Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

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- Added definition of after-care following amendments to the MHA 1983 by the Care Act 2014
- Added the requirements of the MHA Code of Practice (revised 2015)
- Identifying responsible After-care Bodies
- IMHA and IMCA referrals
- After-care and Deprivation of Liberty
- Care planning requirements
- Ending section 117
- Guidance note added by Bevan Britten on s117 (Appendix B)

Originator

Originated By: Mental Health Law Manager

Designation: On behalf of the Mental Health Law Scrutiny Group

Equality Analysis Assessment (EAA) Process

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Review

Review Date: November 2018

Responsibility of: Mental Health Law Manager

Designation: On behalf of the Mental Health Law Scrutiny Group

An e-copy of this policy is sent to all wards and departments (Trust Policy Pack Holders) who are responsible for updating their policy packs as required.

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 5th February 2016

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GUIDING PRINCIPLES

It is essential that all those undertaking the functions under the Mental Health Act 1983 (MHA) understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act.

The five overarching principles are:

Least restrictive option and maximising independence
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Empowerment and involvement
Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Respect and dignity
Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness
Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity
Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Staff must apply all the principles to all decisions. All decisions must be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998 (HRA) and Equality Act 2010. All five sets of principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.

Any decision to depart from the directions of the policy and the Code of Practice must be justified and documented accordingly in the patient's case notes. Staff should be aware that there is a statutory duty for these reasons to be cogent and appropriate in individual circumstances.

MENTAL HEALTH ACT 1983
SECTION 117 POLICY

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1. Introduction and Aim

> Section 117(2) of the Mental Health Act states:
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> *"It shall be the duty of the [clinical commissioning group or] [Local Health Board] and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the [clinical commissioning group or] [Local Health Board] and the local social services authority are satisfied that the person concerned is no longer in need of such services[; but they shall not be so satisfied in the case of a [community patient while he remains such a patient.]".*

1.1 Section 117 of the Mental Health Act (1983) (MHA) requires clinical commissioning groups (CCGs) and local authorities, in co-operation with voluntary agencies, to provide or arrange for the provision of after-care to patients detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Act who then cease to be detained. This includes patients granted leave of absence under section 17 and patients going on community treatment orders (CTOs). It applies to people of all ages, including children and young people.

1.2 After-care is a vital component in patients' overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital.

1.3 The responsible after-care bodies are required to arrange or provide after-care services 'in cooperation with relevant voluntary agencies'. CCGs will, and local authorities may, commission services from other people and organisations instead of providing services themselves.

1.4 The aim of this policy is to:

- Ensure staff understand the legal requirements relating to After-care duties and planning
- Encourage participation and respect of patient's rights particularly relating to After-care services
- Ensure a clear escalation process for issues relating to After-care to avoid unreasonable delays for patients and to maintain an efficient service for all those subject to After-care

2 Terminology, Definitions and Scope of Policy

2.1 After-care services are defined in the Act to mean services which have both of the following purposes: meeting a need arising from or related to the person's mental disorder; and 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.

2.2 CCGs and local authorities should interpret the definition of after-care services broadly. For example, after-care can encompass healthcare, social care and employment services, supported accommodation and services to meet the person's wider social, cultural and spiritual needs, if these services meet a need that arises directly from or is related to the particular patient's mental disorder, and help to reduce the risk of a deterioration in the patient's mental condition.

2.3 After-care is a vital component in patients' overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital.

2.4 Section 117 will only apply to the following individuals;

- Patients detained under Section 3, 37, 45A, 47 or 48 who are discharged from detention and leave the hospital.

- Patients subject to Guardianship if they were previously detained on Section 3 or 37.

- Patients under Section 3, 37, 47 and 48 who are given leave of absence under Section 17.

2.5 Patients under Section 3, 37, 47 and 48 who are made subject to Section 17A - Community Treatment Order. Eligibility continues after discharge from Section 17A in the same way it would for a Section 3 patient.
This is not age specific and Section 117 applies to children and older people.

