Mental Health Act (1983) After-care Section 117 Responsibilities – Practice Guidance

Equality Statement

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Version:	V8	**Date:**	30/03/2022
Summary:	Section 117 imposes on local authorities and the NHS a legal duty to provide after-care services to an individual who has been the subject of a detention under either section 3, 37, 45A, 47 or 48 of the Mental Health Act. It is therefore important that Section 117 after-care is effectively managed and delivered to improve the outcomes for individuals, carers and families.		
Lead/Owner: **Author:** **Contributors:**	Stoke on Trent City Council Staffordshire County Council Midlands Partnership NHS Foundation Trust North Staffordshire Combined Healthcare NHS Trust Midlands and Lancashire Commissioning Support Unit		
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People who need to have an awareness of this document:		All practitioners across health and social care.	

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Contents

1. Purpose of this document

1.1 The purpose of this document is to provide pan Staffordshire and Stoke on Trent guidance and good practice principles for agreeing responsibility for after-care services and funding responsibilities under Section 117 of the Mental Health Act 1983 and the Care Act 2014. The document clarifies responsibility for funding and providing Section 117 services.

2. Introduction Mental Health Act 1983 – Section 117 After-care

2.1 Section 117 (S117) of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) ("the Act") places a joint legal duty on Integrated Care Board's (ICB) and Local Authorities (LAs) to provide (or arrange for the provision) of after-care for individuals who have been detained under specified sections of the Act once they leave hospital. These bodies are known collectively as the "responsible after-care bodies".

2.2 After-care is a vital component in an individuals' overall treatment and care. As well as meeting immediate needs for health and social care, after-care should aim to support individuals to regain or enhance their skills or to learn new skills in order to cope with life outside of hospital (Code of Practice (para 33.5) 2015). It is therefore important that Section 117 after-care is effectively managed and delivered to improve the outcomes for individuals, carers and families.

2.3 Definition – Section 117 (6) defines after-care services as those services which have both of the following purposes:

a) Meet a need arising from or relating to the individual's mental disorder; and-
b) Reduce the risk of a deterioration of the individual's mental condition (and accordingly reducing the risk of the individual requiring admission to hospital again for treatment for the disorder)

2.4 This means that the after-care may relate to a different mental disorder other than the one for which the individual was originally detained.

2.5 Further guidance can be taken from the MHA Code of Practice (2015) (chapter 33.4) which states that "ICB's 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 individual's wider social, cultural and spiritual needs, if these services meet a need that arises directly from or is related to the particular individual's mental disorder and help to reduce the risk of a deterioration in the individual's mental condition."

3 Duties and Entitlements of Section 117 of the Mental Health Act 1983

3.1 Section 117 of the Mental Health Act 1983 places a joint legal duty on Integrated Care Board's and LAs. There are specific compulsory sections of the MHA to which the Section 117 after-care duty relates:

a) When someone has been detained in hospital for treatment under Sections 3, 37, 45A, 47 or 48 of the Mental Health Act, and then cease to be detained and leave hospital.
b) When they are on a Community Treatment Order (CTO) and then continue to require Section 117 provision after discharge from the CTO
c) When they are on Section 17 Leave of Absence when detained on the above sections.

3.2 Where eligible individuals 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 is the same legal position if an individual has returned to prison following a period of detention.

3.3 Section 117 commences upon discharge from the above eligible sections of the Mental Health Act 1983 when the individual leaves hospital.

4. Register

4.1 Because of the statutory requirement for Section 117 after-care, a record should be maintained of all individuals entitled to Section 117 and any after-care services which are provided under that section.

4.2 Register Flow Chart Appendix A

5. Refusal of Section 117 After-care

5.1 There is no obligation upon the individual to take up the Section 117 after-care services that they are offered, but any decisions they may make to decline services should be fully informed.

5.2 An unwillingness to accept services is not the same as not needing those services, nor should it prevent an individual from receiving the services if they change their mind. The refusal does not discharge the Section 117 duty.

5.3 A decision by the individual to refuse should be clearly recorded. Where capacity to make that decision is in doubt, there should be evidence of an assessment of capacity in accordance with the Mental Capacity Act 2005. Where an individual lacks capacity to make decisions regarding some or all of their Section 117 after-care arrangements, whether the same is in their best interests must be determined under the Mental Capacity Act.

6. Services where Section 117 does not apply

6.1 Items not covered are as follows, this list is not exhaustive.

The following services will not be provided under Section 117.

- Storage of property
- Housing pets
- Food

• Holidays
• General Needs/Ordinary Accommodation (see R (Afework) v London Borough of Camden)

http://www.mentalhealthlaw.co.uk/R_ (Afework) v London Borough of Camden)

However please note that where someone is admitted to hospital, the Local Authority must take reasonable steps under s47 of the Care Act to prevent or mitigate the loss or damage to pets and properties: Section 47 (Care Act 2014)

7. Discharge from Hospital

7.1 Discharge planning should be considered as soon after admission as is possible. The multi-disciplinary team (MDT) will arrange to meet with the individual, their carers, families and advocates (where appropriate) to consider the individual's after-care needs. The MDT should ensure after-care enables the individual to learn new skills maximises independence and prevents readmission to hospital. In addition the MDT will consider with the individual and their families/carers and advocates (where appropriate) which aspects of the individual's needs should be met under Section 117 and which come under other legislation which must be specified in the care plan.

7.2 The High Court and Department of Health guidance (HSC 2000/03) confirms that after-care provision does not continue indefinitely. The individual and his/her carers should always be advised during the discharge prior to any services being provided that Section 117 status will be reviewed and can be discharged when no longer needed. When Section 117 is discharged, the named worker should ensure that the individual understands their revised status.

7.3 The named worker will be responsible for producing the appropriate care plan which will identify after-care services under Section 117 or support required under any other legislation. The after-care plan should be strength based which ensures the individual is supported to learn new skills, promotes independence, and prevents readmission.

7.4 The named worker is responsible for eliciting from the ICB and LAs acceptance of responsibility for the relevant aspects of the care plan and ensuring that this is recorded on the care and treatment plan see Appendix C.

7.5 As part of discharge planning individuals will have an identified key worker if appropriate who will be coordinating their support after discharge from hospital.

7.6 Consideration must be given in the first instance to the least restrictive options to meet the individual's Section 117 after-care needs. This could be through universal health services, commissioned health services or services provided by the voluntary and community sector.

7.7 If the individual's after-care needs cannot be met through those services and they require commissioned health and care services to support their needs, the LA must complete a referral which is sent to MLCSU for receipt of joint funding (Appendix E). Exceptions to this are for autistic people and/or those with a learning disability that

are deemed to be part of the Transforming Care Programme (TCP). For confirmation/referral please contact ssicb-ses.transformingcare.nhs.net. The lead agency will follow their organisations commissioning or brokerage process to secure care and support required.

7.8 After discharge from hospital, there should be a review meeting(s), as agreed at the discharge meeting and usually within six weeks of discharge or sooner should the need arise where the individual is in receipt of commissioned care, a joint review must be undertaken between MLCSU and the LA or NSCHT and the LA for the Transforming Care Cohort.

7.9 The individual, his/her carers, and other agencies involved should always be consulted at each stage of the Section 117 after-care process.

8. Review

8.1 Section 117 reviews must take place at a minimum of twelve-monthly intervals as an integral part of the regular review. This will give a clear indication as to whether a need remains as a Section 117 need or has been achieved. Any Section 117 need should be shown clearly on care plans.

8.2 Consideration must be given to the least restrictive options to meet the individual's Section 117 after-care needs. This could be through universal health services, commissioned health services or services provided by the voluntary and community sector.

8.3 At each review the multidisciplinary team (MDT) with the individual and the family/carers/representative (where appropriate) will reassess their continuing needs for health and social care and other support. They will consider whether the service being provided continues to reduce the prospect of the individual being readmitted to hospital for treatment of their mental disorder.

8.4 Consideration should also be given to whether the after-care still needs to be provided to prevent readmission, or whether there should be an assessment under the Care Act 2014 to arrange community care services or a Continuing Healthcare assessment needs to be considered.

8.5 The High Court and Department of Health guidance (HSC 2000/03) confirms that after-care provision does not continue indefinitely. The individual and his/her carers should always be advised during the discharge prior to any services being provided, that Section 117 status will be reviewed and can be discharged when no longer needed. When Section 117 is discharged, the named worker should ensure that the individual understands their revised status.

