Hertfordshire Partnership NHS
University NHS Foundation Trust

Addendum to Aftercare of Patients S.117 Policy

November 2019

Author/ Job Title: Rob Marsden AMHP Practice Development Manager

A draft of the Policy has been submitted to HCC Legal Services and Commissioners and is awaiting agreed development and responsibility for a S.117 Register and Disputes process with the CCGs

Whilst the practice content and guidance within the attached Policy remains relevant and correct (and consistent with current NHS commissioning and ADASS guidance) the Policy can only be ratified and complete when the S.117 Register and Local Disputes process are agreed and included.

Current/ Interim arrangements for attached Policy

Part 1

The definitions, Legislative framework and Eligibility all currently apply and represent the confirmed policy position, up to and including the section on No Recourse to Public Funds.

Part 2

The Legal position (duties and responsibilities) are correct and current in relation to Funding, Who pays? and 'Ordinary Residence'.

Responsibility and arrangements for the S.117 Register and Dispute Resolution are awaiting development and currently omitted- if you have any related queries please contact Tina Kavanagh (Directorate Manager Mental Health Legislation) on: 07885377088

The Review process, ending S.117 and NHS Continuing Health Care sections are accurate and complete, including the imbedded flow charts for the use of clinicians and practitioners.

Needs- led Assessment and the Components of Aftercare is consistent with the current Care Planning Policy.

Choice of Accommodation S75 (6) is Care Act 2014 compliant, as is the content concerning Advocacy arrangements within associated MHA and MCA frameworks.

Part 3 and Appendices

The document control and standards, and all Appendix sections (including the letter templates and prescription exemption guidance) all reflect current procedure.

MENTAL HEALTH ACT 1983

(AS AMENDED)

Aftercare of patients under S.117 of the Mental Health Act 1983

Mental Health Act Code of Practice – Chapter 27

Although this procedural document has passed its review date it remains the current version

Version: **2.2**

Executive Lead: **Executive Director of Quality & Safety**
Lead Author: **AMHP Service Development Manager**

Approved Date: **6th May 2014**
Approved By: **Mental Health Act Strategy Policy Sub-group**

Ratified Date: **13th May 2014**
Ratified By: **Policy Panel**

Issue Date: **9th June 2014**
Review Date: **30th September 2020 'IGC on 20.01.2021 agreed expiry date extension to 30.06.2021 following rapid review'**

Target Audience:
This Policy must be understood by staff working in:

- All staff (including staff in inpatient services) involved in the aftercare of patients
- All staff who act as Responsible Clinicians and Care Co-ordinators
- Approved Mental Health Professionals
- Mental Health Act Administrators

Preface - concerning the Trust Policy Management System (PMS)

P1 - Version Control History:
Below notes the current and previous Version details

Version	Date of Issue	Author	Status	Comment
V1	1st November 2011	Directorate Manager Mental Health Legislation	Superseded	New Policy
V2	9th June 2014	AMHP Social Work	Superseded	Full review
V2.1	27th April 2015	AMHP Social Work	Current	Interim updated Mental Health Act and Care Act 2014, virtually agreed by MHA Quality and Policy Group.

P2 - Relevant Standards:

a) S.117 of the Mental Health Act 1983, Mental Health Act Code of Practice – Chapter 27

b) **Equality and RESPECT:** The Trust operates a policy of fairness and RESPECT in relation to the treatment and care of service users and carers; and support for staff.

.

P3 - The 2012 Policy Management System and the Policy Format:
The PMS requires all Policy documents to follow the relevant Template.

- **Policy Template** is the essential format for most Policies. It contains all that staff need to know to carry out their duties in the area covered by the Policy.
- **Operational Policies Template** provides the format to describe our services, how they work and who can access them.
- **Care Pathways Template** is at the moment in draft and only for the use of the Pathways Team as they are adapting the design on a working basis.
- **Guidance Template** is a sub-section of the Policy to guide Staff and provide specific details of a particular area. An over-arching Policy can contain several Guidance's which will need to go back to the Approval Group annually.