2.6 Where eligible patients have remained in hospital informally after ceasing to be detained under the Act, they are still entitled to after-care under section 117 once they leave hospital. This also applies when patients are released from prison, having spent part of their sentence detained in hospital under a relevant section of the Act.

2.7 The duty to provide after-care services continues as long as the patient is in need of such services. In the case of a patient on a CTO, after-care must be provided for the entire period they are on the CTO, but this does not mean that the patient's need for after-care will necessarily cease as soon as they are no longer on a CTO.

2.8 This policy applies to all staff working for and on behalf of Pennine Care NHS Trust, including agency workers and staff working in the specialist mental health service employed by other agencies e.g. Social Services

2.9 Within this policy we use the terms 'must' and 'should' and they are to be interpreted in the following way;

- Must – 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 you comply with the policy.

2.10 Staff are expected to escalate concerns to their line managers with the application of this policy and the practical requirements or processes contained within.

2.11 The term patient has been used throughout this policy although it is accepted other terminology may be appropriate such as service user.

3 Responsible After-care Bodies

3.1 The duty to provide or arrange for the provision of after-care services under section 117 stands by itself. It is not a duty to provide or arrange for the provision of services under other legislation (eg the Care Act 2014 or the NHS Act 2006). As a result, normal rules about NHS commissioning responsibility or ordinary residence only apply to the extent specified in section 117 and regulations made under the section.

3.2 The Act says that the responsible after-care bodies are the local authority and the CCG, or local health board, where relevant: a) for the area in which the person was ordinarily resident immediately before being detained, or b) if the person was not ordinarily resident in England or Wales immediately before being detained, for the area in which the person is resident or to which he is sent on discharge by the hospital in which he was detained.

3.3 If there is a dispute between local authorities in England about where the person was ordinarily resident immediately before being detained, this will be determined by the process set out in section 40

of the Care Act 2014.

3.4 The NHS body responsible for after-care will be the NHS in the area where the patient is registered with a GP, unless the patient moves to a new area when they leave hospital. If the patient is not registered with a GP, then the NHS in the area where the usually live will be responsible for after-care[1].

3.5 Mental health after-care services must be jointly provided or commissioned by local authorities and CCGs. They should maintain a record of people for whom they provide or commission after-care and what after-care services are provided. Services provided under section 117 can include services provided directly by local authorities or which local authorities commission from other providers. CCGs will commission (rather than provide) these services.

3.6 The NHS Commissioning Board (NHS England) is responsible for a patient's after-care if the after-care services required are of the type that the NHS Commissioning Board would be responsible for commissioning rather than a CCG. In these circumstances local authorities and CCGs should liaise with the NHS Commissioning Board to ensure these services are commissioned promptly.

3.7 Decisions regarding residence may often be complex and for this reason legal advice should be sought via the Mental Health Law offices, which will escalate issues to the Mental Health Law Manager when necessary.

3.8 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.

4. Approach to After-care

4.1 Although the duty to provide after-care begins when the patient leaves hospital, the planning of after-care needs to start as soon as the patient is admitted to hospital. CCGs and local authorities should take reasonable steps, in consultation with the care programme approach care co-ordinator and other members of the multi-disciplinary team to identify appropriate after-care services for patients in good time for their eventual discharge from hospital.

4.2 Before deciding to discharge or grant more than very short-term leave of absence to a patient or to place a patient onto a CTO, the

[1] **NHS England: Who Pays? (August 2013)**

responsible clinician should ensure that the patient's needs for after-care have been fully assessed, discussed with the patient (and their carers, where appropriate) and addressed in their care plan. If the patient is being given leave for only a short period, a less comprehensive review may be sufficient, but the arrangements for the patient's care should still be properly recorded.

4.3 After-care for all patients admitted to hospital for treatment for mental disorder should be planned within the framework of the care programme approach (see chapter 34 of the MHA Code (2015) and the Trust policy on CPA (CL3)).

4.4 This applies whether or not they are detained or will be entitled to receive after-care under section 117 of the Act. But because of the specific statutory obligation it is important that all patients who are entitled to after-care under section 117 are identified and that records are kept of what is provided to them under that section.

