NHS Rotherham Clinical Commissioning Group

Operational Executive – 15/10/21: OE supported policy.

Strategic Clinical Executive – Date

GP Members Committee (GPMC) – Date

Clinical Commissioning Group Governing Body - 3 November 2021

JOINT SECTION 117 AFTERCARE POLICY (RMBC and RCCG)

Lead Executive:	Ian Atkinson, Deputy Chief Officer
Lead Officer:	Garry Parvin Joint Head of Learning Disability, Autism and Transitions Commissioning
Lead GP:	Dr Sophie Holden, Strategic Clinical Executive GP for Learning Disability

Purpose:

The purpose of this report is to present Rotherham's Joint Section 117 after-care policy. The full policy is attached as an appendix.

Background:

Section 117 Mental Health Act 1983 (MHA 1983) imposes duties on NHS Clinical Commissioning Groups (CCGs) and Local Social Services Authorities (LSSAs) to provide After-care for patients who have been detained under section 3, 37, 45A, 47 and 48 of the MHA 1983 once they leave hospital.

Section 117 Aftercare is a statutory duty for both the NHS and Local Authorities and having a joint approach will ensure better patient outcomes. The policy will cut across the following portfolios: Children and Young People, Mental Health, Learning Disability and Neurodevelopmental.

The MHA 1983 does not specify definitively what constitutes After-care services from either the CCG or the Local Authority. However, as a result of court decisions the following definitions were included in the Care Act 2014, so that from April 2015 onwards section 117(6) reads as follows:

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

a) Meeting a need arising from or related to the person's mental disorder; and
b) Reducing the risk of a deterioration 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)."

Section 117 services are not concerned with support in general but are those which are required to meet an assessed care need that arises from a person's mental disorder

and are aimed at minimising the need for future re-admissions to hospital for treatment for that disorder.

The services may include:

- Provision of domiciliary services
- Access to accommodation and welfare rights
- Social work support
- Day services eg support with employment, social inclusion, and relationships
- Medical supervision and psychological support
- Specialist Welfare Rights and Housing benefit advice; and
- Advice on employment

Services providing care or support for a physical disability, illness, substance misuse problems, and common needs not arising from the patient's mental health disorder cannot be provided under section 117. These must be met under separate health and community care legislation.

Although accommodation can be provided under section 117 the need for accommodation must be a direct result of the reason that the patient was detained for in the first place. As a matter of law ordinary accommodation can never be a free After-care service under section 117.

In further decisions the court set out two requirements which must be met for accommodation to be provided under section 117. They are:

i. The need for accommodation is a direct result of the reason that the ex-patient was detained in the first place ("the original condition").
ii. The requirement is for enhanced specialised accommodation to meet needs directly arising from the original condition; and In light of the above,
iii. accommodation provided under section 117 will in most cases go beyond that which can be lawfully commissioned by a Local Authority – e.g. high specification / bespoke accomadation.

Analysis of key issues and of risks

- **If appropriate explain links to Governing Body Assurance Framework (GBAF), Risk Register (RR) and Issues Log (IL)**

This purpose of this policy is to lay out a clear framework on, and commitment to, the provision of After-care services to people who are entitled to those services under section 117 of the MHA 1983 and should ensure that:

- The organisation is aware of their section 117 responsibilities.
- Staff within the organisation are aware of their section 117 responsibilities.
- Local interpretation of section 117 is in line with the legal requirements under the MHA 1983.

This agreement is between is between Rotherham Metropolitan Borough Council (RMBC) and Rotherham Clinical Commissioning Group (RCCG) in relation to section 117 after care decision-making and commissioning of packages of care.

The policy outlines:

a. Scope (section 3)
b. Duties (section 4) of agencies and partners and
c. Procedure (section 5) – this includes direction about care planning

The policy introduces a joint panel process (see section 5.9 and Appendix 4). The panel will (following the completion of a joint statement of need - appendix 2 and funding matrix – appendix 3) may recommend the following funding splits:

- **100% CCG Funding** - where a person meets eligibility criteria for fully funded Health Services, the CCG will resource 100% care provision.
- **Shared LSSA and CCG funding** - all section 117 After-care that have a combination of health and social care requirements, will be funded on a proportional basis, agreed between the commissioners.
- **100% LSSA funding** - when the person meets the eligibility for social care services alone then the LSSA will fund that care provision.

Appendix 4 sets the panels Terms of Reference and remit. The approval for financial packages will made under each organisation financial standing orders.

If the policy is not adopted both Rotherham Council and CCG are at risk of reputational harm due to delays in the current system in approving Aftercare packages.

Patient, Public and Stakeholder Involvement:

The policy is principally between Rotherham CCG and Rotherham Council. However, the policy will be circulated to principal planning partners (RDaSH, TRFT for example) for information. Partners will be asked to review and amend 117 Aftercare policies to ensure alignment.

Public consultation is not required in these circumstances.

Equality Impact:

A full EIA is not required. The rationale is:

The policy sets out when it is appropriate for Section 117 funding to be applied where an individual has a Section 117 Aftercare need. In doing so, it provides guidance relating to the remit of the Section 117 aftercare. There should be no negative impact upon any of the protected characteristics. Given that there is no identified negative impact a full impact assessment has not been completed.

Financial Implications:

The Joint Section 117 Aftercare Commissioning Panel will need to ensure that the CCG is present when 117 aftercare decisions are being made. The TOR for the Joint Section 117 aftercare panel (appendix 4) needs to state that the CCG will be represented to ensure quoracy.

Human Resource Implications:

No HR implications are identified

Procurement Advice:

No procurement implications

Data Protection Impact Assessment
The Section 117 aftercare register is maintained by RDaSH and sits under RDaSH's corporate data protection policies. RDaSH have stated they wish to halt supporting 117 Aftercare Register from 31/03/22. Rotherham CCG have requested formal notification. RDaSH have communicated that they are prepared to be flexible about the handover date. Partner discussions are being planned. There will need to be a discussion between partners about: 1. Where the register will be located (and the Data Governance this requires) and 2. The infrastructure required to support the register.
Governing Body Assurance Framework, Risk Register & Issues Log
N/A
Approval history:
15/10/21: Rotherham CCG Operational Executive supported policy
Recommendations:
Rotherham CCG Operational Executive (OE) are recommended to approve: a. the Joint Section 117 Aftercare Policy. b. approve the creation of a joint 117 Aftercare Panel with the recommendation that the Panel (as proposed in appendix 4) must have a CCG officer to ensure quoracy.
Paper is for Approval

ROTHERHAM METROPOLITIAN BOROUGH COUNCIL

ROTHERHAM CLINICAL COMMISSIONING GROUP

JOINT SECTION 117 AFTERCARE POLICY

Document Control Sheet

Owner	Role	Date of Issue	Version
Marie Staves	Strategic Lead Mental Health Services		V1

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Policy Jointly reviewed and amendments made in partnership with CCG	Marie Staves	21.05.2021	

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By	Date	Signature	Version
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Contents

1. INTRODUCTION

Section 117 Mental Health Act 1983 (MHA 1983) imposes duties on NHS Clinical Commissioning Groups (CCGs) and Local Social Services Authorities (LSSAs) to provide After-care for patients who have been detained under section 3, 37, 45A, 47 and 48 of the MHA 1983 once they leave hospital.

For individuals who are in contact with specialist mental health providers, section 117 of the MHA 1983 does not replace arrangements under the Care Programme Approach and where appropriate these should run in alongside each other.