Symbols used in Policies:

RULE **=internally agreed, that this is a rule & must be done the way described**

STANDARD **= a national standard which we must comply with, so must be followed**

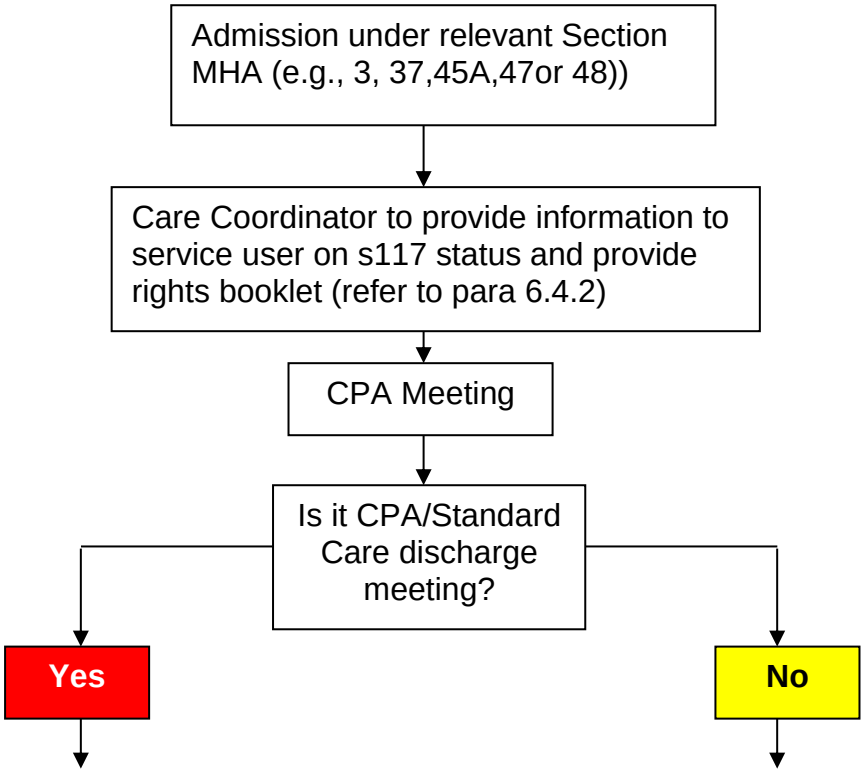
Managers must bring all relevant policies to the attention of their staff, where possible, viewing and discussing the contents so that the team is aware of what they need to do.