4.5 In order to ensure that the after-care plan reflects the full range of needs of each patient, it is important to consider who needs to be involved, in addition to patients themselves (see paragraph 3.8).

4.6 A failure to implement discharge planning within a reasonable time may be in breach of Article 5 of the European Convention of Human Rights, and consequently the Human Rights Act 1998. Staff must take all practicable steps to avoid delay and document reasons and evidence within the patient records.

5. After-care and Deprivation of Liberty

5.1 After-care arrangements cannot amount to a deprivation of liberty, unless this is authorised under the Mental Capacity Act 2005. In its Cheshire West judgment, the Supreme Court clarified that there is a deprivation of liberty in circumstances where a person is under continuous control and or supervision, is not free to leave and lacks capacity to consent to these arrangements. The Supreme Court also noted that factors which are not relevant in determining whether there is a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind a particular placement. The relative normality of the placement (whatever the comparison made) is also not relevant. A deprivation of liberty in relation to a person who lacks capacity may be authorised by an authorisation under Schedule A1 to the Mental Capacity Act 2005 or a Court of Protection order. Please contact your local Mental Law office for further advice.

6. After-care Payments

6.1 A local authority may make direct payments to pay for after-care services under section 117 of the Act.2 An adult who is eligible for after-care can request the local authority to make direct payments to

them, if they have capacity to do this. If the adult lacks capacity to do so, the local authority can make direct payments to an authorised person or suitable person if certain conditions are met. A key condition is that the local authority must consider that making the direct payments to the 'authorised person' is an appropriate way to discharge their section 117 duty, and that they must be satisfied the 'authorised person' will act in the adult's best interests in arranging for the after-care.

6.2 If a local authority is providing or arranging accommodation as part of a patient's after-care, the patient and/or friends or relatives identified in regulations may make top-up payments to enable the patient to live in their preferred accommodation if certain conditions are met.

6.3 A CCG or the NHS Commissioning Board may also make direct payments in respect of after-care to the patient or, where the patient is a child or a person who lacks capacity, to a representative who consents to the making of direct payments in respect of the patient. A payment can only be made if valid consent has been given. In determining whether a direct payment should be made, a CCG or the NHS Commissioning Board is required to have regard to whether it is appropriate for a person with that person's condition, the impact of that condition on the person's life and whether a direct payment represents value for money. A payment can also, in certain circumstances, be made to a nominee.

6.4 Personalised social care should be offered in the same way as patients not eligible for Section 117. 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.

7 After-care Planning

7.1 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 after-care 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.

7.2 When completing plans for after-care staff should ensure they distinguish between those items of care and support that relate to mental health needs and are provided free of charge and the items relating to physical health needs (which are entirely unconnected to the mental health needs) which may be subject to charge by the local social services authority.

7.3 When setting up after care planning meetings for detained patient's staff should offer the patient a referral to the Independent Mental Health Advocate Service. The use of advocacy is encouraged by the Trust and offers an additional safeguard and evidence of the patient's involvement in planning future care. Referrals can be made directly or via the Mental Health Law office.

7.4 A care planning meeting should be held;

- Prior to authorisation of Section 17 leave
- A community treatment order being considered
- A Tribunal hearing or hospital managers hearing is planned
- Discharge from hospital is being considered and implemented

7.5 When considering relevant patients' cases, the Tribunal and hospital managers will expect to be provided with information from the professionals concerned on what after-care arrangements might be made if they were to be discharged. Some discussion of after-care arrangements involving local authorities, other relevant agencies and families or carers (where appropriate) should take place in advance of the Tribunal hearing.

7.6 Where a Tribunal or hospital managers' hearing has been arranged for a patient who might be entitled to after-care under section 117 of the Act, the hospital managers should ensure that the relevant CCG and local authority have been informed. The CCG and local authority should consider putting practical preparations in hand for after-care in every case, but should in particular consider doing so where there is a strong possibility that the patient will be discharged if appropriate after-care can be arranged. Where the Tribunal has provisionally decided to give a restricted patient a conditional discharge, the CCG and local authority should do their best to put after-care in place which would allow that discharge to take place.