The 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 Section 117 Mental Health Act After-care. Policies should set out clearly the criteria for deciding which services fall under section 117 Mental Health Act and which authorities should finance them. The Section 117 Mental Health Act After-care plan should indicate which services are provided as part of the plan. After-care provision under section 117 of the Mental Health Act 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 section 117 Mental Health Act 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'.

The MHA 1983 does not specify definitively what constitutes After-care services from either the CCG or the Local Authority. However, as a result of court decisions the following definitions were included in the **Care Act 2014**, so that from April 2015 onwards section 117(6) reads as follows:

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

a) Meeting a need arising from or related to the person's mental disorder; and
b) Reducing the risk of a deterioration 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)."

Section 117 services are not concerned with support in general but are those which are required to meet an assessed care need that arises from a person's mental disorder and are

aimed at minimising the need for future re-admissions to hospital for treatment for that disorder.

The services may include:

- Provision of domiciliary services
- Access to accommodation and welfare rights
- Social work support
- Day services eg support with employment, social inclusion, and relationships
- Medical supervision and psychological support
- Specialist Welfare Rights and Housing benefit advice; and
- Advice on employment

Services providing care or support for a physical disability, illness, substance misuse problems, and common needs not arising from the patient's mental health disorder cannot be provided under section 117. These must be met under separate health and community care legislation.

Although accommodation can be provided under section 117 the need for accommodation must be a direct result of the reason that the patient was detained for in the first place. As a matter of law ordinary accommodation can never be a free After-care service under section 117.

In further decisions the court set out two requirements which must be met for accommodation to be provided under section 117. They are:

i. The need for accommodation is a direct result of the reason that the ex-patient was detained in the first place (“the original condition”).
ii. The requirement is for enhanced specialised accommodation to meet needs directly arising from the original condition; and

In light of the above, accommodation provided under section 117 will in most cases go beyond that which can be lawfully commissioned by a Local Authority.

2. PURPOSE

This purpose of this policy is to lay out a clear framework on, and commitment to, the provision of After-care services to people who are entitled to those services under section 117 of the MHA 1983 and should ensure that:

- The organisation is aware of their section 117 responsibilities.
- Staff within the organisation are aware of their section 117 responsibilities.

- Local interpretation of section 117 is in line with the legal requirements under the MHA 1983.

This agreement is between is between Rotherham Metropolitan Borough Council (RMBC) and Rotherham Clinical Commissioning Group (RCCG) in relation to section 117 after care decision-making and commissioning of packages of care.

3. SCOPE

This policy applies to all patients / customers entitled to After-care services under section 117 of the MHA 1983 where Rotherham CCG is the responsible commissioner and /or Rotherham MBC is the responsible Local social service authority.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

The duty to provide After-care services under section 117 is a stand-alone duty which is not reliant on any other piece of legislation. The MHA states that the responsible After-care bodies are the CCG and the LSSA in co-operation with voluntary agencies, to provide After-care to patients detained in hospital for treatment under section 3, 37, 45A, 47 and 48 of the Act who then cease to be detained. The relevant CCG for After-care will be identified with reference to the relevant 'Who pays?' guidance issued at that particular time (currently the September 2020 version). The relevant LSSA will be the local authority where the person was ordinarily resident immediately prior to being detained under the MHA. To identify a person's ordinary residence, professionals should refer to chapter 19 of the statutory Care and Support guidance.

As a partnership the RMBC and RCCG are committed to the ongoing support and recovery of residents through the effective co-ordination of section 117 after care provision and with local partners aim to produce a framework that ensures delivery of this.

Through a partnership and joint commissioning approach, the RMBC and RCCG are committed to not only ensuring that individuals receive the services to which they are entitled under section 117, but also ensure that individuals who are not entitled to section 117 After-care services or who no longer require such services have their entitlement reviewed and where appropriate ended.

5. PROCEDURE AND IMPLEMENTATION

5.1 What is Section 117 After Care Services?

The Mental Health Act Code of Practice 2015 states that the purpose of section 117 of the MHA 1983 is to:

- Provide care and treatment for the purposes of meeting a need arising from or related to the patient's mental disorder; and
- Reduce the risk of a deterioration of the patient's mental condition; and
- Reduce the risk of the patient requiring admission to hospital again for treatment for mental disorder.

5.2 When does Section 117 apply?

Section 117 of the MHA 1983 **only** applies to the following individuals if they have been:

- Detained in a psychiatric hospital under section 3 MHA 1983.
- Admitted to hospital under an order made under section 37 MHA 1983.
- Transferred to a psychiatric hospital from prison or remand centre. This includes those individuals who are on remand, detained in prison under civil law or held under immigration legislation; in pursuance of a transfer direction under sections 45A, 47, 48 of the MHA 1983 who cease to be detained and leave hospital (whether or not immediately after the detention has ended).

In addition section 117 MHA 1983 also applies to any individual who has been subject to section 3, 37, 45A, 47 and 48 of the MHA 1983 who are:

- Subject to Guardianship where the After-care plan included a requirement of Guardianship.
- Given leave of absence under section 17 MHA 1983, as part of the preparation for discharge, and where that care plan is based on jointly assessed (and agreed) health and social care needs.
- Made subject to a Community Treatment Order under section 17A MHA 1983.
- Assessed as needing residential accommodation or non-residential community care services as a condition of leave under Section 17 MHA 1983 and/or section 117 MHA 1983.

5.3 The Section 117 Register

The lead mental health agency is required to have a section 117 database. This database should be a live document that can be shared with all the partners subject to this policy.

This register will be held by the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and will be used to ensure that there is no duplication in the recording of section 117 eligible individuals, funding, or exclusion of people with section 117 entitlement.

5.4 Statutory Advocacy

5.4.1 Independent Mental Capacity Advocate (IMCA)

Under the Mental Capacity Act 2005, there is a legal duty to refer a patient to the IMCA Service if they have been assessed as lacking capacity in making decisions. Such an advocate must be appointed before any decisions are taken in relation to serious medical treatment or change in accommodation for example. This must also take place even if the

person has relatives or carers unless they have a lasting power of attorney for health and welfare which allows them to make health related decisions on the person's behalf.

5.4.2 Independent Mental Health Advocate (IMHA)

Since 2009 IMHAs have been available as a statutory right to people under certain aspects of the MHA 1983. IMHAs will support individuals to inform them of their rights under the MHA 1983 and any aspect of their care or treatment under compulsion. This would include information about their rights under section 117, and also their After-care care planning and package of care.

5.5 Care Programme Approach and Section 117 After-care

After-care for **all** patients admitted to hospital for treatment of their mental health needs should be planned for within the framework of the Care Programme Approach (CPA), whether or not they will be entitled to After-care services under section 117 of the MHA 1983.

5.6 Care Planning

Planning for the patients After-care needs should commence on admission. Reasonable steps should be undertaken to identify appropriate services, and make preparations, well before actual discharge from hospital.

The Code of Practice requires that prior to the formulation of any care plan a comprehensive and holistic assessment of need should be undertaken by the Care Co-ordinator and should include a consideration of the sixteen identified aspects of need listed in section 34.19 of the Code of Practice (see Appendix A).

Once a comprehensive assessment of need has been undertaken it is the responsibility of the Responsible Clinician to ensure discussion takes place to develop a care plan to meet the patient's on-going health and social care needs.

