

Guidance and Principles for Aftercare Services Under S117

This document aims to provide pan London guidance and good practice principles for agreeing responsibility for after care services and funding responsibilities under s117 of the Mental Health Act 1983 and the Care Act 2014. The document clarifies responsibility for funding and providing s117 services.

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This document should complement local multi-agency s117 policies and procedures. It is not exhaustive and it recognises that although correct at time of distribution there are likely to be changes to national guidance/policy developments or case law. This document should NOT be used as a substitute for seeking local legal advice when required.

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SECTION 1 - S117 AFTER CARE ARRANGEMENTS

Section 117 of the Mental Health Act 1983 places a joint duty on local NHS and adult social services commissioners to provide free aftercare services for people that have previously been sectioned under the treatment sections of the Mental Health Act, i.e. Sections 3, 37, 45A, 47 and 48. The duty to provide aftercare services begins at the point that someone leaves hospital and lasts for as long as the person requires the services.

The Act does not define what constitutes “aftercare services” but the Dept. of Health’s Code of Practice states:

After-care is a vital component in patients’ overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital and reduce the likelihood of the person being re-admitted to hospital.

[Section 6](#) of this document provides some definitions of aftercare.

Furthermore the Act does not stipulate which body is responsible for providing which services. However, it is prudent for the NHS to fund the health components of a person’s package and for adult social services to fund the social care elements.

The [Mental Health Act Code of Practice](#) states that CCGs and the local Authorities should interpret the definition of after-care services broadly. For example, after-care can include healthcare, social care, employment services, supported accommodation and services to meet the person’s wider social, cultural and spiritual needs if these needs arise directly from or are related to the person’s mental disorder and help to reduce the risk of deterioration in the person’s mental condition.

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

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

The Care Act 2014 defines after-care services for the first time:

After-care services must have both the purposes of meeting a need arising from or related to a person's mental health disorder and reducing the risk of a deterioration of the person's mental health condition and so reducing the risk of a person requiring re-admission for treatment for mental disorder.

SECTION 2 - ELIGIBILITY

Any person that has been treated under Sections 3, 17, 37, 45A, 47 or 48 of the Mental Health Act is entitled to receive aftercare services from the point at which they are discharged from hospital. This applies even if:

- The person remains in hospital for a period on a voluntary basis having been discharged from these sections;
- The person is released from prison having spent some of their sentence in hospital under these sections of the Act;
- The person is going onto a Supervised Community Treatment (also known as Community Treatment Orders (CTO).) It would be advisable for local areas to have agreed standard funding protocols in place where an individual is discharged under a CTO in order to prevent delayed discharge.
- The person is granted s17 leave under the Mental Health Act.

SECTION 3 – IDENTIFYING THE RESPONSIBLE CCG AND LOCAL AUTHORITY COMMISSIONER

Identifying the responsible CCG and Local Authority should be established as soon as the requirement to provide s117 aftercare services is established. The governing rules are different for CCG and Local Authority and are complex.

CCGs

It is important to note the amendments of the ‘Who Pays Guidance’ and the effect these have on the Responsible Commissioner in different time periods:

Prior to 2013 and after April 2016, the definition of the responsible CCG is the one where the patient was registered with a GP prior to hospital admission.

Between 2013 and 2016, wherever the individual has moved to or been placed and is registered with a GP, the CCG of this GP will be responsible if the individual is sectioned. For individuals who are not registered with a GP please see Section B of ‘Who Pays’ Guidance and Sections [10](#) & [11](#) of this guidance.

Annex B of [‘Who pays’ guidance 2013](#) defines ordinary residence and provides a useful distinction of the changing commissioner responsibilities for patients discharged under s117.

Patients discharged pre 1 April 2013 come under the pre August 2013 PCT Who Pays Guidance and the legacy/originating CCG continues to be responsible for subsequent compulsory admissions under the MHA, and current and subsequent S117 services until such time as they are assessed to no longer need these services.

Patients discharged between 1 April 2013 and 31 March 2016 fall under August 2013 Who Pays Guidance – CCG B would be responsible if a patient is discharged into a location in CCG B and registers with a GP in CCG B.

New revised guidance from 1 April 2016 will revert back to the pre 1 April 2013 position where the legacy/originating CCG continues to be responsible in most cases.”

LOCAL AUTHORITIES

The Local Authority responsible for providing or commissioning after care services is the local authority in which the person was found to be ordinarily resident (under s75 of the Care Act) – see [Appendix 1](#). See also [Care Act Sections 19.14-19.22](#)

If there are disputes regarding ordinary residency, local authorities should try and resolve these disputes locally if possible following local procedures. If the issues cannot be resolved they become a formal dispute and can be referred to the Secretary of State. Any disputes regarding where a person was ordinarily resident must be resolved through the application of [section 40 of the Care Act 2014](#). Information on ordinary residence contained within the Care Act is available [here](#).

SECTION 4 – CHARGING FOR AFTER CARE SERVICES

The Local Authority must not charge for any of the services provided under Section 117. During assessment and care planning the relevant professional must consider if the need for any service to be provided arises from their mental disorder and will reduce the risk of deterioration in the person's mental health state. A care and support plan may have wider assessed needs/outcomes than those that are provided under s117. Services that do not relate to assessed mental health needs may be eligible for charges under the Local Authority charging policy.