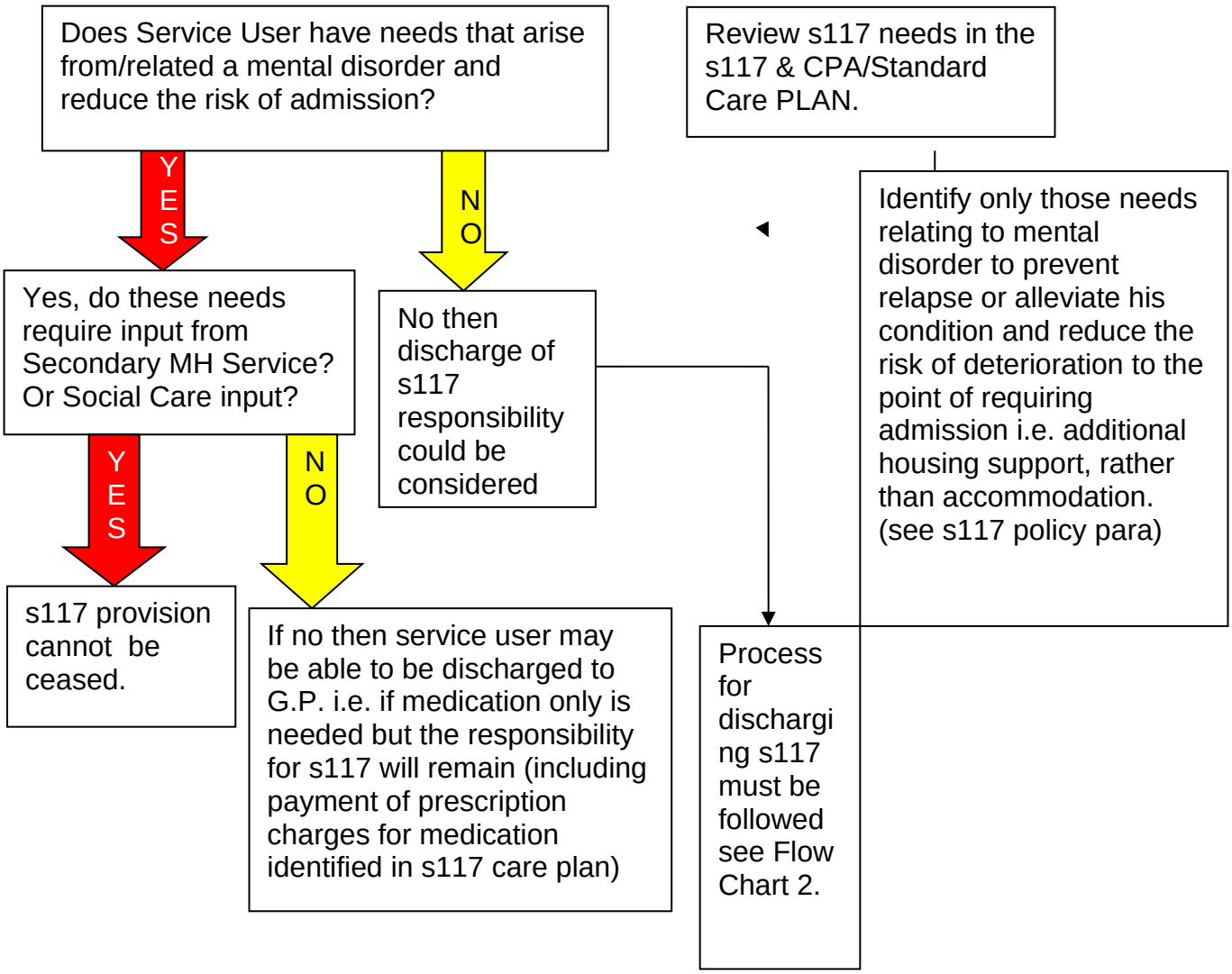
Individual staff/students/learners are responsible for implementing the requirements appropriate to their role, through reading the Policy and demonstrating to their manager that they understand the key points.
All Trust Policies will change to these formats as Policies are reviewed every 3 years, or when national Policy or legislation or other change prompts a review. All expired & superseded documents are retained & archived and are accessible through the Compliance and Risk Facilitator Policies@hpft.nhs.uk
All current Policies can be found on the Trust Policy Website via the Green Button or
http://trustspace/InformationCentre/TrustPolicies/default.aspx

