

PAN ESSEX
SECTION 117
Mental Health Act 1983 Protocol

Essex, Thurrock and Southend Section 117 After-care Protocol and Guidance

1. Policy Statement

1.1. Essex County Council, Southend Borough Council, Thurrock Borough Council and the Essex Clinical Commissioning Groups (CCG) are committed to ensuring, through this policy, that individuals who are subject to S117 of the Mental Health Act 1983 (MHA 1983) receive care in line with the principles articulated within the MHA Code of Practice. The primary purposes of S117 of the MHA 1983, as defined in S117 (6), are as follows:

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

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

1.3. It is the intention of this policy to ensure that S117 status is reviewed in a timely fashion and that all decisions in respect of this are clearly documented. People subject to section 117 may not be 'banked' and must be held as active cases by local social care authority and their relevant CCG who may delegate this responsibility to the appropriate Mental Health Trust.

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

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

2. Purpose

2.1. The objective of this procedure is to set out the policy requirements for provision of after-care services under S117 of the MHA 1983 to the residents of Essex, Southend and Thurrock.

2.2. This document aims to lay out a clear framework for the Health and Social Care services in Essex, Southend and Thurrock to utilise when delivering statutory after-care to people who are entitled to those services under S117 MHA 1983.

2.3. All staff should be familiar with the relevant sections in the Code of Practice and the Reference Guide to the MHA in respect of Section 117.

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

3. Definitions

- Care Programme approach (CPA): Framework of assessment, care planning and review for people who receive mental health services.
- Care management: Framework of assessment, care planning, provision of care packages and review for people who receive services via Local Social Services Authorities (Within adult mental health services, CPA and care management are fully integrated. This is true to a lesser and varied extent where CPA applies for other care groups. Therefore, both CPA and care management will be referred to where applicable throughout the policy.)
- Clinical Commissioning Group (CCG): Replaced Primary Care Trusts in April 2013.
- NHS Continuing Healthcare
Relevant sections of MHA 1983:
 - Section 3: Order detaining an individual in hospital for treatment
 - Section 17 leave: Period of agreed community leave for a service user currently liable to detention in hospital.
 - Section 17A (Community Treatment Order): Order providing a legal framework around the care plan of an individual who has been detained under section 3 (or section 37 hospital order), when they are discharged from hospital, although they remain liable for recall or revocation from the Community Treatment Order
 - Section 37: Hospital Order detaining an individual who has been transferred by the Courts to hospital for treatment. Note: Guardianship under section 37 does not confer S117 status
 - Section 37/41: Order detaining an individual who has been transferred by the Courts to hospital for treatment, with restrictions
 - Section 37/41 – conditionally discharged Service users: section 42 allows the Secretary of State to direct that someone under a restriction order should be discharged from hospital but subject to conditions e.g. place of residence, supervision by psychiatrist and social supervisor

- Section 45A: When imposing a prison sentence for an offence other than when the sentence is fixed by law, the Crown Court can give a direction for immediate admission to and detention in a specified hospital, with a limitation direction under Section 41. The directions form part of the sentence and have the same effect as a hospital order. The Home Secretary can approve transfer back to prison at any time.
- Section 47 or 48: Orders detaining an individual transferred from prison to hospital for treatment.
- Section 47/49: Orders detaining an individual transferred from prison to hospital for treatment, with restrictions

4. Legal Context.

4.1. Local Social Services Authorities (LSSAs) and Clinical Commissioning Groups (CCGs) have a statutory duty to provide, in cooperation with relevant voluntary organisations, after-care services for any person to whom S117 of the MHA 1983 applies.

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

4.3. The Care Act 2014 amended S117 and changes are summarised below:

- Amended S117 (3) with the effect that the term “resident” now means “ordinarily resident”.
- This brings determination of LSSA responsibility in line with the Ordinary Residence Regulations and Care and Support Statutory Guidance which accompanies the Care Act 2014.
- Introduced a dispute resolution process (S117 (4)).
- Introduced statutory definition of the purpose of after-care (S117 (6)).
- Introduction of new subsection (S117 (A)) which introduces the statutory duty to offer choice in accommodation for individuals being.