It should also be noted that anybody receiving services funded by a CCG should not be charged for those services. This should be discussed with the responsible commissioner detailing the reason for the decision, which must be recorded on the Care Plan.

TOP UP PAYMENTS

Under s117A of the MHA the Secretary of State can make regulations requiring a local authority to agree the choice of an individual for particular accommodation with the individual paying a top up fee if the accommodation is more than the authority usual cost.

In discharging its duty under section 117, the local authority may be required to provide or arrange for the provision of accommodation and support for the person concerned. Section 75 of the Care Act 2014 also allows that where the person concerned expresses a preference for particular accommodation, this must be arranged provided any prescribed conditions are met. However, where such preference incurs an additional cost (i.e. any amount above the amount that the local authority would expect to be the usual cost of providing such accommodation) the person may be required to fund this additional cost. (See [Appendix 4, Case Study 4](#)).

PERSONAL HEALTH BUDGETS AND DIRECT PAYMENTS

A **Personal Budget** is the funding allocated to an individual for social care services by a Local Authority. It can either be a 'notional' Personal Budget managed by a third person such as the Local Authority on the person's behalf or given as a **Direct Payment** to the person or an authorised person.

Local authorities have a **duty** to make a Direct Payment to an adult with the capacity to request one under S31 of the Care Act 2014 (subject to any other parts of the Act or regulations that apply). Direct Payments can be made to people who are assessed as requiring services under Section 117.

A **Personal Health Budget** is an amount of money to support the identified healthcare and wellbeing needs of an individual, planned and agreed between the individual and their representative and the local clinical commissioning group. Adults eligible for NHS Continuing Healthcare and children in receipt of continuing care have had a right to have a Personal Health Budget since October 2014. Clinical Commissioning Groups can offer Personal Health Budgets to other groups of patients. A personal health budget can be given as:

- A notional budget managed by the NHS on the patient's behalf;
- A direct payment (CCGs can make direct payments for aftercare services under the National Health Service Direct Payment Regulations 2013, when the prescribed criteria are met);
- As a third party budget where an organisation independent of the NHS manages the PHB on behalf of the person.

A Personal Health Budget can be used for the health funding element of s117 aftercare. It can be combined with a Personal Budget through a shared care arrangement with the local authority.

More information on direct payments/personal budgets can be found in the following links:

- [NHS Guide to direct payments and personal budgets](#)
- [Guidance on Direct Payments for Healthcare: Understanding the Regulations](#)
- [What is a personal health budget? \(NHS\)](#)

SECTION 5 - PLANNING & ASSESSMENT

Planning for a person's discharge, including their aftercare services should begin at the point at which they are detained and should be undertaken using the Care Planning Approach (CPA). This planning process should be person-centred and recovery focussed. The CPA process requires the clear identification of a named individual who has responsibility for co-ordinating the preparation, implementation and evaluation of the CPA care plan (section 34.5 of the MHA Code of Practice). It is also incumbent upon the local authority to undertake an assessment of need in line with section 9 of the Care Act 2014. Local authorities must carry out an assessment of anyone who appears to require care and support regardless of their likely eligibility for state-funded care. In the case of those being discharged under section 117, this assessment must address the individual's social care related needs in their own right while also considering any social care services required to contribute to section 117 after care. 'After-care services' means services which have both of the following purposes:

1. meeting a need arising from or related to the person's mental disorder; and
2. 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).

It is vital that the local authority assessment complements the assessment and planning carried out as part of the individual's CPA and is carried out in partnership with the relevant parties.

For more information on what needs to be covered in this assessment, click [here](#).

The person should be involved in the planning process and, if the person consents, their carer(s). Other relevant professionals should be included as appropriate. The Code of Practice suggests the following:

- the person's responsible clinician;
- nurses and other professionals involved in caring for the person in hospital;
- a clinical psychologist, community mental health nurse and other members of the community team;
- the persons GP and primary care team;
- a representative of any relevant voluntary organisations;
- in the case of a restricted person, the probation service;

- a representative of housing authorities, if accommodation is an issue;
- an employment expert, if employment is an issue;
- an independent mental health advocate, if the person has one;
- an independent mental capacity advocate, if the person has one;
- the person's attorney or deputy, if the person has one; and
- any other representative nominated by the person.

Prior to discharge a holistic assessment should be carried out to determine what aftercare services will be required when the person leaves hospital. The Code of Practice suggests that that assessment should consider:

- continuing mental healthcare, whether in the community or on an out-patient basis;
- the psychological needs of the person and, where appropriate, of their family and carers;
- physical healthcare;
- daytime activities or employment;
- appropriate accommodation;
- identified risks and safety issues;
- specific needs arising from, for example, co-existing physical disability, sensory impairment, learning disability or autistic spectrum disorder;
- specific needs arising from drug, alcohol or substance misuse (if relevant);
- any parenting or caring needs;
- social, cultural or spiritual needs;
- counselling and personal support;
- assistance in welfare rights and managing finances;
- the involvement of authorities and agencies in a different area, if the patient is not going to live locally;
- the involvement of other agencies, for example the probation service or voluntary organisations;

- for a restricted patient, the conditions which the Secretary of State for Justice or the Tribunal has imposed or is likely to impose on their conditional discharge; and
- contingency plans (should the person's mental health deteriorate) and crisis contact details.

