Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health Community Treatment Order (Announced)

Community Treatment Order: Cwm Taf UHB

October and November 2015

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance. Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

Digital ISBN 978-1-4734-5922-9
© Crown copyright 2016

Contents

1. Introduction 4
2. Methodology 5
3. Context and description of service 6
4. Summary 8
5. Findings 9
   - Considering a Community Treatment Order 9
   - Authorising a Community Treatment Order 11
   - Monitoring a Community Treatment Order 13
   - Recalling and revoking a Community Treatment Order 16
   - Reviewing a Community Treatment Order 20
6. Next Steps 22
   - Appendix A 23

1. Introduction

Our mental health Community Treatment Order inspections for 2015-16 cover mental health services provided by the National Health Service (NHS). Inspection visits are a key aspect of our assessment of the quality and safety of mental health Community Treatment Order provision in Wales.

During our visits Healthcare Inspectorate Wales (HIW) ensures that the interests of the patients are monitored and settings fulfil their responsibilities by:

- Monitoring the compliance with the Mental Health Act 1983 (the Act) and the Mental Capacity Act
- Complying, as applicable, with the Welsh Government's National Minimum Standards in line with the requirements of the Care Standards Act 2000 and the Independent Health Care (Wales) Regulations 2011.

The focus of HIW's mental health Community Treatment Order inspections is to ensure that individuals accessing such services are:

- Safe
- Cared for in the least restrictive way
- In receipt of appropriate care and treatment from staff who are appropriately trained
- Encouraged to input into their care and treatment plan
- Supported to be as independent as possible
- Allowed and encouraged to make choice
- Given access to a range of activities that encourage them to reach their full potential
- Able to access independent advocates and are supported to raise concerns and complaints
- Supported to maintain relationships with family and friends where they wish to do so.

2. Methodology

The inspection model HIW uses to deliver the mental health Community Treatment Order inspections includes:

- Comprehensive interviews and discussions with patients, relatives, advocates and a cross section of staff, including the responsible clinician[1], nursing staff, Approved Mental Health Professionals[2] (AMHP) from local authorities, staff from independent providers of accommodation
- Interviews with senior staff including board members where possible
- Examination of care documentation including the multi–disciplinary team documentation
- Scrutiny of the documentation for patients detained under the Mental Health Act 1983
- Consideration of the implementation of the Welsh Measure (2010)[3]

[1] in relation to a patient liable to be detained by virtue of an application for admission for assessment or an application for admission for treatment, or a community patient, the approved clinician with overall responsibility for the patient's case.
[2] A professional with training in the use of the Act, approved by a local social services authority to carry out a number of functions under the Act.
[3] The Measure is primary legislation made by the National Assembly for Wales; amongst other matters it makes provision in relation to assessment, care planning and coordination within secondary mental health services.

3. Context and description of service

Cwm Taf Health Board provides community mental health services across its health board which incorporates the localities of Rhondda, Cynon, Taf Ely and Merthyr Tydfil's areas. These community mental health services include the provisions of care for patients on Community Treatment Orders (CTO).

Community mental health services are provided via multi-disciplinary, multi-agency Community Mental Health Teams for adults and older persons' services. These are in each of the four localities in partnership with Merthyr Tydfil County Borough Council and RCT County Borough Council.

In addition to the individual Community Mental Health Teams (CMHTs) across the health board, there are:

- Two Crisis Resolution & Home Treatment Teams providing 24-hours-7-days-aweek crisis assessment services and seven day home treatment services.

- Two Assertive Outreach and Recovery Teams providing seven days a week support and treatment to those with serious and enduring illness.

The purpose of a CTO is to enable patients to be treated safely in the community rather than under detention in hospital. To provide a way to help prevent relapse and any possible harm, to the patient or others. A CTO is intended to help the patient maintain stable mental health outside hospital and to promote recovery.

A CTO provides a framework for the management of patient care in the community and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary.