Contents

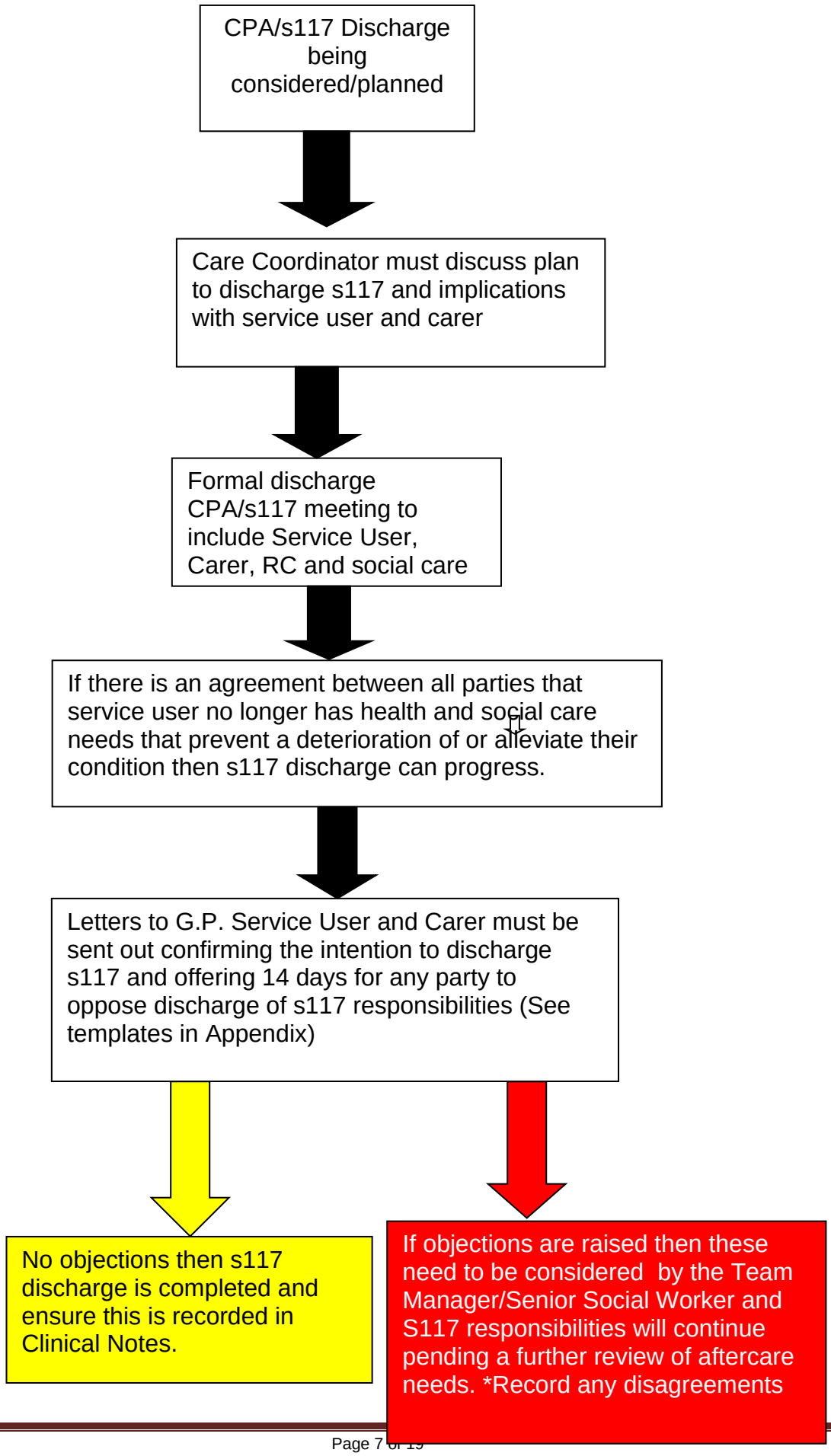
PART 1 – Preliminary Issues:

1. Flow Chart 1 - Procedure when reviewing s117 responsibilities at CPA/Standard Care review meeting




Does Service User have needs that arise from/related a mental disorder and reduce the risk of admission?
YES
NO
Yes, do these needs require input from Secondary MH Service? Or Social Care input?
No then discharge of s117 responsibility could be considered
YES
NO
s117 provision cannot be ceased.
If no then service user may be able to be discharged to G.P. i.e. if medication only is needed but the responsibility for s117 will remain (including payment of prescription charges for medication identified in s117 care plan)
Review s117 needs in the s117 & CPA/Standard Care PLAN.
Identify only those needs relating to mental disorder to prevent relapse or alleviate his condition and reduce the risk of deterioration to the point of requiring admission i.e. additional housing support, rather than accommodation. (see s117 policy para)
Process for discharging s117 must be followed see Flow Chart 2.

Flow Chart 2 - Procedure when discharging s117 responsibilities at CPA review meeting.



2. Summary

This policy has been developed by Hertfordshire Partnership University NHS Foundation Trust (HPFT) and Hertfordshire County Council's Health and Community Services Department. This policy is primarily for the staff of Health and Community Services and HPFT but it should be recognised that aftercare services under S. 117 may be provided from time to time solely by Primary Care Services.