Based on this assessment a support plan for aftercare should be agreed with the person and clearly documented. The plan must include the needs which arise from the person's mental disorder, the services that are required to meet those needs so as to reduce the risk of deterioration, and timescales within which each of the identified needs is to be addressed or reviewed. The aftercare should be recorded on the care plan as part of the CPA process and may include risks management, medication, self-neglect, accommodation and other needs as presented. This will help to ensure the recovery outcome can be clearly monitored and reviewed. The plan should also indicate whether the need to be met is a health need, a social care need or a joint health and social care need and which needs should be met under s117 funding.

SECTION 6 - DESIGNATED AFTERCARE SERVICES

As stated above the Mental Health Act does not define what services should be provided under Section 117. Potential services could include:

- Specialist mental health services
- Integrated Community Equipment Services
- Placement in a Nursing Care Home
- Placement in a Registered Care Home
- The support provided in Supported Living services (but neither rent nor service charges related to the building)
- Floating support
- Drug treatment services
- Aids and adaptations to the person's home
- Telecare
- Home care services
- Advocacy
- Employment, volunteering and training services
- Day Opportunities & other daytime activities
- Supervision of medication requiring close monitoring by a healthcare professional e.g. Clozapine
- Assistance and support with self-medication programme
- Interventions and behaviour management programmes which need constant oversight by a trained healthcare professional, e.g. Registered Mental Nurse+
- Interventions and behaviour management programme which can be delivered by trained support workers with occasional oversight by a healthcare professional

This list is not exhaustive. The Mental Health Act Code of Practice states that CCGs and local authorities should interpret the definition of after-care services broadly and that a wide range of service should be considered provided they meet the

individual's needs for aftercare. Further information and guidance can be found in the Mental Health Code of Practice Chapter 33.

SERVICES WHERE SECTION 117 DOES NOT APPLY

The following services will not be provided under Section 117.

- Storage of property
- Housing pets
- Household bills
- Food
- Holidays
- General Needs/Ordinary Accommodation (see [R\(Afework\) v LB Camden](#))

NO RECOURSE TO PUBLIC FUNDS

Section 117 aftercare services are available regardless of a person's immigration status or their nationality. Immigration exclusions under Schedule 3 Nationality, Immigration and Asylum Act 2002 do not apply.

When preparing to discharge someone who has no recourse to public funds from Section 117, due regard must be given to the person's immigration status and entitlement to support in the UK.

SECTION 7 - FUNDING RESPONSIBILITIES

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

- community-based health services
- resettlement services
- universal advice, advocacy and information services
- employment support services
- community activity services
- leisure services
- peer support
- Other elements of the package should be individually priced.

The package of care and support will then be subject to ratification by the appropriate local resource allocation mechanism (often referred to as a Panel). The support plan and the proposed package of care and support should be reviewed to consider which elements of the package should be funded by the CCG and which by the Local Authority. The panel may challenge any element of the proposed package and suggest alternative options, but should not unreasonably withhold funding consent.

All cases should follow local processes. However, good practice suggests that these processes are carried out jointly with the best interests of the individual at the forefront of agreed outcomes and a lead commissioning authority agreed.

SECTION 8 – DISPUTES

Disputes must not unreasonably delay a person’s discharge from hospital and should be negotiated with the best outcomes for the individual in mind. It is recommended that each local area should develop a multi-agency Disputes Resolution Procedure. This should include how and when legal advice should be sought, the agreed joint appointment of an arbitrator or other similar individual and mutual commitment to be bound by the outcome.

ORDINARY RESIDENCE DISPUTES

The Care and Support (Disputes between Local Authorities) Regulations 2014, sets out the specific procedures local authorities must follow when disputes arise between local authorities regarding a person’s ordinary residence. See relevant clause in [section 40 of the Care Act](#).

The local authority that is meeting the needs of the person on the date that the dispute arises must continue to do so until the dispute is resolved. If no local authority is currently meeting the person’s needs, then the local authority where the person is living or is physically present must accept responsibility until the dispute is resolved. The Care Act 2014 gives the Secretary of State for Health in England the authority to resolve ordinary resident disputes between English authorities.

RESOLVING DISPUTES BETWEEN CCGS

The ‘Who Pays Guidance’ 2013 states that:

- The safety and well-being of patients is paramount. The underlying principle is that there should be no gaps in responsibility - **no treatment should be refused or delayed due to uncertainty or ambiguity as to which CCG is responsible for funding an individual’s healthcare provision.**
- Since it is not possible to cover every eventuality within this guidance, the NHS is expected to act in the best interests of the patient at all times and work together in the spirit of partnership.
- NHS England expects that all disputes will be resolved locally, ideally at CCG level, with reference to the guidance in this document and coming to pragmatic solutions where responsibility is not immediately obvious or where it may be shared. In cases that cannot be resolved at CCG level, Area Teams of NHS England should be consulted and should arbitrate where necessary.