7.7 In order to ensure that the after-care plan reflects the needs of each patient, it is important to consider who needs to be involved, in addition to patients themselves This meeting should be initiated by the Responsible Clinician and may, subject to the patient's views include the following people: -

- nurses and other professionals involved in caring for the patient in hospital
- a practitioner psychologist registered with the Health and Care Professions Council, community mental health nurse and other members of the community team
- Care Co-ordinator
- the patient's general practitioner (GP) and primary care team (if there is one). (It is particularly important that the patient's GP should be aware if the patient is to go onto a community

treatment order (CTO). A patient who does not have a GP should be encouraged and helped to register with a practice
- any carer who will be involved in looking after them outside hospital (including, in the case of children and young people, those with parental responsibility)
- the patient's nearest relative (if there is one) or other carers
- a representative of any relevant voluntary organisations
- in the case of a restricted patient, multi-agency public protection arrangements (MAPPA) co-ordinator
- in the case of a transferred prisoner, the probation service
- a representative of housing authorities, if accommodation is an issue
- an employment expert, if employment is an issue
- the clinical commissioning group's appointed clinical representative (if appropriate)
- an independent mental health advocate, if the patient has one
- an independent mental capacity advocate, if the patient has one
- the patient's attorney or deputy, if the patient has one
- a person to whom the local authority is considering making direct payments for the patient
- any another representative nominated by the patient, and anyone with authority under the Mental Capacity Act 2005 (MCA) to act on the patient's behalf.

7.8 Although the duty to provide after-care begins when the patient leaves hospital, the planning of after-care needs to start as soon as the patient is admitted to hospital. CCGs and local authorities should take reasonable steps, in consultation with the care programme approach care co-ordinator and other members of the multi-disciplinary team to identify appropriate after-care services for patients in good time for their eventual discharge from hospital. The Code of Practice (4.33) 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. The Mental Health Law office should also be informed at the earliest possible opportunity to allow for support and planning regarding the patients detention papers.

7.9 Pennine Care and Social Services must take reasonable steps to ensure the identification of appropriate after-care facilities and services for the patient before his/her actual discharge from hospital, and for CCGs and local authorities, the actual cost of such service provision. Where there are funding panels or similar in operation these need to be taken into account, and timescales planned accordingly. In some cases it will be important to involve local authority and CCG/NHS commissioning managers at an early stage. Again, where external services need to be commissioned this is the responsibility of the local authority and the CCG.

7.10 It is important that those who are involved are able to make decisions regarding their own, and as far as possible, their agencies' involvement, including a commitment to single agency or joint funding.

7.11 At the meeting, an appropriate Care Plan needs to be formulated based on a risk assessment and clearly identified needs, including: -

Care planning requires a thorough assessment of the patient's needs and wishes. It is likely to involve consideration of:

- continuing mental healthcare, whether in the community or on an outpatient 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, eg 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
- involvement of authorities and agencies in a different area, if the patient is not going to live locally
- the involvement of other agencies, eg 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 – or is likely to – impose on their conditional discharge, and
- contingency plans (should the patient's mental health deteriorate) and crisis contact details.
- a treatment plan which details medical, nursing, psychological and other therapeutic support for the purpose of meeting individual needs promoting recovery and/or preventing deterioration.
- details regarding any prescribed medications
- details of any actions to address physical health problems or reduce the likelihood of health inequalities

7.12 Care planning should take particular account of the patient's age. Where the patient is under the age of 18 the responsible clinician and the care co-ordinator should bear in mind that the most age-appropriate treatment should be that provided by a child and adolescent mental health service (CAMHS). It may also be necessary to involve the patient's parent, or whoever will be responsible for

looking after the patient, to ensure that they will be ready and able to provide the assistance and support which the patient may need (see also MHA Code (2015) paragraphs 19.6 – 19.10 and 19.90 – 19.104). Similarly, specialist services for older people

7.13 The wishes and views of the patient and those of any carers should be taken into account, and a carers' assessment should be offered.