This discussion will usually be a multi-professional meeting in the hospital and should involve:

- Responsible Clinician.
- A nurse involved in the hospital care of the patient.
- The care co-ordinator/community psychiatric nurse or register nurse LD (where appropriate).
- A social worker.
- The patient.
- The patient's relative or nominated representative eg Advocate.
- The patient's GP.
- A representative from relevant voluntary organisation, (where appropriate).
- In the case of a restricted patient, the probation service.

Discharge planning should start at the earliest opportunity to enable funding streams to be agreed in principle, prior to the patient's final discharge to avert any potential delay. It is important that those who are involved in the discharge planning are able to make, as far as

possible, decisions regarding their own agency's involvement. If approval for a plan needs to be obtained from a more senior level (for example, for funding) it is important that this causes no delay to the implementation of the care plan.

Those contributing to After-care planning must always consider:

- The patient's wishes and needs.
- The views of relatives or friends.
- Establish a care plan based on assessment of identified needs; and
- Commissioning of services.

The After-care plan should set out clearly the section 117 After-care services to be provided and record which authority/authorities are funding which parts of the package of care.

Finally the Care Plan must be jointly agreed between health and social care services at a multi-disciplinary discharge meeting. If a social worker is not involved in the care planning, then the care co-ordinator/social worker must discuss the case with the Local Authority Principle Social Worker, Approved Mental Health Professional Lead or Head of Service who will agree and sign the care plan on behalf of the Local Authority.

5.7 Registering Section 117 After-care

When a patient is admitted to hospital under one of the relevant sections, the Mental Health Act Office within RDaSH will register the patient on the Trust patient information system as being entitled to After-care under section 117. The MHA Office will maintain an up-to-date register of people on section 117. Section 117 status will be available to a nominated person at RMBC and RCCG.

5.8 After-care Arrangements and Section 117

Before deciding to discharge a patient, granting periods of leave or placing a patient on to a Community Treatment Order, the Responsible Clinician should ensure that the After-care needs for the patient have been fully assessed and discussed with the patient and that confirmation of section 117 funding arrangements have been agreed and recorded. Any period of leave, which includes an overnight stay, will necessitate a full After-care plan.

5.9 Funding Responsibilities

Section 117 Commissioning Panel

Rotherham Metropolitan Borough Council and Rotherham Clinical Commissioning Group are committed to a consistent approach to the commissioning of Section 117 Aftercare, the remit of the commissioning panel is to:

- Inform the decision-making and commissioning of care under section 117.
- Make funding decisions for all specialist provisions and complex high-cost care packages.
- Ensure that individuals whose circumstances change are reviewed and funded appropriately.
- Ensure that individuals who no longer require services have their entitlement reviewed and where appropriate ended.
- To ensure that all discussion and decisions made at meetings are accurately recorded.

Funding a person's health and social care needs:

- **100% CCG Funding** - where a person meets eligibility criteria for fully funded Health Services, the CCG will resource 100% care provision.
- **Shared LSSA and CCG funding** - all section 117 After-care that have a combination of health and social care requirements, will be funded on a proportional basis, agreed between the commissioners.
- **100% LSSA funding** - when the person meets the eligibility for social care services alone then the LSSA will fund that care provision.

These arrangements apply only to the funding of support packages and additional health and social care provision relating to the person's section 117 After-care needs.

If individual needs are identified that are unrelated to the mental health condition and After-care under section 117 these will continue to be subject to the usual eligibility and potential charging under the Care Act and/or eligibility under Continuing Health Care (CHC) criteria.

It is therefore important for the lead professional to distinguish within the discharge care plan, the care and support that relates to the patient's mental disorder which will be provided free of charge, and the physical health difficulties the patient may experience which may be subject to an appropriate charges by the Local Authority or subject to CHC.

Additional Costs

Preferred accommodation - section 117A. The Local Authority in discharging its duty to provide or arrange accommodation for a person under section 117; must provide or arrange the person's expressed preference.

However, there is provision within the regulations under this section for the person concerned, or the person of the prescribed form, to pay for some or all of the 'additional cost' incurred. For example, the cost of providing or arranging for the person's preferred option less the amount the Local Authority would expect to pay for accommodation of this kind.

5.10 Out of Area Placements

For those patients being transferred out of area, or those patients being placed into an area of the Local Authority, please refer to the RDaSH Section 117 Operational Protocol for further advice and guidance.

5.11 Review of Section 117 After-care

The Local Authority will arrange a review of the care plan / section 117 eligibility within six weeks of discharge from hospital and thereafter at intervals of six months, until such time as the care plan and/or section 117 eligibility is no longer required.

5.12 Ending Section 117 After-care

The MHA Code of Practice 2015 states that "the duty to provide After-care services continues until the CCG and LSSA are satisfied that the patient no longer requires them. The circumstances in which it is appropriate to end section 117 After-care will vary from person to person and according to the nature of the services being provided. The most clear-cut circumstance in which After-care would end is where the person's mental health improved to a point where they no longer needed services to meet needs arising from or related to their mental disorder. Fully involving the patient and (if indicated) their carer and or advocate in the decision-making process will play an important part in the successful ending of After-care."

Services should not therefore be withdrawn on the basis that:

- The patient has been discharged from the care of specialist mental health services.
- An arbitrary period has passed since the care was first provided.
- The patient is deprived of their liberty under the Mental Capacity Act 2005.
- The patient is re-admitted to hospital informally or under section 2 MHA 1983; or
- The patient is no longer on Community Treatment Order or section 17 leave.

After-care services may be reinstated if it becomes obvious that they have been withdrawn prematurely e.g. where the patient's mental condition begins to deteriorate immediately after services are withdrawn.

Even where the provision of After-care has been successful in that the patient is now well-settled in the community the patient may still continue to need After-care services eg to prevent a relapse or further deterioration in their condition.

Patients are under no obligation to accept the After-care services they are offered but any decisions they may make to decline them should be fully informed. An unwillingness to

accept services does not mean that patients have no need to receive services, nor should it preclude them from receiving them under section 117 should they change their minds.

Any recommendation to discharge section 117 After-care resulting from consideration of the above must be agreed by the Care Team and Responsible Clinician on behalf of both the CCG and the LSSA.

5.13 First Tier Tribunals Service, Hospital Managers' Hearings and Section 117 After-care

When consideration is given to a First Tier Tribunal and/or a Managers' Hearing there is an expectation that a care plan will be made available which includes the patient's After-care arrangements should they be discharged.

Where the tribunal has provisionally decided to grant a restricted patient a conditional discharge, and there are funding implications as part of this conditional discharge, the CCG and LSSA are required as far as possible to put in place After-care, which would allow discharge to take place.

6. REFERENCES

Mental Health Act 1983
Mental Health Act 1983: Code of Practice 2015
Mental Capacity Act 2005
Independent Mental Health Advocacy – Guidance for Commissioners (NIMHE) 2008
Care Act 2014
Care and Support statutory guidance

7. COURT CASES

R (Mwanza) -v- LBs Greenwich and Bromley [2010]
R (Afework) -v- London Borough Camden (2013)

8. DEFINITIONS

Care programme approach (CPA): Framework of assessment, care planning and review for people who receive mental health services.

Care management: Framework of assessment, support planning, provision of care packages and review for people who receive services via Local Social Services Authority.

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.

Localism Act 2011: Entitles local authorities to do anything which they consider is likely to achieve the promotion or improvement of the social well-being of their area provided that they are not forbidden from so doing by any prohibition, restriction or limitation on their powers in any enactment.