The criteria of which the responsible clinician must be satisfied are found in Section 17 A(5) of the Mental Health Act:

(a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
(b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;
(c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;
(d) it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) to recall the patient to hospital; and
(e) appropriate medical treatment is available for him.

Under section 17A(4) an AMHP must certify in writing that he agrees the criteria are met and that it is appropriate to make the CTO.

The time period for a CTO lasts initially for a maximum of six months, but can be extended for a further six months and thereafter can be extended for 12-month periods.

Section 17B(3) states the two mandatory conditions:

(a) condition that the patient make himself available for examination under section 20A; and
(b) a condition that, if it is proposed to give a certificate under Part 4A of this Act in his case, he make himself available for examination so as to enable the certificate to be given.

The first mandatory condition relates to extension of the CTO; the second to assessment for a Second Opinion Appointed Doctor (SOAD) certificate[4].

Section 17B(2) enables other discretionary conditions to be specified if the responsible clinician and AMHP agree that they are necessary or appropriate for one or more of the following purposes:

(a) ensuring that the patient receives medical treatment;
(b) preventing risk of harm to the patient's health or safety;
(c) protecting other persons.

[4] Where a patient does not have the capacity to consent to their treatment within the community, a Second Opinion Appointed Doctor (SOAD) will review the proposed treatment plan and authorise it on the statutory form C07 (certificate of appropriateness of treatment to be given to a community patient) http://www.wales.nhs.uk/sites3/docopen.cfm?orgId=816&id=105709

4. Summary

Six sets of patient notes and statutory documentation were reviewed. Along with speaking to staff at the health board, local authorities and independent providers of supported living accommodation. We also spoke to a number of patients who were able to give their views on their Community Treatment Order.

It was evident from entries in patients' notes that consideration for the commencement, extension, recall or revocation of a CTO was a multidisciplinary team decision involving staff from the health board and local authority. Staff from all disciplines and teams views were considered and valued.

There were good communications between the different teams involved with the CTO process. However, without a unified computer system between the health board and the local authorities some information wasn't always readily available for staff involved with the patient's care. Therefore, other arrangements had to be made to retrieve the information which delayed the availability of information and increase the workload of staff unnecessarily. This is inappropriate; a system should be in place so that all staff can easily access the most up-to-date information.

The use of CTOs enabled patients to receive care in the least restrictive way, as guided by the Mental Health Code of Practice for Wales[5] (the Code of Practice). CTOs were kept under review by the care team to ensure that they were still necessary for providing care to the patient within the community.

Conditions of CTOs were clear and appeared the least restrictive. However, staff must consider the wording used when writing additional conditions, particularly in terms of patients receiving their medication in the community.

Not all statutory documentation relating to patients CTOs were available on patients' files held within the community teams. HIW expect staff working with patients detained under the Act to be able to easily access statutory documentation. Some staff would be required to contact colleagues if they needed to review the statutory documentation, which could cause delays to the provision of care.

[5] A guide for mental health practitioners who have to make decisions within the scope of the Mental Health Act 1983, shaping the way that the legislation is put into practice. The Code also acts as a guide to patients and those who support and advise them.
http://www.wales.nhs.uk/sites3/documents/816/mental%20health%20act%201983%20code%20of%20practice%20for%20wales.pdf

5. Findings

Considering a Community Treatment Order

Through conversations with staff the consideration of whether a patient would benefit from the use of a CTO and decision to authorise a CTO was a multi-disciplinary team approach, involving staff from inpatient and community services. CTOs were used for patients who have had a history of relapse in the community and had been required to be re-admitted to hospital. Or alternatively, where the multidisciplinary team felt that there was a risk of non-compliance with medication and/or risky behaviours which could result in a relapse that may require re-admission to hospital.

Inpatient and community staff would consider a CTO at the patient's Care and Treatment Plan (CTP)[6] meeting prior to discharge, along with other regular meetings leading up to CTP meeting.

