SECTION 117 AFTERCARE PROTOCOL

Document Reference	Prot514
Version Number	5.0
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Consultation	Various meetings and email communication by: • Humber Teaching NHS Foundation Trust, • East Riding of Yorkshire Council, • Kingston Upon Hull City Council, • Hull Health and Care Partnership • East Riding Health and Care Partnership
Date of Last Changes	20 September 2023
Date of Next Review	September 2026
Date approved and name of Approving Group	Mental Health Legislation Steering Group 20 September 2023

VALIDITY – Protocols should be accessed via the Trust internet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.0	*June 2001*	
2.0	*5/11/12*	*Reviewed and re-written*
2.1	*4/2/13*	*Added Removal of Section 117 Entitlement form*
3.0	*June 2018*	*Review in progress*
4.0	*March 2021*	*Full review in line with new guidance*
5.0	*20 Sep 2023*	*Reviewed. Feb-22: Amended in line with Court of Appeal Ruling re Worcestershire Judgement (page 11). Jul-22: Paragraph added about free prescriptions at 11.5.1 (Page 12) and a paragraph about Specialist Enhanced Accommodation at 11.5.2 (Page 12). Nov-22: Changed all references from CCG to Health and Care Partnership. Updated section on page 11 to align with new Who Pays? Guidance (June 2022). Appendix 1 (page 21) amended to reflect the responsibility of the Health and Care Partnerships. Aug-22: Amended following the outcome of the Supreme Court decision re the Worcestershire judgement (page 11).* *Approved at Mental Health Legislation Steering Group (20 September 2023).*

Contents

1. INTRODUCTION

This Trust, the Humber and North Yorkshire Integrated Care Board and both local Authorities (East Riding of Yorkshire and Hull City) are jointly committed to planning and provision of appropriate aftercare arrangements. The agencies involved are:-

Humber Teaching NHS Foundation Trust
East Riding of Yorkshire Council Kingston Upon
Hull City Council
Hull Health and Care Partnership
East Riding of Yorkshire Health and Care Partnership

Section 117 of the MHA 83 requires Health and Care Partnership s and local authorities in co-operation with voluntary agencies, to provide or arrange for the provision of aftercare to patients detained in hospital for treatment under Section 3, 37, 45A, 47 or 48 of the Act who then cease to be detained. This includes patients granted leave of absence under Section 17 and patients going onto a community Treatment Order (CTO). It applies to people of all ages, including children and young people (Code of Practice 33.2). This protocol will ensure that staff are aware of the processes needed for all patients who fall into this category.

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

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

The duty of care continues as long as the patient / service user is in need of support which meets these criteria. Only support which clearly does meet these criteria may be provided under s117. The person may have other needs, which do not meet the criteria and these may be met under the Care Act, NHS continuing care or Continuing Health Care (CHC).

This protocol recognises that aftercare should be provided for all patients, but addresses specifically the statutory aftercare provisions under Section 117 of the MHA (1983). Reference, where appropriate, will also be made to the Care Programme Approach (CPA).

2. SCOPE

This protocol applies to all patients entitled to aftercare services under section 117 of the MHA 1983 to which the signatory bodies owe a duty.

This is a joint multi-agency protocol, and its procedures apply to all signatory bodies, operational staff, contracted agency staff and supporting agencies which access and provide inpatient care that focuses on treatment. It relates to those people who are entitled to aftercare under S117 of the Mental Health Act 1983.

3. POLICY STATEMENT

The aim of this document is to ensure that all signatory bodies are jointly committed to the planning and provision of appropriate aftercare arrangements for those people who are subject to the appropriate parts of the Mental Health Act (1983) and subsequently discharged from detention.

4. DUTIES AND RESPONSIBILITIES

The MHA 1983 says that the responsible after-care bodies are the Local Authority (LA) and the Health and Care Partnership for the area in which the person concerned was ordinarily and usually resident prior to detention.

As a partnership the Trust and the Health and Care Partnerships and LAs are committed to the on-going support and recovery of residents through the effective coordination of section 117 after care provision and with local partners aim to produce a framework that ensures delivery of this.

Through a partnership and joint commissioning approach the Trust, Health and Care Partnerships and LAs are committed to ensuring that individuals receive the services to which they are entitled under section 117 and individuals who are not entitled or who no longer require such services have the entitlement reviewed and where appropriate ended.

It is the responsibility of all signatory bodies to ensure compliance with this protocol.

Chief Executive (HTFT)
The Chief Executive has a duty to ensure the co-operation of HTFT with the relevant local authority and Health and Care Partnership when planning the aftercare of people with s117 entitlement. This should be achieved at the partnership meetings.

Executive Director of Nursing, Allied Health and Social Care Professionals, Caldicott Guardian (HTFT)
The Director of Nursing will ensure policies and processes are in place to facilitate the co-operation of Trust staff with the relevant local authority and Health and Care Partnership in the planning of aftercare of individuals with entitlement under s117.

Chief Operating Officer (HTFT)
The Chief Operating Officer will ensure policies and processes are in place to facilitate the co-operation of Trust staff with the relevant local authority and Health and Care Partnership in the planning of aftercare of individuals with entitlement under s117.

Medical Director (HTFT)
The Medical Director is responsible for ensuring that the duty to co-operate with the relevant local authority and Health and Care Partnership when planning and commissioning aftercare under s117 is understood by medical staff.

Responsible Clinician (RC)
On all admissions the RC will:

- Ensure that case notes or electronic records are checked to see if a previous entitlement to aftercare has been established and will ensure notification to the relevant local authority and Health and Care Partnership takes place.
- Plan for discharge as soon as entitlement to aftercare provision has been established.

Plans for aftercare should be an integral part of the patient's stay in hospital. When a decision has been taken to discharge or grant leave to a patient, it is the responsibility of the RC to ensure that:

- a proper assessment is made of risks to the patient or other people
- in the case of patients admitted under an unrestricted Part 3 of the MHA 83, the circumstances of any victim and their families are taken into account
- consideration is given to whether the patient meets the criteria for Community Treatment Order, or under Guardianship
- a discussion (multi-agency team meeting) takes place to inform the assessment and support planning for the person, including but not limited to support provided under s117. This will be carried out according to the policies and procedures of the relevant local authority and Health and Care Partnership.

Ward Manager
When it becomes apparent that a discharge is being considered or the patient has an upcoming Mental Health Tribunal the Ward Manager should ensure that a Section 117 Pre discharge meeting is convened in order to inform the assessment and support planning by the relevant local authority and Health and Care Partnership upon whom the duty to assess, plan, provide or commission aftercare arrangements under s117 falls. This will be carried out according to the policies and procedures of the relevant local authority and Health and Care Partnership.