Mental Health Act 1983:

Section 3:
Order detaining an individual in hospital for treatment

Section 17 leave:
Period of agreed community leave for a patient currently liable to detention in hospital.

Section 17A (Supervised Community Treatment):
Order providing a legal framework around the care of a patient 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 section 117 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 patients:
Section 42 allows the Secretary of State to direct that someone under a restriction order should be discharged from hospital but subject to conditions eg 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.

9. APPENDICES

16 Identified Aspects of Need

(Code of Practice, Mental Health Act 34.19)

- Continuing mental healthcare, whether in the community or on an out-patient basis;
- The psychological needs of the patient and, where appropriate, of their carers;
- Physical healthcare;
- Daytime activities or employment;
- Appropriate accommodation;
- Identified risks and safety issues;
- Any specific needs arising from, for example, co-existing physical disability, sensory impairment, learning disability or autistic spectrum disorder;
- Any specific needs arising from drug, alcohol or substance misuse (if relevant);
- Any parenting or caring needs;
- Social, cultural or spiritual needs;
- Counselling and personal support;
- Assistance in welfare rights and managing finances;
- the involvement of authorities and agencies in a different area, if the patient is not going to live locally;
- The involvement of other agencies, for example the probation service or voluntary organisations (if relevant);
- For a restricted patient, the conditions which the Secretary of State for Justice or the first tier Tribunal has imposed or is likely to impose on their conditional discharge; and
- Contingency plans (should the patient's mental health deteriorate) and crisis contact details.

APPENDIX 2

SECTION 117 STATEMENT OF NEED / CARE PLAN

Name:		DoB:		NHS No. / LAS No. / Any other personal identifiable No.:	
Address:					
How long have they lived at this address:		Have they previously lived in residential / nursing care, or been detained or accommodated in any other place – either privately, NHS or Local Authority?		Yes ☐ No ☐	
Have they previously lived in residential / nursing care, or been detained or accommodated in any other place – either privately, NHS or Local Authority?				Yes ☐ No ☐	
If Yes, who was the placing authority?		Contact details:			
Diagnosis:					
Mental Health Act status, section:		Start date:		End date:	
Section 117 Aftercare entitled? Rational for detention under MHA:	Yes ☐ No ☐				
Is the patient restricted under section 41 of the Mental Health Act?	Yes ☐ No ☐				
If Yes, record of conditions:					
Nearest relative *(as defined under section 26 MHA 1983)*		Contact details:			

Person to be contacted in emergency:		Contact details:	
Care Coordinator:		Contact details:	
Social Services representative:		Contact details:	
GP:		Contact details:	
Consultant:		Contact details:	
Ward representative:		Contact details:	
IMHA / IMCA:		Contact details:	

Mental Health

***Guidance**:* What is the nature of the mental disorder? When were they diagnosed? Consider impact of pre-existing mental health needs in Learning Disability of Autistic Spectrum Disorder. Why were they detained under the MHA Act? What the signs of possible relapse? What actions may be required in the event of a crisis? What are the risks? Are they vulnerable to relapse, self-harm, unpredictable or a high risk of suicide? Do they lack insight into their condition?

Statement of Need
Planned Outcomes

Intervention Agreed

Behaviour

***Guidance**:* Does the Patient / Service User experience any of the following:

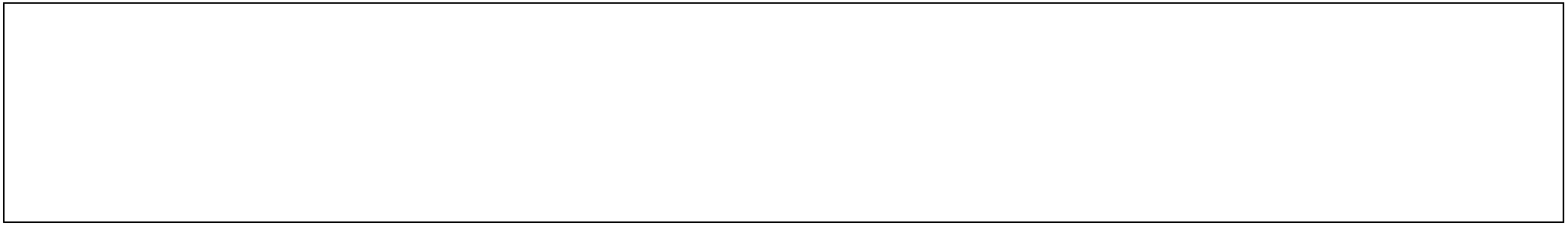
- Aggression or violence behaviours
- Passive non-aggressive behaviour
- Dis-inhibition
- Resistance to necessary care and treatment
- Severe fluctuations in mental state
- Inappropriate interference with others
- Were any of these behaviours present prior to admission
- Nature and intensity of these behaviours
- How can this behaviour be managed, i.e. do they response to reassurance?
- Level of staff, environment and skills of carers and family support
- Will they receive ongoing involvement from the Community Mental Health / Learning Disability Team

Statement of Need
Planned Outcomes
Intervention Agreed

Cognition

***Guidance**:* Are there any concerns regarding orientation and ability to perform everyday tasks or ability to meet personal care needs? Has there been any cognitive testing and, if so, what was the outcome? Are they able to partake in decision-making and make choices? Are they able to follow instruction, or join in conversations? Do they recognise people that are familiar to them? Is there a diagnosis of Learning Disability (prior to age 18) or Autistic Disorder, and how has this affected their abilities as described above?

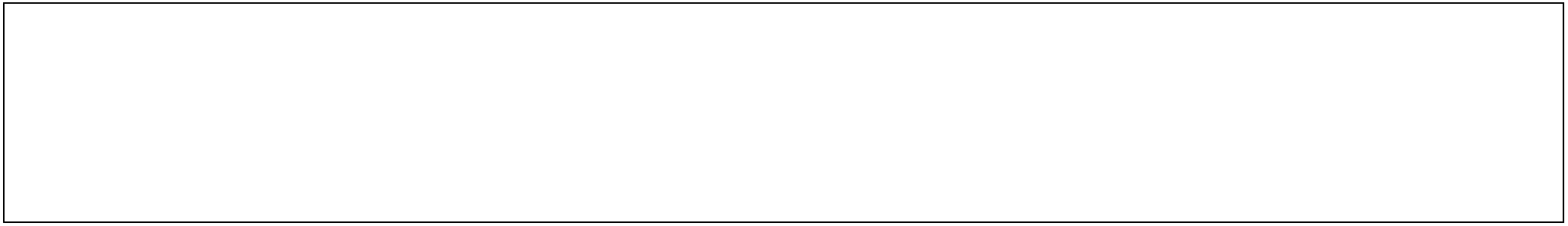
Statement of Need
Planned Outcomes
Intervention Agreed



Psychological / Emotional

***Guidance**:* Is the service user anxious or fearful; is there any trigger for their fear or anxiety? Are there any symptoms of depression? Does the service user have a history of not coping in situations? Does the service user express feeling of loneliness in their environment? How does their emotional state manifest itself, eg crying, shaking and sweating? Are there any identified reasons for their emotional state? How does the service user respond to reassurance? Take into consideration the impact of any Learning Disability or Autistic Spectrum Disorder developmental states, and how this might affect the service user; take into account lack of motivation.