4.4 Local Government Association August 2018 Ordinary Residency Guide.

Determining Local Authority under the Care Act and Mental Health Act

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

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

- Service users detained in a psychiatric hospital under Section 3 MHA (compulsory admission to hospital for treatment);
- Service users admitted under an order made under Section 37 MHA (detention in psychiatric hospital under a court order);
- Service users transferred to a psychiatric hospital from prison or remand centre (including those on remand, detained in prison under the civil law or held under immigration legislation) in pursuance of a transfer direction under Section 45A, 47 MHA and Section 48 MHA; and who cease to be detained; and leave hospital (whether immediately after the detention has ended).

4.6. In addition, S117 MHA applies to:

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

4.7. After-care under S117 is to be provided until such time as the Local Social Services Authority and Clinical Commissioning Group are jointly satisfied that the person concerned is no longer in need of statutory after-care. This is achieved through care co-ordination with systematic, high quality assessment, review and discharge arrangements. It must be remembered that an individual may have needs that fall outside s.117 and the local authorities charging policies will apply

- 4.8. Health Service Circular HSC 2000/003 and Local Authority Circular LAC 2000(3) states that: 'Social services and health authorities should establish jointly agreed local policies on providing S117 MHA after-care. Policies should set out clearly the criteria for deciding which services fall under S117 MHA and which authorities should finance them. The S117 MHA after-care plan should indicate which service is provided to meet needs falling under S117. After-care provision under S117 MHA does not have to continue indefinitely. It is for the responsible health and social services authorities to decide in each case when after-care provided under S117 MHA should end, taking account of the patient's needs at the time. It is for the authority responsible for providing particular services to take the lead in deciding when those services are no longer required. The patient, his/her carers, and other agencies should always be consulted'.
- 4.9. Within this policy we use the terms 'will' and 'should' and they are to be interpreted in the following way;
- Will – is used to indicate the requirement is a legal or overriding duty or principle. Where staff are unable to complete this requirement, they must report this to a manager and request advice as to alternative ways to comply with the legislation.
 - Should – is used where the duty or principle may not apply in all situations and circumstances, if there are factors outside the control of staff that may affect how they comply with the policy.
- 4.10. For purposes of clarity the term discharge in this document applies to discharge from services (inpatient/community). Discharge of S117 status is referred to as 'ending of section S117'.

Procedural matters

This section covers the practice and procedural mechanisms required to discharge our S117 responsibilities. This content is summarised in the flow charts attached at **Annex A**.

5. Mandatory procedures

- 5.1. The S117 statutory duty arises at the point of discharge but after-care bodies must ensure that appropriate planning takes place as soon as possible following detention/admission.
- 5.2. S117 after-care planning meetings must be documented fully. Further practice guidance is provided in Appendix A (adapted from Bevan Brittan: S117 Briefing).

- 5.3. Service users who are subject to S117 and receiving community services will be offered an IMHA to support them at reviews, where the service user would have substantial difficulty in taking part in the process and has no appropriate person to assist him.
- 5.4. Decision to end S117 can only happen with the agreement of both social care authorities and clinical commissioning groups who may delegate the decision to the responsible Mental Health Trust (see section – discharge). Any such decision will be recorded in writing in line with this policy and sent to the service user and with their agreement their advocate/carer.
- 5.5. Service users should not be automatically discharged from S117 if they are discharged from specialist mental health services. A care plan must be in place which incorporates the dates for `S117 reviews in the future. Service users cannot be discharged from services whilst assessed as continuing to have S117 needs.
- 5.6. The after-care will be provided from when a service user's Responsible Clinician (RC) authorises Section 17 leave of absence, – the service user is discharged on to Community Treatment Order (CTO) and upon discharge from hospital.
- 5.7. Service users are not charged for services they receive relating to their after-care needs under S117 (see section 35).
- 5.8. Discharge of S117 can only be made with the agreement of both the LSSA and the CCG. In some circumstances this is delegated to lead partner organisations, e.g. EPUT
- 5.9. The duty to provide S117 after-care is not broken by the Service user's subsequent readmission to hospital, either informally or under Section 2 of the MHA.