Individual patient notes evidenced that prior to commencing a CTO patient would have trial leave at placements within the community or their own homes. The leave would be authorised under Section 17[7] of the Act by the patient's responsible clinician specifying the location and duration of the leave, along with any applicable conditions. The trial leave durations would depend on the individual patient's circumstances and requirements. Staff from community mental health teams further away from Royal Glamorgan Hospital spoke of the difficulties caused by the distance travelled and time for home leave for short periods, such as one or two hours. This was easier to facilitate when patients were in a hospital closer to their homes than the current inpatient setting at Royal Glamorgan Hospital.

The CTO allowed for structured care of patients in the community and allowed for any intervention and assistance to be easier and quicker, especially if re-admission to hospital was required.

Staff from different disciplines confirmed that their views were welcomed and valued by all other disciplines. The Approved Mental Health Professionals (AMHPs) we spoke to stated that they give strong consideration to each CTO proposal. AMHPs were comfortable in challenging the views of the multidisciplinary team to ensure that a CTO is required and treatment is

---

[6] Care and Treatment Plan and Care and Treatment Plans should consider eight areas of a person's life: finance and money / accommodation / personal care and physical well-being / education and training / work and occupation / parenting or caring relationships / social, cultural or spiritual / medical and other forms of treatment including psychological interventions. A Care and Treatment Plan should include information against each of these areas as to: what outcomes the person is seeking / what services are being provided or what actions are being taken / when and who by.

[7] Patient leave from the hospital grounds authorised by the patient's responsible clinician.

provided to the patient following the least restrictive guiding principles of the Code of Practice.

Where possible, an AMHP with previous knowledge of the patient would be involved in the discussions of whether a CTO would be appropriate which provided continuity of care. Since the introduction of CTOs in November 2008 in-patient and community teams have realised the importance and time required to plan a CTO prior to it being authorised. It was evident on reviewing the statutory documentation that this was commonly the case.

Where AMHPs were unfamiliar with the individual patient, the AMHP ensured that they had sufficient time to familiarise themselves with the case, by reviewing patient’s notes, reports and speaking to the patient. Following that the AMHPs would then consider the appropriateness of the CTO.

Good communication was reported between individual staff on the mental health treatment wards at Royal Glamorgan Hospital and community teams; this was evidenced in patient notes. With regular meetings between inpatient staff and Community Practice Nurses (CPNs), including weekly ward rounds. Staff commented that this has assisted in building relationships between the teams, particularly since services were merged from St Tydfil’s Hospital into mental health services based at Royal Glamorgan Hospital. However, staff from areas further away from Royal Glamorgan Hospital within the health board commented on the time spent traveling between their areas and the hospital was a negative consequence of having all the in-patient mental health beds at Royal Glamorgan Hospital.

Community staff spoke positively that the patient’s clinician would be the same clinician on the treatment wards at Royal Glamorgan Hospital as when they are in the community. This provided continuity of care for patients between the in-patient services and community services.

Staff had no concerns and we could see no evidence to suggest that the use of CTOs was considered solely for the freeing up of in-patient beds. When used, CTOs were planned parts of the patient journey.

Authorising a Community Treatment Order

The statutory documentation authorising each of the CTO reviewed was completed in accordance with the Act.

During the review of statutory documentation, the authorisation form, CP1[8], was completed for the commencement of a CTO. The CP1 form had been completed by patients' responsible clinicians and an AMHP.

AMHPs reported that they felt that they were considered an important role within the CTO authorising process and their views considered. A number had noted that the change in language from other disciplines had supported this belief; where now it was common that when a CTO was being considered and discussed other disciplines regularly commented *a CTO should be considered **if** the AMHP agrees*. Some of the AMHPs had felt that there role had previously seen by other disciplines as a box ticking exercise to simply complete the authorisation of a CTO. Reviewing patients notes it was evident that AMHPs were part of the multi-disciplinary team consideration for authorising a CTO.

Whilst there are two statutory conditions[9] of a CTO the Act allows for the patient's Responsible Clinician, with the agreement of an AMHP, attach additional conditions to the CTO[10]. Staff spoke that patients' human rights were at the forefront of the decisions they made, and how any additional conditions may impact on them. With any additional conditions must be expectable for the patient to follow. It was evident from reviewing patient notes and speaking to staff that any additional conditions authorised were as least restrictive as possible with the aim to support the patient within the community.

