Mental Health and Learning Disabilities - Section 117 Aftercare Oversight & Monitoring Arrangements Across Wales

Terms of Reference

Background

Section 117 of the MHA 1983 imposes a joint duty on local social services authorities and LHBs to provide after-care for certain categories of mentally disordered patients who have ceased to be detained and leave hospital.

The Mental Health Measure Code of Practice recommends that the requirements to review aftercare arrangements under section 117 and the statutory duty to review care and treatment plans are combined meaning that as a minimum there should be an annual review.

There are currently no national arrangements that provide monitoring or oversight of how Section 117 aftercare is delivered in Wales. Each health board and local authority manages its own registers and policies, leading to risk of significant variation in practice, governance, and audit arrangements across Wales. Recent reports from Healthcare Inspectorate Wales have highlighted issues in audit and governance oversight, and following initial engagement with some health boards suggests that problems identified in one area are likely to exist elsewhere.

On behalf of Welsh Government, the NHSWP&I Performance and Assurance team have been asked to provide an understanding of the oversight and monitoring arrangements for section 117 across Wales

Objective

- Understand how statutory duties under section 117 of the Mental Health Act are met.
- Identify current approaches to oversight and monitoring for Section 117 in Wales.
- Understand the arrangements for training and supervision for the staff who provide Section 117 aftercare.
- Highlight best practices, areas for improvement, and ways to enhance consistency across regions.

Scope

The focus will be on the monitoring and oversight for adults who are considered as eligible for Section 117 aftercare. All health boards in Wales will be included and with a focus on:

- Governance, accountability, and reporting structures.
- How often and how well reviews, audits, and feedback processes happen.
- What training is available for staff, how accessible it is, how often staff access it, and what they think.
- How people are involved in their aftercare planning and reviews.

Approach

The approaches used to understand the current provision and oversight of 117 aftercare will be:

- Document reviews of the processes, protocols, operational procedures and governance arrangements (including audits) in place to support the provision and monitoring of 117 aftercare

- Semi - structured interviews with relevant staff e.g. MHA administrators and senior operational and team leaders to understand how health boards monitor their section 117 responsibilities

Timescales

January -March 2026

Outcome

Following completion, localised and national reports will be produced that will include findings, key messages and recommendations. Reports will be provided to each health board and to Welsh Government.

Roles and Responsibilities:

NHS Wales Performance and Improvement, on behalf of Welsh Government will work collaboratively with health boards in line with the terms of reference. The nominated lead officer will be the Assistant director for MH and LD within NHS Performance and Assurance (P&A). The nominated lead officer will be responsible for the overall undertaking and reporting of the oversight assessment, including providing an evidence base to support findings and any recommendations.

The health board will nominate a lead executive and service group lead. The role of the nominated health board leads will be to provide update on progress and assist with coordinating any on site attendance by the assessment team. An important role of the health

board nominated leads is to ensure staff are aware of the oversight assessment and its purpose and to support any potential anxieties within services this may create

NHS Wales Performance and Improvement lead:

Dave Semmens – Assistant Director, Mental Health and Learning Disabilities, Performance and Assurance,

Lara Homan- Quality Performance Improvement Manager Mental Health and Learning Disabilities, Performance and Assurance.

Welsh Government lead:

Matt Downton- Deputy Director Mental Health, Substance Misuse and Vulnerable groups, Welsh Government.

Escalation

Identification of Significant Risk

If during any of the phases the assessment team identifies significant risk to staff or patient care, this will be escalated to the health board service group nominated lead. It is the responsibility of the health board lead to confirm the actions to be taken by the health board to address the identified risk or concern. Any significant risks or concerns identified will also be shared with Welsh Government

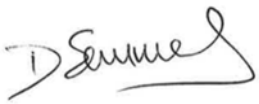
Escalation to the Executive Team

If there remains concern about the level of action taken, this will be escalated to the Executive Lead.

Escalation to an Appropriate External Agency

If the health board has not fully addressed the identified significant risk, this will result in escalation to the appropriate external agency.

The NHS Performance and Improvement will be working closely with the health boards and making recommendations for the purpose of further improving and developing the services. On signing this document, both the NHS Performance and Improvement and the health board are agreeing to proceed under the above terms of reference.

Health Board Executive Lead	Assistant Director, Mental Health & Learning Disabilities, NHSWP&I
	
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