6. The Purpose of After-care

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

7. Scope of After-care

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

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

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

7.3. The provision of accommodation in and of itself is not considered to be an S117 after-care need unless:

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

8. Carers

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

9. Assessment

9.1. The planning and implementation of after-care services should be completed using the existing processes of the Care Programme Approach.

9.2. Personalised care and support should be offered in the same way as patients not eligible for S117.

9.3. Legislation is not intended as a barrier to providing creative and personalised support and the personal health budget or direct payments policies should be considered.

10. Hospital Discharge Planning

10.1. Failure to implement discharge planning arrangements within 'a reasonable time' is in breach of Article 5 of the European Convention of Human Rights, and therefore in breach of the 1998 Human Rights Act. Health and social care staff responsible for discharge planning need to ensure that the reasons for any delay are well documented and evidenced. Discharging remains a joint responsibility between the CCG and the LSSA.

10.2. Patients should be the focal point of planning care service provision and should be involved in so far as possible. Their views on what will be needed to support them should be a primary concern for staff planning 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. A care planning meeting should be held;

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

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

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

10.4. Where possible this should be at least a week before discharge. The Code of Practice (2.29) requires the care team to inform the patients nearest relative of

discharge from detention or CTO (where practicable) at least seven days prior to the discharge. This would include discharge from detention on to CTO. If the patient or the nearest relative has asked for this information not to be shared, then there is no legal authority to discuss with them.

10.5. Identification of needs and services can be a protracted process. Discharge planning should be started on admission. Reasonable steps must be taken to ensure the identification of appropriate after-care facilities and services for the patient before his/her actual discharge from hospital, and the actual cost of such service provision. This should include identification of the relevant CCG/LSSA that will be responsible for after-care.

10.6. In the event that after-care cannot be provided by already commissioned services and/or universal services then an application for after-care funding may be required.

11. Review

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

11.2. This meeting may include the following people:

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

- 11.3. Each review must include an explicit decision on whether the person continues to be eligible for S117 after-care, the reasoning for the decision and what services are required to support them, based on whether the individual continues to have identified, assessed S117 needs.
- 11.4. All reviews must be formally documented.
- 11.5. All care plans must include specific detail of which needs are to be met under S117.
- 11.6. Any changes in S117 status of the service user (or patient as referred to in the Act) will be immediately recorded using the respective organisations process to amend the register (i.e. transfers/discharge). This information will be regularly updated and shared with the LSSA, Trust and CCG or other successive body. This Register will be used as part of the process for reviewing individual status for S117 across partner agencies.

12. Recording

- 12.1. It is very important to distinguish on care plans and S117 MHA 1983 documentation those items of care and support that are meeting needs related to S117 mental health needs and are provided free of charge, and those items that relate to social care needs unrelated to the relevant mental disorder, which may be subject to an appropriate charge by the local social services authority. It is therefore important that the care co-ordinator in the S117 MHA 1983 planning arrangements is fully aware of the legal position and any funding commitments that may result.
- 12.2. Within effective care co-ordination, written documentation giving full assessment details should be available to inform an individual's care plan. All the services relevant to the S117 after-care plan must be carefully recorded and agreed with the person and or their representative. There should be a record of which services are to be provided by each agency.
- 12.3. Refusal by the service user to receive assessed after-care services is not a reason to determine that there is no longer any after-care need. Instead, the services themselves will cease but the service user must be made aware of the complaints process and that they can contact the statutory bodies should they change their mind. Responsible authorities should regularly review the refusal to accept services identified as S117 needs.