Statement of Need
Planned Outcomes
Intervention Agreed



Medication

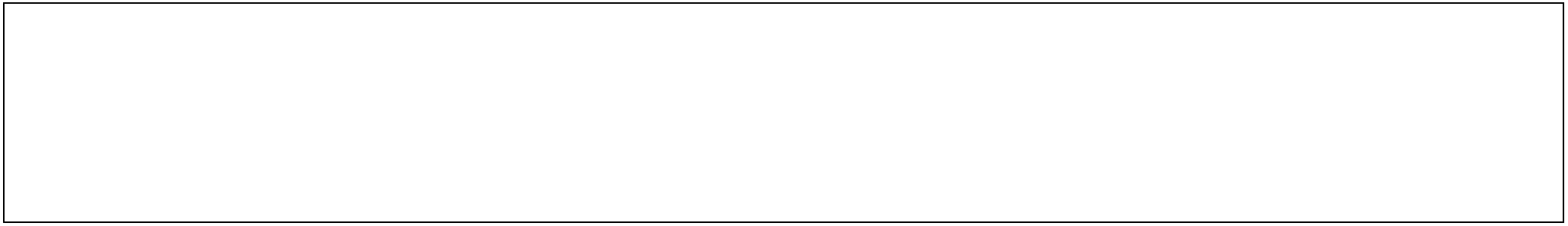
***Guidance**:* If the medication is for the service user's mental health or challenging behaviour which is a result of cognitive / functional problems of Learning Disability or Autistic Spectrum Disorder, what is the purpose of this treatment? How will the medication regime be reviewed, ie using Glasgow Anti-psychotic Side-effect Scale / LUNSERS or any other recognised tool used for the monitoring of prescribed medication? Has their capacity to consent been explored?

Statement of Need
Planned Outcomes
Intervention Agreed

Communication

***Guidance**:* Does the service user require any aids to enable them to communicate, ie visual aids, hearing aids, glasses? What is the service user's first language, do they need an interpreter? Have they been referred to Speech and Language Therapy? Is the service user able to demonstrate that they understand what is said to them, eg ask questions to clarify issues? Does the service user display postures, gestures, facial expression, noises or blinks to communicate wants or needs? Can the service user maintain eye contact? Consider the impact of their Learning Disability or Autistic Spectrum Disorder on the service user's ability to communicate in alternative ways.

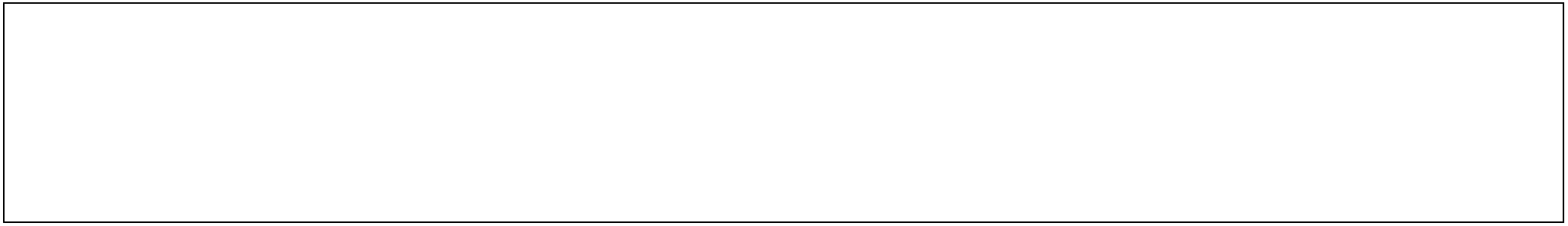
Statement of Need
Planned Outcomes
Intervention Agreed



Personal Care / Domestic Routines

***Guidance**:* Does the service user have the ability to meet their personal care needs, maintain their personal hygiene levels and their environment? Have they previously had support in these areas, or is it as a result of their mental health / Learning Disability / Autistic Spectrum Disorder that they have never had the ability, or are no longer able to perform these tasks? Are they unable to perform tasks as a result of lack of motivation? If so, have they been referred to Occupational Therapists or other specialist services to promote independence in these areas? What current level of assistance is required to support independence, appearance, dignity and comfort, and by whom?

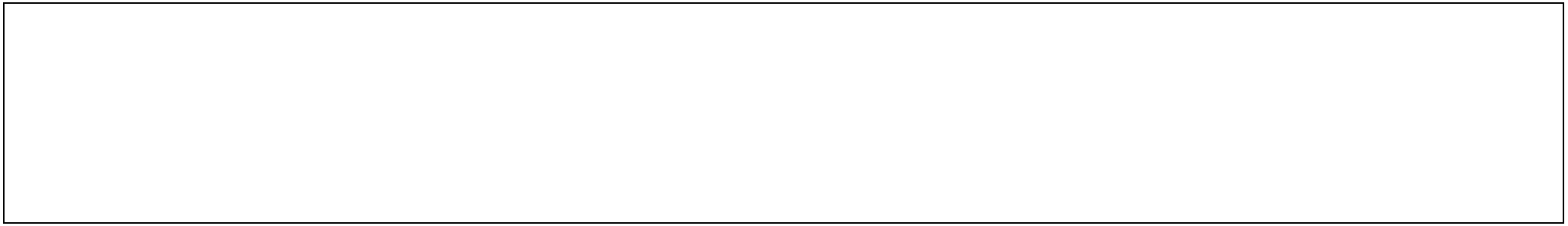
Statement of Need
Planned Outcomes
Intervention Agreed



Nutrition

***Guidance**:* Is the service user able to prepare food and drink? Are there any contributing factors preventing maintenance of nutritional intake, including cross-referencing with cognition and considering other factors including mental health issues, eg Anorexia, Bi-polar, Prada-Willi Syndrome, Learning Disability, Autistic Spectrum Disorder or physical health issues? What intervention / support are required? What and how will the service user's weight be monitored? Is there an identified food and fluid balance chart?

Statement of Need
Planned Outcomes
Intervention Agreed



Substance Misuse

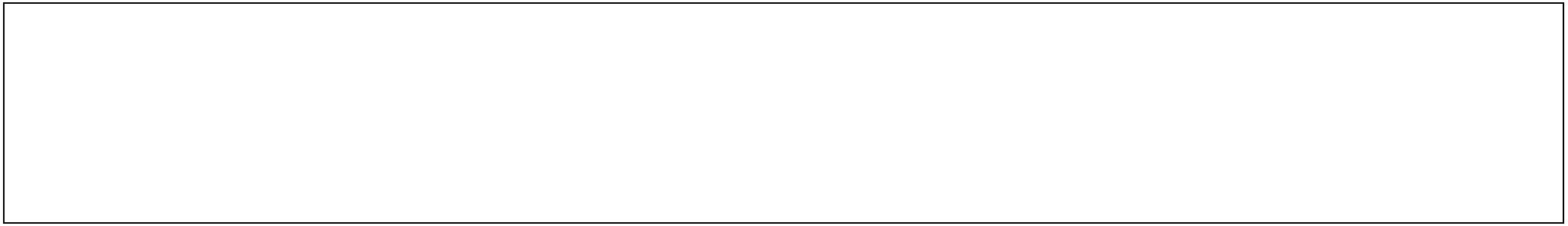
***Guidance**:* Does the service user have a dual diagnosis? How does it affect their mental health? Do they require follow-up by specialist services? Are they compliant with s management plan to reduce substance misuse?