SECTION 9 - REVIEW

Reviews of s117 packages should be in accordance with agreed local policy. It is important that staff understand the s117 duty including the need to end the s117 when appropriate. The [Health Equality Framework \(HEF\) and Commissioning Guide](#) can help when carrying out reviews.

The review process should include:

- The Care Co-ordinator /Care Manager will arrange a review within the locally agreed timescales and then at regular intervals;
- The local CCG or the Local Authority will maintain an up-to-date register of service users on Section 117;
- This register must be maintained and regularly updated with notifications of any changes e.g. discharge from section 117 or transfer;
- This information will be regularly reviewed by the local authority and CCG. This Register can be used as part of the process for reviewing individual status for Section 117. Information on the register will also feed into the local Transforming Care dynamic register;

A review should follow a CPA approach and should:

- Review the quality of care provided and address the financial issues arising from outstanding quality markers;
- Consider whether the following have changed:
 - Health service tasks
 - The services provided to complete health tasks
 - Associated costs for health tasks
 - Consider any risk issues including those arising via the Transforming Care register (see [Section 12](#))
 - Address any crisis management issues
- Where an aspect of health tasks has changed a new funding application should be made to the Mental Health Funding Panel within one month;

- Review update reports should be sent to the CCG and Local Authority for information to enable the CCG to discharge its duty to ensure that aftercare plans are in place and that health needs have not changed;
- A patient can be discharged back to primary care in line with local agreed policies and remain eligible for an annual review of their s117 needs.

SECTION 10- DISCHARGING THE SECTION 117 DUTY

- Aftercare under s117 does not have to continue indefinitely. It is the joint responsibility of the CCG and the Local Authority, in consultation with the person, carers and professionals involved, to decide whether aftercare should end.
- However, the duty to provide aftercare services continues until the responsible aftercare bodies are satisfied that the person no longer needs any after-care service for his or her mental health disorder.
- An exception to the above is where a person is subsequently once more detained in hospital under section 3, 37, 47, 48, or 45A MHA 1983. In these circumstances any existing after care duty owed to that person ceases, but a new entitlement would start when discharged from hospital following the new period of detention. The process of identifying the responsible after care bodies and making an aftercare plan [would start over](#).
- Circumstances in which it is appropriate to end such services vary by individual and the nature of the services provided.
- s117 requires both of the responsible Aftercare statutory bodies to be satisfied that the person no longer requires aftercare services in order for s117 MHA duty to be lawfully brought to an end, and any such decision may only be taken after a lawful multi-disciplinary reassessment of the person's needs.
- People should be considered for discharge from s117 aftercare if care/support/treatment related to their mental disorder is no longer needed to minimise the risk of deterioration and/or readmission. This is a measure of recovery and increasing independence.
- No element of the Section 117 duty should be discharged without a formal assessment taking place by the appropriate professional(s) and presentation to the CCG/LA to formally discharge from the Section 117. However, some elements of the aftercare package may be discharged sooner than others if a specific need has been successfully met, e.g. resettlement support may stop after a relatively short period of time, though continuing mental healthcare may be required for a longer period.

The Code of Practice is clear that the duty cannot be discharged simply because

- the patient has been discharged from the care of specialist mental health services;

- an arbitrary period has passed since the care was first provided;
- the patient is deprived of their liberty under the Mental Capacity Act 2005;
- the patient may return to hospital informally or under section 2; or
- the patient is no longer on supervised community treatment or section 17 leave.

Professionals must undertake regular reviews of the aftercare support plan, in line with the agreed timescales within it but at least annually, in order to assess whether or not the patient's needs have been met. Any changes to the support plan and care and support package, including a recommendation to discharge some or all of the services, must be formally recorded and authorised by a Service Manager or the relevant resource panel.

See [Appendix 3](#) for guidance on factors that could be relevant when looking at discharge from s117 and [Appendix 4](#) for case studies.

SECTION 11 - CONTINUING HEALTH CARE (CHC)

Section 117 applies after an individual has been the subject of a compulsory order under the Mental Health Act 1983 (usually section 3, but it could be a hospital order made under section 37, or a hospital direction made under section 45A or a transfer direction made under section 47 or 48). In such situations, the NHS and LA have a statutory joint responsibility to arrange and fund the necessary support under the terms of their local arrangements for this.

An individual subject to section 117 should only be considered for NHS CHC where they have significant healthcare needs which are not related to their mental health aftercare needs.

NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'. Such care is provided to an individual aged 18 or over, to meet needs which have arisen as a result of disability, accident or illness.

The National Framework for NHS Continuing Healthcare [National Framework](#) clarifies the relationship between s117 and NHS CHC in sections 118 - 122, with the main points being:

Where a patient is eligible for services under section 117 these should be provided under section 117 and not under NHS continuing healthcare. (National Framework section 120)

It is not, therefore, necessary to assess eligibility for NHS continuing healthcare if all the services in question are to be provided as after-care services under section 117. (National Framework section 121)

However, a person in receipt of after-care services under section 117 may also have ongoing care/support needs that are not related to their mental disorder and that may, therefore, not fall within the scope of section 117. Also, a person may be receiving services under section 117 and then develop separate physical health needs (e.g. through a stroke) which may then trigger the need to consider NHS continuing healthcare only in relation to these separate needs, bearing in mind that NHS continuing healthcare should not be used to meet section 117 needs. (National Framework section 122)

In addition, NHS-funded nursing care (FNC) is a universal service available to people under section 117 and on the same criteria as to anyone else. Patients placed in nursing homes should be funded by that CCG where the patient is registered with the GP. See [National Framework](#).