It describes the statutory framework by which patients are recognised for the purpose of S. 117 and the legal duty which the Local Social Services Authority and the Clinical Commissioning Groups are under to provide the aftercare that is needed. Services provided under S. 117 can include services provided directly by Clinical Commissioning Groups or Local Social Services Authorities as well as services that are commissioned from other providers[1].

The legal duty to provide aftercare services continues for as long as the patient is in need of such services[2].

3. Purpose

- To ensure that all professionals involved in the care and treatment of patients with a mental disorder understand their responsibilities in relation to those patients recognised for the purpose of S. 117.
- To provide guidance to all professionals involved in the aftercare and treatment of patients with a mental disorder about the principles as set out within the Mental Health Act Code of Practice.
- To provide guidance on what the components of aftercare include and for the purpose of determining the need for aftercare to continue to give equal weight to both the health and social care needs of patients.
- To ensure that services are provided as part of the care plan and are done so free of charge.

4. Definitions

STANDARD

The requirement under S117 of the Mental Health Act 1983 for the provision of aftercare is intended to ease the transition on discharge from hospital and to try to prevent relapse and readmission to hospital.

"After-care services" means services which have both of the following purposes –

(a) Meeting a need arising from or related to the person's mental disorder; and
(b) Reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder)."

[1] Code of Practice 27.4
[2] Code of Practice 27.3
3 Care Act 2014 Section 75 (5)

5. Duties & Responsibilities

RULE

5.1 S.117 (2) of the Mental Health Act 1983 reads:
"It shall be the duty of the Clinical Commissioning Group and of the Local Services Authority to provide, in cooperation with relevant voluntary agencies, aftercare services for any person to whom this section applies until such time as the Clinical Commissioning Group and Local Social Services Authority are satisfied that the person concerned is no longer in need of such services: but they shall not be so satisfied in the case of a community patient while he remains such a patient"[3].

5.2 The right to aftercare includes those on Leave of Absence (S.17)[4] and those who will be subject to Supervised Community Treatment (S.17A). The Care Coordinator should ensure that the patient is aware that (s)he is recognised for the purpose of Section 117 and what this means.

5.3 S. 117 provides a legal right to aftercare services for anyone who ceases to be detained, having previously been detained under the following powers:

- S. 3 provides for the compulsory detention of a patient for the purposes of treatment ;
- S. 37 provides for a Court to order the treatment of a patient;
- S. 45A provides for a requirement for hospital treatment with limitation directions together with a prison sentence;
- S. 47 provides for the power to make a direction transferring a sentenced prisoner to a psychiatric hospital;
- S. 48 provides the power to make a direction transferring an un-sentenced prisoner to a psychiatric hospital;

[3] Mental Health Act 1983 Section 117(2)
[4] Code of Practice 21.25

6. Legislative Framework

6.1 Once S. 117 commences it is on-going and can only be discharged when **both** Health and Social Care professionals jointly agree that the patient no longer requires aftercare for both health and social care needs to prevent a relapse in their mental health.

- The duty of aftercare cannot end whilst a patient remains subject to a Community Treatment Order[5]. Where patients eligible for provision under s117 of the Mental Health Act 1983 have remained in hospital informally after ceasing to be detained under the Mental Health Act, the entitlement to aftercare under S. 117 continues once they leave hospital. This also applies when patients are released from prison, having spent part of their sentence detained under a relevant section of the Act[6].

- Services provided under S. 117 are not liable to financial assessment or charging[7].

- Services include all those which are a component of the patient's Aftercare plan.

- Services includes medication for mental disorder which should be provided free of charge[8]. Therefore the NHS (Charges for Drugs and Appliances) Regulations 2000 (SI 2000/620) do not apply.

- Determining the responsible authorities for aftercare. The LSSA and CCG for the area in which the patient concerned is resident or to which he is sent on discharge by the hospital in which he was detained[9].

6.2 The Meaning of "Ordinary Residence"

6.2.1 S.75 Care Act 2014 changes the position regarding who is responsible for the provision of services under S117. Responsibility is now given to the local social services authority and clinical commissioning group in which the person was "ordinarily resident" immediately prior to being detained under the 1983 Act, even if the person becomes resident in another area where they are detained, or on leaving hospital. The responsible authority may change, if the person is ordinarily resident in another area immediately before a subsequent period of detention

6.2.2
In light of this it is essential to understand how the patient came to be detained.

In addition:-

- A patient who is resident in an area prior to hospital admission does not cease to be resident there because of the hospital admission.