Statement of Need
Planned Outcomes
Intervention Agreed

Physical Disability / Sensory Impairment

***Guidance**:* Are there any health conditions or disabilities that have an impact on the service user's need for support? Are there any identified pre-existing physical disabilities prior to becoming detained under the Mental Health Act? Has their physical health affected their mental health? Does the service user require input from specialist services to manage identified sensory impairment, such as sensory teams, Learning Disability and Autistic Spectrum Disorder teams, is hypo / hyper sensitivity part of those conditions?

Statement of Need
Planned Outcomes
Intervention Agreed



Mobility

***Guidance**:* Is the service user vulnerable to falls? Do they need support / motivation in or outside the home? Are aids and adaptations required? Does the service user suffer from muscle weakness / spasms? How does this affect their mobility? Does the service user recognise danger, ie do they require assistance crossing the road that is not associated with any other pre-existing diagnosis, eg Cerebral Palsy?

Statement of Need
Planned Outcomes
Intervention Agreed

Continence

***Guidance**:* Does the service user urinate in inappropriate places? Is this a result of their disorders or associated with any Learning Disability or Autistic Spectrum Disorder? Do they suffer from frequent urinary infections, constipation or chest infections, and does this affect their mental health? Will they remove catheter bags inappropriately and have they always done so prior to being Section 117 status? Has a continence assessment taken place?

Statement of Need
Planned Outcomes
Intervention Agreed

Employment / Education / Occupation

***Guidance**:* Does the service user need some practical or emotional support to enable them to engage with employment or education opportunities that were not required previously? How will this improve their mental health?

Statement of Need
Planned Outcomes
Intervention Agreed

Accommodation / Environment

***Guidance**:* Does the service user need support or residential accommodation that was not required previously? Has the need arisen because of difficulties associated with the service user's mental disorder? Does the service user need supported / residential accommodation in order to avoid further compulsory admissions to hospital? Is the supported / residential accommodation required because the service user is a danger to themselves or others?

Statement of Need
Planned Outcomes
Intervention Agreed

Financial Management

***Guidance**:* Is the service user vulnerable to financial exploitation? If they are, is this a consequence of their mental health? Consider the effect of their Learning Disability / Autistic Spectrum, Disorder in this domain. Does this impact on their ability to manage their own financial affairs? Do they require support to secure their welfare benefit entitlement? Is there a Power of Attorney or Court Appointed Deputy or an Appointee?

Statement of Need
Planned Outcomes
Intervention Agreed

Unmet Needs

***Guidance**:* Are there any identified services or provisions that may be beneficial for the service user not able to be commissioned due to lack of resources in the area?

Statement of Need
Planned Outcomes
Intervention Agreed

Please complete the eligibility grid below which indicates if a person is eligible for Section 117 Aftercare, based on your assessment under each of the domains above:

Care Domain	Yes	No
Mental Health	☐	☐
Behaviour	☐	☐
Cognition	☐	☐
Psychological / Emotional	☐	☐
Medication	☐	☐
Communication	☐	☐
Personal Care / Domestic Routines	☐	☐
Nutrition	☐	☐
Substance Misuse	☐	☐
Physical Disability / Sensory Impairment	☐	☐
Mobility	☐	☐
Continence	☐	☐
Employment / Education / Occupation	☐	☐
Accommodation /Environment	☐	☐
Financial Management	☐	☐

Unmet Needs	☐	☐

Does the service user have capacity to consent to the decision-making process?		Yes ☐ No ☐ Please attach current capacity assessment
Best Interest (BI) decision-maker, please attach MCA 2/3:	Name:	
	Role:	

Has identified carer been offered a carer's assessment?	Yes ☐ No ☐
Date of next section 117 review:	

Does case need to be transferred?	Yes ☐ No ☐	If Yes, who to? please provide details	
Have they received a copy of the care plan?	Yes ☐ No ☐	If No, why not?	

Service User:		Signature (if able):	
Health representative's name, ie Care Coordinator:		Signature:	

Date:		

Service User:		Signature (if able):	
Health representative's name, ie Care Coordinator:		Signature:	
Date:			

APPENDIX 3

Section 117 After-Care Funding Responsibility Matrix

This matrix has been devised to support commissioners of Section 117 After-care care packages to identify their funding responsibilities. It allows for the individual's needs and presentation to be checked against an outline detailing levels of NHS and Social Care funding responsibility. It is to be presented with any necessary CPA documentation, risk assessment, After-care Plan. The assessor is required to familiarise themselves with the indicators within this document prior to completion, and provide evidence within the appropriate level to support their recommendation of NHS/LA funding responsibility for the Sec 117 After-care Care Plan.

Completed by: **(detail all NHS/LA professionals involved)**		**Designation:**	**Social Worker:** **Named Nurse:**
Date of Completion:		**Contributors:** **(detail all active contributors including patient/representative)**	**IMHA – Advocate:**
Responsible Commissioner (CCG):		**Responsible Commissioner (LA):**	
Name of Individual:		**D.o.B:**	
NHS. Number:		**Current Whereabouts:**	
Date Presented:		**Recommended NHS Contribution:**	

Level of need / Funding	**Indicators**	**Evidence to support MDT/CPA Co-ordinator recommendation**

Band 1 Costs for care package met by the Local Authority with access to mainstream health services or specialist services provided by the NHS	Living in the community in either own home, or supported living or residential type setting where health needs can be met by primary and secondary care services only. This residence could be 'in house' or external due to a lack of local provision. There would be little evidence of requirement for health services above the provision of primary and secondary care services. May not trigger on CHC checklist. May require oversight from a health professional on a regular basis that may include access to therapy that is not provided by frontline services or there is a delay in accessing these services that puts the individual at risk of harm or deterioration. Individual may be living in a care setting or their own home. Visits from specialist statutory services when required for advice e.g. Dietician but with no ongoing care management.	
Band 2a Cost for the care package met by the allocation of the Funded – Nursing Care provision by the CCG and by the Local Authority and/or the individual.	Requires the oversight of a registered nurse over the 24 hour period to plan, monitor and evaluate care needs from both a physical or mental health perspective and living in a 24 hour registered care home with nursing (non-specialist).	
Band 2b The CCG would contribute 30% of the care package.	**The individual may require:** A skilled regime of care that could relate to: • Ongoing or Recurrent Psychosis with a low to moderate level of acuity • Psychosis & Affective Disorder with a low to moderate level of acuity • Non-Psychotic Chaotic and Challenging Disorders with a low to moderate level of acuity • Moderate to High Cognitive Impairment • Development and implementation of a care plan detailing proactive and reactive interventions related to challenging behaviour on a regular basis, with a range of verbal and physical responses required. • Daily support in regard to routine, establishing and maintaining boundaries, order, structure and routine. • The staff team will require specific accredited training to provide any necessary physical interventions. • MDT/CPA Engagement • Carers will be required to be trained and experienced in intensive interaction, positive behaviour support or similar approaches to maximise communication and meaningful activities.	