13. Section 117 Register

- 13.1. CCGs and the Trusts information team will ensure that registers of those under section 117 are kept up-to-date and are compliant with the data sharing agreement

13.2. The registers will be shared with the respective local authorities by the Trusts information team.

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

14.1. 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.

14.2. 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.

14.3. 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.

15. Funding Responsibility and Residency: General Statement

15.1. S117 after-care responsibility comes into effect at the point of discharge. It is therefore essential as part of the discharge planning process to identify the relevant funding bodies and the funding split between the CCG and the LSSA prior to discharge.

15.2. All parties will follow the guidance set out in the Care and Support Guidance (D O Health and Social Care, 2018 amended) and the relevant NHS Responsible Commissioner Guidance. As these new regulations are not retrospective, the following provisions apply:

- Patient's residency prior to 1st April 2013 should be determined according to their residence prior to detention. Further details are provided in Paragraph 16 below.
- Patient's residency on/after 1st April 2013 should be determined according to the new regulations, Commissioning Guidance
- Patient's residency on/after 1st April 2015 should be determined in accordance with the amendments made to S117 by the Care Act.

- 15.3. Residency in the context of S117 should be interpreted as a “settled presence in a particular place other than under compulsion” (R. (on the application of M v Hammersmith and Fulham LBC [2010])). This applies regardless of the duration of the residence. In cases of dispute the matter of residency should be determined on a case by case basis (which includes the service users views of where they reside), seeking legal advice if required.
- 15.4. Decisions regarding residence may often be complex and for this reason advice should be sought via Senior Managers, who can/will escalate issues to legal services as appropriate.
- 15.5. Where the responsible authorities have been identified the patient’s case should be allocated to a Care Coordinator as soon as possible after implementation of the detaining section. This allows for assessments and discharge planning commencing at the earliest opportunity.

16. Previous Responsible Commissioner Guidance (pre-Care Act)

- 16.1. Care Coordinators should refer to the following table in the event they are dealing with a person who was discharged prior to the Care Act Guidance 2015:

Discharge pre- 1 st April 2013	If a patient who is resident in one area (CCG A) is discharged to another area (CCG B), it is then the responsibility of the CCG in the area where the patient moves (CCG B) to pay for their after-care under section 117 of the Act as agreed with the appropriate local social services authority.
Discharge Post 1 st April 2013 and pre-April 1st 2016	For service users under S117 who moved, or will move, to another area and were discharged after 1st April 2013 it will be the CCG where they are registered with a GP or are usually resident that is responsible for them, until such time that they register with a GP in the new area. At that point in time the CCG which the GP practice is registered with will be responsible for ongoing S117 Health needs. Since this may mean that the current CCG will change immediately on placement it is important that the receiving CCG is involved in the after-care planning process.
Discharge post 1 st	For any patient discharged after 1 April 2016, the

April 2016	CCG and LA responsible for that patient's after-care are the CCG and LA responsible for the geographic area in which the person was Ordinarily Resident immediately prior to being detained under a Qualifying Detention. It is fixed with <i>that</i> LA and <i>that</i> CCG (it will not change or transfer if the patient moves).
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16.2. Out of Area placements are those services which are located outside the catchment areas of the CCG and LSSA and to which patients have moved in accordance with their after-care needs.

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

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

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

17.1. Section 75 of the Care Act 2014 has amended S117 (3) to the effect that from 1 April 2015 the term resident will mean ordinarily resident. Therefore, the regulations regarding ordinary residence will apply. The duty on Local Authorities rests with the area in which the person was ordinarily resident immediately before they were detained, even if the person subsequently becomes ordinarily resident in another area after leaving hospital.

17.2. As the Care Act is not intended to be retrospective this only applies to cases where the individual was detained on/after 1st April 2015. For pre-existing cases residency should be determined under the rules and case law and NHS responsible commissioner guidance applicable at the time of their detention or discharge.

18. Funding Responsibility: Children and Young People

18.1. LSSA S117 after-care responsibility for children and young people is determined through the usual means as detailed in section 15 above.