Local Authority
Both local Authorities have a duty to assess individuals who may be entitled to social care provision. Any eligible service may be commissioned / arranged by the LA or delivered via a direct payment to the service user. Some of these individuals may have Section 117 entitlement. There are joint funding responsibilities under S117 and in case of high cost / complexity, this may be fully funded by the Health and Care Partnership.

CPA Care Coordinator / Key Worker
The person appointed as the Care Co-ordinator/case manager (as defined under Care Programme Approach (CPA) guidance) will be responsible for:

- Ensuring any special requirements under Section 117 are met / considered as well as ensuring that the principles of the CPA are followed where required. A full description of the CPA Care Co-ordinator responsibilities can be found in the "The Care Programme Approach - Trust Policy". This document also sets out the procedure to be followed when a change of Care Co-ordinator becomes necessary.
- Responsibility for organising the multi-disciplinary team meeting, (or key nurse. where CPA Care Co-ordinator has not yet been allocated)
- Send notice of the decision of the relevant local authority and Health and Care Partnership (or Trust staff acting on behalf of) to end the aftercare arrangements under Section 117 to the Mental Health Legislation Department. This responsibility is delegated to the patient's key nurse on the in-patient unit where CPA Care Co-ordinator has not yet been allocated
- If HTFT is no longer involved in the patient's care the relevant Local Authority or Health and Care Partnership should notify HTFT Mental Health Legislation Department so that the recording system can be updated.

5. PROCEDURES RELATING TO THE PROTOCOL

5.1. Establishing Entitlement

A patient's entitlement to after-care under section117 begins when they are detained under the following sections of the Mental Health Act 1983 once they leave hospital:

- Section 3 An application for admission for treatment
- Section 37 A hospital order (with or without a restriction)
- Section 45A A hospital direction (with or without a limitation direction)
- Section 47 or s.48 A transfer direction (with or without a restriction order)

By definition, this includes all patients on community treatment orders (CTOs) and all conditionally discharged patients. Section 117 does not automatically apply to guardianship (section 7) unless they have been detained under one of the above sections.

A patient's entitlement to section 117 continues even if they are:

- discharged from their section and remain in hospital as an informal patient
- returned to prison after being detained in hospital; or
- re-admitted to hospital either informally or under another section of the Act, e.g. section 2.

Section 117 after-care services are available regardless of a person's immigration status or their nationality.

S117 entitlement is NOT derived following individuals being admitted to hospital:

- under Section 2
- under Section 4
- under Section 5(2) or 5(4)
- Sections 135 or 136
- under 35, 36, 38 and 44.
- Informally

S117 does not apply to:

- Individuals where s117 has been rescinded
- Individuals where **all** their presenting needs are unrelated to their diagnosed mental disorder

It is essential that all admissions should have their records scrutinised in order to check if any prior section 117 entitlement exists.

Once entitlement has been established, the obligation under the MHA (1983) continues even when a patient is re-graded to informal prior to discharge, and/or following all subsequent admissions to hospital until the responsible agencies agree that aftercare is no longer necessary for the original episode to which the aftercare was established. This entitlement must be considered at each Section 117 review in order to confirm ongoing eligibility or otherwise.

Entitlement to aftercare services does not cover the entirety of someone's needs. Only Aftercare services which have the purpose of meeting a need arising from or related to the patient's mental condition (and accordingly, reducing the risk of the patient requiring admission to hospital again for treatment of mental disorder) can be met under s117.

Other needs may be met under the Care Act 2014, NHS continuing Care of Continuing Health Care (CHC). The duty to provide after care services continues as long as the patient is in need of such services.

After-Care services only relate to a person's mental health. It may be that the person also requires other community care services which are not part of their plan and which usually relate to physical ill-health. These services will generally be subject to means-tested charging arrangements. NHS care is free at the point of delivery.

If a person was receiving services relating to their mental health in the community and being charged for those services, following admission under the Mental Health Act pursuant to section 3, 37, 45A, 47 and 48, and subsequent discharge from hospital under section 117, those services would no longer be chargeable.

Residential care is certainly covered by section117 after-care, but only if the need for that care arises from the patient's mental condition which resulted in their detention under any of the above sections of the MHA.

5.2. Care Plan Arrangements

Aftercare should be based on a joint needs assessment process which includes joint risk management strategies where appropriate. This process may involve various types of assessment and may result in 2 separate care plans (Health and Social Care). The following factors must be considered and planned for where eligible needs exist and resources identified:

- day time activities/employment
- appropriate accommodation
- out-patient treatment
- counselling
- support with personal care

- welfare rights/benefits entitlement assistance
- benefit agency welfare rights arrangements
- management of risk
- funding arrangements (i.e. personal budgets, continuing health care funding) where appropriate
- consideration of Care Act 2014 eligibility

As part of the personalisation agenda people eligible for 117 after-care are also included in the Personal Health Budget (PHB) the National 'right to have' Policy. Therefore, A person eligible for section 117 after-care has the 'right to have' a PHB, and further, a PHB should always be considered as an option for people with fluctuating mental health conditions.

Where an assessment highlights areas of unmet need, then the appropriate line management should be informed. Those contributing to the multi-agency meetings should give consideration in their discussions to the following issues:

- the patient's own wishes and needs (Advanced decisions / statements)
- the views of any relevant relative, friend or supporter of the patient/IMHA/IMCA
- the need for agreement re roles and responsibilities and functions in funding with an appropriate representative at the receiving authority/ Health and Care Partnership or Trust if it is different from that of the discharging authority
- the need for agreement re roles and responsibilities and functions where the Local Authority provides support in addition to the support provided by mental health services
- the possible involvement of other agencies, e.g. probation, voluntary organisations

5.3. First Tier Tribunals Service, Hospital Managers Hearings and Section 117 Aftercare

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

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

5.4. Planning Aftercare

The discussion and planning of aftercare needs to start as soon as the patient is admitted to hospital although the duty to provide aftercare begins when the patient leaves hospital. A Section 117 meeting should to ensure after care arrangements are in place prior to:-

- Discharge from hospital
- Section 17 leave
- A first tier tribunal
- A hospital managers review

The responsible clinician should ensure that the patient's needs for after care have been fully assessed, discussed with the patient (and carers where appropriate) and addressed in their care plan. This should be produced by a partnership of the person, their carers where appropriate, the trust, and the relevant local authority and Health and Care Partnership. It is subject to the usual processes of the relevant local authority and Health and Care Partnership for approval and funding agreement and these must be followed before a care plan can be agreed. Aftercare for all patients admitted to hospital for mental disorder should be planned within the framework of the Care Programme Approach (this applies whether they are detained or not), but because of the specific statutory obligation it is important that all patients who are subject to Section 117 are identified and records kept of them of what is provided to them under that section (COP Chapter 33.14). The records need to clearly set out the services or support being provided and who is responsible for delivery.