	• Care staff are required to demonstrate a range of skills in regard to identification of symptoms relating to mental ill health and deliver required interventions on a day to day basis with the support of the MDT. • Interventions due to hallucinations or delusions have an increasing impact upon the individual requiring proactive monitoring, management of symptomatic relief through management of medication, or direct verbal intervention to reduce distress. • Interventions related to the presence of a moderate to high level of cognitive impairment, including but not limited to re-orientation, use of validation techniques, and the use of appropriate communication methods. • The support of 1 or 2 staff to address some ADLs due to resistive behaviour caused by poor cognition or mental health. • Appropriate assessment and recording of a service user's mental state for use where necessary by the individual, or MDT, the provision of therapeutic interventions as directed by the appropriate professional related to mental ill health. • A care plan that reflects a cyclical presentation requiring staff to adopt an alternative approach dependent upon mood or to address experience of hallucinations or delusions that rarely cause distress. • Intervention due to non-concordance with medication regime and where non-compliance may result in a moderate risk of harm • Reactive intervention including predictors of change in mood to reduce harm or distress. • Interpretation of verbal/non-verbal cues following a clear care plan, with ongoing low moderate risk of unmet needs. • Care staff to demonstrate skill in interaction and communication in alternative forms. **Physical Needs** • Development and implementation of care plans relating to managing mobility, continence, nutritional and tissue viability needs secondary to requirement for support with mental health needs. • Review of moderate levels of pain or other symptoms with a predictable pattern and a moderate effect on health and/or wellbeing • Regular episodes of seizure activity or other altered state of consciousness that require the supervision/ reassurance of a carer or care worker to minimise the risk of harm and the development and implementation of care plans including rescue medication protocols or contacting emergency services	
Band 2c	**The individual may require:** • A skilled regime of care that could relate to: • Ongoing or Recurrent Psychosis with a moderate to high level of acuity	

The CCG would contribute 50% of the care package.	• Psychosis & Affective Disorder with a moderate to high level of acuity Non-Psychotic Chaotic and Challenging Disorders with a low to moderate level of acuity • High Cognitive Impairment • Development and implementation of a care plan including risk management and relapse prevention detailing proactive and reactive interventions related to challenging behaviour or fluctuating mental health on a regular basis, with a range of verbal and physical responses required. • The staff team will require specific accredited training to provide any necessary physical interventions. • MDT/CPA Engagement • Carers will be required to be trained and experienced in intensive interaction, positive behaviour support or similar approach to maximise communication and meaningful activities. • Care staff are required to demonstrate a range of skills in regard to identification of symptoms relating to mental ill health and deliver required interventions on a day to day basis with the support of the MDT. • Hallucinations or delusions, or persistent elation/low mood has an increasing impact upon the individual requiring proactive monitoring, management of symptomatic relief through management of medication, or direct verbal or physical intervention to reduce distress. **Historical ratings that remain relevant to the current plan of care** • Makes verbal/gestural threats, pushes/pesters but no evidence of intent to cause serious harm • Causes minor damage to property • Over-active or agitated behaviours • Superficial cutting, biting, bruising etc. or small ingestions of hazardous substances unlikely to lead to significant harm even if hospital treatment not sought • Illness or behaviour has an impact on the safety or well-being of vulnerable persons. Individual is aware of potential impact but is supported and able to make • adequate arrangements • Difficulties in engagement sometimes missing appointments or contacting services between appointments inappropriately, some understanding of own problems • Concern about the individual's ability to protect their health, safety or well-being requiring support or removal of support would increase concern **Physical Needs** • Development and implementation of care plans relating to managing mobility, continence, nutritional and tissue viability needs secondary to requirement for support with mental health needs.	

	• Complex medication regimes including pain management and other symptom control which requires monitoring and condition can be problematic to manage despite interventions • Regular episodes of seizure activity or other altered state of consciousness unconsciousness (seizures/ transient ischemic episodes, Cerebral Vascular Accident, Vasovagal episodes) that require the supervision/ reassurance of a carer or care worker to minimise the risk of harm and the development and implementation of care plans including rescue medication protocols or contacting emergency services	
Band 2d The CCG would contribute 70% of the care package.	**The individual may require:** A highly skilled and intense regime of care that could relate to: • Ongoing or Recurrent Psychosis with a moderate to high level of acuity • Psychosis & Affective Disorder with a moderate to high level of acuity • Non-Psychotic Chaotic and Challenging Disorders with a high level of acuity • High to Severe Cognitive Impairment • Development and implementation of a proactive care plan including risk management and relapse prevention • Compliance and ongoing monitoring of therapeutic drugs in line with SWY Area Prescribing Committee • Frequent or intense interventions on at least a weekly basis including physical intervention to immediately reduce/remove the risk of harm to self or others. • MDT/CPA engagement • Subject to legal restrictions i.e. CTO • Carers trained and experienced in intensive interaction, positive behaviour support or similar approach to maximise communication and meaningful activities. • Intense therapeutic interaction to interpret need through functional analysis or other tool. • Frequent or intense intervention on a regular or frequent (more that weekly) basis to reduce distress, and maintain safety of self or others **Historical Ratings that remain relevant to the current plan of care** • Agitation or threatening manner causing fear in others • Physical aggression towards people or animals • Destruction of property • Serious levels of elevated mood, agitation, restlessness causing disruption to functioning • Repeat self- injury requiring hospital treatment, possible dangers if not sought but unlikely to leave lasting severe damage if continues providing hospital treatment sought	

	• Illness or behaviour has an impact on the safety and wellbeing of vulnerable persons, however individual has insight and able to take action to reduce the impact with support • Contacts services inappropriately, with little understanding of own problems. Is unreliable attendance at appointments unless prompted and supported • Clear evidence of significant vulnerability affecting the individual to protect their health and safety and well-being, removal of support would increase the risk **Physical Needs** • Development and implementation of care plans relating to managing mobility, continence, nutritional and tissue viability needs secondary to requirement for support with mental health needs. • Complex polypharmacy • Regular episodes of seizure activity or other altered state of consciousness unconsciousness (seizures/ transient ischemic episodes, Cerebral Vascular Accident, Vasovagal episodes) that require the supervision/ reassurance of a carer or care worker to minimise the risk of harm and the development and implementation of care plans including rescue medication protocols or contacting emergency services.	
<u>Band 3</u> The CCG would fully fund the care package	**The individual may require:** A highly skilled and intense regime of care that could relate to: • Psychosis & Affective Disorder with a high to severe level of acuity • Non-Psychotic Chaotic and Challenging Disorders with a high to severe level of acuity • Severe Cognitive Impairment • Development and implementation of an intense and proactive care plan including risk management and relapse prevention • Compliance and ongoing monitoring of therapeutic drugs in line with SWY Area Prescribing Committee • Frequent or intense interventions on at least a daily basis including physical intervention to immediately reduce/remove the risk of harm to self or others. • MDT/CPA engagement and involvement with MAPPA • Carers trained and experienced in intensive interaction, positive behaviour support or similar approach to maximise communication and meaningful activities. • Intense therapeutic interaction to interpret need through functional analysis or other tool. • Frequent or intense intervention on a regular or frequent (more than weekly) basis to reduce distress, and maintain safety of self or others. • Subject to legal restrictions i.e. CTO	

	• Requirement for enhanced observation levels on a consistent basis to reduce immediate risk and maintain safety. **Historical Ratings that remain relevant to the current plan of care** • Agitation or threatening manner causing fear or harm caused to persons or others • Seriously intimidating others or exhibiting highly obscene behaviour • Elevated mood, agitation, restlessness causing complete disruption • Major destruction of property • Repeated serious self-injury requiring hospital treatment, lasting severe damage if continues • Without action illness or behaviour likely to have significant impact on safety or well-being of vulnerable persons • Contacts multiple agencies constantly with little or no understanding of problems. Fails to comply with planned care, misses appointments and refuses service input • Severe vulnerability – total breakdown in individuals ability to protect themselves resulting in major risk • Severe alcohol or substance misuse. **Physical Needs** • Development and implementation of care plans relating to managing mobility, continence, nutritional and tissue viability needs secondary to requirement for support with mental health needs. • Regular episodes of seizure activity or other altered state of consciousness unconsciousness (seizures/ transient ischemic episodes, Cerebral Vascular Accident, Vasovagal episodes) that require the supervision/ reassurance of a carer or care worker to minimise the risk of harm and the development and implementation of care plans including rescue medication protocols or contacting emergency services • Complex medication regimes including pain management and other symptom control which requires monitoring and condition can be problematic to manage despite interventions	

APPENDIX 4

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

JOINT SECTION 117 AFTERCARE COMMISISONING PANEL

INTRODUCTION

Section 117 Mental Health Act 1983 (MHA 1983) imposes duties on NHS Clinical Commissioning Groups (CCGs) and Local Social Services Authorities (LSSAs) to provide After-care for patients who have been detained under section 3, 37, 45A, 47 and 48 of the MHA 1983 once they leave hospital.