[5] Code of Practice 25.22
[6] Code of Practice 27.6
[7] *R. v Manchester City Council Ex p. Stennett [2002] UKHL. 34; [2002] 4 All E.R. 124*
[8] *ibid (Lord Steyn) see paragraph 7.*
[9] S. 117 (3) See also *R v. MHRT ex parte Hall [1999]*

- When a patient is conditionally discharged the Mental Health Review Tribunal may send the patient to an area by imposing a condition of residence. The responsible authorities are those for the patient in which the patient was resident prior to admission to hospital.

- When a patient becomes detained under one of the provisions set out at paragraph 5.3. above from an address in Hertfordshire where (s)he was resident in a residential care service commissioned by another local social services authority they will become responsible for the patient's aftercare on discharge.

- When a patient is placed by Health and Community Services or Hertfordshire Partnership Foundation NHS Trust in a residential service outside Hertfordshire any responsibility by Hertfordshire for the patient's mental health aftercare needs will normally continue should the patient become detained under one of the provisions set out at paragraph 5.3 above, The reason for this is the Local Social Services Authority responsible for the patient's social care needs will remain the Local Social Services Authority in which area the patient was residing prior to becoming detained in hospital.

- Patients residing in Hertfordshire recognised for the purpose of S. 117 who are not receiving a commissioned aftercare service who decide to move home and become ordinarily resident outside of Hertfordshire should have their clinical care transferred to the new area. Hertfordshire will remain responsible for the patient's aftercare needs under S. 117 which would change in the event that the patient, whilst resident in the new area, became detained under one of the provisions set out at paragraph 5.3 above.

6.2.2 In relation to identifying the AMHP to consider a decision relating to a Community Treatment Order for a patient, the Mental Health Act does not specify who this AMHP should be. In the event that local social services authorities are unable to agree responsibility for this task the responsibility for ensuring that an AMHP considers the case lies with the local social services authority which would become responsible under S. 117 for the patient's aftercare if the patient were discharged[10].

6.2.3 When the circumstances are unclear it is advisable to seek legal guidance before making any commitment representing local authority responsibility.

6.3 Needs-Led Assessment and the Components of Aftercare

6.3.1 Aftercare for all patients admitted to hospital for treatment for mental disorder should be planned within the framework of the Care Programme Approach (CPA) (or its equivalent), whether or not they are detained or will be entitled to receive aftercare under S. 117 of the Act[11]. See Care Coordination Policy. Incorporating the CPA Approach and Sharing Information Guidance.

6.4 Choice of Accommodation S.75 (6) Care Act 2014

[10] Code of Practice 25.96
[11] Code of Practice 27.11

6.4.1. The Care and Support and Aftercare (Choice of Accommodation) regulations 2014 enable persons who qualify for after- care under S117 to express a preference for particular accommodation if accommodation of the types specified in the regulations is to be provided as part of that after-care.

Where the cost of the person's preferred accommodation is more than the local social services authority would pay to meet that identified need, arrangements must be made for them to be placed there, provided that either the person or the third party is willing and able to meet the additional cost.

6.5 NHS Continuing Healthcare

6.5.1 The patient may also have needs for NHS Continuing Health care which are not related to their mental disorder and which may therefore not fall within the scope of S. 117. An example would be a person who was already receiving NHS Continuing Healthcare in relation to physical health problems before being detained under the Mental Health Act 1983 and whose physical health problems remain on discharge. Where such needs exist it may be necessary to carry out an assessment for NHS Continuing Healthcare[12].

6.6 Ending After Care Under S. 117

6.6.1 The process for reviewing the need for aftercare should be an integral part of each CPA review and should be properly recorded.