5.5. Funding Responsibilities

The Hull and East Riding of Yorkshire Local Authorities and Hull and East Riding of Yorkshire Health and Care Partnership s NHS eligibility panels will consider funding responsibilities through an agreed local funding tool.

If individual needs are identified that are unrelated to the mental health condition and aftercare under section 117 these may be met under the Care Act, NHS continuing Care or Continuing HealthCare (CHC) A contribution to the cost of support provided under the Care Act may be requested from the person.

It is therefore important for the Care Co-ordinator to distinguish within the discharge care plan, the care and support that relates to the patients mental disorder and meets the criteria for s117 funding, which will be provided free of charge, and any other needs which must be met under other legislation. These will be subject to financial assessment and contribution.

The duty on local authorities to commission or provide mental health after-care rests with the local authority for the area in which the person concerned was ordinarily resident immediately before they were detained under the Mental Health Act 1983, even if the person becomes ordinarily resident in another area after leaving hospital (Care Act 2014, 19.43).

The duty to provide after-care services does not end because the patient is readmitted to hospital even if they are detained under the Act. NB. The Worcestershire judgement has amended this position (see below).

The current legal framework for health responsibility:
The Health and Care Act 2022 confers a new duty for NHS England to "publish rules for determining the group of people for whom each ICB has core responsibility". New regulations for determining ICB responsibility for section 117 Mental Health Act aftercare came into force on 1 July 2022. These regulations move the basis of section 117 aftercare health responsibility from ordinary residence to GP registration.
The 2022 revision of 'who pays' sets out the framework for establishing which NHS commissioner will be responsible for commissioning and paying for an individual's NHS care. It replaces the previous version of Who Pays? published in August 2020.

Under CCG arrangements, the default rule in legislation and *Who Pays?* has been that responsibility falls to the CCG of which the patient's current registered GP practice is a member. GP practices will not be members of ICBs in the same way, however.
Responsibility will fall to the ICB with which the patient's registered practice is associated. The association of practices with ICBs is based on the historic CCG membership of each practice, so there will be continuity with current arrangements.
Responsibility for patients not registered with a GP will continue to fall to the ICB in whose area the patient is usually resident, as currently with CCGs.
NHS England » Who Pays?

The current legal framework for local authority responsibility:
After a long period of uncertainty, we now have the final answer from the Supreme Court in relation to the case of R (on the application of Worcestershire County Council) v Secretary of State for Health and Social Care and responsibility for commissioning and funding aftercare under s.117 of the Mental Health Act. This decision ends the 'limbo' for a number of similar disputes nationally, which were effectively on pause pending the outcome of this further appeal. Worcestershire County Council, R (on the application of) v Secretary of State for Health and Social Care [2023] UKSC 31 (10 August 2023) (bailii.org)

Early 2014.	JG suffers from treatment-resistant schizoaffective disorder and lived in Worcestershire. LA 1
March 2014	Detained under section 3 (first detention).
July 2014	Discharged to care home in Swindon to be closer to her daughter.

	After-care services funded by Worcestershire Council (first discharge).
February 2015	Worcestershire CC moved JG to a second care home in Swindon because the first care home could no longer adequately meet her needs. After-care services funded by Worcestershire Council.
June 2015	Detained under section 3 in Swindon (second detention). LA 2
November 2015	Discharged from section, however, remained an in-patient in the Swindon hospital
August 2017	Discharged to after-care (second discharge).
	A dispute arose as to where JG was "ordinarily resident" immediately before her Second Detention which would determine which local authority should pay for her after-care services.
2021	Worcestershire and Swindon referred the dispute to the Secretary of State who decided that **Worcestershire** was responsible. LA 1
2021	Worcestershire sought judicial review of this decision. At first instance, the High Court decided that Swindon was responsible; the Secretary of State held that JG was ordinarily resident in **Swindon** LA 2 because that was where she was living just before her second detention.
2021	The Court of Appeal reached the opposite conclusion: that **Worcestershire** was responsible. LA 1
	Worcestershire now appeals from that decision to the Supreme Court. The Secretary of State cross-appeals seeking to uphold the decision of the Court of Appeal on a different ground from that which the Court of Appeal gave.
27th April 2023.	The Supreme Court unanimously allows Worcestershire's appeal and rejects the Secretary of State's cross-appeal. It declares that, following the second discharge, **Swindon**, and not Worcestershire, had a duty to provide after-care services for JG under section 117 of the Act. LA 2

Summary:
Aftercare duty ceases when person is detained in hospital* as the criteria for aftercare under s.117(1) is no longer met. Therefore new duty for second Local Authority arises. This is provided person is ordinarily resident in that other Local Authority area immediately before the second detention. *This only applies when detained under sections that have the aftercare duty.

Example:
If a person who ordinarily lives in Hull is admitted under the relevant qualifying criteria to a mental health hospital in Hull and is discharged under S.117 aftercare arrangements back to their previous or new accommodation in Hull, the responsible local authority for S.117 planning, support and reviews is Hull City Council.

If it was planned that the person would instead move to live in York, the responsible local authority for S.117 aftercare planning and subsequent reviews is still Hull City Council. However, if that person, having now moved to York some months ago, is admitted to a mental health hospital in York, under the relevant qualifying criteria, then the S.117 duty for providing and paying for 'aftercare services' will be taken over by York City Council.

If there is a dispute between local authorities in England about where the person was ordinarily resident immediately before being detained, this will be determined by the process set out in section 40 of the Care Act. Disputes between a local authority in England and a local authority in Wales will be determined by the Secretary of State for Health or the Welsh Ministers. (Care Act 2014, 19.48).The Secretary of State and the Welsh Ministers have published arrangements for determining which of them will determine such disputes.

Needs which are not eligible to be met under s117 may be met under the Care Act, NHS continuing Care or Continuing HealthCare (CHC) A contribution to the cost of support provided under the Care Act may be requested from the person. Healthcare and support provided under s117 is free and no contribution can be requested toward the cost of these.

Guidance states that LAs and Health and Care Partnership s should have agreements in place detailing how they will carry out their Section 117 responsibilities, and these agreements should clarify which services fall under Section 117 and which authority should fund them. LAs and Health and Care Partnership s use a variety of different models and tools as a basis for working out how Section 117 funding costs should be apportioned. However, where this results in a Health and Care Partnership fully funding a Section 117 package this does not constitute NHS continuing healthcare. The Hull Local Authority and Hull Health and Care Partnership NHS eligibility panel will consider funding responsibilities through an agreed local funding tool.