7.14 Before or at the meeting, a Care Co-ordinator must be identified together with all key people with specific responsibilities with regard to the patient. It will be the responsibility of the Care Co-ordinator to arrange/review of the Care Plan until it is agreed that it is no longer necessary. The Care Co-ordinator may be appointed dependant upon qualification according to the balance of need, and their relationship with the patient. Where the only service to be provided on discharge is through outpatient appointments with a psychiatrist then the psychiatrist discharges care co-ordinator duties (as set out in the CPA policy).

7.15 The outcome of the meeting must be fully recorded and circulated to all members of the Multi-Disciplinary Team. Minutes of the meeting should include clearly identified objectives of the after-care services proposed. Timescale for review should not be more infrequent than six monthly, other than in exceptional circumstances. The meeting should also record agreement as to the appropriate circumstances and arrangements for discharge from Section 117, including where possible, an anticipated date of discharge. However, after care services should not be discontinued while the patient remains in need of them.

7.16 If the Multi-Disciplinary Team identify that there is no specific need for Section 117 services to be provided, there still may be a duty under the NHS Continuing Health Care or the Care Act 2014 for other services to be provided and or under any other community care legislation. This would be the case if the care to be provided was not to satisfy the purpose of Section 117 but was, for example, services to meet needs not arising from the mental health condition of the patient. Services that are continued from prior to admission under the MHA would constitute services under s117 if they were to meet needs arising from the mental health needs of the patient, but not otherwise. The s117 Care Plan format provides for the separate identification of s117 provision and non-117 provision.

7.17 If it comes to the attention of Community Mental Health Teams that a person is to be discharged from detention under the MHA without a Section 117 meeting, then the appropriate Team Manager should contact the appropriate Service Manager to discuss this if they are concerned that a discharge to the community will be effected without adequate after-care being in place.

7.18 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.

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

8.1 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.

8.2 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 after-care 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 after-care plan is implemented.

8.3 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.

9. Charging For Section 117 After-Care Services

9.1 No charge may be levied for services provided under Section 117. It is important, therefore, that a patient's Section 117 status is kept under constant review. The restriction on charging applies to both the local authority and the NHS. After-care patients are exempt from charges for prescriptions that arise from psychiatric treatment, although liable for prescription charges for medications prescribed for non-psychiatric purposes. Local MHL Forums should ensure local issues / processes for this are in place. Issues with local pharmacists should be taken to the MHL Forum for resolution.

9.2 The duty to provide after-care services is not broken by a patient's subsequent re-admission to hospital for assessment under Section 2. Similarly, the fact that a patient has either been granted a leave of absence under Section 17 of MHA, or transferred from detention under

section 3 to guardianship under the provisions of Section 19, does not affect a patient's entitlement to receive services under Section 117.

9.3 If at the Multi-Disciplinary Ward meeting or subsequent reviews of the Care Plan, it is agreed that the Local Authority does not have a role in meeting the needs of the patient, that patient may nevertheless continue to receive after-care from the NHS and other agencies. If subsequently, the person is re-referred by the key worker to the Local Authority due to a change in the patient's needs, then the patient will remain exempt from charges during the period when the Section 117 applies, i.e. unless and until a meeting or arrangement on the discharge form records that neither health or local authority elements of Section 117 after-care are required.

9.4 Pennine Care NHS Trust and Social Services staff need to be clear that where the services that a person is receiving are not being provided for the purposes of meeting a need arising from or related to the patient's mental disorder and reducing the risk of a deterioration of the patient's mental condition (and, accordingly, reducing the risk of the patient requiring admission to hospital again for treatment for mental disorder, then these services should be deemed to be provided under other community care legislation and as such subject to the usual financial assessment and charging.

9.5 Appendix C provides more detailed guidance with regard to the care co-ordination of local authority services, and Appendix D is a form for recording when elements of a care package are ended. CPA documentation incorporates a s117 Care Plan format.

9.6 Third Party Funded Top Ups

9.6.1 Where a preferred placement is identified that exceeds the local authorities usual rate and where an alternative is available they are entitled to decline to fund any excess amount. The patient is entitled to proceed with the preferred placement if a source of funding is identified to make up the difference.

