsibilities); or*
 - *a “relevant child” within the meaning of s23A Children Act 1989; or*
 - *a child qualifying for advice and assistance under s24(1A) or (1B) Children Act 1989; or*
 - *a child provided with accommodation at a school to which (s)he is admitted with a statement of educational needs made under s324 Education Act 1996; or*
 - *a child who requires accommodation in a care home, a children’s home or an independent hospital to meet his or her continuing care needs;*

23. Funding Extra Care and S117

23.1. The majority of people who are subject to S117 will be able to have their aftercare needs met through access to already commissioned mental health services, universal services and other community services. However there will be a certain percentage of people whose health or social care needs cannot be met as described. In these circumstances it will fall to the responsible aftercare bodies to meet those needs, provided that all reasonable alternatives have been explored.

23.2. It should be noted that this section relates **only to** Service Users where Gloucestershire CCG and LSSA are jointly responsible for S117 aftercare. There will be occasions where s117 responsibility is split between different CCGs and LSSAs. 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 CCG for that area are notified as soon as is practicable.

23.3. Requests for additional funding will be presented to the respective funding panel. All applications should be presented with a completed S117 Funding Matrix Tool (see appendix d) which will be used **as a guide** to determine relative funding splits.

23.4. There are three options for funding a person’s aftercare needs:

- *100% CCG Funded Provision.*
- *100% Local Social Services Authority funded care.*
- *Joint funding between the CCG and the LSSA.*

24. Cross Border Issues

24.1. Where a patient is resident in Wales and registered with a GP practice in England, the Welsh Local Health Board (LHB) in whose area they reside is responsible for their care. Under a protocol between England and Wales for patients living on the England and Wales border, however, the CCG of which the GP practice is a member will commission services for that person on behalf of their LHB and will be the responsible commissioner.

Table 2

Residency	GP location	Responsible commissioner	Legal responsibility
Wales	Wales	LHB	LHB
England	England	CCG	CCG
Wales	England	CCG	LHB
England	Wales	LHB	CCG

25. 100% CCG Funded Provision

25.1. Where a person meets the eligibility criteria for fully funded Health Services, the CCG will resource 100% care provision.

25.2. The circumstance where this could occur are explained in the following paragraphs:

- Paragraph 26: Section 17 leave.
- Paragraph 27: Section 17A Community Treatment Orders.
- Paragraph 30 S117 and NHS Continuing Healthcare.

26. Section 17 Leave

26.1. Section 17 leave can apply to any patient detained under the Act, including Section 2 (except short term holding powers such as sections 4, 5(4) etc). In any case it allows the Responsible Clinician (RC) to grant to any patient who is for the time being liable to be detained in a hospital leave to live outside of the hospital, subject to certain conditions considered necessary in the interests of the person or for the protection of others.

26.2. A person on Section 17 leave may be permitted leave to return to their own home, or to the home of a friend or family member. Whilst the detailed planning for such an event would take place within the multi-disciplinary team, the RC remains the lead professional. The RC does not have the power to delegate this function and remains legally the sole prerogative of the RC.

26.3. If the leave of absence forms part of a trial period in a residential setting, then the contractual lead for making the necessary arrangements would lie with the CCG. This is because:

- *The granting of Section 17 leave can only be given by the RC;*
- *The patient remains liable to be detained;*
- *The patient remains subject to the consent to treatment provisions under Part 4 of the MHA;*
- *A person subject to Section 3 and who is on Section 17 leave can have their period of detention renewed under Section 20.*

26.4. Section 17 leave should last only for a short period of time after which, and if the trial period is a success, the person can then be formally discharged. If appropriate the Local Authority, either singly or together with the CCG, can then take over the lead arrangements for the continuation of the placement.

27. Section 17A Community Treatment Orders

27.1. The primary purpose of CTOs is to ensure that the Service User continues to receive treatment in the community. An AMHP must certify that the grounds for a CTO are met, as well as agreeing any non-mandatory conditions that are to be made. However once the CTO is made the RC may vary the non-mandatory conditions. The Service User can be recalled to hospital by the RC if the mandatory/non-mandatory conditions are not met. This allows for the patient to be re-assessed on an inpatient unit after which they can be released back onto the CTO,

discharged from the CTO or the CTO can be revoked (requiring the person to remain in hospital). As the primary purpose is to ensure that the person's mental disorder is treated in the community then their needs are deemed to be primarily health needs and therefore funded by Health.