It is preferable for a Health and Care Partnership to have separate budgets for funding Section 117 and NHS continuing healthcare. Where they are funded from the same budget they still continue to be distinct and separate entitlements.

Medication under S117 Aftercare

For people who are not already entitled to free prescriptions the Trust will cover the cost of prescriptions **if they are prescribed / administered psychotropic medication by the Trust** and in receipt of S117 aftercare (see Medication under S117 Aftercare SOP). People subject to Community Treatment Order will receive free prescriptions for psychotropic medication.

The prepayment certificate will be stopped If section 117 aftercare is ended or if the person becomes eligible for free prescriptions.

Specialist Enhanced Accommodation

After-care services mean services which have the purposes of meeting a need arising from or related to the patient's mental disorder and reducing the risk of a deterioration of the patient's mental condition (and, accordingly, reducing the risk of the patient requiring admission to hospital again for treatment for mental disorder (MHA Code of Practice 33.3).

After-care can encompass…… supported accommodation…… if it meets a need that arises directly from or is related to the particular patient's mental disorder, and helps to reduce the risk of a deterioration in the patient's mental condition (MHA Code of Practice 33.4).

Accommodation is a common need for everyone so the court has decided that in order for accommodation to be 'aftercare' it needs to be something more than ordinary accommodation ie specialist enhanced accommodation that meets a need that arises from a person's mental disorder. For example aftercare accommodation might include caring residential accommodation (such as supported living) that provides intensive therapy and treatment or ensures concordance with medication. It is important though to distinguish between an aftercare need of a package of support from carers – which could be delivered in any accommodation (accommodation would not be aftercare) and actual specialist accommodation itself (could be aftercare). The court was clear that just because a former patient is unemployed / homeless and that social situation may increase the chance of deterioration in mental condition, it does not require the Health and Care Partnership / LA responsible for s.117 aftercare to provide accommodation; although it may give rise to a need for assistance in gaining employment or housing.

R (Mwanza) v Greenwich LBC and Bromley LBC [2010] EWHC 1462 (Admin)

Applying the statutory definition in conjunction with guidance from the caselaw, the test for accommodation as an aftercare need could be said to be:

1. Patient requires specialist, enhanced accommodation – i.e. "accommodation-plus"; and
2. That requirement arises from or is related to the patient's mental disorder for which he was detained under a Qualifying Detention; and
3. The accommodation-plus reduces the risk of:
    a. The patient's mental state deteriorating; and
    b. The likelihood of the patient requiring re-admission to hospital for treatment of his mental disorder.

5.6. Ordinary Residence

The meaning of ordinary residence under the Care Act is not the same as the meaning of ordinary residence in the Mental Health Act 1983.

Care Act 2014	**MHA 1983 S117**
The Care Act is subject to the deeming provisions, which means that when a person is placed by a local authority out of the area, the placing local authority retains funding responsibility for that person. The placed person remains ordinarily resident in the placing local authority. Where a LA places a person who lacks the capacity to decide on their living arrangements out of their area then this would be done under the Best Interest process (MCA 2005) and the placing LA maintain responsibility as the Decision Makers; this is different to someone with capacity making their own arrangements to be placed out of their originating area.	"These deeming provisions do not apply to section 117 of the 1983 Act, nor have they been incorporated into section 117 of the 1983 Act" (Care and Support Statutory Guidance,19.68).
"There are several provisions in the Care Act (section 39(1)-(3) and (5)-(7) and paragraph 2 of Schedule 1) which deem a person to be ordinarily resident in a particular local authority's area in specified circumstances for the purposes of Part 1 of the Act" (Care and Support Statutory Guidance, 19.68).	So in the Mental Health Act 1983, when it refers to the local authority responsible as being the one where the person is ordinarily resident, it is the straightforward meaning of the words 'ordinarily resident', not the Care Act meaning.

Case law has established the meaning of ordinary residence from the 'Shah' test' (https://www.adass.org.uk/supreme-court-decision-on-ordinary-residence) and the recent Worcestershire case. https://www.gov.uk/government/publications/care-act-statutory-guidance/dhscs-position-on-the-determination-of-ordinary-residence-disputes-pending-the-outcome-of-r-worcestershire-county-council-v-secretary-of-state-for

AMHPs acting on behalf of another authority

Section 13 of the Act places a specific duty on local authorities to arrange for an AMHP to consider the case of any patient who is within their area if they have reason to believe that an application for detention in hospital may need to be made in respect of the patient. Local authorities must make such arrangements if asked to do so by (or on behalf of) the nearest relative (MHA Code of Practice 2015 - 14.36).

If a patient is already detained under section 2 as the result of an application made by an AMHP, the local authority on whose behalf that AMHP was acting is responsible for arranging for an AMHP to consider the patient's case again if the local authority has reason to believe that an application under section 3 may be necessary. This applies even if the patient has been detained outside that local authority's area. These duties do not prevent any other local authority from arranging for an AMHP to consider a patient's case if that is more appropriate (MHA Code of Practice 2015 - 14.37).

The Local Authority AMHP who carries out a MHA assessment on a person should be the AMHP from that Local Authority where the patient is (where the body is) regardless of where their ordinary residence is. This differs from the test for S117 which is about residence and not where the body is. So for example if a Hull or East Riding AMHP assessed and detained a person from London under S2 and then transferred them back to London it would be our responsibility to go and reassess for a S3 but this would not have a bearing on S117 as the patient's ordinary residence is in London. The AMHPs from the London area could be asked to carry out the assessment on Hull or East Riding AMHP's behalf but the S117 responsibility would still belong to them (London).

5.7. Hull City Council

The assessment process should recommend whether the person may be eligible for NHS funding, either under s117 OR CHC if CHC then checklist must be submitted. An NHS eligibility panel meets to determine this. The process and documentation can be found on the Hull App.

NHS Hull ICB CHC Team maintain a local policy regarding the oversight and support for people fully CHC funded who become detained under the MHA.

Hull CC recording expectations on Liquid Logic database:

- All caseworkers to check, validate and update legal status (s117 in this case) on person's demographics on Liquid Logic.
- AMHP assessments should be recorded on Liquid Logic and any relevant s117 status updated.
- s117/ CPA reviews should be recorded on Liquid Logic so there is a record that Hull CC can view.
- Prior to a case being transferred to Hull city council teams for ongoing monitoring and review the s117 entitlement should be reviewed and recorded on Liquid Logic.