Speaking to staff from varying disciplines they spoke of the changes in their views of additional conditions from the inception of CTOs in November 2008 compared to present. Staff's experiences working with CTOs had resulted in additional conditions now being more practicable for both the patients and staff than when CTOs were initially introduced.

[8] CP1 is the prescribed form completed by a patient's responsible clinician and an AMHP to authorise the commencement of a patient's CTO.
http://www.wales.nhs.uk/sites3/docopen.cfm?orgId=816&id=105719

[9] A condition that the patient make himself available for examination under Section 20A (Extension of a CTO); and a condition that, if it is proposed to give a certificate under Part 4A (Treatment of community patients) of this Act in his case, he make himself available for examination so as to enable the certificate to be given.

[10] Other discretionary conditions can be specified if the RC and AMHP agree that they are necessary or appropriate for one or more of the following purposes (Section 17B(2)):
(a) ensuring that the patient receives medical treatment;
(b) preventing risk of harm to the patient's health or safety;
(c) protecting other persons

However, we noted that it was common practice to include an additional condition requiring the patient *to take prescribed medication*. The wording should be *to receive prescribed medication.* It is an important distinction that needs to be adopted as practice. A patient should be recalled to hospital under Section 17E[11] if they refuse to accept medical treatment for their metal disorder. It is not possible for a condition to be used to compel a patient to receive such treatment in the community.

It was common place to see additional condition *to engage with all aspects of the Care and Treatment Plan*. Speaking to staff they felt that this allowed for the CTO to reflect the current circumstances surrounding the patient and to be reflective of the patients Care and Treatment Plan. The necessity of the inclusion within the CTP of areas such as illicit substances, alcohol, residing at residence, general health monitoring, etc. were monitored during regular reviews or sooner if required.

Staff also commented that the Mental Health Review Tribunal for Wales[12] were challenging additional conditions to ensure that they were appropriate and still valid. With this in mind, staff involved in the authorising of CTOs ensured that they carefully considered the proposed additional conditions, and subsequent restrictions, being considered.

In the majority of cases it was explicitly stated within patient notes of the change of legal status that patients had commenced a CTO, however this was not always the case. The health board must ensure that changes in patients' legal statuses are included in their notes.

Recommendations

The health board should ensure that any additional condition in relation to medication is written appropriately.

---

[11] Must meet the criteria in subsection Section 17E(1) The responsible clinician may recall a community patient to hospital if in his opinion:

(a) the patient requires medical treatment in hospital for his mental disorder; and
(b) there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.

[12] The Mental Health Review Tribunal for Wales is an independent judicial body. It hears applications and references for people subject to the Mental Health Act 1983.

Monitoring a Community Treatment Order

The monitoring of patients on CTO was based on the individual patient's requirements. The regularity of involvement from staff would depend on the patient's current circumstances and previous behaviours and risks. Where required, patients could have daily contact from the health board's Outreach and Recovery Teams[13]. Other patients on a CTO were seen less frequently by health board staff and their care co-ordinator (or their care co-ordinator from the local authority) with staff from independent accommodation placements providing patients' care co-ordinators with regular updates. When required, staff from independent accommodation placements contacted the patients' care co-ordinator to discus any changes to patient presentation.

Staff from the health board, local authority and independent accommodation providers spoke of good open communication between the services. Multi-disciplinary working was evident in patient records and through talking to staff. Staff from various services, within and outside of the health board, were engaged in providing care and evaluating patients' wellbeing.

With staff from the health board and local authority located within the same community buildings, there were good working relationships between the two organisations. Staff also felt they worked well within their teams which assisted in providing care to patients within the community.