6.6.2 The duty to provide aftercare services exists until both the Clinical Commissioning Group and the Local Social Services Authority are satisfied that the patient no longer requires the services. Circumstances when it is appropriate to end Section 117 aftercare would include where the person's mental health has improved to a point where they are no longer in need of services because of the mental disorder. However, even when the provision of aftercare has been successful, in that the patient is now well settled in the community, the patient may still continue to need aftercare services to prevent, for example, a relapse or further deterioration in their condition[13]. In discharging the S.117 duty, the Council is permitted to provide the person with a Direct Payment.

6.6.3 Aftercare services under S. 117 should not be withdrawn solely on the grounds that[14]:

- the patient has been discharged from the care of specialist mental health services.
- an arbitrary period has passed since the care was first considered.
- the patient is deprived of their liberty under the Mental Capacity Act 2005
- the patient may return to hospital informally or under S. 2
- the patient is no longer on SCT or Section 17 leave.

6.6.4 Patients are under no obligation to accept the aftercare they are offered, but any decisions they may make to decline them should be fully informed. An unwillingness to

[12] The National Framework for NHS Continuing Healthcare and NHS funded Nursing Care, DoH, 2007, para 67.
[13] Code of Practice 27.19
[14] Code of Practice 27.20

accept services does not mean that patients have no need to receive services, nor should it preclude them from receiving them under S. 117 should they change their minds. A patient's expressed wish to be discharged from S. 117 has no legal effect if (s)he continues to have a need for aftercare services[15].

6.6.5 Those professionally involved should consider discharging the patient from S. 117 if:

- the patient has been stable and is likely to remain so.
- the patient no longer requires any aftercare service to address or treat an assessed mental health need.
- the patient is not at risk of being readmitted to hospital if the alternative plan was no longer in place.
- the patient is not a risk to him/herself or others.

6.6.6 Those professionally involved should consider not discharging the patient from S.117 if:

- the patient continues to receive aftercare services which prevent a relapse or further deterioration in their condition. This will include out-patient appointments or continued prescribing for mental disorder.
- The patient declines the offer of aftercare services but continues to have needs which entitle him/her to services under S. 117.

6.6.7 In considering this question, the professionals involved should distinguish from Community Care Services which are provided to help maintain a person's independence and safety in a way that is unrelated to their mental health needs.

6.6.8 Decisions to end S. 117 cannot be made retrospectively. Decisions will not be valid unless there is an appropriate level of patient and carer consultation and consideration of their views before a decision is reached. The process of patient and carer involvement should normally take place within the framework of the Care Programme Approach (or its equivalent).

6.6.9 A decision to discharge a patient from aftercare must be communicated to the patient in writing and giving two weeks' notice. Information as to how to appeal the decision should also be provided and this will be considered by the relevant Service Manager. Services shall not be withdrawn until the appeal has been considered.

6.6.10 Any subsequent claims challenging a decision to end aftercare should be brought to the attention of the appropriate social care and/or health care professional for practice and legal advice.

6.7 Independent Mental Capacity Advocates (IMCA)

6.7.1 In the event that it is intended to arrange for a patient to be provided with long stay residential accommodation under S. 117 or for the accommodation to be changed, a referral to an IMCA would be necessary if:

- there is no one (apart from a professional or paid carer for the authority) to consult in determining whether the placement would be in the patient's best interests and
- the patient lacks mental capacity to make a decision about the arrangements.

[15] See report of the Local Government Ombudsman on an investigation into complaint no: 04/B/01280.

In these circumstances the authority is required to instruct an IMCA to represent the patient and any information given or submissions made by the IMCA must be taken into consideration when a decision is made about the placement[16].

6.8 Independent Mental Health Advocates

6.8.1 A patient detained in hospital for treatment is a qualifying patient in respect of the services of an Independent Mental Health Advocate (IMHA). See separate policy relating to IMHAs.

7. Training

Course	For	Renewal Period	Delivery Mode	Contact Information
Refresher training	AMHPs	Annually	Taught	HCS Learning & Development Lead: [Peter.Godleman@hertfordshire.gov.uk]
Mental Health Act (1983) mandatory training	All clinicians & practitioners	Annually	E-learning	http://trustspace/InformationCentre/learningDevelopment/dropdownlist2.aspx
Advice and training	Staff in supervisory roles	As required	Taught	MHA Manager and AMHP Manager

8. Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

RULE: Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

[16] Code of Practice Mental Capacity Act 2005 Chapter 10

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

.