5.8. East Riding of Yorkshire Council

East Riding of Yorkshire Council has a weekly Commissioning Panel, attended by senior manager from the Health and Care Partnership, and local authority adult social care. This meeting considers the most appropriate funding route for people with mental health needs, either under s117, Care Act or continuing health care (CHC). If CHC is appropriate, then a checklist must be completed. If the checklist then triggers a Decision Support Tool (DST) then a multi-disciplinary meeting must be convened to facilitate this.

5.9. Commencement of Aftercare

For recording purposes, aftercare will commence from the date the individual leaves hospital or is discharge from in-patient care. This also applies when a patient is released from prison, having spent part of their sentence detained in hospital under a relevant section of the Act. This date should be shown on the CPA Review form and should correspond with the discharge date as shown on the computer system. Joint Mental Health Services Review forms should be filed in the patients notes once input onto the IT system. The local authority must also be informed of the discharge.

5.10. Review of Section 117

Service users / patients who have Section 117 entitlement usually have their care managed within the CPA Framework particularly for those who are receiving secondary mental health care, or they could be receiving services via the case management process if their mental health needs are less complex. Section 117 reviews can be held at the same time as CPA reviews.

A patients needs for secondary mental health service provision may change and following review could be discharged from NHS Mental Health Services.

Discharge from CPA does not necessarily require discharge from S117 aftercare. An example of this would be where the patient no longer needs secondary level mental health services but, as a consequence of the impact of continuing mental health issues, may need support/care in a residential or nursing home setting funded by the local authority and / or Health and Care Partnership.

It is a requirement that section 117 eligibility is reviewed at 6 months and then annually thereafter, or sooner, if circumstances change. These reviews should be recorded and documentation should reflect either continued section 117 eligibility, or where appropriate the documented evidence should demonstrate that section 117 eligibility has ended.

When looking at case transfer to the Local Authority – s117 entitlement should be reviewed so that it is clear before the transfer that S117 needs are still relevant and still required.

Who should be involved in the review?
When a review of aftercare entitlement is required as a minimum it can be undertaken by two statutory personnel, that being an appropriate approved person from Health who represent the Health and Care Partnership (this could be the Trust if they are involved in the person's care) and a Local Authority representative. The person entitled to services under S117 or a suitable representative should be included in the minimum. However the following people, where applicable, should be invited to contribute to the Section 117 meeting:

- the patient, if he or she wishes and\or a nominated representative/family member
- the patient's Responsible Clinician
- a nurse involved in care for the patient in hospital
- appropriate LA representative, e.g. Approved Mental Health Professional (AMHP), Social Worker
- CHC representative if person's care funded prior to detention
- Independent Mental Health Advocate (IMHA) or other advocates (if appropriate)
- the GP and primary care team
- a community psychiatric nurse
- a representative of relevant voluntary organisations
- in the case of a restricted patient, the probation service
- subject to the patient's consent, any informal carer who will be involved in looking after him or her outside hospital
- subject to the patient's consent, his or her nearest relative
- a representative of housing authorities, if accommodation is an issue

In the event that the Care Co-ordinator is not from a social work background, the Section 117 Discharge Plan must be discussed with a nominated local authority officer, which could be a Social Worker in one of the CMHTs if the Trust is involved in the person's care.

If the Trust's CMHT is not involved in the person's care then a written invitation to attend the Section 117 meeting must be sent to the relevant Local Authority by the Health and Care Partnership or ward key nurse (whichever is relevant). This invitation should be sent out well in advance of the planned meeting which should, where possible, be at least one month prior to the person's possible discharge. Where there is a likelihood of consideration being given to Guardianship or a Community Treatment Order the invitation to the Section 117 meeting must indicate this, thus triggering the involvement of an Approved Mental Health Professional. The Care Co-ordinator is responsible for coordinating these reviews.

In the East Riding invitations should be directed to the relevant Community Wellbeing Team. For Hull residents invitations should be directed to:

- East or West CMHT for working age adults
- Older People's Mental Health Team for older people

5.11. Patients Discharged from Hospital to Police Custody

Section 117 entitled patients who are discharged from hospital into police custody/prison or who go to prison from the community are still entitled to aftercare under Section 117. The identified Care Co-ordinator is responsible for maintaining contact with the patient and any other agencies who need to be involved e.g. community forensic team, the Local Authority, probation services health care wing, and Forensic Medical Examiner (FME). However the aim of this contact would be to provide continuity for the patient until an agreement is reached with the Prison Inreach Team for handover. This would usually be at a point when the Inreach Team have developed a relationship with the person, generally no longer than 3 months. If the person is sentenced before the three-month period then the Inreach team should take over the care coordination. The Inreach Team can then refer back to the Trust when plans are being made for release.

5.12. Patients Transferred to Out of Area Placements

There are occasions where patients subject to Section 117 will be placed out of area to receive appropriate services. In these circumstances, the S117 eligibility will remain with the placing local authority and/or Health and Care Partnership and any such placement can only be made by following the usual processes of the Health and Care Partnership and local authority for support plan approval and agreement to fund.

If the patient's assessed needs increase and require additional services it is the responsibility of the placing local authority and/or Health and Care Partnership to renegotiate the appropriate care package for that individual including additional funding authorisation, where appropriate from the funding panel.

If the patient moves to another Local Authority area and becomes resident in that area, then Section 117 eligibility remains with the previous Local Authority and Health and Care Partnership until such time as Section 117 is no longer required.

Where a patient is placed into the local area by another authority the Section 117 funding will remain with the placing authorities until such time as the S117 is no longer required. It is anticipated that the service in point of origin are fully involved in the ongoing review and support unless our local services are requested to support and we have agreed.

5.13. Cross Border Placements

Cross border issues will arise where an individual is resident in Wales or Scotland and registered with a GP in England. These cases will be addressed by Humber and North Yorkshire HCP and Local Authorities on a case-by-case basis. The LA and HCP would in all these cases follow applicable legislation, regulations and accompanying guidance, including the NHS guidance 'Who Pays? Determining Responsibilities for Payments to Providers.'

5.14. S117 and Children's Placements

Whilst it is acknowledged that entitlement to s117 aftercare for children and adults is the same, additional consideration may be required when implementing s117 aftercare outside of the family home for individuals aged 18 or under. Children who are cared for away from their family are entitled to additional safeguards, and any care arrangements may require regulation in line with statutory regulations and guidance. However, each case should be considered on its each unique circumstance.