10 NHS Continuing Health Care

10.1 The National Framework for NHS Continuing Healthcare clarifies and supports consistency in the determination of eligibility for NHS Continuing Healthcare and NHS Funded Nursing Care. Section 117 is a freestanding duty that is distinct from the CCGs general obligation to provide health services.

10.2 Paragraphs 120 to 122 of the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care (November 2012 (revised)) states:

120. Responsibility for the provision of section 117 services lies jointly with LAs and the NHS. Where a patient is eligible for services under section 117 these should be provided under section 117 and not under

NHS continuing healthcare. It is important for CCGs to be clear in each case whether the individual's needs (or in some cases which elements of the individual's needs) are being funded under section 117, NHS continuing healthcare or any other powers, irrespective of which budget is used to fund those services.

121. There are no powers to charge for services provided under section 117, regardless of whether they are provided by the NHS or LAs. Accordingly, the question of whether services should be 'free' NHS services (rather than potentially charged-for social services) does not arise. It is not, therefore, necessary to assess eligibility for NHS continuing healthcare if all the services in question are to be provided as after-care services under section 117.

122. However, a person in receipt of after-care services under section 117 may also have ongoing care/support needs that are not related to their mental disorder and that may, therefore, not fall within the scope of section 117. Also a person may be receiving services under section 117 and then develop separate physical health needs (e.g. through a stroke) which may then trigger the need to consider NHS continuing healthcare only in relation to these separate needs, bearing in mind that NHS continuing healthcare should not be used to meet section 117 needs. Where an individual in receipt of section 117 services develops physical care needs resulting in a rapidly deteriorating condition which may be entering a terminal phase, consideration should be given to the use of the Fast Track Pathway Tool.

11 Discharge/Ending Section 117 After-care

11.1 The duty to provide after-care services exists until both the CCG and the local authority 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. If these services included, for example, care in a specialist residential setting, the arrangements for their move to more appropriate accommodation would need to be in place before support under section 117 is finally withdrawn. 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.

11.2 After-care services under section 117 should not be withdrawn solely on the grounds 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 MCA
- the patient has returned to hospital informally or under section 2, or
- the patient is no longer on a CTO or section 17 leave.

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

11.4 Even when 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.10.4 In following the procedures relating to joint assessment, care planning and review, staff should be clear about the provision of each element of the after care package. Making the discharge care plan clear and specific is essential to the future process of 'ending' s117 provisions. Section 117 after-care elements of the care plan need to be clearly identified as such. AThe purpose of any after-care service (regardless of s117 status)is to equip a patient to cope with life outside hospital and to function there successfully without danger to him/herself or to other people. Different elements of this provision may be ended at different times. If and when there are no services being provided under Section 117, the service user will then be subject to the Local Authority charging policy. Again the Care Co-ordinator must ensure those responsible for administering the charging policy are notified.

11.5 Any services provided continue to be in place until both agencies are jointly satisfied that they are no longer needed. In practice this means that a patient who continues to be subject to the Care Programme Approach or equivalent care system and is receiving specialist services from the NHS and local authority will remain eligible to Section 117;

11.6 Where progress is such that specific elements of the care package are no longer essential = for the purposes of meeting a need arising from or related to the patient's mental disorder and reducing the risk of a deterioration of the patient's mental condition (and, accordingly, reducing the risk of the patient requiring admission to hospital again for treatment for mental disorder, these should be reviewed and formally recorded as being no longer provided under Section 117. Such services may be provided under other legislation to help people with mental health problems to live, with care or support, in the community.

11.7 It is therefore essential that a client's Section 117 status, and after-care plan, is regularly reviewed and accurately recorded by the allocated Care Co-ordinator. Decisions to discontinue the provision of <u>elements</u> of a care package under Section 117 must be made with reference to the client, carer, and multi-disciplinary team. (See Appendix C).

11.8 Staff should be aware that people who have incorrectly had to pay for services are entitled to reclaim costs plus interest. Removal of Section 117 cannot be completed retrospectively and where assessments to end Section 117 have been completed but there exists doubt or challenge to their validity then restitution can be done until more robust assessments are carried out.