8.6 In circumstances where the individual has been discharged from secondary care services to primary care and Section 117 still applies, it is the joint duty of the LA and ICB to ensure the annual review takes place with the GP. If there is a deterioration in the individual's presentation a review should take place.

8.7 The individual, his/her carers, and other agencies involved should always be consulted at each stage of the Section 117 after-care process.

8.8 Neither the ICB nor LA can unilaterally withdraw from an existing funding arrangement without a joint review of the individual and without first consulting one another and informing the individual about the proposed change of arrangement. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change.

8.9 **Local Review Principles** –

a) The individual, his/her carers, and other agencies involved should always be consulted at each stage of the Section 117 after-care process.
b) The review will be centred on the individual, in the right environment and the MDT will make any reasonable adjustments to ensure the individual is able to engage and contribute fully.
c) The individual will be supported by their significant others or an advocate where necessary and or appropriate.
d) The review will be holistic and in line with principles of the Care Programme Approach.
e) The review will be asset-based putting emphasis on the individual's strengths and talents.
f) The review will be outcome focused.
g) The quality and experience of services provided will be considered where appropriate.
h) Social care will be the lead agency to co-ordinate the review with the exception of transforming care.
I) The review will be a joint review and as a minimum must include the individual and health and social care representatives.
j) The lead agency will give the individual and statutory partners 28 days' notice to review.
k) The MDT will plan the six-week review at the point of hospital discharge
l) At the six week review the MDT will plan the 12 month review.
m) Each agency will use their current review documentation which will include the agreed principles
n) The review will identify actions, timescales, and the person responsible for the action, based on changes to the current care plan.
o) The Lead agency will share the minutes from the review with the individual and the MDT.
p) Consideration will be given to discharging the Section 117 duty where it is no longer required.
q) The statutory partners (Staffordshire and Stoke on Trent ICB, Staffordshire County Council and Stoke on Trent City Council) will aspire to review all individuals that are Section 117 within a twelve-month period.
r) Universal and commissioned services will be considered at each review
s) No partner (Staffordshire and Stoke on Trent ICB, Staffordshire County Council and Stoke on Trent City Council) will unilaterally withdraw from the agreed arrangements.
t) The review will be undertaken at the next scheduled review date or as the need arises.

9. Ending Section 117 after-care

9.1 Section 117 after-care services can only be ceased when both the ICB and the LA are satisfied that the individual is no longer in need of after-care services. After-care services may be reinstated if it becomes obvious that they have been withdrawn prematurely, e.g. where an individual's mental condition begins to deteriorate immediately after services are withdrawn.

9.2 The ICB and the LA are responsible for ensuring that the individual's progress in the community is monitored and reviewed following discharge. It is important that the individual and their carer/advocate (if they have one) are consulted in this decision-making process.

9.3 If an individual wishes to be discharged from Section 117 after-care services, it will have no effect until the ICB and the LA are both satisfied that the individual no longer needs after-care services. For the duty/entitlement to be discharged, it is the responsibility of the organisation providing the service to take the lead on ceasing it, even though both need to agree that the individual no longer needs after-care.

9.4 Removing services that relate to Section 117 needs is a separate decision from that of ending entitlement. Having no services provided under Section 117 may indicate that a review of the entitlement is indicated. Whilst a person may be well settled in the community, they may continue to need aftercare services to prevent relapse or a further deterioration in their condition. Where it appears that aftercare services have been withdrawn prematurely, they can be re-instated without the need for further detention under a qualifying section. Fully involving the individual and (if indicated) their carer and/or advocate is an important part in the successful ending of aftercare.

9.5 Entitlement to after-care services under Section 117 should not be ceased solely on the grounds that:

a) The individual has been discharged from specialist mental health services
b) An arbitrary period has passed since the care was first provided
c) The provision of care is successful in that the individual is well settled in the community or in residential care
d) The individual is lawfully deprived of their liberty under the Mental Capacity Act or by operation of law. e.g., subject to the Court of Protection
e) The individual is no longer on a CTO or s17 leave
f) The diagnostic category of the individuals condition changes

10. Considerations

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

f) What services are now required in response to the individual's current mental health needs?
g) Does the individual still require medication for mental disorder?
h) 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. Discharge of Section 117 Duty - Local Management

11.1 Discharges from Section 117 must be accepted by representatives from both agencies - Health and LA - and joint agreement between those with the authority to agree discharge.

11.2 Normally the responsibility for discharging the duty is delegated by the LA to the social worker. If the issues are not clear, then the line manager should be invited to attend the joint review meeting and take responsibility for accepting/discharging the Section 117 duty.

11.3 The consultant psychiatrist/approved clinician/key worker has overall responsibility for discharging Section 117 on behalf of the ICB. The consultant psychiatrist/approved clinician/key worker must attend the review meeting and take responsibility for discharging the Section 117 duty on behalf of the ICB when discharge from Section 117 is being proposed.

11.4 Where there is a dispute about discharging the Section 117 duty, provision of care to the individual must continue until the dispute is resolved.

11.5 Where agreement cannot be reached within the review meeting, the issues should be taken to senior management in the LA and to the appropriate lead clinician/team manager within the mental health service for a decision to be reached.

11.6 If individuals and/or carers disagree with decisions, they may go through the complaints procedures for the relevant health or social services organisation. These generally contain options for resolution, including access to independent review and/or external scrutiny.

12. Funding Responsibilities

12.1 The MHA does not stipulate funding responsibilities for the package of care under Section 117.

12.2 A package of care and support will be developed based on the after-care support plan. The plan should follow the principles of self-directed support and personalised services and the package should utilise existing universal, free to access services where possible. These could include:

- Community-based health services
- Resettlement services
- Universal advice, advocacy and information services
- Employment support services
- Community activity services

- Leisure services
- Peer support

12.3 All cases should follow local jointly agreed processes which determine the funding split (Appendix E) and lead commissioning arrangements.

12.4 Section 117 arrangements start when an individual is assessed as requiring Section 117 after-care and is discharged. Local arrangements have been agreed in relation to funding s17 leave. S17 leave will be fully funded by the ICB. Community treatment orders (CTO) will be considered as a 50/50 split. (See appendix F)

13. Financial arrangements (Please refer to local policies and practice guidance for processes in relation to financial assessments)

13.1 People who are entitled to Section 117 after-care services will not be financially assessed or charged by the LA. The cost of these services will be met by the ICB and LA as agreed between the LA and the ICB see Appendix E.
Only individual services identified as such within the Care and Treatment plan will be considered to be Section 117 services:

- The ICB and LA agree that Section 117 only applies to services required by the individual to meet their assessed Section 117 needs.
- In some cases needs not applicable to Section 117 are likely to be met by other funding streams for example care act, continuing healthcare.
- Services arranged as Section 117 after-care services will be funded on a 50/50 split as agreed by the ICB and LA.

13.2 The joint duty between the relevant ICB and the relevant LA to provide after-care services continues as long as the individual is in need of such services.

13.3 In the case of an individual on a Community Treatment Order (CTO), after-care must be provided for the entire period they are on the CTO and continue past this time if needed.

14. No Recourse to Public Funds

14.1 No Recourse to Public Funds - Section 117 after-care services are available regardless of an individual's immigration status or their nationality. Immigration exclusions under Schedule 3 Nationality, Immigration and Asylum Act 2002 do not apply. When preparing to discharge someone who has no recourse to public funds from Section 117, due regard must be given to the individual's immigration status and entitlement to support in the UK.

15. Direct Payments

15.1 The drive for future practice is to increase use of direct payments for Section 117 after-care. In developing policy, we may wish to future proof practice through considering how this is done e.g. LAs have a duty to make available a Direct Payment under s31 of the Care Act 2014 (subject to any other parts of the Act or

regulations that apply). Direct Payments can be made to individuals who are assessed as requiring services under Section 117.

16. NHS Continuing Health Care (NHS CHC)

16.1 NHS CHC means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'. Such care is provided to an individual to meet needs that have arisen as a result of disability, accident or illness.

16.2 Section 117 applies after an individual has been the subject of a compulsory order under the Mental Health Act 1983 (see section 2 above).

16.3 An individual subject to Section 117 should only be considered for NHS CHC where they have significant healthcare needs which are not related to their mental health after-care needs.