5.15. Ending of S117 Entitlement

After-Care provision does not have to continue indefinitely. It must continue until such time as the Health and Care Partnership and local authority are satisfied that the individual is no longer in need of such services. The duty to provide after-care services under section 117 exists until the Local Authority (whichever relevant) and the Health and Care Partnership or Trust acting on behalf of Hull/ERY Health and Care Partnership s, are satisfied that the patient no longer requires them. Circumstances in which it is appropriate to end such services vary by individual and the nature of the services provided. Fully involving the patient and (if indicated) their carer and/or advocate in the decision-making process will play an important part in the successful ending of after-care (MHA Code of Practice 2015-33.20).

If the multi-disciplinary team decide that after-care is no longer required and that its removal will not put the person at risk of readmission to hospital, a decision to discharge the service user from section 117 after-care arrangements should be considered, and action taken where this is found to be substantiated. However, any such decision must be fully justified and preceded by a proper reassessment of the service user's needs.

A decision that a patient no longer qualifies for services under this section can only be made based on an assessment of the person's current needs i.e. mental capacity assessment, Care Act assessment, Discharge Care Plan. "**It is for the authority responsible for providing particular services to take the lead in deciding whether those services are no longer required**" (Local

Authority Circular LAC (2000) 3, para.4). This would suggest that if the Local Authority are the only body involved in providing those after-care services then they alone can decide whether to end the S117 entitlement, however in Hull and East Riding localities best practice also requires involvement of a health representative in the decision making. The patient, his/her carer and other agencies should always be consulted.

Given the nature of after-care services, many patients will require such services for substantial periods. A patient should not be discharged from care under this section solely on the ground that:

1. he has been discharged from the care of a responsible clinician or specialist mental health services;
2. an arbitrary period has elapsed since the care was first provided;
3. the provision of care is successful in that he is well settled in the community or in residential care and the continuation of after-care is needed to prevent a relapse or further deterioration in his condition;
4. he is no longer subject to a community treatment order or s17 leave;
5. he returns to hospital as an informal patient or under s2 and subsequently leaves the hospital;
6. the diagnostic category of the patient's mental disorder changes;
7. the patient has been made the subject of a deprivation of liberty authorisation under the Mental Capacity Act 2005.

With regard to (3) responsibility under this section could end if the needs that were being addressed after the patient became settled in a care home related to the patient's age and mental frailty rather than to the patient's mental disorder. However "even when the provision of after-care has been successful in that the patient is now well-settled in the community, the patient may still continue to need after-care services, e.g. to prevent a relapse or further deterioration in their condition (MHA Code of Practice 2015 - 33.23).

Those individuals who were assessed as lacking mental capacity to make decisions as part of their enduring mental illness at the time they were sectioned and for whom no recovery of mental capacity is envisaged are unlikely to be considered suitable for discharge from section 117.

As part of regular review and monitoring the multi-agency/multi-disciplinary team may consider that aftercare, or some element of an aftercare is no longer necessary. Such decisions should only be taken at a formal review meeting and will be recorded in the patient's record using the appropriate form.

Before terminating S117 entitlement, the following must be considered:

- "Would removal of this person (settled or not) from the (care home or services) mean that he/she is at risk of readmission to hospital?" Has specialist mental health input been reduced or withdrawn since discharge?
- Has specialist mental health input been reduced or withdrawn since discharge?
- Is there no longer an imminent risk of the placement (where appropriate) breaking down?
- How does the current risk assessment compare to risk assessments at the time of the Section being implemented that led to the S117
- Has the person engaged well with the support services/networks that have contributed to the current position?
- Are all the factors considered in the planning of the after-care package no longer of relevance?
- Has the person being informed that there is a potential financial impact on them if s.117 is ended?

If a full discharge is warranted then the Section 117 discharge notice must be completed. It should be noted at this point that both the Health and Care Partnership and the local authority must agree that the patient's mental health has improved to a point where they no longer need services to

meet needs arising from or related to their mental disorder. **Appropriately qualified staff** from both agencies will sign the Section 117 discharge notice to confirm discharge. In this instance **appropriately qualified staff means staff who have authority to make a commitment on behalf of the Local authority or** Health and Care Partnership. The care coordinator/case manager is responsible for ensuring that all relevant people are notified of this decision.

For Hull CC only - it will be the NHS panel (jointly attendee by the LA and Health and Care Partnership) that ultimately decides to end any s117 entitlement; the social worker (Local Authority Rep) and the Health and Care Partnership Rep will make a recommendation with evidence as a result of their review. This process is emphasized in the Hull NHS panel TOR.

When discussing discharge, the person must be informed that should he/she continue to require services after S117 entitlement has ended, then they could be means tested and have to pay for relevant services in the future. The person may refuse to agree to discharge from S117, which could lead to legal challenge. It would be the responsibility of each authority to seek legal advice on whether to continue with discharge in these circumstances.

After-care services may be reinstated if it becomes obvious that they have been withdrawn prematurely, e.g. where a patient's mental condition begins to deteriorate immediately after services are withdrawn (MHA Code of Practice 2015 - 33.22). A meeting should be organised by the supporting Authority as soon as this deterioration is recognised in order to agree the reinstatement of S117. Local Authority data inputting systems must be updated when S117 entitlement has ended and started again.

Where the patient refuses to accept Section 117 after-care services, consideration needs to be given to proactive engagement with the patient to encourage take up of support services. Where the patient continues to refuse services, this should be documented and Section 117 eligibility should be reviewed regularly until such time as the patient no longer requires Section 117 after-care. This could be enhanced by going down the VARM (Vulnerable Adult Risk Management) route if the risk of refusing services outweighs the person's right to refuse them.

Patients are under no obligation to accept the after-care services they are offered, but any decisions they may make to decline them should be fully informed. An unwillingness to accept services does not mean that patients have no need to receive services, nor should it preclude them from receiving them under section 117 should they change their minds (MHA Code of Practice 2015 - 33.24).

A patient's expressed wish to be discharged from this section has no legal effect if he continues to have a need for after-care services (Jones 22nd edition page 542).

5.16. Advocacy

There are three types of statutory advocacy relevant to this policy:

Mental Health Act

As of 2009 Independent Mental Health Advocate (IMHAs) have been available as a statutory right to people under certain aspects of the Mental Health Act (1983) as amended.

Individuals are eligible to use IMHA services if they are:

- detained in hospital under the Mental Health Act (1983) as amended (excluding people detained under certain short-term sections)
- conditionally discharged from hospital with restrictions
- subject to guardianship order
- subject to CTOs

The role of an IMHA is to assist eligible individuals to understand the legal provisions to which they are subject under the Mental Health Act (1983) and the rights and safeguards to which they are entitled. IMHAs will support individuals to inform them of their rights under the Mental Health Act

and any aspect of their care or treatment under compulsion. This would include information about their rights under s117, and also their aftercare care planning and package of care. IMHAs also support those eligible to participate in decision-making.