28. 100% LSSA funding

28.1. When the person's needs are exclusively social care needs then the LSSA will fund that placement.

28.2. These arrangements apply only to the funding of support packages and additional social care provision relating to the person's MHA after-care needs. Individuals will still be entitled to 'universal' services that they would have received were they not subject to Section 117 e.g. CMHT services, LSSA assessment, non S117 community care services, care management services, carer support services etc.

29. Joint Funding

29.1. All S117 placements that are not fully Health or Social Care, that is to say they have a combination of health and social care requirements, will be funded on a 50:50 basis. Funding splits will be agreed through locality funding panels organised across the different client groups. If there is a disagreement between agencies as to whether or not a funding split should be entered into then the case can be escalated to the **Multi Agency Joint Funding Panel** which consists of :

- *Senior Commissioning Managers – GCC and Glos CCG*
- *Senior Managers 2gether NHSFT*
- *Senior Managers GCC (Adult Social Care/Learning Disabilities)*

Senior Managers (Care Services)

29.2. The cost of extra care will be shared equally between Health and Social Care costs

30. S117 and the National Framework for NHS Continuing Health Care and NHS Funded Nursing Care

30.1. People subject to S117 are entitled to all the health and social care services that every other member of the community is entitled to, including those services which would otherwise come under the National Framework for NHS Continuing Healthcare (CHC) and NHS funded Nursing Care. The main difference is that there is no need to raise the question as to whether or not the services provided under S117 are exempt from charging. There is, however, the question as to how the mix of health and social care services should be determined.

30.2. The National Framework relies on a number of core values and principles which include:

- *Assessment and decision making should be fair and consistent – there should be no discrimination on the grounds of race, disability, gender, age, sexual orientation.*
- *Decision making must be clear and reasoned, which is accurately and fully recorded. - S117 requires the Local Authority to provide those aftercare services for which it is lawful for it to provide. Where someone is in a care home setting as part of S117 aftercare, then the Local Authority can provide general nursing care which is “merely incidental or ancillary to the provision of the accommodation” and is of a “nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide”. Under these circumstances the Local Authority would make the necessary contractual arrangements for the provision of services, which would be free to the person under S117.*
- *If the NHS CHC assessment process determines that the person has a Primary Health need, whether that be due to a mental health or a non mental health, health need, then the person would, if it were not for S117 be eligible for NHS funded Continuing Health Care. Under these circumstances, the CCG would make the necessary arrangements for the provision of services.*
- *On some occasions the appropriate panel may decide as a result of the CHC assessment process that a jointly funded care arrangement would be the most effective way of meeting a person’s needs. Under these circumstances, the Local Authority would normally take the lead contractual role for the provision of services.*

- *A person subject to S117 may have a mental disorder, which in its own right would not make the person eligible for NHS Funded Continuing Health Care, but may have a physical disability or age related illness or condition, which following assessment is determined to be a primary health need and therefore eligible for NHS Funded Continuing Health Care. Under these circumstances the CCG would make the necessary arrangements for the provision of fully funded NHS Continuing Health Care.*
- *People subject to S117 aftercare are also eligible for those Continuing Health Care services, if they meet the appropriate eligibility criteria, wherever they live, including their own home.*

31. Top Up payments

31.1. From April 2015, following the introduction of S117 A by the Care Act 2014 individuals who are subject to S117 and for whom GCC are providing or arranging accommodation under S117 are entitled to choose their preferred accommodation provided that the conditions set out in the Regulations are met.

31.2. A person subject to S117 is entitled to purchase additional services over and above those identified to meet their assessed care needs. Any additional services must be separately invoiced directly to the individual.

32. Top Up Payments and Risks

32.1. In relation to the top ups for accommodation then this will be subject to the Regulations. The Regulations provide as follows:

- *(3) The additional cost conditions referred to in paragraph (2)(g) are that*
- *(a) the local authority is satisfied that a person (“the payer”) is willing and able to pay the additional cost of the preferred accommodation for the period during which the local authority expects to meet needs by providing or arranging for the provision of that accommodation; and*
- *(b) the payer enters into a written agreement with the authority in which the payer agrees to pay the additional cost.*

32.2. There is no need to undertake a financial assessment but the risks detailed below in 32.3 must be clearly explained and recorded.