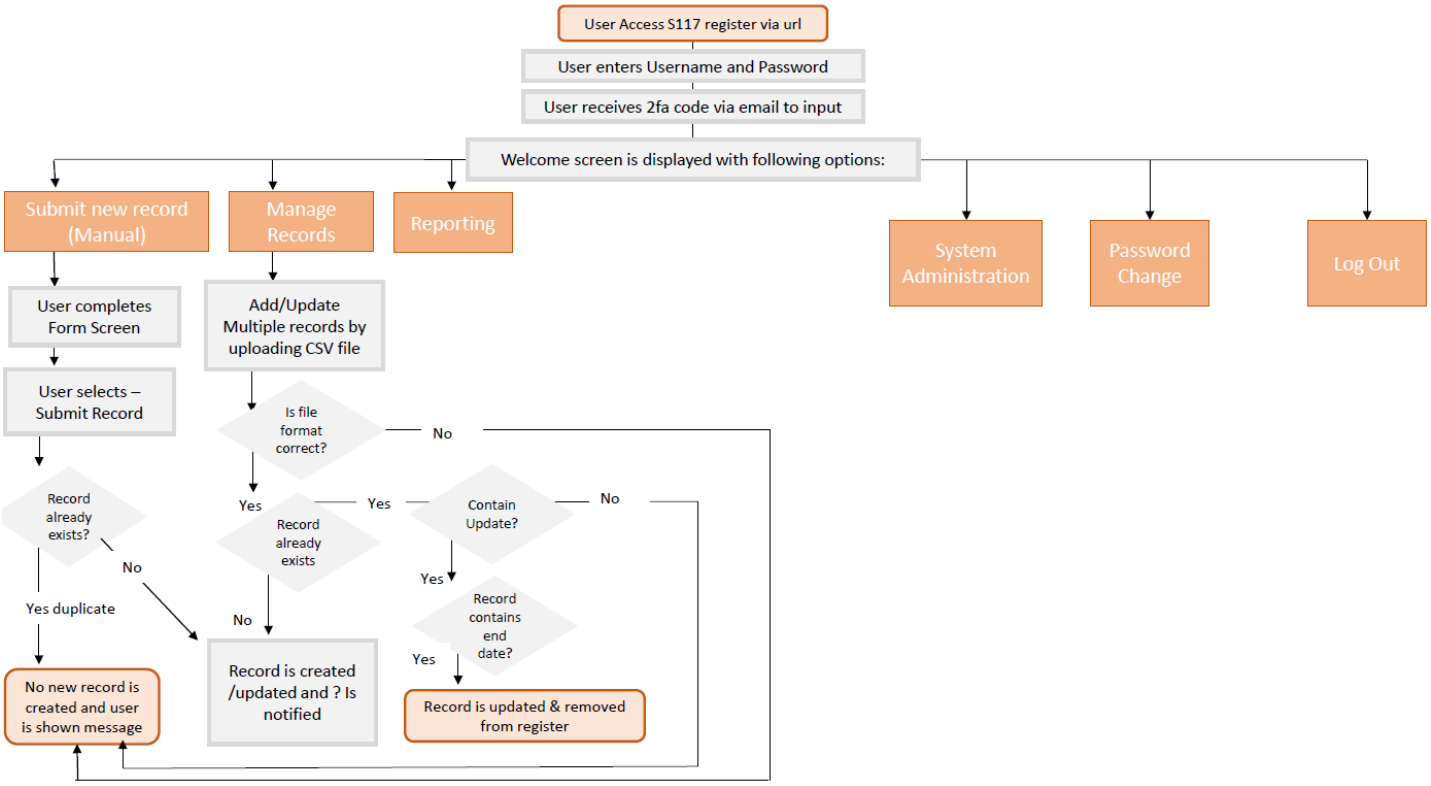
16.4 The National Framework https://www.england.nhs.uk/healthcare for NHS CHC clarifies the relationship between Section 117 and NHS CHC in paras 333-343, with the main points being:

16.5 It is not, therefore, necessary to assess eligibility for NHS CHC if all the services in question are to be provided as after-care services under Section 117. (National Framework para 338).

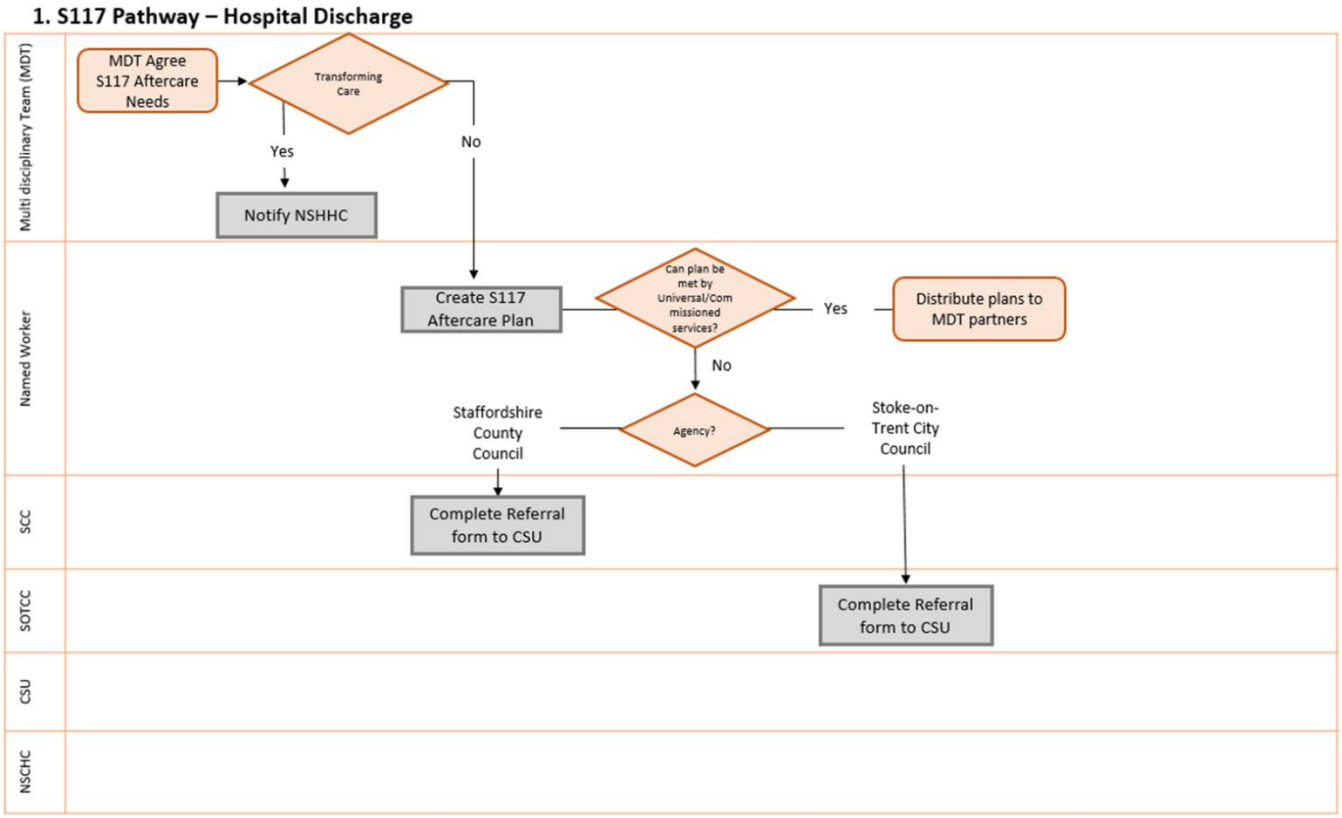
16.6 However, an individual in receipt of after-care services under Section 117 may also have ongoing care/support needs that are not related to their mental disorder and that may, therefore, not fall within the scope of Section 117. Also, an individual may be receiving services under Section 117 and then develop separate physical health needs (e.g. through a stroke) which may then trigger the need to consider NHS CHC only in relation to these separate needs, bearing in mind that NHS CHC should not be used to meet Section 117 needs. (National Framework para 339).

16.7 The Legislation relating to assessment for NHS-funded nursing care contained in the Standing Rules, applies to section 117 individuals as it does to other individuals. (National Framework para 343).