Mental Capacity Act
Under the Mental Capacity Act (2005), there is a legal duty to refer an individual to the Independent Mental Capacity Advocate (IMCA) Service, under prescribed circumstances, unless they have lasting power of attorney which covers an ability to make health and welfare related decisions on the individual's behalf.
"The prescribed circumstances are:

- Providing, withholding or stopping serious medical treatment
- Moving an individual into long term care in hospital or a care home
- Moving an individual to a different hospital or care home

The only exception to this can be in situations where an urgent decision is needed." (*Mental Capacity Act (2005) Code of Practice 10.3*)
The Mental Capacity Act only applies where the individual is over 16 years of age.

Care Act
The Care Act (2014) section 67 also makes statutory provision for independent advocacy, where an individual has no other appropriate individual to represent and support them. This provision applies where it appears to the Local Authority that without this, the individual would experience significant difficulty in understanding, retaining, using or weighing information or in communicating their views and wishes whilst the Local Authority is carrying out prescribed functions in the Care Act around assessment or care and support planning. This only applies where an individual is over 18 years of age or planning for support post 18 years.

6. EQUALITY AND DIVERSITY

The core Mental Health Act policies and procedures have been impact assessed. Where individuals are being detained or receiving treatment under the terms of the Act it is vital that no community group is treated less favourably.

The impact assessment has identified the following actions which will be monitored by the Mental Health Legislation Committee and Equality and Diversity Steering Group.

- Any reports to the Mental Health Legislation Committee on the use of the Mental Health Act will include data on equality fields.
- Trends in the use of the Mental Health Act will be monitored against national data to identify any impacts on the target groups and a report produced annually for the Trust Equality and Diversity Steering Group.

Where an individual's legal status is affected we have a clear duty to inform them of their rights regardless of their language or communication difficulties. DVDs in 28 languages other than English are available on the rights of detained patients. When people with physical impairments are detained clinical staff should identify this need as soon as possible to enable the Trust to access appropriate support, e.g. British Sign Language (BSL) interpreter, Independent Mental Health Advocates.
Where religious belief is important to patients this will be respected and the Trust chaplain will support access to relevant faith leaders and information. Wherever possible, clinical settings should be able to accommodate individual prayer/meditation space with appropriate access facilities.

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust approved EIA.

7. HUMAN RIGHTS ACT (1998)

The Human Rights Act came into effect in October 2000 which means that the Trust and its staff, along with its supporting agencies, are seen as a public authority have an obligation to respect the Convention rights. That means that employees must understand those rights and take them into account when carrying out this protocol and procedures. Convention rights are identified in the Articles within the Human Rights Act.

8. IMPLEMENTATION

- Protocol agreed by Local Authorities (LA), Health and Care Partnerships and Trust – signed off and review date set.
- Protocol to be circulated to all Trust staff and relevant LA staff.
- Protocol to be discussed within Multi-Disciplinary Teams (MDT), relevant LA forums and team meetings, led by the senior staff in the team.
- Any issues with regards to implementation to be raised via the awareness process within each particular statutory agency.
- All other stake holders, partners and services to be made aware of the protocol and the responsibilities to it.
- Protocol to be posted on the Trust website and staff intranet and LA sites.
- Protocol to be discussed and implemented in all teams led by team manager.

This protocol will be disseminated by the method described in the Trust's Document Control Policy.

9. MONITORING AND AUDIT

The monitoring of this protocol will be via the statutory agencies that are responsible for ensuring that their duty is complied with. The Mental Health Legislation Steering Group will monitor its effectiveness based on any areas of concern that may arise or instruction from the Mental Health Legislation committee. Individual's entitlement to S117 is logged within the Humber Teaching NHS Foundation Trust electronic patient administration system. Reports can be accessed if requested. It must also be logged on the relevant Local Authority system (Liquid Logic for Hull CC and Azeus for ERYC).

10. AUTHORSHIP AND CONSULTATION

The Mental health legislation department in consultation with Hull and East Riding local authorities, Health and Care Partnership leads, Mental Health Legislation steering group and the Mental Health Legislation Committee.

Dissemination and Implementation:

- Protocol agreed by Local Authorities (LA), Health and Care Partnership's and Trust – signed off and review date set.
- Protocol to be circulated to all Trust staff and relevant LA staff.
- Protocol to be discussed within Multi-Disciplinary Teams (MDT), relevant LA forums and team meetings, led by the senior staff in the team.
- Any issues with regards to implementation to be raised via the awareness process within each particular statutory agency.
- All other stake holders, partners and services to be made aware of the protocol and the responsibilities to it.
- Protocol to be posted on the Trust website and staff intranet and LA sites.
- Protocol to be discussed and implemented in all teams led by team manager.

11. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Mental Health Act 1983

Mental Health Act 1983: Code of Practice 2015 The Care Act 2014: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Mental Health Act Manual, Jones 22nd Edition
The Care Programme Approach Policy (Humber Teaching NHS Foundation Trust) Mental Capacity Act 2005Refocusing the Care Programme Approach (DOH March 2008)
R. v Mental Health review Tribunal, ex p. hall (1999) 1 CCLR Continuing Healthcare guidance (para. 116)

ADASS Ordinary Residence Guide 2018

DoH Mental Health Aftercare in England and Wales

DoH Who Pays? Establishing the Responsible Commissioner 2013
http://webarchive.nationalarchives.gov.uk/20130105191026/
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_126387.pdf

Who Pays? - Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers (June 2022) NHS England » Who Pays?

Local Government Association 2018: Ordinary residence guide; Determining local authority responsibilities under the Care Act and the Mental Health Act

Department of Health & Social Care: Care and support statutory guidance updated 01 October 2018: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

RDASH Section 117 Policy, The Mental Health Act 1983

Mersey Care NHS Foundation Trust Section 117 After-Care under the Mental Health Act 1983
DHSC's position on the determination of ordinary residence disputes pending the outcome of the Worcestershire case - Updated 24 June 2020
https://www.gov.uk/government/publications/care-act-statutory-guidance/dhscs-position-on-the-determination-of-ordinary-residence-disputes-pending-the-outcome-of-r-worcestershire-county-council-v-secretary-of-state-for

Medication under S117 Aftercare SOP (Humber Teaching NHS Foundation Trust)

Worcestershire County Council, R (on the application of) v Secretary of State for Health and Social Care [2023] UKSC 31 (10 August 2023) (bailii.org)

Appendix 1: Definitions

After Care - Care services provided to patients who have been discharged from hospital following admission under the following Sections of the Mental Health Act 1983: s3, s37, s45A, s47 or s48. A patient's entitlement to after-care section 117 begins when they are detained under one of the above sections. The duty to provide after-care is triggered at the point of discharge.