11.9 In respect of the ending of Section 117 and cases before the courts they have noted that it would be difficult in practice to foresee discharges being possible when the patient suffers from a progressive illness such as dementia.

11.10 In determining whether Section 117 can be discharged staff should focus upon whether removal of the service i.e. residential placement or support, would mean they are at risk of readmission. Whether or not the patient is settled or engaging with the service is irrelevant to the decision to end Section 117.

11.11 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?

11.12 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.

11.13 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

12 Review and Monitoring

12.1 Community visits by the Care Co-ordinator must be related to the person's identified needs, but a minimum level of visiting must be agreed upon at the Initial Care Plan meeting although it is likely this will change and fluctuate depending on the on-going needs of the person at the time. All the visits must be recorded.

12.2 Reviews should be held either when the objectives in the Care Plan are achieved, or within the Review timescale whichever is sooner. Reviews should involve members of the Multi-Disciplinary Team, the patient, their relatives/carer and advocate.

12.3 If the person is unable or unwilling to abide by the Care Plan, then monitoring arrangements should be agreed. Any potential difficulties with implementation of the Care Plan should be noted at the initial Care Plan meeting and any subsequent reviews highlighting specific risk factors.

12.4 Any changes in behaviour, deterioration in health, or difficulties with the Care Plan should be investigated and discussed with members of the Multi-Disciplinary Team, and a review held if necessary.

13. Departmental Records

13.1 It is the responsibility of the Care Co-ordinator to ensure that it is properly recorded on the basic details of the client's record that they are entitled to Section 117 services, and to complete the form indicating the ending of s117 duties (by both the local authority and the Trust, and passing this to the mental health law administrator in their borough).

13.2 In some cases where services are only or primarily being provided by or on behalf of the local authority, care responsibility may be passed to a non-specialist review team. In such cases it falls to that team to discharge the duties of care co-ordinator as outlined in this policy, including identifying and recording the ending of local authority s117 responsibilities.

14. Implementation

14.1 Most staff 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.

14.2 Decisions and action taken with regard to 117 status should be incorporated within the CPA process and will be incorporated into the CPA training.

14.3 Recording of s117 status and the ending of it takes place on forms attached to this policy and is administered by the Mental Health Law Administrators.

14.4 All Mental Health Law offices maintain and distribute a list of patients subject to Section 117 at least twice yearly. This can be accessed at any time by contacting the Mental Health Law Office directly.

15. Responding to concerns raised by the patient's carer or relative

15.1 Carers and relatives may contact staff when they are concerned with either the services provided or the appropriateness of services for the patient. The team responsible for the patient needs to give due weight to those concerns and any requests made by the carers in deciding what action to take. Carers are typically in much more frequent contact with the patient than professionals, even under well-run care plans.

15.2 Any concerns must be evidenced in health or social care records and acted upon by the care co-ordinator in line with CPA policy.

15.3 In the case of patients detained under part 3 of the Act, people with a valid interest may include victims and the families of victims (see victim policy).

15.4 If the concern is regarding services provided staff should refer to the Complaints policy for guidance.

16 Implementation Plan

16.1 This policy will be issued and implemented to staff to ensure employees have access to and are able to comply with the processes within by way of;

- Lists of all new policies are published in the Trust's Corporate Brief including a brief description and its intended audience.
- All policies are held on the Trusts intranet to which all staff have access. Staff should always consult the intranet for the latest version available.
- Ward and Clinical areas should have the latest version on file and the responsibility for monitoring this is the Ward Manager / Team Leader.
- The Mental Health Law Manager is responsible for distributing the latest version of this policy through the existing governance structures to healthcare professionals
- Ward Managers / Team Leaders are responsible for cascading details of the policy to staff they supervise.
- All employees are responsible for ensuring they understand the contents of this policy and associated procedures and act accordingly.

Appendix A

DISCHARGE FROM SECTION 117 AFTER-CARE SERVICES

A Section 117 Aftercare Review Meeting for: (Patients Name)	Was Held On: (Date)

We are satisfied that the patient is no longer in need of Section 117 services as specified below.