18.2. CCG responsibility is determined through the usual means (as outlined above and in the responsible commissioner guidance) except in the following circumstances where the duty will be imposed on a different CCG. The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 outline the circumstances in which the duty (S117) may be imposed on another CCG or on the NHS Commissioning Board. Regulation 14(2)(b) refers to schedule 1 and sub –paragraphs (c) and (g) outline the circumstances, for specific groups of children, where S117 responsibility remains with the placing CCG even after they have registered with a GP in the CCG area to which they have been placed. With regards to children those groups are:

- Any child with regard to whom (1) a local authority has made an arrangement before 1 April 2013 by virtue of which the child is provided with accommodation at a school in the area of another CCG, to which the child is admitted in accordance with a statement of special educational needs, (2) immediately before the child was so accommodated, the child was either provided with primary medical services by a person who is now a member of the ‘placing’ CCG or usually resident in the area of the ‘placing’ CCG and not provided with GP services by a person who is now a member of the ‘placing’ CCG and (3) the ‘placing’ CCG would not otherwise be responsible under s3(1A)(a) of the 2006 Act (because the child has now been registered with a GP practice in the area of the ‘receiving CCG’).
- Any child who is:
 - a “looked after child” within the meaning of s22 Children Act 1989 (but excluding a child accommodated in a secure children’s home for whom the Commissioning board has commissioning responsibilities); or
 - a “relevant child” within the meaning of s23A Children Act 1989; or
 - a child qualifying for advice and assistance under s24(1A) or (1B) Children Act 1989; or
 - a child provided with accommodation at a school to which (s)he is admitted with a statement of educational needs made under s324 Education Act 1996; or
 - a child who requires accommodation in a care home, a children’s home or an independent hospital to meet his or her continuing care needs;
 - Funding Complex after-care and S117

19. Funding Complex Care Packages.

19.1. The majority of people who are subject to S117 will be able to have their after-care needs met through access to already commissioned mental health services, universal services and other community services. However, there will be a certain percentage of people whose health or social care needs cannot be met as described. In these circumstances it will fall to the responsible after-care bodies to meet those needs, provided that all reasonable alternatives have been explored. It should be noted that this section relates only to service users where Essex CCGs and LSSAs are jointly responsible for S117 after-care. There will be occasions where S117 responsibility is split between different CCGs and LSSAs. In such cases funding will have to be agreed on a case by case basis. It is therefore essential where individuals are placed out of area and are registered with a different GP that the CCG for that area are notified as soon as is practicable. Requests for additional funding will be presented to the Pan Essex 117 Panel.

All applications should be presented with the required complete paperwork to the required standards (in line with the ToR annex B) which will be used as a guide to determine relative funding splits.

19.2. There are three options for funding a person's after-care needs:

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

19.3. 100% CCG Funded Provision. Where a person meets the eligibility criteria for fully funded Health Services, the CCG will resource 100% care provision.

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

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

20. Section 17 Leave

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

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

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

- The granting of Section 17 leave can only be given by the RC;
- The patient remains liable to be detained;
- The patient remains subject to the consent to treatment provisions under Part 4 of the MHA;
- A person subject to Section 3 and who is on Section 17 leave can have their period of detention renewed under Section 20.
- Section 17 leave should last only for a short period of time after which, and if the trial period is a success, the person can then be formally discharged. If appropriate the Local Authority, either singly or together with the CCG, can then take over the lead arrangements for the continuation of the placement.