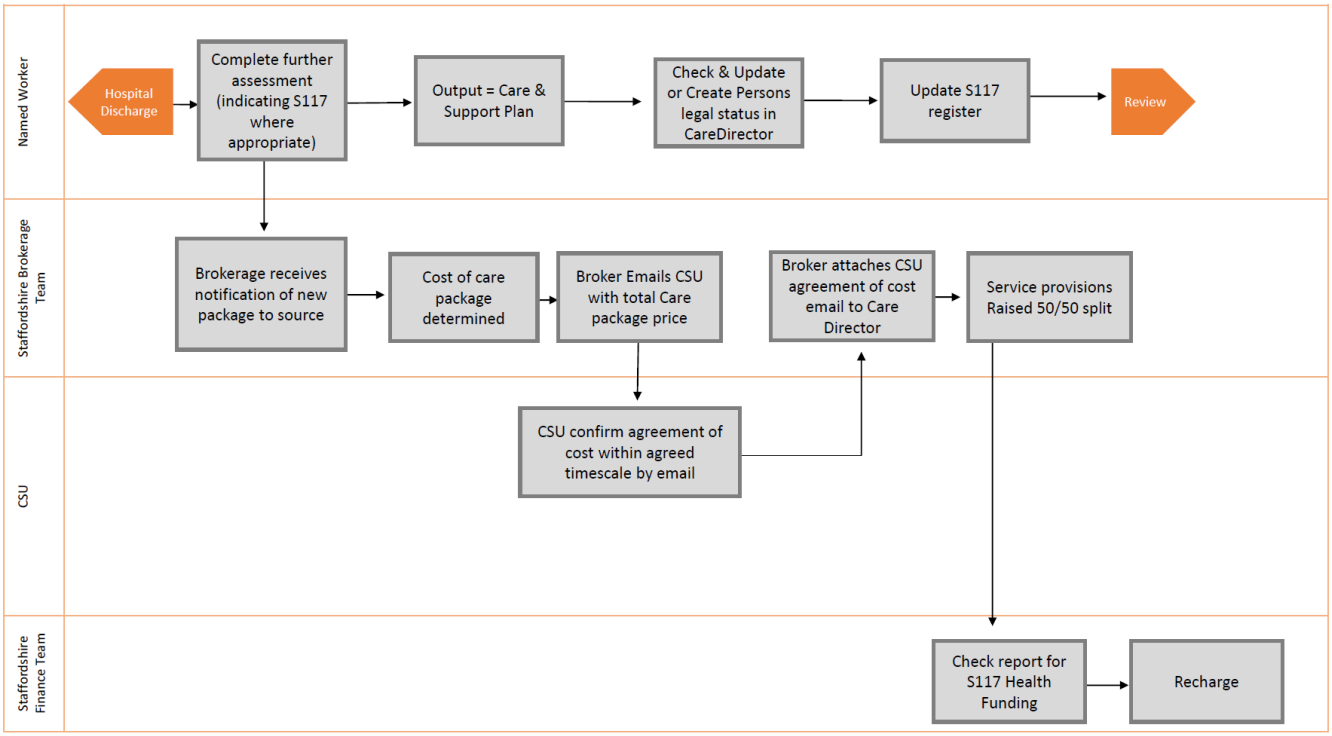
Appendix A: Register Flow Diagram (PLEASE REFER TO YOUR ORGANISATIONS S117 DESIGNATED NAMED REGISTER USER)