SECTION 12 - TRANSFORMING CARE PROGRAMME IMPLICATIONS

[The NHS 'Care and Treatment Reviews –Policy and Guidance'](#) sets out guidance related to people of all ages with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition who are at risk of admission or currently in receipt of specialist learning disability or mental health inpatient services.

The guidance requires the local CCG Commissioner to maintain a register of people assessed to be at risk of admission in their local area (called the dynamic risk register). This will include all people at risk, regardless of current funding responsibilities and including those in local authority commissioned placements. The registers should include any individuals currently under or discharged from s117 arrangements as they may be at risk of re-admission in future.

The aim of the registers and the use of community Care and Treatment Reviews (CTRs) are to avoid unnecessary admissions to hospital.

APPENDIX 1 – ORDINARY AND USUAL RESIDENCE

ORDINARY RESIDENCE UNDER THE CARE ACT

The test for determining which local authority is responsible for section 117 aftercare is based on where the individual was ordinarily resident at the time they were detained under the relevant section. If that cannot be established it will be the area to which he is sent on discharge.

Ordinary residence is the concept used in the Care Act to allocate local authority responsibility and may be important in deciding responsibility on discharge in the Transforming Care programme. It is not defined in the Act but the Statutory Guidance refers to the leading case of *Shah v London Borough of Barnet* as the [source for the test](#).

In that case, Lord Scarman said, “*ordinarily resident refers to a man’s abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration*”

The Statutory Guidance advises that “the concept of ordinary residence involves questions of both fact and degree. Factors such as time, intentions and continuity (each of which may be given different weight according to the context) have to be taken into account.”

The above test involves the place of abode to be voluntarily adopted which requires the individual to have the mental capacity to do so. For individuals who do not have the mental capacity to decide where to live one would look at all the circumstances of the case to decide where they are ordinarily resident, including whether they can be considered to remain ordinarily resident with their parents even after they have left home.

It is important to remember that the deeming provisions in the Care Act do not apply to determining ordinary residence under section 117 of the Mental Health Act, so one is simply looking at the individual’s current situation as it is. The question of who was responsible for placing the individual in their setting does not make any difference in terms of aftercare responsibility. So, if local authority A placed an individual in area B and the individual was subsequently detained for treatment under section 3, local authority B would be responsible for aftercare.

USUAL RESIDENCE (AS DETERMINED BY THE [WHO PAYS GUIDANCE 2013](#), ANNEX B)

It is important to note that:

- *the ‘usually resident’ test must only be used to establish the responsible commissioner when this cannot be established based on the patient’s GP practice registration;*
- *‘usually resident’ is different from ‘ordinarily resident’. If a person is not ordinarily resident in the UK and not covered by an exemption in regulations then they are liable for NHS hospital treatment costs themselves (see Annex A). The ‘usually resident’ test may still be needed to establish the responsible commissioner for non-hospital services;*
- *by contrast, local authority responsibility in relation to the public health services they commission is based on a duty to take steps to improve the health of the people in their area. The duty is not limited to residents, or people permanently in the area. It can include people who are only temporarily in the area, e.g. a visiting student or worker, or a tourist or a commuter. It is therefore for the local authority to determine who is the relevant population (residents or wider) in relation to the services they commission deciding whether any step to improve their health is appropriate, given their resources, other priorities etc.;*
- *local authority responsibility for the provision of accommodation and community care services is largely based on the concept of ‘ordinary residence’.*
- *the main criterion for assessing ‘usual residence’ is the patient’s perception of where they are resident in the UK (either currently, or failing that, most recently). The same principles apply in determining usual residence for determining which CCG has responsibility for arranging care for a patient.*
- *where the patient gives an address, they should be treated as usually resident at that address.*
- *certain groups of patients may be reluctant to provide an address. It is sufficient for the purpose of establishing usual residence that a patient is resident in a location (or postal district) within the CCG geographical area, without needing a precise address. Where there is any uncertainty, they remain free to give their perception of where they consider themselves*

resident. Holiday or second homes should not be considered as “usual” residences.

- *if patients consider themselves to be resident at an address, which is, for example, a hostel, then this should be accepted. If they are unable to give an address at which they consider themselves resident, but can give their most recent address, they should be treated as usually resident at that address.*
- *another person (for example, a parent or carer) may give an address on a patient’s behalf.*
- *where a patient cannot, or chooses not to, give either a current or recent address, and an address cannot be established by other means, they should be treated as usually resident in the place where they are present.*

APPENDIX 2 – 2016 AMENDMENT TO THE WHO PAYS GUIDANCE 2013

- [Original document \(2013\)](#)
- [Amendment \(2016\)](#)

PURPOSE

1. This paper provides:
 - a. An update on the progress in reviewing the responsible commissioner 'Who Pays' guidance as related to persons detained under the 1983 Mental Health Act, and
 - b. An amendment to the NHS England 'Who pays? Determining responsibility for payments to providers' guidance effective from 1st April 2016, with no retrospective impact on existing individuals in receipt of section 117 aftercare services and their commissioners.