21. Section 17A Community Treatment Orders

21.1. The primary purpose of CTOs is to ensure that the service user continues to receive treatment for their mental disorder in the community. People subject to Community Treatment Orders may also require funding for a complex care package and the Pan Essex S117 panel process therefore applies

22. 100% LSSA funding

22.1. When the person's needs are exclusively social care needs then the LSSA will fund that after-care package.

22.2. These arrangements apply only to support that is commissioned and not to 'universal' services that they would have received were they not subject to Section 117 e.g. CMHT services, LSSA assessment, non S117 community care services, care management services, carer support services etc. This could also include residential care, with or without nursing (in which case an FNC equivalent cost may be applied)

23. Joint Funding

23.1. All S117 placements that are not fully Health or Social Care, that is to say they have a complex combination of health and social care requirements, will be funded on a 50:50 basis. If there is a disagreement between agencies as to whether or not a funding split should be entered into then the case can be escalated to the senior managers of the Individual Placements Team (Health) and the local authority in whose area the service user resides. If needs change prior to the next panel cost of extra care will be shared equally between Health and Social Care until presentation at the subsequent panel

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

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

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

- Assessment and decision making should be fair and consistent – there should be no discrimination on the grounds of race, disability, gender, age, sexual orientation.
- Decision making must be clear and reasoned, which is accurately and fully recorded.

24.3. S117 requires the Local Authority to provide those after-care services for which it is lawful for it to provide. Where someone is in a care home setting as part of S117 after-care, then the Local Authority can provide general nursing care which is “merely incidental or ancillary to the provision of the accommodation” and is of a “nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide”. Under these circumstances the Local Authority would make the necessary contractual arrangements for the provision of services, which would be free to the person under S117.

- If the NHS CHC assessment process determines that the person has a Primary Health need, whether that be due to a mental health or a non -mental

health, health need, then the person would, if it were not for S117 be eligible for NHS funded Continuing Health Care.

- Under these circumstances, the CCG would make the necessary arrangements for the provision of services and will fund 100%.
- On some occasions the appropriate panel may decide as a result of the CHC assessment process that a jointly funded care arrangement would be the most effective way of meeting a person's needs. Under these circumstances, the Local Authority would normally take the lead contractual role for the provision of services.

24.4. A service user may have needs which do not fall within the scope of S117. Those needs may be of a degree that means that they will be met under Continuing Healthcare. The relevant CCG must keep a clear record of which needs are met under S117 and which are met under Continuing Healthcare.

25. Top Up Payments and Risks

25.1. Agreement to any top-up payments will be subject to the proposal meeting the conditions set out in Annex A of the Care and Support Guidance (Department of Health and Social Care 2018, as amended) and local governance arrangements.

26. Direct Payments as a part of a personal budget or personal health budget

26.1. Changes to the Direct Payments Regulations, effective from November 2009, now mean that LSSAs have a duty to offer direct payments to people who are subject to mental health legislation. This is with the principal exception of people who are on conditional discharge from hospital under Part III of the MHA 1983 where there is now a power (but not a duty) to offer direct payments. Local social services authorities also have a power (but not a duty) to offer direct payment arrangements for conditions attached to a Guardianship Order.

26.2. It is very likely that NHSE will extend the right to a Personal Health Budget (PHB) to those people eligible for section 117 and who make use of NHS mental health services. Therefore, in planning care for people under section 117, care coordinators should discuss the option of a PHB or, where appropriate, an integrated personal Budget and PHB with the person being discharged from hospital.

27. Ending S117

27.1. The Code of Practice also states (paragraph 27.3) that the 'duty to provide after-care services continues as long as the patient is in need of such services' and confirms (in paragraph 27.19) that 'the duty to provide after-care services exists until both the primary care trust [CCG] and the local social services authority are satisfied that the patient no longer needs them.'

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

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

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

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

27.5. After-care under S117 may be terminated for the following reasons:

- A review has determined that the service user no longer has S117 needs
- Death of a service user

S117 after-care cannot be terminated solely:

Because the service user refuses the services

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

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

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

- What is 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?

27.8. 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.

27.9. 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.

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

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

- The care coordinator and the relevant Team Manager/Social Care Representative or Social Services Department **and** the Consultant Psychiatrist.
- If there is a difference of opinion between Health and Social Services regarding the decision to discharge from S117, which cannot be resolved at operational level, this will need to be escalated to Senior Management within the CCG and LSSA.