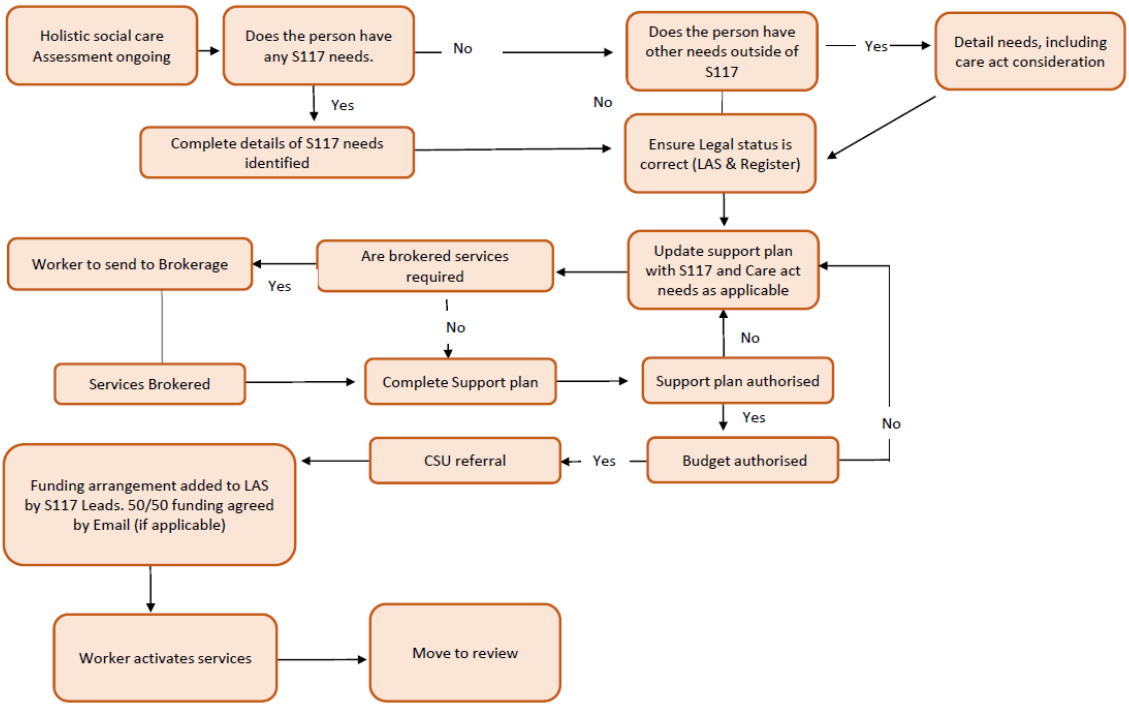
Appendix B: Pathway for all groups



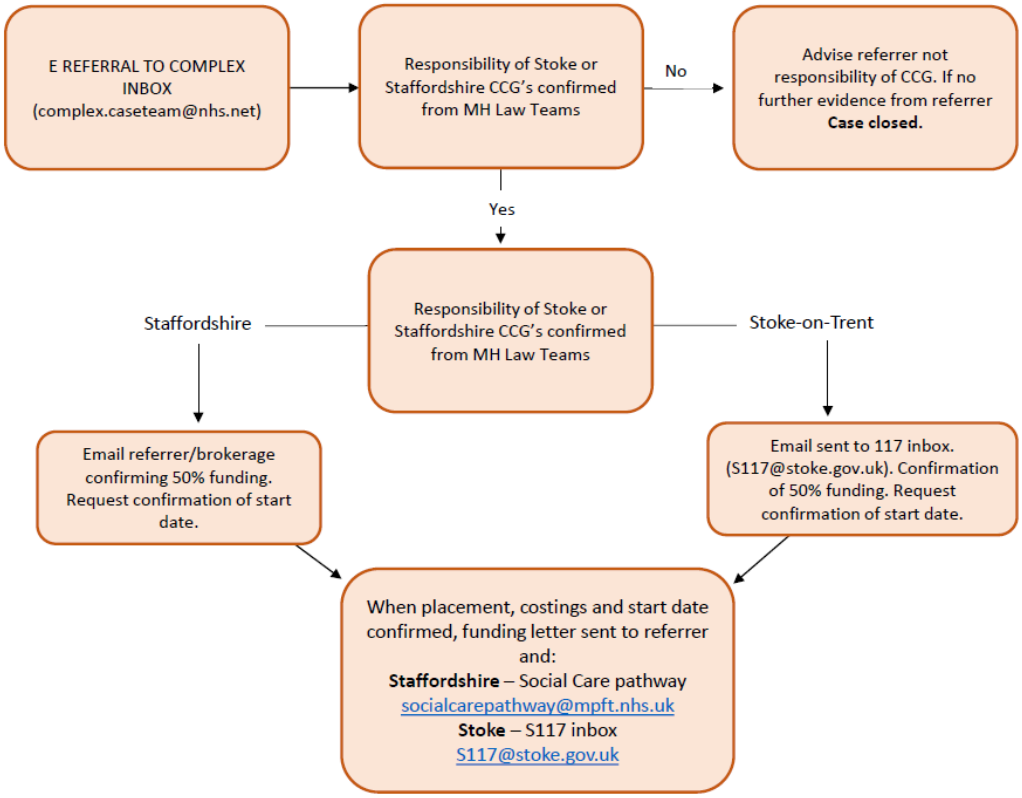
1.2 Staffordshire County Council



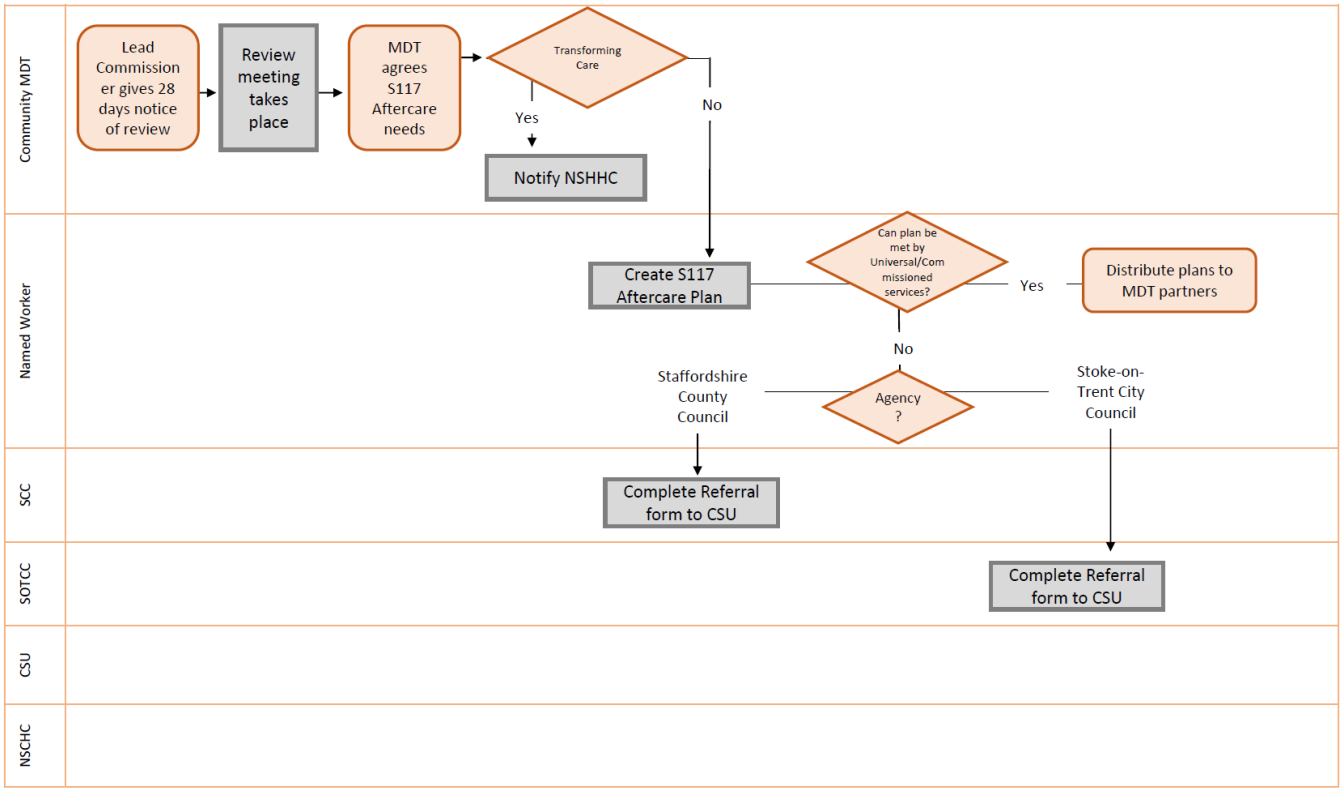
Stoke Social Care S117 Process



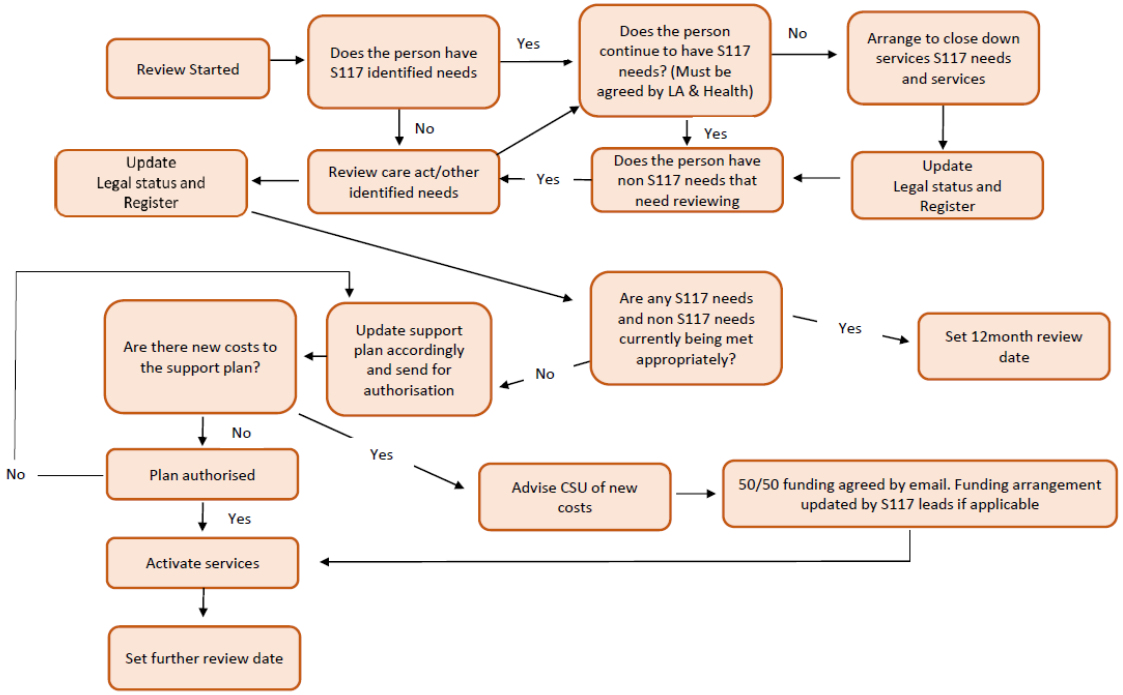
MLCSU Process



Review Process



Stoke Review Process – S117



Appendix C: Care and Treatment Plan

CARE AND TREATMENT PLAN

Name: Mr Robert Beaver

NHS number: 123456

Care co-ordinator: Ms Carol Knows

Care and treatment plan dated: 23 March 2022

Responsible ICB : Stufford ICB
Responsible local authority: Stufford Council
Next review: by 23 September 2022

SECTION 117 AFTER-CARE SERVICES

Section 117 needs?	How will the needs be met?	Who will meet the needs?
Mental wellbeing and behaviour 1. Robert has historically presented with the following behaviours: physical aggression (bites, head butt, slaps, grabs, scratches, throw items, hits etc.), vocalisations (loud and high-pitched screams), property damage (pull down curtains, pull items off walls etc.), self-harm (hit his head against surfaces such as walls or doors, pulling his hair out, pica, hitting his back, chin or head with his fist etc.). The support required to meet his behavioural needs is significant and to a degree which can require restraint. It is significantly complex, intense and	Two to one support at all times inside the property. The staff team will support Robert with any intractable behaviours through Positive Behaviour Support Plans, to communicate his needs using more appropriate means and will work with RB in reducing the need and motivation for intractable situations.	Commissioned care provider and Community Learning Disability Team