32.3. If the service user is discharged from S117 and meets the eligibility criteria for social care services usual financial arrangements will apply. An assessment will be made on the cost

effectiveness of the placement and the risks to the service user of a move to a more cost effective placement.

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

33. Direct Payments

33.1. Changes to the Direct Payments Regulations, effective from November 2009, now mean that LSSAs 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 1983 where there is now a power (but not a duty) to offer direct payments. Local social services authorities also have a power (but not a duty) to offer direct payment arrangements for conditions attached to a Guardianship Order.

34. Ending S117

34.1. The Code of Practice also states (paragraph 27.3) that the '***duty to provide aftercare services continues as long as the patient is in need of such services***' and 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.***'

34.2. The Code of Practice goes on to state that whilst a service user discharged from hospital subject to S117 MHA may be well settled in the community this is not to be taken as assuming there is no need for ongoing aftercare services. Such services may still be needed to prevent a future relapse or further deterioration in the person's mental health. Services should not therefore be withdrawn on the basis that:

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

34.3. There have been a number of court judgements and ombudsmen's reports in recent years regarding the legality of discharge from S117, and relevant guidance from the Department of Health. These decisions have confirmed that after-care provision does not have to continue indefinitely and that discharge should be considered on the individual merits of each case, bearing in mind the original purpose of the provision of after-care.

34.4. The ombudsman has suggested that services will still be provided under S117 when they are aimed at maintaining the service user in the community and are necessary to prevent mental health relapse or readmission to hospital to meet mental health needs. The Authority responsible for providing/ funding the particular services should take the lead in deciding when those services are no longer required.

34.5. Aftercare under S117 may be terminated for the following reasons:

- *Death of a service user*
- *A review has determined that aftercare is no longer required.*

34.6. S117 aftercare cannot be terminated solely:

- *Because the service user refuses the services*
- *On the ground that he or she has been discharged from the care of a consultant.*
- *On the ground that an arbitrary period of time has elapsed*
- *On the ground that the care need is being successfully met in that the he or she is now settled in the community or residential establishment*

34.7. Consideration of discharge from S117 **will** be made at review between the Care Coordinator/Care Manager, the Service User, Carer, Nearest Relative, the multi-disciplinary team and service providers where possible, following a re-assessment of the Service User's needs. Prior to ending S117 it should be demonstrated that there has been active engagement with the Service User/their representatives. This must be clearly documented at review.

34.8. In the light of the advice issued above, the following guidance is offered about the factors to be considered regarding whether or not discharge from S117 may be appropriate:

- *What are the Service User's current assessed mental health needs?*

- *Have the Service User'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 service user 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 Service User's re-admission to hospital for treatment for mental disorder/experiencing relapse or has that purpose now been fulfilled?*
- *What services are now required in response to the Service User's current mental health needs?*
- *Does the service user 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?*

34.9. The above list is not exhaustive, but 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*
- *No ongoing need for involvement of a consultant psychiatrist or specialist mental health services or for medication.*

34.10. 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.

34.11. People cannot be discharged from S117 if they are also subject to section 17A after-care under supervision or if they are a conditionally discharged Section 37/41 service user, or on section 17 leave from section 3, 37, 45A, 47, or 48. .

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

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

34.13. If there is a difference of opinion between Health and Social Services 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 CCG and LSSA.

34.14. Where partnership arrangements to provide integrated mental health services are in place, S117 responsibilities are still retained by each “Health Authority” (CCG) and “Social Services Authority”. Only when representatives from the two separate organisations agree, can S117 be discharged.

34.15. The decision to end S117 **must** be recorded using the proforma in appendix B. This should be sent to the owner of the S117 database in order to update the records with copies uploaded to the electronic Mental Health Clinical System (RIO or equivalent) and the LSSA electronic Social Care Record (ERIC or equivalent). The Service User/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

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

35. Charging

35.1. GCC is unable to charge Service Users 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 Gloucestershire Council Financial Assessments and Benefits Team 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

35.2. S117 aftercare is essentially aimed at providing aftercare services for people who have: been detained in hospital and as well as meeting their immediate needs for health and social care,

aftercare should aim to enable the service user to regain, learn or enhance their skills in order to cope with life outside hospital (Code of Practice).

