

Hospital Discharge process Mental Health Act Section 117 Aftercare

Process for detained CYP in out of area Hospitals.

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| CYP admitted to Hospital.  Section papers passed to the hospital  Hospital informs the Local Authority where the individual was ordinarily resident  Hospital informs the Lincolnshire Mental Health Act Administrators of the detention and any subsequent changes to the detention  The placing team ensures that their records are fully completed on the relevant data base and informs the relevant Local Authority and Integrated Care Board.  The receiving hospital also contacts the responsible funding authorities in respect of the assessments and pre discharge planning.  The responsible Local Authority.  The responsible Integrated Care Board  The Hospital will inform the relevant Local Authority where the CYP admission is anticipated to be 12 weeks or longer of the admission |
| Hospital lead professional allocated from hospital team.  To co-ordinate the treatment and care planning processes within the hospital, and links with the section 117 aftercare lead professional and Social Worker in preparation for planning the discharge.  Section 117 aftercare lead professional will be allocated who is usually the current care coordinator from the children’s Mental Health Team (LPFT) or if the CYP is not known to LPFT CYP will be allocated a lead professional from the CAMHS Crisis and Enhanced Treatment Team managed by LPFT from the children’s urgent care directorate.  This individual will link with the Hospital lead professional and Social Worker in preparing for a seamless discharge back to usually the family, with where identified an appropriate package of care. |
| Hospital Lead Professional updates the individual in respect of their rights and commences an assessment process for any eligible section 117 aftercare needs  (For those individuals on an eligible section).  Discusses with the CYP and the involved Social Worker and section 117 aftercare lead professional attendance at the relevant assessments and meetings. |
| The role of the hospital lead professional is to ensure all relevant assessments and care plans are completed prior to discharge identifying the CYPs needs in conjunction with the appropriate responsible Social Worker from the responsible Local Authority and Section 117 aftercare lead Professional and that all relevant individuals are included in the assessments and processes in preparation for discharge planning. |
| The section 117 aftercare lead professional ensures that the Joint Health Agency Assessment and subsequent care planning documents are completed.  The Social Worker will complete the child and family assessment which couples as the care plan, this document will encompass all needs relating to the CYP. |
| The CYP and their family must be at the heart of the aftercare planning and where necessary and appropriate or requested have the relevant advocacy service involved. |
| If the recommendation is agreed this is recorded and the identified service is put in place. |
| The Lead Professional from the hospital, the section 117 aftercare lead professional, and the Social Worker will work together to ensure that there is a smooth transition from the hospital setting back into the family setting.  Upon discharge the role of the section 117 aftercare lead professional and where appropriately with the Social Worker to co-ordinate the needs of the individual post discharge undertaking reviews at the specified times. |
| A pre discharge multi-Disciplinary meeting must be convened prior to discharge. |
| Where there are aftercare needs that do not require funding, or where there are statutory services involved (services that are available to the general CYP population) they would become the Section 117 aftercare Lead Professional. |
| Record keeping  The section 117 aftercare Lead Professional from LPFT and Social Worker finalises their organisations assessment and care planning documents on either RiO or Mosaic and ensures copy is available on both RiO and Mosaic systems. The LPFT health representative from LPFT shares the assessment and care planning documents with the ICB for updating their data base Broadcare. |
| The Section 117 aftercare Lead Professional and Social Worker will review progress towards recovery at the agreed time scales of:  72 hours post discharge from hospital, then after 6 weeks, 6 months, 12 months and annually thereafter. Ad hoc reviews can be held as required. |

Eligible Mental Health Act Sections

A person will be eligible for section 117 after-care services once they become subject to one of the qualifying sections of the Mental Health Act and thereafter cease to be detained and leave hospital:

* + Section 3 – Admission for treatment
  + Section 37- Power of courts to order hospital admission or guardianship
  + Section 45A – Power of the higher courts to direct hospital admission
  + Section 47 – Removal to hospital of persons serving sentences of imprisonment

Section 48 – Removal to hospital of prisoner

Section 117 needs: -

* Needs arising from or related to the patient’s mental disorder
* Needs that reduce the risk of a deterioration of the patient’s mental condition (and, accordingly, reducing the risk of the patient requiring admission to a hospital again for treatment for mental disorder.
* Identified and unmet non-section 117 aftercare needs, and any referrals arising from these unmet needs. (Appropriate referrals may be required for non-section 117 needs)

The Section117 Lincolnshire Joint agency assessment and separate aftercare planning and review document.

The identified Lead Professional is responsible for ensuring section 117 after-care needs are reviewed at the agreed timescale, recording progress towards the patient’s independence, and supported with a focus on promoting recovery and wherever possible independent living. The Joint Quality Assurance Group are also able to recommend additional review timeframes where it is deemed appropriate.

The s.117 Lead Professional is the individual responsible for completing the S117 Joint Health and Social Care Plan for all adults who are eligible for s117. It must be completed for all eligible patients on either RiO or on MOSAIC. The s.117 Lead Professional must ensure that a copy of the completed document is available on both systems. That is if the s.117 Lead Professional has completed the form on RiO then a copy of that form must be printed off and uploaded into documents in MOSAIC and called S117 Joint Health and Social Care Plan or *vice versa*.

NC 5.01.23 adult

24.10.23 for CYP