**Responsible Authorities for Section 117 aftercare.**

**Health** – Lincolnshire Integrated Care Board / Other (Enter ICB) [DELETE AS APPROPRIATE]

**Social Care** – Lincolnshire County Council / Other (Enter Local Authority) [DELETE AS APPROPRIATE]

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| **REVIEW TIMESCALE**  Reviews will be undertaken 72 hours, 6 weeks, 6 months after discharge from hospital, and annually thereafter. Unplanned reviews can be arranged as required. |

**CONSENT**

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| We ask for and record your consent before completing the section 117 aftercare care and support plan review. For people who do not have decision specific capacity to consent, we will record why we believe you lack capacity. We will also record details of any decisions to continue with the assessment, taken in your best interests by either your formally appointed representative or your assessor. |
| Record of consent: Choose an item. |

**1. PERSON DETAILS**

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| **DATE OF REVIEW:** Click or tap to enter a date. | **WHICH REVIEW:** Choose an item. |

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| Name: |

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| Date of Birth: Click or tap to enter a date. |

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| Current Location: |

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| Home Address: |

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| Contact details (Telephone / Email):  Telephone:  Mobile:  Email: |

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| Gender: Choose an item. |

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| Religion: Choose an item. |

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| NHS Number: |

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| Broadcare identifier: |

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| RIO identifier: |

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| MOSAIC identifier: |

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| Telephone number: |

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| GP name and Address: |

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| Record any cultural needs the individual has: |

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| Lead Professional  Name:  Designation: | Work base: |

**2. MENTAL HEALTH ACT DETENTION DETAILS**

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| Qualifying Detention under which section of the Mental Health Act 1983: Choose an item.  Date of Discharge from last detention *if applicable*: Click or tap to enter a date.  Current Status: Choose an item.  Date(s) of Previous Detentions: |

**3. DIAGNOSIS**

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| 3. Diagnosis: |

The below care plan section 117 aftercare document Identifies the Mental Health Act 1983 section 117 aftercare needs following assessment by the appropriate agency(s). The identified met and unmet needs that do not arise from the mental disorder will be recorded and where appropriate be referred to the relevant service.

**4. CARE PLAN SECTION 117 AFTERCARE NEEDS**

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| * 1. PSYCHOLOGICAL AND EMOTIONAL NEEDS | |
| Assessed care and support needs:  Description of need and risks to be transposed from the assessment form. | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| * 1. BEHAVIOUR | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| * 1. COGNITION | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| * 1. COMMUNICATION AND DECISION MAKING | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| * 1. MEDICATION AND SYMPTOM CONTROL | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| 4.6. EATING AND DRINKING | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| * 1. FAMILY RELATIONSHIPS | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| * 1. INFORMAL SUPPORT | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| * 1. MAINTAINING PERSONAL CARE | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| 4.10. MAINTANING THE HOME | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| * 1. ACCESSING ESSENTIAL COMMUNITY FACILITIES LEISURE AND SOCIAL INCLUSION | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| 4.12. EDUCATION AND OCCUPATION | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| 4.13. ACCOMMODATION | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| 4.14. MANAGING FINANCE | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often, (link to care plan): | Frequency |
| Review outcome: | |

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| 4.15. OTHER SECTION 117 NEEDS, THESE COULD RELATE TO MOBILITY, CONTINENCE, SKIN AND BREATHING | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| 4.16. CO-EXISTING CONDITIONS | |
| Assessed care and support needs: | |
| What are the persons desired outcomes from this support: | |
| Who will provide this support and how often. (link to care plan): | Frequency |
| Review outcome: | |

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| 4.17. IDENTIFIED AND UNMET NON-SECTION 117 NEEDS | | |
| Identified and unmet non-Section 117 needs, and any referrals arising from these unmet needs. | | |
| Planned needs and identified unmet Need: | Referral to: | Name of Referrer: |
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| Please record the outcome of the referrals: | | |

**5. CRISIS PLAN**

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| Record if the crisis plan has been implemented, or any change to the crisis plan:  Please indicate the signs and symptoms that may trigger a relapse and the actions agreed in managing this. These needs must be entered on the section 117 aftercare care plan. |

**6. REVIEW OF SECTION 117 ELIGIBILITY**

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| Reviewers to give consideration to discharge from section 117 eligibility.  Choose an item. |
| An initial discussion with the individual and their next of kin or representative may be required if there is consideration of discharging from section 117 aftercare, giving initial information and identifying a further review would be convened when discharge from Section 117 is considered and all decisions be recorded. |

# Guidance notes from Policy – Discharging from section 117 aftercare

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| Aftercare under Section 117 may not continue indefinitely, and each person’s needs and circumstances should be reviewed regularly. The MHA Guidance makes it clear that even if the person is settled well in the community, they may still need Section 117 services to reduce the likelihood of a relapse, or to stop their condition deteriorating. Section 117 aftercare services should therefore end only if someone has been functioning well for a sustained period and no longer needs services that meet the statutory definition for S117.  Aftercare services under s117 should not be withdrawn solely on the grounds that:  • 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 individual is deprived of liberty under the MCA.  • The individual has returned to hospital informally or under section 2 or  • The individual is no longer on a CTO or section 17 leave. Even where the provision of aftercare has been successful in that the individual is now well settled in the community, the person may still continue to need aftercare services e.g. to prevent a relapse or further deterioration in their condition.    A Section 117 multidisciplinary discharge meeting must be convened when discharge from Section 117 is considered and all decisions must be recorded as evidence of the outcome. The views of the person and their family or carers should form an important part of the discussion. When a person disengages from services, refuses the S117 aftercare services or wishes to discharge themselves from aftercare, a review must be arranged, and a risk assessment undertaken. They must also remain on the S117 register as their entitlement will still be active unless they are discharged from Section 117.  The following guidance is offered about the factors to be considered regarding whether or not 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 service user being re-admitted to hospital for treatment for mental disorder, experiencing relapse of their mental illness.  • Are those services still serving the purpose of reducing the prospect of the individuals re-admission to hospital for treatment for mental disorder, relapse or has that purpose now been fulfilled.  • What services are now required in response to the individuals current mental health needs.  • Does the service user still require medication for a mental disorder. |

**7. PERSONAL BUDGET AND PERSONAL HEALTH BUDGETS**

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| The ICB and LCC work together to identify those individuals subject to Section 117 after-care and consider offering, personal budgets and or personal health budgets for their package of community support.  Personal Budgets are offered by the Local Social Service Authority and Personal Health Budgets offered through the NHS, are a way of enabling people with long-term conditions and disabilities to have greater choice, flexibility and control over the support they need and receive, and to be more involved in discussions and decisions about their care.  Your Lead Professional will be able to discuss this in more detail with you. |

Reviews to be scheduled as follows: the first 72 hours after discharge, 6 weeks, 6 months and annually thereafter

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| Date of next review: | Click or tap to enter a date. |

**Provider Details.**

Please note the provider(s) involved.

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| Provider 1. |

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| Provider 2. |

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| Provider 3. |

**Participant details.**

Involved professionals to enter details of their designation and organisation.

The individual and relations leave the organisation box empty.

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| Name of lead Professional (print): |  |
| Designation/Relation: |  |
| Organisation: |  |
| Contact details: |  |
| Signature: |  |

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**NB** – Care plan to be forwarded to the relevant panel for Quality Assurance