unpredictable in nature and is a consistent outlet for Robert to express his emotions and especially when he is in pain. 2. Needs staff support to self-regulate and will require staff to prompt him to safe areas to self-regulate (though he will sometimes take himself to another room, suggesting some evidence of a coping mechanism). 3. Challenging behaviour increases when Robert is in discomfort, particularly self-injurious behaviour and is usually linked to issues with his bowel. 4. If Robert has become accustomed to a particular routine any change or delay can be a major stress factor for him. 5. His body language and monitoring his anxieties can help gauge how Robert is feeling. Challenging behaviour is often a sign that Robert is physically unwell. Monitoring will be crucial for Robert's physical and mental wellbeing. 6. Robert requires a high level of support to prevent damage to property due to his challenging behaviour. 7. Robert will require 3 members of staff to safely access the community. This is specifically due to the risk of an increase in challenging behaviour which would require multiple members of staff to manage appropriately.	The care provider will be able to manage all of the aforementioned behaviours within a positive behaviour support plan and reduce the need for these behaviours to be exhibited through the implementation of effective proactive and reactive strategies including: communication strategies, robust boundaries and maintaining a consistent and predictable daily routine. The staff will be trained in MAPA (Management of Actual and Potential Aggression) and they will, if necessary, physically intervene as a last resort to protect Robert and others. Three to one support when outside the property for 7 hours 7 days each week e.g: • Sensory rooms • Community walks (especially parks) • Swimming and water-play • Football • Trampolining • Play areas in parks. On site additional support should it be required for incidents. On call emergency support should it be required off site or outside daytime hours.	
<u>Medication for mental health and behaviour</u> 8. Full support to take prescribed psychotropic medication: o Clomipramine 50mg caps – 5x at tea (OCD) o Diazepam 5mg tabs – 3x daily (anxiety) o Naltrexone 50mg – 1.5x daily (PICA & OCD) o Zuclopenthixol 2mg – 2 tablets, 3 x per day as required (agitation) o Lorazepam 1mg – 1 tablet up to 4 x daily as required (agitation and anxiety) 9. Ongoing monitoring of his mental state and optimisation of his psychiatric medication.	Care provider to support Robert to take medications. Care provider to monitor effects and side effects of medications through completion of relevant reports and questionnaires Regular reviews with GP and consultant psychiatrist or nurse prescriber	Commissioned care provider and Community Learning Disability Team

10. Support to ensure his mental state remains stable and incidents of 'abnormally aggressive or seriously irresponsible conduct' (e.g. eating non-edible materials) are prevented.		
<u>Sensory needs</u> 11. He is hypersensitive to touch, heat, sound, busy environments (e.g. fireworks, loud noise, balloons popping) and struggles with imperfection (e.g. will remove any bits of damage to his environment). He can become under-stimulated if left for too long. 12. He cannot tolerate shared spaces so needs his space. 13. Robert requires a clear consistent and structured weekly plan.	Very basic and robust bedroom. Staff will ensure Robert's environment is calm and quiet. The décor be largely plain and simple. For sound will wear ear defenders. He responds well to weighted blankets, has issues with labels. Spacious surroundings, low maintenance decoration due to potential property damage. Environment should be kept as similar as possible to when he moved in, changes can lead to increased anxiety. Doors and windows should be reinforced (Both vehicles and property) Robert likes to go into the community but will withdraw interest in a low mood As long as the plan is clear, and routine is followed Robert generally shows no signs of agitation. Therapy input to review the sensory integration needs assessments and plans	Commissioned care provider and Community Learning Disability Team
<u>Activities and social network</u> 14. Support to engage in meaningful activities in the community on a frequent basis and to reduce the risk of social isolation.	Access to all care provider activities. Enjoys simple ball games and playing with water. Active support is used as a means to support and entice his engagement in activities, it also allows for the structure of which staff are doing what, who is leading and who is supporting Family contact will be regular and organised.	Commissioned care provider Social worker to be point of contact for family

Communication: 15. Robert has extremely limited verbal skills and are limited to immediate needs. He is generally non-verbal and uses some personalised Makaton signs, and uses these to inform on basic needs, this is supplemented mainly by staff knowing his body language and other aspects of his presentations to identify the needs to support him. Robert can use visual support such as Picture Exchange Communication System (PECS). 16. Robert needs a consistent staff team that know him well who can understand his needs. Understanding Robert's body language, simple gestures and personalised signs are crucial to understanding Robert's current mood and status. 17. He is usually unable to communicate where pain is and if he is suffering. However he will sometimes run/ point to affected area on his body. Robert has historically had tooth issues that affected his behaviour because he was unable to communicate his pain. Robert struggles to communicate how he is feeling. 18. Can become overstimulated if left too long without interaction from staff.	Ensure you have Robert's attention when you are communicating with him. Allow time for Robert to process the information you have given him. Staff should explain things to Robert using short, clear sentences (1 piece of simple info or PECS). Only one staff member should speak and Robert should not be overloaded with information. Staff will encourage Robert to let staff help him. Staff will encourage Robert to use techniques to calm (Either verbally requesting Robert to his room to safe vent, or through gesture) Robert may need staff to verbally and physically prompt him in many aspects of his care. Robert needs staff to maintain their boundaries, this can lead to frustration and confusion if staff differ in approach. Robert will at times need lots of reassurance particularly when his moods are low. Staff should maintain a positive reassuring tone with Robert when he is calm. Interact with Robert to build rapport and ensure a positive professional relationship is built – get to know his mannerisms Speak clearly, use simple sentences – 1 or 2 pieces of key information Use PECS when appropriate to do so. Limit choices to 2, if a choice is required. Have a clear structure to the day with positive boundaries Provide lots of positive praise when Robert completes an activity or task, this will help	Commissioned care provider and Community Learning Disability Team

	Robert find enthusiasm for repeating again next time. Provide Robert with lots of opportunities to do the activities he likes to do Regular opportunities to be visited by his family. Ensure staff maintain their boundaries, maintain appropriate limits about how long he should be showering, TV access and what does and doesn't belong to Robert. Speech and language therapy reviews as required.	
<u>Structured Daily Routine</u> 19. Robert requires a clear consistent and structured weekly plan. 20. Active support is used as a means to support and entice his engagement in activities, it also allows for the structure of which staff are doing what, who is leading and who is supporting. 21. Set eating, cleaning, and sleep times as consistency is crucial in Robert's routines. 22. Robert has historically worked well with some visual timetables to plan his activities, but these need to be consistently followed.	Staff should stick to his weekly plan as much as possible. Robert has historically worked well with some visual timetables to plan his activities, but these need to be consistently followed. Structured plans for the delivery of 'capable' social care support and environments (NHSE 2015)	Commissioned care provider

<u>NON SECTION-117 HEALTH CARE SERVICES</u>

Physical health needs?	How will the needs be met?	Who will meet the needs?
<u>Pain management</u>	Robert requires a proactive care plan that anticipates pain and discomfort and uses a staged approach to determining what is causing that, managing the cause and managing the pain arising from it.	Commissioned care provider and Community Learning Disability Team

		GP and mainstream health services
<u>Epilepsy management</u> Robert has had no seizures in the last year but still needs help to manage his epilepsy.	Understanding what triggers seizures for Robert and managing those setting conditions; when seizures occur managing the situation including breathing and physical sate which may include administering medication for status. Delivery of care so as to avoid triggers or setting conditions for seizures. Administration of medication to manage seizures and status epilepticus. Monitoring of condition, effects and side effects of medications and access to GP and mainstream health services as required.	Commissioned care provider GP and mainstream health services
<u>Continence</u> He has currently undiagnosed Gastroparesis which is a condition in which your stomach cannot empty itself of food in a normal fashion. It can be caused by damage to the vagus nerve, which regulates the digestive system. Robert has no other known health concerns and has not required enemas for a year.	Monitoring of this condition, accessing GP and mainstream health services as required.	Commissioned care provider GP and mainstream health services
<u>Medication for physical health matters</u> Robert takes a number of medications each day for a variety of health matters. He requires full support for the management of medication including sourcing, storing, administering and monitoring the effects and side effects.	regular review by GP and other specialists as required for specific physical health conditions Administration of medications as prescribed Monitoring of effect and side effects of prescribed medications Daily • Cosmocol - 2x sachets daily (bowel function) • Esomeprazole 40mg – 2x daily (gastric reflux)	Commissioned care provider GP and mainstream health services

	• Lamotrigine 75mg – 2x daily (epilepsy) • Loratadine 10mg – 1x daily (antihistamine/allergies) • Pregabalin 100mg – 2x, 3x daily (epilepsy) • Ranitidine 150mg – 2 tablets at night (gastric reflux) • Peptac liquid – 10ml x 3 daily (gastric reflux) PRN: • Nefopam 30mg – 1x up to 3x daily (pain relief) • Hyoscine Butylbromide (Buscopan) – take 2x tablets up to 3x daily (stomach cramps/IBS) • Buccal Midazolam 10mg/1ml – Use 1ml, up to 2x daily (status epilepticus) (see epilepsy care plan).	