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

27.13. The decision to end S117 must be recorded in line with the Trust or Social Care Authorities policies on record keeping and in full compliance with professional standards.

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

28. Charging

- 28.1. The Local Authority is unable to charge service users for a contribution to any after-care services (including residential care) that are provided under S117. When someone who is subject to S117 is in receipt of services or support (not covered in the 117 after-care plan) they are chargeable, the care co-ordinator/care manager is responsible for ensuring that the relevant social care authority conducts the Financial Assessment.
- 28.2. S117 after-care is essentially aimed at providing after-care services for people who have: been detained in hospital and as well as meeting their immediate needs for health and social care. After-care should aim to enable the service user to regain, learn or enhance their skills in order to cope with life outside hospital (MHA Code of Practice).
- 28.3. Individuals may have at the same time or, may develop other needs for service provision, which are not connected to their mental health after-care needs, for example, a physical disability or age-related illness or condition. The social consequences of such a need may amount to a community care need in its own right if it is assessed. When this is the case, and whilst the individual remains subject to S117, community care services to meet their “physical” social care needs, which are clearly independent of their community care services to meet their needs from a mental disorder, may be subject to a financial assessment, with a view to charging the person for those services. This is likely to be a rare occurrence and whenever it arises the care coordinator must always:
- Send the details of the assessment, proposed care plan and any other associated documents to the LSSA’s legal services so that they can give a legal view on the lawfulness of such an approach. Only once legal services confirm that, in this case, it is possible to charge the person for a community care service will the care co-ordinator then make the necessary arrangements with the FAB team.
 - The care co-ordinator will explicitly define for the service user and their representative those services which will continue to be provided under S117 and those which will be provided under the Care Act 2014 and subject to a financial assessment.
 - The person and their representative should always be offered independent advocacy during this process.

28.4. There can exist a close inter-relationship between the presence of a mental disorder and a physical disability. The decision to end S117 after-care, in the presence of an ongoing, long term physical disability must take into careful account both psychiatric and medical assessments and consider the person's circumstances in the round.

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

s117 and Prescription Charges

28.6. There cannot be charges for prescriptions which form part of the after-care plan. For prescriptions not covered by the after-care plan, the usual rules will apply.

29. Complaints

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

30. Dispute Resolution

30.1. Disputes between the parties to this protocol will be resolved under the local dispute's arrangements attached to this document. The presumption will be that disputes between one of the parties and another body (for example a CCG from out of the area) will also be resolved under the attached arrangements unless the bodies in dispute agree to use a separate scheme. These arrangements may change from time to time to reflect local requirements. In all cases the disputes resolution arrangements will be fully compliant with relevant national guidance and statutory duties.

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

- Uploading the policy to the public website and intranet of the Essex Local Authorities and the CCGs
- Essex Partnership University Foundation Trust, Hertfordshire Partnership Foundation Trust, North East London Foundation Trust
- Disseminating the policy to all relevant professionals via team managers across relevant Health and Social care organisations in Essex
- Disseminating the policy to service user groups, carers groups and organisations and advocacy providers.

31. Health and Safety at Work Act

31.1. When considering the use of a placement in the context of this protocol, the following case law determines the practice of panel members. Further details will be added to the Essex 117 Panel Terms of Reference as part of the up and coming review: <https://www.mills-reeve.com/files/Publication/7f6b48f9-28ec-4cf4-8634-1010bf331ad1/Presentation/PublicationAttachment/662ecc63-ed0a-4ced-a0e6-f9046511f2fd/Hertfordshire%20Partnership%20Trusts%20conviction%20-%20July%202012.pdf>

32. Review

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

Appendices:

Annex A

- *“for the purposes of EPUT “the relevant Team manager/social care representative or social services department” would be the care coordinator who has delegated responsibility under the s75 agreement.”*

Operational Flow Charts



117 flow charts
Catherine.pptx

Terms of Reference and Process Guidance for the Pan Essex S117 Funding Panel



Essex 117 Funding
Panel Protocol May 1