The patient was therefore discharged from those after-care services (s.117 of the Mental Health Act 1983)

Give reasons leading to the above decision

Are they any remaining after-care services being delivered under s117?

Yes ☐ No ☐

Signed		Print Name	
On behalf of Pennine Care NHS Foundation Trust		Title	
Signed		Print Name	
On behalf of Local Authority		Title	

Copies of this form must be sent to the Mental Health Law Office and everyone involved in the patients after-care

APPENDIX B

S.117 BRIEFING NOTES

AFTER-CARE 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 after-care.

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 and who will be responsible for delivering this?

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;
- Care Co-ordinator
- 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
- Any safeguarding issues

Step Two – Determine which are After-care 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 "after-care needs" and listing any after-care 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 after-care 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 after-care 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 after-care need or a general need. An assessed s.117 after-care need could have a service provided by a primary healthcare organisation. Equally, a general/common need could be addressed by a primary mental health service.

The Courts have been very clear that the nature and extent of services required to meet assessed after-care 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 after-care needs, the Courts will be reluctant to interfere with the exercise of professional discretion.

Overall, does the patient have any s.117 after-care 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 after-care services have been identified, the clinical team needs to set out *which* of the after-care services could be met by the Trust (and how) and which after-care services require bespoke commissioning.

Consultation

The care co-ordinator should take the lead in any s.117 after-care reviews. That being said, it is imperative that the clinical/care 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 after-care 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 after-care needs and general health/social care/common needs and identifying appropriate services to meet assessed needs.

Reference:

Bevan Brittain LLP Briefing Note S117
https://www.bevanbrittan.com/insights/articles

APPENDIX C

LOCAL AUTHORITY MENTAL HEALTH SERVICES

CARE CO-ORDINATOR GUIDELINES WHEN CARE MANAGING

SECTION 117 CASES PROCEDURE

1. SOCIAL SERVICES FUNDING PANEL CASES; RESIDENTIAL/NURSING

1.1 It will be the responsibility of the Care Co-ordinator to indicate on the relevant panel pro-forma if a potential placement will be subject to Section 117.

1.2 Once an application is approved it will be the Care Co-ordinator's responsibility in conjunction with Contracts Section to indicate on the "Contract" that a placement is subject to Section 117. The Contracts Officer will then be sent a copy of this contract so that their Section 117 list can be updated and a revised copy sent to finance.

1.3 If a client is reviewed and taken off "Section 117" the Care Co-ordinator is responsible for informing the contracts of the change. The contracts list can then again be updated and a copy sent to Social Services finance.

2. OTHER CHARGEABLE SERVICES e.g. Home Care etc.

2.1 If any chargeable service is commissioned by a Care Co-ordinator and the client is subject to Section 117, then the Care Co-ordinator must indicate clearly on the appropriate documentation and send notification to Social Services Finance. The Care Co-ordinator must also ensure that the client/provider is clear that they will not be charged and why.

2.2 As with 1.3 above any changes following review should be clearly communicated so that master list can be kept up to date.

2.3 The requirement to provide after-care services goes beyond the provision of specific identified Health and LA services and should be deemed to encompass all forms of service provision and all methods of delivery (e.g. Direct Payments, 'In Control' etc). In particular, the exemption from charges continues to apply, regardless.

3. GUARDIANSHIP ORDERS

3.1 Care Coordinators will inform contracts of any clients who come on/off a **Guardianship Order**. Master list can then be updated and Social Services Finance informed accordingly.

Pennine Care NHS
NHS Trust

APPENDIX D

RECORD OF DISCUSSION

SECTION 117 MENTAL HEALTH ACT 1983

NAME:

ADDRESS:

LEGAL STATUS:

DATE(S) OF SECTION(S)

Following a review of the Care Package and services previously provided under Section 117 of the Mental Health Act 1983, the following elements of the care package will either be no longer provided, or will no longer be provided as Section 117 provisions, for reasons as indicated:-

_____

_____

_____

_____

_____

An amended Care Plan is attached.

Signed……. Care Co-ordinator

Signed……. Team Manager

Date ……

Please forward a copy to the local MHL Administrator