The following table reflects – specifically for this policy – how the design of the service and processes involved has given consideration to all protected groups so ensuring equality and dignity for everyone.

Involvement	HPFT strive to encourage service user and carer involvement and have an active peer experience listening project which aims to provide feedback from service users and carers with regard to their Mental Health Act assessment experiences.
Relationships & Sexual Orientation	The service will work with anyone referred who meets the eligibility criteria in relation to a MHA assessment. 1.4 Of the MHA 1983 Code of Practice (COP) states "people taking decisions under the Act must recognise and respect the diverse needs, values and circumstances or each patient…..including their sexual orientation. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination."
Culture & Ethnicity	1.4 of the MHA 1983 COP states "people taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture…".
Spirituality	Service users and carer's spirituality are assured where necessary. All practitioners should follow the HOPE model H – Sources of Hope O – Needs re organized religion P – Personal belief structure (including non-faith) E – Effects on care practicing spiritual beliefs. (positive and negative)
Age	1.4 of the MHA 1983 COP states " people taking decisions under the Act must recognize and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture,
Gender & Gender Reassignment	As above, 'Respect Principle'
Advancing equality of opportunity	This Policy supports and underpins the Equality Principle (MHA CoP): Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and well-being (mental and physical) of patients, promoting their recovery and protecting other people from harm.

9. Process for Monitoring Compliance with this Document

Team Managers will monitor practice on a case by case basis to address any issues of non-compliance in line-management supervision.

If trends of non-compliance emerge the MHA Manager will meet with AMHP Development Manager to plan remedial action.

This document will be reviewed regularly by MHA Manager, AMHP Development Manager and the HCS MH/LD Learning and Development Lead to reflect changes in legislation and practice.

10. Version Control

STANDARD

Version	Date of Issue	Author	Status	Comment
V1	1st November 2011	Directorate Manager Mental Health Legislation	Superseded	New Policy
V2	9th June 2014	AMHP Social Work	Superseded	Full review.
V2.1	27th April 2015	AMHP Social Work	Current	Interim updated Mental Health Act and Care Act 2014, virtually agreed by MHA Quality and Policy Group.

11. Archiving Arrangements

STANDARD: All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet

A database of archived policies is kept as an electronic archive administered by the Compliance and Risk Facilitator. This archive is held on a central server and copies of these archived documents can be obtained from the Compliance and Risk Facilitator on request.

This document will be archived and updated on the HCC and HPFT staff intranet

12. Associated Documents

STANDARD

- Community Treatment Orders
- Leave of Absence
- Absence without Leave policy
- CPA and Discharge Planning
- Tribunals and Reviews

13. Supporting References

STANDARD

- Care Act 2014
- Mental Health Act 1983 as amended by the Mental Health Act 2007
- Code of Practice to the Mental Health Act 2008
- *R v Manchester City Council Ex p. Stennett [2002] UKHL. 34; [2002] 4 All E.R. 124*
- *R v. MHRT ex parte Hall [1999]*
- The Care and Support and Aftercare (Choice of Accommodation) Regulations 2014
- The report of the Local Government Ombudsman on an investigation into complaint no: 04/B/01280

13. Comments and Feedback

Directorate Manager MHA Legislation	Hertfordshire AMHP Workforce
AMHP Practice and Development Manager	Compliance and Risk Facilitator
HCS Legal Department	

GUIDING PRINCIPLES

In making decisions about a course of action under the Act you should give consideration to the Guiding Principles in Chapter 1 of the Code of Practice.

Purpose Principle

Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.

Least Restriction Principle

People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

Respect Principle

People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), as far as they are reasonably ascertainable, and to follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination

Participation Principle

Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

Effectiveness, Efficiency and Equity Principle

People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decisions was taken.

Our Values

Welcoming Kind Positive Respectful Professional