35.3. 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 community care need in its own right if it is assessed as either critical or substantial within the meaning of Fair Access to Care. 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 person 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 LSSA'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 person 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 service user and their representative those services which will continue to be provided under S117 and those which will be provided under Fair Access to Care and subject to a financial assessment.
- The person and their representative should always be offered independent advocacy during this process.
- People suffering from organic disorders such as Alzheimer's disease, Huntington's chorea etc will always have all their community care services delivered to them as being exempt from the charging policy if they are subject to S117, irrespective of the nature, degree, intensity and balance of any physical disability vis a vis their mental disorder.

35.4. Where the need for S117 no longer applies and has been properly ended with the full agreement of both the CCG and of the Local Authority, 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 person's mental disorder, then such a service would then be eligible to the normal charging regime. This will never apply to people suffering from organic psychiatric disorders.

35.5. There can exist a close inter-relationship between the presence of a mental disorder and a physical disability. 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 person's circumstances in the round.

35.6. 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 discharge S117. Similarly, the person and or their representative should always be offered access to independent advocacy.

36. S117 and Prescription Charges

36.1. Most aspects of health policy, including the prescription charge, are devolved. It is therefore possible for the different countries of the UK to have different policies relating to the charge. In practice both Wales and Scotland do not charge for prescriptions. This has particular implications for residents of Gloucestershire who have a Welsh GP (see cross border issues).

36.2. The legislation covering prescription charges is the NHS Act 2006. Subsection 3 states that:

“The services so provided must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed”

36.3. Part 9 of the *NHS Act 2006* deals with NHS charges. Among other things, it enables including prescription charges, pre-payment certificates and exemptions to the prescription to be made by regulations. It also lists certain situations where charges may not be made, for example, prescription charges for hospital in patients are ruled out in the Act itself rather than in the regulations with most of the other exemptions.

36.4. S117 does not automatically entitle individuals to free prescriptions. The Regulations (National Health Service (Charges for Drugs and Appliances) Regulations 2000**(b)**) state that individuals may be able to claim free prescriptions if, at the time the prescription is dispensed, they:

- *Are 60 or over*

- *Are under 16*
- *Are 16-18 and in full-time education*
- *Are pregnant or have had a baby in the previous 12 months and have a valid maternity exemption certificate (MatEx)*
- *Have a specified medical condition and have a valid medical exemption certificate (MedEx)*
- *Have a continuing physical disability that prevents you from going out without help from another person and have a valid MedEx*
- *Hold a valid war pension exemption certificate and the prescription is for your accepted disability*
- *Are an NHS inpatient*

36.5. Individuals are also entitled to free prescriptions if they or their partner (including civil partners) are named on, or are entitled to, an NHS tax credit exemption certificate or a valid HC2 certificate (full help with health costs), or they receive either:

- *Income Support*
- *Income-based Jobseeker's Allowance*
- *Income-related Employment and Support Allowance, or*
- *Pension Credit Guarantee Credit*
- *Universal Credit*

36.6. Individuals with certain medical conditions can get free NHS prescriptions if they have a defined medical condition **and** they hold a valid exemption certificate, or they are receiving treatment for cancer or the effects of previous cancer treatment. Mental disorders are not included in the list of medical conditions.

36.7. The National Health Service (Charges for Drugs and Appliances) Amendment Regulations 2008 amended the 2000 Regulations so that individuals who are subject to a Community Treatment Order will not be charged for medication if it is supplied to them by a CCG, Trust or a Patient Group Directive. Individuals who are not subject to a CTO but who are receiving medication from a trust will not be charged for the prescription.

37. Complaints

37.1. If a Service User, or their representative, has a complaint regarding the operation of this policy then this should in the first instance be addressed with their Care Co-ordinator/care Manager and/or the relevant team manager. Where this is not successful then the complaint should be handled in line with the complaints procedures of the lead agency.

38. Dispute Resolution

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

38.2. If two or more local authorities fall into dispute about where a person is ordinarily resident, or about a person'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 a person appointed by the Secretary of State. Details specifying the dispute resolution process will be set out in regulations and statutory guidance. It is intended that the regulations will also set out the procedure local authorities must follow when a dispute occurs when there is a business failure of a provider of care and support who is regulated by the Care Quality Commission.