Ordinary Residence: Refers to a person's residence as being the place in which they have settled voluntarily. The settlement can be of long or short duration but there must be a degree of settled purpose.

Health and Care Partnerships - bring together all provider health organisations in a given area to work as one. Partnerships design and deliver services to meet the needs of everyone they serve based on their local population. They focus services on areas of greatest need, helping to reduce health inequalities and improve life expectancy. Health and Care Partnerships work in partnership with NHS organisations, councils, Healthwatch, hospices, charities and the community voluntary and social enterprise sector to improve the health and wellbeing of local people.

Continuing Healthcare - NHS continuing healthcare is arranged and funded solely by the NHS. To be eligible, the main or primary need must relate to the person's health.

Local authority (LA) – At a local level, the country is divided into a series of local authorities or councils. These authorities are responsible for providing local services to the community such as education, adult and children social care, regeneration, leisure, housing and environmental services

Care Programme Approach (CPA) - CPA is a way of co-ordinating health and social care services for people with mental health problems. It requires an assessment of the person's presenting difficulties with the aim of identify needs and coordinating the provision of services to meet those needs.

Mental Health Review Tribunal - There are two levels of mental health review tribunals 1st tier and upper. 1st tier Tribunals hear applications and references for people detained under the Mental Health Act 1983 (as amended by the Mental Health Act 2007) or living in the community following the making of a conditional discharge, or a community treatment or a guardianship order. The main purpose of the tribunals is to review the cases of individuals detained under the Mental Health Act and to direct the discharge of any individuals where the statutory criteria for detention are not met. The Upper tribunal hears appeals from decisions from the 1st tier Tribunal. Both tiers are normally held in private and take place in the hospital where the individual is or used to be detained or a convenient community unit.

Responsible Clinician - An individual's responsible clinician is defined as the approved clinician with overall responsibility for the individual's case. All individuals subject to detention or Supervised Community Treatment have a responsible clinician; nurse, occupational therapist, psychiatrist, psychologist or social worker.

Appendix 2: Z46 – Removal of Section 117 Entitlement

Client name:	
DOB:	
Address:	
NHS IDENTIFIER No:	
Local Authority Identifier No:	
L.A. responsible for S117:	
Health and Care Partnership responsible for S117:	
GP:	

Date of Review where S117 Continuation / Removal discussed _____
Original date of S117 coming into effect _____
Before terminating S117 entitlement, the following must be considered by the Health and Social Care Practitioners making the decision:

- "Would removal of this person (settled or not) from the care home or services mean that he/she is at risk of readmission to hospital?"
- *Has specialist mental health input been reduced or withdrawn since discharge?*
- *Is there no longer an imminent risk of the placement (where appropriate) breaking down?*
- *How does the current risk assessment compare to risk assessments at the time of the Section being implemented that led to the S117*
- *Has the person engaged well with the support services/networks that have contributed to the current position?*
- *Are all the factors considered in the planning of the after-care package no longer of relevance?*

Rationale for removal of S117 Entitlement Details (MUST evidence the above considerations)

The person has been informed that there may be a charge for Adult Social Care services
Confirm that the 'Paying for Care' handbook has been signed/issued and a financial assessment has been requested, and that this is recorded on the relevant Local Authority Database

Yes / No

If no please explain why:

Removal of S117 Entitlement Details

The following agree to the removal of s117 entitlement to the above named client.
The Humber Teaching NHS Foundation Trust (HTFT) representatives, or relevant Health and Care Partnership if patient not receiving services from HTFT, and relevant Local Authority (LA) employees involved in the care of the above are satisfied that the client is no longer in need of the aftercare services delivered under this statute.

This decision has been discussed with and explained to the client and carer (if applicable).

People present at the meeting: **(signatures MUST be provided by all present)**

	Name	Position	Team/Address	Signature	Date
HTFT (if involved)					
Local Authority Representative					
Health and Care Partnership Representative (if HTFT not involved)					
Client					
Carer / representative					
Other					

(Add lines where necessary)

Record of any disagreement with removal of entitlement (where there is disagreement entitlement should not be removed until attempts are made at resolution – please record actions to be taken to resolve disagreement in box – copies to all below)

Please place original document in client's legal records.
Copies should be sent to:

- Mental Health Legislation Department , Humber NHS Foundation Trust, Trust Headquarters, Willerby Hill, Hull HU10 6ED **(regardless of whether the client is in receipt of HTFT services)**
- Responsible Local Authority
- Responsible Health and Care Partnership
- General Practitioner
- Client & carer/representative (where consent has been given)

Appendix 3: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: S117 Aftercare Protocol
2. EIA Reviewer (name, job title, base and contact details): Michelle Nolan, Mental Health Act Clinical Manager
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Protocol

Main Aims of the Document, Process or Service
The aim of this document is to ensure that all signatory bodies are jointly committed to the planning and provision of appropriate aftercare arrangements for those people who are subject to the appropriate parts of the Mental Health Act (1983) and subsequently discharged from detention.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	This protocol is consistent in its approach regardless of age.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	This protocol is consistent in its approach regardless of disability. For service users who have a communication need or have English as their second language consideration must be given to providing information in an accessible format.
Sex	Men/Male Women/Female	Low	This protocol is consistent in its approach regardless of gender.
Marriage/Civil Partnership		Low	The protocol applies to all irrespective of relationship status.
Pregnancy/ Maternity		Low	This protocol is consistent in its approach regardless of pregnancy/maternity status.

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Race	Colour Nationality Ethnic/national origins	Low	The protocol applies to all irrespective of race. Services must ensure where translator services are provided to ensure 'all practicable steps' are taken to ensure understanding in line with the five key principles of the MCA 2005.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The protocol applies to all irrespective of religion or believes
Sexual Orientation	Lesbian Gay men Bisexual	Low	The protocol applies to all irrespective of sexual orientation
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	This protocol is consistent in its approach regardless of the gender the individual wishes to be identified as. We recognise the gender that people choose to live in hence why the terms gender identity and gender expression ensure we are covering the full spectrum of LGBT+ and not excluding trans, gender fluid or asexual people.

Summary

Please describe the main points/actions arising from your assessment that supports your decision. The protocol is specifically aimed at ensuring people who are entitled to aftercare under S117 of the Mental Health Act are assessed and supported in line with their needs regardless of any equality target group. Significant attention has been paid to ensure that no groups are discriminated against either directly or indirectly.	
EIA Reviewer: Michelle Nolan	
Date completed: 29/09/23	Signature: M. Nolan