NON-SECTION 117 SOCIAL CARE SERVICES

Eligible social care needs?	How will the needs be met?	Who will meet the needs?
Managing and Maintaining Nutrition 1. Robert needs full support to maintain adequate nutrition including meal planning and preparation. 2. Robert needs supervision and support to eat, giving him a bit of food at a time as otherwise he will eat too quickly and could choke. 3. Robert needs his food to be cut up. 4. Robert has acid reflux and needs support to ensure his diet is appropriate to prevent him experiencing ongoing discomfort. 5. Robert needs support to promote and develop his independence in all areas of his life.	Care provider will support Robert in a person-centred way, involving Robert and all stakeholders in designing and evaluating his PCP. Promoting Robert's independence will revolve around the care provider supporting Robert to be provided and supported to make choices and to be as independent as possible within his home (e.g. cooking, cleaning, personal hygiene, washing clothes etc.) and to access all of the outdoor activities that the care provider provides, including the	Commissioned care provider GP and mainstream health services Social worker

	continuation of daily community access with the clinically assessed requirement of 3 staff. Minimum of annual review by social worker.	
<u>Managing Personal Hygiene</u> 6. Robert requires full support to manage and maintain his personal hygiene. This includes full support to maintain a suitable and predictable routine which Robert responds well to. 7. Robert requires full support with laundry tasks. 8. Robert will not instigate activities and he needs staff encouragement and reassurance. Robert is very routine based and can become distressed if he is unable to carry out certain sequences and routines within his day.	Care provider to deliver support as per care plan in relation to personal hygiene needs. Minimum of annual review by social worker.	Commissioned care provider Social worker
<u>Managing Toilet Needs</u> 9. Robert needs support through a combination of verbal and physical prompting and physical assistance to attend to his own personal care needs and requires support to wash; change clothing; launder clothing and locate and use toilets when outside the home 10. Robert needs full support to maintain his personal hygiene following a bowel movement. 11. Robert is prescribed medication to promote regular bowel movements. He may become increasingly anxious if he is unable to go to the toilet and needs support to recognise this and support him appropriately.	Care provider to deliver support as per care plan in relation to use of toilet, bowel management and continence and any related personal hygiene needs. Regular review of bowel function and prescribed medication by GP and mainstream health services. Minimum of annual review by social worker.	Commissioned care provider GP and mainstream health services Social worker
<u>Being appropriately clothed</u> 12. Robert needs prompting and encouragement to get dressed and change his clothing. 13. Support is needed to choose appropriate clothing and prompt him to put each item on in the correct order. 14. Robert needs support to put his socks on. 15. Robert does not like buttons and zippers and these are avoided where possible.	Care provider to deliver support as per care plan in relation to clothing and accessories including purchase, daily selection, dressing and laundering. Minimum of annual review by social worker.	Commissioned care provider Social worker

16. Robert needs support to appropriate clothing Robert needs full support with laundry 17. Robert needs support to ensure he has access to his noise cancelling headphones		
<u>Maintaining a Habitable Home Environment</u> 18. Robert requires full support to maintain a safe and clean environment including ensuring that all household tasks are completed. 19. Robert requires full support to uphold the obligations of his tenancy agreement.	Property to be maintained by the landlord. Care provider to maintain regular contact with landlord for speedy resolution of any environmental concerns. Care provider to have a procedure for checking, cleaning and maintaining the environment in line with Roberts needs. Minimum of annual review by social worker.	Landlord Commissioned care provider Social worker
<u>Developing or Maintaining Family or other Personal Relationships</u> 20. Communication: Robert has a severe learning disability which impacts upon his understanding, retention, weighing and communication of information. Robert does not communicate verbally. He can make basic choices but requires complex decisions to be made on his behalf as he is unable to communicate his views and wishes with regards to more complex decisions. 21. Robert enjoys the company of others whom he trusts and feels secure with, he needs full support to maintain contact with family and the enable him to engage with other citizens (not staff) when accessing community facilities. 22. Robert needs ongoing support to reduce social isolation. 23. Robert needs support to communicate his wishes and choices.	Contact with family integrated into the structured weekly activity planner. Support plan specific to family engagement and preparation Robert needs before a visit co-produced with family members. Minimum of annual review by social worker.	Commissioned care provider Social worker
<u>Finances</u> 24. Robert does not understand money or transactions; he has a DWP appointee who ensures the benefits received	Robert can access all usual benefits (HB, DLA Mobility and Care plus, ESA with disability premiums).	Commissioned care provider

are used to pay bills, purchase essential items such as food and clothing and finance preferred activities and occupation	Care provider as his appointee will manage and account for all financial transactions including arranging independent audits of accounts Annual review by social worker	Social worker
<u>Safeguarding from abuse and neglect</u> Robert would not be able to protect himself from exploitation and abuse or neglect.	Care provider to deliver care as per care plans Care provider to have internal systems for monitoring delivery of care Care provider to have procedures for the recruitment and training of staff and ongoing monitoring and management of the care they deliver Care provider to alert authorities to any concerns regarding abuse or neglect. Care package to be lawfully authorised by relevant authorities Minimum of annual review by social worker Local authority safeguarding investigations as required	Commissioned care provider Social worker

CRISIS CONTINGENCY PLAN (this is a summary of key points, please refer to detailed PBS Plan)

GREEN

What do we all notice?	What has/does help?	What is unhelpful (including key known triggers)?
Robert is calm and content Robert is engaging with his activities as per structured daily planner Robert is free from pain and discomfort Robert accepts support from and engagement with staff Robert's communication is understood and responded to	Care and support is delivered as per care plans Staff anticipate Roberts needs and proactively meet these	Change to structured day / week Staff who are not in tune with Roberts needs or do not respond in a timely manner Ignoring Robert and what he is communicating Placing too many demands on Robert Staff changes / unfamiliar staff

ORANGE

What do we all notice?	What has/does help?	What is unhelpful (including key known triggers)?
Refer to detailed PBS plan for operational definitions and escalation cycle. Changes to body language and levels of engagement Vocalisations (loud and high-pitched screams) Self-harm (hit his head against surfaces such as walls or doors, pulling	Ensure plans are running consistently / changes are minimal Remove any obvious triggers or setting conditions Diversion to preferred activities Diversion to safe low stimulus environment for sensory regulation Diversion to toilet if bowel motion considered to be needed	Ignoring Robert and what he is communicating Placing too many demands on Robert Further change to usual manner of delivering care and support Staff changes / unfamiliar staff

his hair out, pica, hitting his back, chin or head with his fist). Property damage (pull down curtains, pull items off walls) Physical aggression (bites, head butt, slaps, grabs, scratches, throw items, hits, kicks),	Administration of pain relief Administration of as required medication for agitation and anxiety Use of breakaway and block techniques as per individualised MAPA plan	

RED

What do we all notice?	**What has/does help?**	**What is unhelpful (including key known triggers)?**
Refer to detailed PBS plan for operational definitions and escalation cycle. Self-harm (hit his head against surfaces such as walls or doors, pulling his hair out, pica, hitting his back, chin or head with his fist etc.). Physical aggression (bites, head butt, slaps, grabs, scratches, throw items, hits etc.),	Diversion to preferred activities Diversion to safe low stimulus environment for sensory regulation Use of physical restraint as a last resort as per PBS Plan	

Appendix D: Discharge Template/Letter

Discharge from Section 117 Mental Health Act 1983			
Name	James	**DOB**	
Address		**NHS Number**	

S117 review meeting date	

People present at the meeting			
Name	**Role**	**Agency**	**Contact details**
James	Person receiving s117 aftercare	N/A	James@person.com
Jacquie	wife	N/A	jacquie@nearestrelative.com
Jenny Slater	Social worker	Best local authority	Jenny.slater@bestlocalauthority.gov.uk
Justin Green	Consultant Psychologist Approved Clinician	Best NHS Trust	Justin.geeen@BFT.nhs.uk

Summary of the Review
S117 after-care reduced over time as a result of progress with recovery and rehabilitation. After-care in place at last review had reduced to having named contact within local mental health team and social work team just in case any needs arise. Annual review date agreed. James is content that he has been able to manage for over a year without the need to contact social worker or CMHT staff. He is happy with the progress he has made and is agreeable to being discharged from s117 after-care eligibility. Jacquie agreed that there has been no concern about James' mental health for many years and does not feel that as a family they need the support of mental health services at all. Neither James nor Jacquie could envisage the potential for any destabilising factors.