CONTEXT

2. The recently published Learning Disability transformation plan: Building the right support - a national plan to develop community services and close inpatient facilities for people with a learning disability committed to revising Who Pays guidance in relation to section 117 of the Mental Health Act 1983:

In addition, from November 2015, Who Pays guidance - determining responsibility for payment to providers - will be revised to facilitate swifter discharge from hospital of patients originating from one CCG but being discharged into a different local area. This will ensure continuity of care with responsibility remaining with one CCG rather than being passed from commissioner to commissioner.

3. As part of the Learning Disability Transforming Care Programme, we were asked to review the responsible commissioner guidance and, in particular, section 117 of the 1983 Mental Health Act. Given that any proposed amendment would impact on both learning disability and mental health services, we have recently consulted with nursing and commissioning contacts in the regions, CCGs and specialised services to:
 - a. Assess if they agree with the proposed amendments, and
 - b. Identify any major concerns/issues with the proposed amendments.
4. Working through the transforming care agenda, the current guidance has been seen as a major factor in inhibiting hospital discharge as commissioners

have not engaged fully in the process as CCGs have sometimes attempted to place someone into another CCG area then pass the funding responsibility for the person's package of support on to them as well. This has led to numerous disputes between commissioners.

STAKEHOLDER VIEWS

5. From 32 communications with commissioners across the country, we have had 23 responses (72%) that were positive about the proposed changes, there were 3 responses (9%) against the change and the remaining 6 responses (19%) were neutral on the amendment.
6. The Finance Working Group and the NHS England Learning Disability Programme Board are both supportive of the changes proposed. We have also had discussions with the Department of Health who are supportive and are planning to repeal related elements of the 2012 Regulations with effect from 1st April 2016.

THE ORIGINAL PROPOSAL

7. The aim is to revise the 'who pays' guidance during 2015/16. There will be no retrospective changes to the guidance so that no existing individuals currently in receipt of S117 aftercare service will be affected by the proposed change and CCGs do not have any significant change to their financial positions. Moreover, this change should not be seen as an opportunity for commissioners to rebase or undertake a retrospective transfer process as current commissioner - patient responsibilities will remain the same (unless there is mutual agreement between CCGs and is in the best interest of the individual).
8. We have also recognised that there is a need to implement this change as soon as possible rather than wait until a fully revised 'Who Pays' document is published. This is due to the need to attribute commissioning responsibility to current hospital in-patients who are requiring a discharge following a Care & Treatment Review.
9. The rationale for an amendment to the guidance focusses on the need:
 - a. To facilitate swifter discharge from hospital of patients originating from one CCG but being discharged into a different local area as specialist provision is not available locally. It should also increase commissioner motivation to maintain local services and help individuals stay in their local areas post discharge.
 - b. To make it clearer around responsibilities and enable better service planning.

- c. To ensure continuity of care from the person's locality community team. Furthermore, the knowledge of and responsibility for the persons needs will remain with the responsible commissioner/CCG rather than be passed from commissioner to commissioner.
10. Following the consultation process, we have reviewed the correspondence and have reflected amendments in the revised guidance in the paragraphs below. It is intended that paragraphs 33 and 34 of the August 2013 'Who Pays' document will be replaced by the following sections (*in italics below*) effective from 1st April 2016:

If a person is detained for treatment under the Mental Health Act 1983, the responsible commissioner will be as set out in paragraph 1 of the 'who pays' guidance. Every effort should be made to determine GP practice registration or establish an address where they are usually resident, but if this fails and the patient refuses to assist, then as a last resort the responsible commissioner should be determined by the location of the unit providing treatment.

It is the duty of both the CCG and the appropriate local authority to commission after-care services for those persons discharged from hospital following detention under one of the relevant sections of the Mental Health Act. The responsible CCG should be established by the usual means (see paragraph 1) for their typical secondary healthcare. However, if a patient who is resident in one area (CCG A) is discharged to another area (CCG B), it is then the responsibility of the CCG in the area where the patient moves (CCG B) to jointly work with CCG A, who will retain the responsibility to pay for their aftercare under section 117 of the Act as agreed with the appropriate local authority. The purpose of this is to ensure that the person has access to local clinical support and advice in the area they will be moving to (CCG B), whilst remaining the commissioning responsibility of the original CCG (CCG A).

If a detained person who has been discharged, and is in receipt of services provided under section 117 of the Mental Health Act, is subsequently readmitted or recalled to hospital for assessment or treatment of their mental disorder, the responsible CCG will continue to be the CCG that is currently responsible for funding the aftercare under section 117 (except where the admission is into specialised commissioned services).

If a detained person who was registered with a GP in one area (CCG A) is discharged to another area (CCG B) and is in receipt of services provided under section 117 of the Mental Health Act) is subsequently readmitted or recalled to hospital for assessment or treatment of their mental disorder, it is the responsibility of CCG A to arrange and fund the admission to hospital (except where the admission is into specialised commissioned services). Furthermore, the originating CCG (CCG A) would remain responsible for the NHS contribution to their subsequent aftercare

under S117 MHA, even where the person changes their GP practice (and associated CCG).