39. Implementation and Review

39.1. Significant numbers of staff in Gloucestershire are already aware of the existence of the S117 duty and its implications. However, some are not, and more are not aware of the importance of ending it when appropriate, nor of the steps necessary to properly separate and identify services provided under S117 to meet needs arising from a mental disorder and those provided to meet needs arising from other sources.

39.2. It will therefore be necessary to develop a detailed policy implementation plan. Year one of this plan will be used to test the use of the S117 Matrix Funding Tool (appendix D).

39.3. Decisions and action taken with regard to S117 status should be incorporated within the CPA process and will be incorporated into the CPA training.

39.4. This policy will be issued to all relevant staff to ensure employees have access to and are able to comply with the processes within. This will be done by way of:

- *Uploading the policy to the public website and intranet of the Council, the CCG and 2gether NHSFT.*
- *Disseminating the policy to all relevant professionals via team managers across relevant Health and Social care organisations in Gloucestershire.*
- *Disseminating the policy to Service User groups, Carers groups and organisations and advocacy providers.*
- *Planned briefing sessions for all staff*

39.5. There will be a review of this policy and its implementation within the first 12 months.

39.6. An audit of S117 policy will be undertaken within the first 6 months of 12 months of implementation and will form the basis of the review.

40. Appendices

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 CCG and local authority.

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 CCG
- Representative from the Local Authority

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, personal 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 local authority 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 CCG and Local Authority 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 Section 117 Mental Health Act 1983					
Name		DOB			
NHS Number		PRN			
S117 Review Meeting Date					
People present at the review meeting					
<p>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 1983)</p>					
<p>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.</p>					
Signed		Name		Date	
On behalf of Gloucestershire Clinical Commissioning Group		Title			
Signed		Name		Date	
On behalf of Gloucestershire County Council		Title			

Appendix C: Summary of Recent Case Law

R (Mwanza) v Greenwich LBC and Bromley LBC [2010] EWHC 1462 (Admin):

- nature and extent of aftercare facilities must, to a certain degree fall, within the discretion of the authorities which must have regard to other demands in their budget;
- accommodation is a "common need" for all people - s.117 is not concerned with provision of support and accommodation at large;
- can be for "accommodation plus":
 - residential accommodation which is specifically designed to care for the needs of persons who have been detained under section 3 and who have left hospital;
 - Caring residential accommodation (such as supported living) (ensuring for example, that prescribed medication is taken, or providing intensive therapy and treatment)
- just because a former patient is unemployed/homeless and that social situation would increase the chance of deterioration in mental condition does not require S.117 to provide employment/housing – it may give rise to a need for assistance in gaining employment/housing;
- s.117 does not require the relevant authorities to provide a former s.3 patient with any and all services simply because those services do or may prevent deterioration or relapse of a mental condition, or require readmission.

R (on the application of Tewodros Afework) v The Mayor and Burgess of the London Borough of Camden [2013] EWHC 1637 (Admin)

- Accommodation is only after-care if:
 - Need for accommodation is a direct result of the reason that the patient was detained under the MHA; and
 - It is enhanced specialised accommodation to meet needs directly arising from the mental condition; and
 - Ex-patient is being placed in the accommodation on an involuntary (in the sense of being incapacitated) basis arising as a result of the mental condition.

[Wiltshire Council v Hertfordshire County Council and SQ](#) [2014] EWCA Civ 712

Giving the judgment of the court, Mr Justice Bean said he considered it “clear that where a person has been made subject to a hospital order with restrictions, then conditionally discharged, then recalled to hospital, and then conditionally discharged for a second time, for the purposes of s. 117(3) of the Act he is still to be treated as ‘resident in the area’ of the same local authority as that in which he lived before the original hospital order was made.

“This makes it unnecessary to consider whether or not a fresh duty to provide after-care services arose on SQ’s second discharge earlier this year. Whether the duty is a fresh one or a continuing one, on the facts of this case it is Wiltshire’s duty.”

Appendix D

Joint Funding Matrix – Section 117

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 service user 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 service user 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		

PERSONAL CARE		
MEDICATION		
SLEEP		

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

MEDICAL DIAGNOSIS IF KNOWN

ADDITIONAL INFORMATION REQUIRED

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

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:		