Outcome
James has agreed to be discharged from s117 after-care. Jacquie is also in agreement with the proposal to discharge from s117 after-care

As key workers involved in James' after-care we propose that James be discharged from s117 after-care

Statement by responsible authorities
We are satisfied that the above individual is no longer in need of s117 after-care services. We can confirm that the person and their nearest relative have been involved in the decision to discharge from s117 after-care.
Signatories of responsible authorities

Signature		**On behalf of Best Local Authority**
Name		
Title		
Date		

Signature		**On behalf of Best ICB**
Name		
Title		
Date		

Copies to

- Person
- Nearest Relative
- GP
- social services file
- NHS file
- ICB file

Template Letter confirming discharge from s117 after-care – consider if an easy read versions of this letter is required

Dear [name]

Re: Mental Health Act 1983 – Aftercare under Section 117 – Notification of discharge

Our records show that you were detained in hospital under a treatment order of the Mental Health Act [Section] on [date]. At the time of your discharge from hospital section 117 after-care as set out in the after-care plan commenced and your name was added to our list of people who are eligible for s117 after-care.

Section 117 of the Mental Health Act 1983 places a joint duty on local NHS and adult social services commissioners to provide free after-care services for people that have previously been sectioned under the treatment sections of the Mental Health Act. Eligibility for section 117 after-care remains in force until the responsible authorities (the Local Authority and Integrated Care Board), are satisfied that the person concerned is no longer in need of these services.

On [date] you were involved in a review of your circumstances by [team name] and have received a copy of the documentation associated with that review.

This review concluded that you no longer require after-care services under section 117 as you no longer have needs arising from or related to a mental disorder.

I am writing to confirm that this recommendation has been accepted by the responsible authorities and that you are now discharged from the Section 117 after-care. Your name will be removed from the current version of the after-care list that we maintain as of the date of the review.

Yours sincerely

Signature	***Signature***
Name	***Name***
Position	***Position***
For Best Local Authority	***For Best ICB***

Appendix E: Funding

Section 117 Funding arrangements

1 April 2022

Section 117 of the Mental Health Act 1983 places a joint duty on the Council and the Integrated Care Board to provide aftercare services for people discharged from hospitals after being sectioned for treatment under the Mental Health Act 1983 Sections 3, 37, 45A, 47 and 48.

The following funding agreement has been made between Staffordshire County Council, Stoke-on-Trent City Council, and the ICB:

All New individuals from 01/04/2022 will be funded on a 50:50 basis to include FNC where appropriate

All historic cases from prior to 01/04/2022 would be funded on a 50:50 to include FNC where appropriate from the date of their next annual review

There will be no longer a need to complete the Staffordshire tool in Staffordshire

Appendix F: Section 17 Leave and Section 117

The Mental Health Act Code of Practice (Paragraph 27.26) highlights that Section 117 applies to individuals who have been granted Section 17 leave:

> "The duty on local authorities and the ICB (or, in certain circumstances, NHS Commissioning Board (NHS England)) to provide after-care under Section 117 of the Act for certain individuals who have been discharged from detention also applies to those individuals while they are on leave of absence"

Previous case law found that the duty to provide after-care under Section 117 extends to individuals who, having been detained under Section 3, are granted leave of absence under Section 17 (R v Richmond LBC Ex p. W [1999]). However, the High Court has concluded that Section 117 after-care can apply when a patient is granted leave under s17, but only where the nature of that leave signifies the likely conclusion of the patient's period of acute inpatient care. (CXF, R (on the application of) v Central Bedfordshire Council & Anor [2017] EWHC 2311 (Admin) (15 September 2017),

Appendix G: Ordinary Residence

Ordinary Residence (as determined by the Care Act)

Ordinary residence is:

Ordinary Residence under the Care Act
Ordinary residence is the concept used in the Care Act to allocate local authority responsibility and may be important in deciding responsibility on discharge in the Transforming Care programme.

- The Section 117 duty falls to the local authority where the patient was ordinarily resident immediately before being detained. The deeming provisions within the Care Act do not apply to aftercare responsibility under the Mental Health Act. The approach to be taken is to follow the three-stage Shah approach to identify where someone is ordinarily resident, modified where necessary for people who don't have the capacity to choose where they live, and considering all the circumstances leading up to the compulsory detention.

- It does not matter who is paying for care and support at the time of detention or which local authority employed any Approved Mental Health Professional (AMHP) who might have been involved in the detention.

- If it cannot be established where the individual was ordinarily resident at the time of compulsory detention, it will be the local authority where that person is 'resident'.

- Where any dispute arises over aftercare responsibility, one authority would have to take responsibility for care planning and provision on a 'without prejudice' basis, and if no services are currently being provided that will be the authority where the person is physically present. If there is disagreement as to aftercare responsibility this is likely to become apparent at the discharge planning stage when the individual is still in hospital. Therefore, it is possible that the local authority in whose area the hospital is situated will need to accept provisional responsibility, even if there are no other connections to that area.
  Following the recent appeal of the Worcestershire case it was found that the duty to provide after-care services ends when an individual is compulsorily detained in hospital for treatment. This means ordinary residence, for the purpose of Section117, could have changed and is determined to be where the person was ordinarily resident prior to being admitted to the hospital for that subsequent period of detention.
  https://www.supremecourt.uk/cases/uksc-2022-0022.html

- Where there are complex circumstances and ordinary residence is not obvious, additional support should be sought from senior managers and/or legal services.

Appendix H: Children and Young People Operational Guidance:

CYP revised s.117 policy.docx

Glossary:

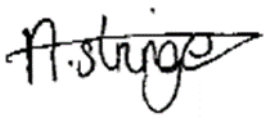
GLOSSARY OF TERMS AND ACRONYMS	
Key Worker / Care Co-ordinator	Coordinates the Inpatient Care
Named Worker / Care Co-ordinator	Coordinate the Community Discharge
ICB	Integrated Care Boards
LAs	Local Authorities
MHA	Mental Health Act – "the Act"
"the Act"	Mental Health Act 1983 (as amended 2007)
CTO	Community Treatment Order
MDT	Multi-disciplinary team
MLCSU	Midlands and Lancashire Commissioning Support Unit
TCP	Transforming Care Programme
SCC	Staffordshire County Council
SSOT	Staffordshire and Stoke on Trent
SOSCC	Stoke On Trent City Council
PHB	Personal Health Budget
NHC CHC	NHS Continuing Health Care

Links:

LINKS	
Staffs and SS117 WEBSITE	https://www.twbstaffsandstoke.org.uk/about-us/our-work/section-117-communication
Easy Read MHA code of Practice	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/421541/MHA_Code_EasyRead.pdf
MHA code of Practice	Mental Health Act 1983 (publishing.service.gov.uk)
London ADASS S117 Protocol 2018	Section-117-Protocol-reviewed-Dec-2018.pdf (londonadass.org.uk)
NHS S117 Guide	Mental health aftercare if you have been sectioned - Social care and support guide - NHS (www.nhs.uk)

Deaf Mental Health Service	Deaf mental health services - Birmingham and Solihull Mental Health NHS Foundation Trust - BSMHFT

Signatories:

Name and Job Role	Organisation	Signature	Date
Ben Richards Chief Operating Officer	North Staffordshire Combined Healthcare NHS Trust		19 September 2023
Chris Bird Chief Transformation Officer	Staffordshire & Stoke-on-Trent Integrated Care Board		21 September 2023
Amanda Stringer Lead ASC Assurance, Improvement & Transformation	Staffordshire County Council		4/10/23

Dr S Gower Personalised Healthcare Commissioning Clinical Director	NHS Midlands and Lancashire Commissioning Support Unit		22 January 2024
Dawn Crowther Head of Mental Health Act & Mental Capacity Act	Midlands Partnership NHS Foundation Trust	Signed off by policy and procedure committee	10 January 2024
Peter Tomlin Director Adult Social Care	Stoke-on-Trent City Council		02.05.2024