The table below should provide a useful distinction of the changing commissioner responsibilities for patients discharged under section 117.

Patients discharged pre 1 April 2013 come under the pre August 2013 PCT Who Pays Guidance and the legacy/originating CCG continues to be responsible for subsequent compulsory admissions under the MHA, and current and subsequent S117 services until such time as they are assessed to no longer need these services.

Patients discharged between 1 April 2013 and 31 March 2016 fall under August 2013 Who Pays Guidance –CCG B would be responsible if a patient is discharged into a location in CCG B and registers with a GP in CCG B.

APPENDIX 3 – REVIEWING AND ENDING S117

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

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

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

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

Aftercare under S117 may be terminated for the following reasons:

- Death of a service user
- A review has determined that aftercare is no longer required.

S117 aftercare cannot be terminated solely:

- Because the service user refuses the services
- On the ground that he or she has been discharged from the care of a consultant
- On the ground that an arbitrary period of time has elapsed

On the ground that the care need is being successfully met in that he or she is now settled in the community.

Consideration of discharge from S117 should be made at a review between the relevant professionals, the individual, carer, nearest relative and service providers where possible, following a re-assessment of the individual's needs. Prior to ending S117 it should be demonstrated that there has been active engagement with the Service User/their representatives. This must be clearly documented at review.

The following guidance is offered about the factors to be considered to establish if discharge from S117 may be appropriate:

- What are the individual's current assessed mental health needs?
- Have the individual's needs changed since their discharge from hospital under S117?
- What are the risks of return to hospital/relapse?
- Has the provision of after-care services to date served to minimise the risk of the individual being re-admitted to hospital for treatment for mental disorder/experiencing relapse of their mental illness?
- Are those services still serving the purpose of reducing the prospect of the individual's re-admission to hospital for treatment for mental disorder/experiencing relapse or has that purpose now been fulfilled?
- What services are now required for the individual's current mental health needs?
- Does the individual still require medication for mental disorder?
- Is there any ongoing need for care under the supervision of a consultant psychiatrist or any ongoing need for involvement of specialist mental health services such as a community mental health team?

The above list is not exhaustive, but indicators that S117 could be discharged may include any of the following:

- Stabilised mental health which no longer requires the level of care that has been provided under S117 in order to be maintained
- Services no longer needed for the purpose of reducing the risk of return to hospital or relapse.

However, any decision should be taken with reference to the individual circumstances of each case and none of the indicators above should be used solely as grounds for discharge.

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

Any recommendation to discharge should be agreed by both the relevant CCG and Local Authority being satisfied that the individual is no longer in need of such after-care services by virtue of their mental disorder.

If there is a difference of opinion between Health and Social Services regarding the decision to discharge from S117, which cannot be resolved at operational level, this will need to be escalated following local dispute procedures.

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

The decision to end S117 should be recorded. A template for a pro forma form is attached below. The individual/their representatives should be informed of this decision in writing, including the relevant factors/reasoning.

DISCHARGE FROM S117 PRO FORMA

Discharge from Section 117 Mental Health Act 1983

Name		DOB	
NHS Number			
S117 Review Meeting Date			
People present at the review meeting			
<p>We are satisfied that the above individual is no longer in need of S117 services as specified below.</p> <p>The individual was therefore discharged from those aftercare services (s.117 of the MHA 1983)</p>			
<p>This form must be signed by representatives from both organisations. If you are uncertain if you are able to sign this form please consult with a Senior Manager prior to doing so.</p>			
Signed		Name	Date
On behalf of X Clinical Commissioning Group		Title	
Signed		Name	Date
On behalf of X Local Authority		Title	

APPENDIX 4 – S117 GUIDANCE CASE STUDIES

CASE STUDY 1 - DISCHARGE FROM S117 AFTERCARE

Mr M, a Portuguese man, was street homeless in a London borough and after a MHA assessment was admitted to hospital on section 2, then section 3. He was discharged in 2008 and escorted back to Portugal. He returned to the UK in 2010 and was again admitted to hospital under section 2, then section 3, then discharged in 2010 via a hospital transfer to Portugal.

He returned to the UK for several months looking for work. During his last stay in the UK he was assessed by the joint health team and his mental health had improved. On the final contact in 2013 he described feeling much improved on a higher dose of medication and was keen to return to Portugal.

The reason for discharging him from s.117 aftercare is that he is no longer resident in the UK having returned to his home country Portugal. MHA does not apply outside the UK.

CASE STUDY 2 - DISCHARGE FROM S117 AFTERCARE

R reported a history of Paranoid schizophrenia for over 10 years. He is currently stable on Olanzapine 15mg nocte which he has been compliant for 5 years. He is also taking Simvastatin 40mg nocte.

R has recently moved into new independent accommodation. R reported that things were going well in his new accommodation. He had been a bit anxious in the early days as he didn't know anyone there, but has now settled into his new home and is comfortable there.