The 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 Section 117 Mental Health Act After-care. Policies should set out clearly the criteria for deciding which services fall under section 117 Mental Health Act and which authorities should finance them. The Section 117 Mental Health Act After-care plan should indicate which services are provided as part of the plan'.

PURPOSE

The purpose of the section 117 Commissioning Panel is to ensure that there is a consistent approach within Rotherham Local Authority and Rotherham Clinical Commissioning Group to:

- Inform the decision-making and commissioning of care under section 117
- Make funding decisions for all specialist provisions and complex high cost care packages
- Ensure that individuals whose circumstances change are reviewed and funded appropriately
- Ensure that individuals who no longer require services have their entitlement reviewed and where appropriate ended
- To ensure that all discussion and decisions made at meetings are accurately recorded

TERMS OF REFERENCE FOR SUBMISSION TO COMMISSIONING PANEL

All staff/Lead Professional are required to complete relevant documentation which should be informed by the Joint s.117 policy. Submissions to the Panel are required 3 working days prior to panel date via ……. (admin support/ E Mail).

Documents required for Panel are:

- Summary Sheet
- Statement of Need
- Section 117 Funding Matrix
- Supporting evidence (ABC behaviour, incident reports/daily narratives etc)

It is the responsibility of the lead professional to ensure the documentation is accurate and the case has been fully discussed with their line manager prior to submission

The s.117 commissioning panel will meet on a weekly basis.

PANEL MEMBERSHIP

Strategic Lead MH (Local Authority)

CCG Section 117 Strategic Manager

Team Manager (Local Authority)

CCG Section 117 Lead

Administration Support

- Receive and circulate funding request documentation
- Record outcome and inform relevant parties
- File documentation

DISPUTE RESOLUTION

If the commissioning panel are unable to come to agreement on the proportional funding split then the case will be escalated to RMBC Head of Service and CCG Deputy Chief Nurse/Designated Nurse Safeguarding and Looked After Children for resolutions,

COMPLAINTS

Any complaints regarding section 117 after-care will be dealt with within the usual complaint's procedures of the respective organisations which are party to this guidance. Complaints should be sent to the relevant organisation responsible for dealing with the specific issue.

APPENDIX 5

MENTAL HEALTH ACT (1983) SECTION 117

Pre-Discharge Meeting Record

The planning of aftercare needs to start as soon as the patient is admitted to hospital. Health and Social Care Services should take reasonable steps to identify appropriate aftercare services for patients before their actual discharge from hospital.

Code of Practice Mental Health Act 1983.

Name:	Date of Birth:
NHS Number:	LAS Number:
Address:	GP: Practice:

Specify reason for original detention

Section 117 pre-discharge review	Tick as attended

Date of meeting/review:		
Attended by (give names)		
Patient:		
Carer/Family:		
Advocate:		
Named Nurse:		
Care Coordinator:		
RC:		
Social Services Representative (Social Worker):		
GP:		
Others:		

Outline of s117 aftercare plan

Copies to: (tick)	Consultant	Care Coordinator	Social Worker
MHA Admin.	Patient	Carer	G.P.
Others (name)			

APPENDIX 6

MENTAL HEALTH ACT (1983) SECTION 117 Record of Review SECTION 117 Review			
Name		**LAS Number**	
DOB		(*please attach this plan to copy of Section 117 review paperwork for outcome of the review)*	

	Diagnosis & medication
1	
2	**Psychiatric History** (please include the applicable section and date eligibility commenced)
3	**What are the section 117 elements under review?**
	Does the current identified section 117 care plan continue to meet the service user's needs and remain appropriate?

4	
5	**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 their mental disorder?**
6	**What impact would it have on the service user if section 117 aftercare services were withdrawn?**
7	**Are there any identified changes to the current service provision as a result of this review?** Yes ☐ please provide details below No ☐ move on to next question

8	**Service user/carer's views.**
9	**Recommendations:**

Name (print)		**Date**	

Signed		**Designation**	

Next review date	

MENTAL HEALTH ACT (1983) SECTION 117

Record of Review

This form is completed following the s117 review

The duty to provide aftercare services exists until both the CCG (through delegated authority to the Provider Trust) and the LSSA (Social Services) are satisfied that the patient no longer requires them. This decision will vary from person to person according to the nature of services provided but is likely to be at a time when the person's mental health has improved to the point where they no longer need services because of their mental disorder. ***Code of Practice Mental Health Act 1983.***

Name:	Date of Birth:
NHS Number:	LAS Number:
Address:	GP.
	Practice:

Section 117 review record		Tick as attended
Date of review:		
Attended by (give names)		
Patient:		
Carer/Family:		
Advocate:		

Care Coordinator:	
RC:	
Social Services Representative:	
GP.:	
Others:	

The s117 review has agreed that the patient is to continue to receive aftercare services under s117 of the Mental Health Act.

Signed…… Care Coordinator

Copies to: (tick)	File	Consultant	G.P.
MHA Admin.	Patient	Carer	Care Coordinator
Others (name)			

Please ensure copies of this form are submitted to the MHA Administration office within 2 weeks of decision in order to ensure s117 status on Maracis is recorded.

S117 Form B – Pre-discharge Meeting Record

APPENDIX 7

MENTAL HEALTH ACT (1983) SECTION 117

Record of Decision to End

This form is completed when it is agreed that a person with s117 (MHA) status no longer requires aftercare.

The duty to provide aftercare services exists until both the CCG (through delegated authority to the Provider Trust) and the LSSA (Social Services) are satisfied that the patient no longer requires them. This decision will vary from person to person according to the nature of services provided but is likely to be at a time when the person's mental health has improved to the point where they no longer need services because of their mental disorder.

Code of Practice Mental Health Act 1983.

Name:	Date of Birth:
NHS Number:	LAS Number:
Address:	GP.
	Practice:

Section 117 review record		Tick as attended
Date of review:		
Attended by (give names)		
Patient:		
Carer/Family:		
Advocate:		

Care Coordinator:	
RC:	
Social Services Representative:	
GP.:	
Others:	
Reason for decision to end section 117 Aftercare	

Certificate of agreement to end s117 (MHA) aftercare		
Signed on behalf of the LSSA (Social Services)	Sign Print	Date: Designation
Signed on Behalf of the CCG	Sign Print	Date Designation
Ratified by Joint 117 Commissioning Panel	Sign	Date

	Print	

Copies to: (tick)	File	Consultant	G.P.
MHA Admin.	Patient	Carer	Care Coordinator
Others (name)			

Please ensure copies of this form are submitted to the Section 117 Joint Commissioning Panel to ensure that the decision to end s.117 aftercare is ratified and recorded.