He is compliant with his medication (see above), taking it at 7pm every night and says he hasn't missed a dose in years. He said that if he did not take the medication, he would feel "weird", so he wanted to avoid that. He did not have any problems with side effects. He is willing to continue taking current meds with no changes. He has been having his prescription from GP and will continue to do so.

The reason for discharging him from s117 aftercare is that he has no social care needs and although still prescribed oral medication to keep stable he is fully compliant with it, does not require administration of it as he collects routinely from his pharmacy.

CASE STUDY 3 - DISCHARGE FROM S117 AFTERCARE

Mrs S was originally diagnosed with schizophrenia which led to an admission under s3. She was diagnosed with Huntington's Chorea more recently and her health steadily declined to the point that she required placement in a nursing home. Her primary needs are now related to her physical health diagnosis and the care and treatment that she receives is to meet those needs. She is immobile and cannot communicate. She was discharged from s117 after care as the care that is being provided is not related to a mental disorder and is to prevent admission to a general medical hospital not a psychiatric facility. Her placement is now being funded under CHC.

CASE STUDY 4 - CHARGING FOR AFTERCARE SERVICES

Brian is due to be discharged from hospital under section 117 and has had an assessment by the local authority. Brian, his family and other professionals all agree that his needs would be met best in a supported living provision in the local community, with medium levels of professional mental health specialist support.

The local authority identifies a supported living service in the community that can meet Brian's needs which charges support costs of £750 per week; this is the usual amount that providers in the area charge for this kind of service. However, Brian's family have found another service which meets Brian's needs, but costs £1,000 per week. Brian and his family would like him to move here. It is agreed that, as both options can meet his assessed needs, Brian will top up £250 per week so that he can move to the service of his choice. The rental costs will be covered by Housing Benefit.

CASE STUDY 5 - CONTINUING HEALTHCARE FUNDING

Tom was living in Local Authority A and registered with a GP in area of the Local Authority (CCG A) when he was first sectioned in 1992, due to a Mental Disorder (Psychosis). However, whilst detained, Tom was diagnosed with a degenerative cognitive condition which is slowly worsening. His current presenting needs now require nursing care for incontinence, bathing, feeding and mobilising. A placement that can meet his nursing care needs has been found for him in Local Authority A.

Tom living in the community in A	First admission	Ready for discharge
↓	↓	↓
1980-1992	2008	2017
Funding area:		
A		
Resident in:		
A		

Key factors:

- Tom was first detained in Local Authority A in 2008.
- Tom has a GP in CCG A
- Tom has a condition which means he is may be eligible for continuing healthcare funding.
- As Local Authority A has responsibility for his S117 aftercare, it is their responsibility to complete a CHC checklist for consideration for a CHC assessment.
- Due to his degenerative condition Tom has needs that are not as a result of his Mental Disorder and is assessed by CCG A as eligible for CHC.
- Section 117 aftercare is also indicated to meet his mental health needs

Outcome:

Local Authority A carried out a CHC checklist for Tom. He had a full CHC assessment and was found eligible for CHC funding, he moved into the nursing home in area A identified for him. He is also eligible for a Section 117 aftercare.

CASE STUDY 6 - INDIVIDUAL NOT KNOWN TO SERVICES

Michael lived in CCG H and committed a crime in his area. He was detained under section 37/41 and placed by CCG H in a medium secure unit. He was not receiving any services before he was detained.

Michael was soon ready for discharge and a placement was found for him. CCG H agreed to pay for the health portion of Michael’s S117 aftercare. Michael also needed some support with social care on discharge due to his mental health needs.

Michael living in the community in H	Section 37/41 – placed in medium secure unit	Ready for discharge under S117
↓	↓	↓
1980-2010	2010-2011	2011
Funding area:		
H		
Resident in:		
H		

Key factors:

- This is Michael’s first section in area H.
- Both CCG H and Local Authority H have responsibility to deliver Michael’s S117 aftercare.
- Michael has no recorded history with services, however this has no bearing on the need for both responsible organisations to ensure his S117 is secured.

Outcome:

Local Authority H agreed to take responsibility for funding the social care portion of Michael’s S117 aftercare.

CASE STUDY 7 - INDIVIDUALS WITH NO FIXED ABODE

Leah is 26 and has been sleeping rough and in hostels in Borough A. Leah was detained under section 2 following an extreme anxiety and a panic attack in Borough B and was subsequently detained under section 3 and admitted in a low secure unit in Borough B. When Leah was ready for discharge she was assessed as requiring low level supported living to help her with budgeting, her anxiety disorder and securing a home.

When Leah was sectioned she was not registered with a GP. Leah identified Borough A as the place she was from as she had been sleeping there for months and was able to regularly access the hostel there.

Local Authority A has been involved with Leah’s discharge. There is a dispute as to which CCG will be the responsible commissioner for section 117 aftercare.

Leah sleeping rough in streets in Borough A	Section 2 in Borough B	Section 3 in Borough B and admission to low secure unit	Ready for discharge under S117
↓	↓	↓	↓
2012-2016	2016	2016-2017	2017
Funding area:			
A	B	B	A
Resident in:			
A			

Key factors:

- Leah was sectioned in Borough B.
- Leah identifies herself as a resident in Borough A.
- CCG A is the responsible commissioner.