Monitoring patients CTOs was a joint process with monitoring the patients Care and Treatment Plans. Care and Treatment Plans were written to assist patients with receiving care in the community on a CTO. This provided a record for documenting the progress patients were making on their CTO. There were a structured programme of reviews for patients Care and Treatment Plans and their CTOs. The frequency of the reviews was dependant upon the individual patient's needs. When required, staff could arrange multi-disciplinary meetings to discus any necessary changes in patient care that could not wait until the next scheduled review.

However, not all of the most recent Care and Treatment Plans were available on the health board's computerised records system. Therefore the most recent Care and Treatment Plan would not always be available to all relevant staff involved in the patient's care. The health board, working with the local authorities, must ensure that an appropriate system is in place so that all staff can access the most up-to-date information on the patient that they are involved with providing care for.

[13] Heath board teams that providing seven days a week support and treatment within the community to those with serious and enduring mental health illness.

The overarching theme for monitoring the CTO conditions and compliance with medication was to engage the individual patient and where possible discus options with the patient. This enabled patients to make decisions about their care with support from the community mental health teams. It was a multi-disciplinary decision about the level of monitoring patients would require, based on their current presentation, risks and history.

The intensive involvement of the Outreach and Recovery Teams, when required, was spoken of positively by community staff. The team provided regular support to patients to attempt to prevent re-admission to hospital. Where patients did not require as intensive support, their progress on a CTO was monitored by regular meetings with their care co-ordinator and at regular medical appointments such as depot clinics, wellbeing clinics, physical health screenings, etc. Any concerns for patient's welfare would initiate a review of the patient by staff.

Patients who were living in independent supported accommodation were monitored by staff working at those settings. These may be placements were patients were supported by staff 24 hours a day, or staff that regularly attended the accommodation. The frequency of staff involvement was dependant upon the individual patient's support requirements. Community staff stated that there were good communications between the services. When required, patients' Care Co-ordinators would be contacted by the staff at the independent settings to discus any concerns regarding a patient.

Monitoring whether patients took their oral medication could be difficult for staff. Patient's history of compliance with taking medication was taken in to account when considering the medical treatment on a CTO. Where patients received oral medication their involvement with community staff would reflect this to monitor the patient's wellbeing and observe any relapse indicators and/or deterioration in health that maybe associated with the patient not taking their medication. In some circumstances depot medication[14] was considered for patients where compliance with medication may be problematic. Where patients were receiving depot medication, this assisted staff in monitoring compliance with medication as the patient would be attending clinics for the administration of their medication.

Where possible, staff also communicated with patients' families and carers to discus the wellbeing of patients and any concerns that they may have.

[14] The administration of a sustained-action drug formulation that allows slow release and gradual absorption, so that the active agent can act for much longer periods than is possible with standard injections. Depot injections are usually given deep into a muscle.

On reviewing a sample of patient files held within the community teams, not all statutory documentation relating to patients CTOs were available. HIW would expect staff working with patients detained under the Act to be able to easily access statutory documentation, as is the expectation with in-patient settings. Whilst all statutory documentation was available on the health board's computer system, not all staff involved with CTO patients had access to this system. Some staff would be required to contact the Mental Health Act Administration Team within Royal Glamorgan Hospital if they needed to review the statutory documentation. This is inappropriate because it is not only time consuming for the community staff but also added unnecessarily to the Mental Health Act Administration Team's workload.

Recommendations

The health board must ensure that that an appropriate system is in place so that all staff can access the most up-to-date information on the patient that they are involved with providing care for.

The health board should ensure that all statutory documentation relating to patients CTOs are available on patients' community files.

Recalling and revoking a Community Treatment Order

All staff spoke of proportionate consideration via multi-disciplinary discussions when deciding whether there was a requirement to recall[15] a CTO patient to hospital, and possible revocation[16] of the CTO, this was documented within patients notes. The use of CTO recall was the final option once all other steps had been attempted on a patient's crisis plan. The aim of CTO recall was to allow for a short re-admission (up to 72 hours) in to hospital to stabilise and improve the patient's wellbeing to enable them to return to the community and receive care.

Prior to using the power of recall under the Act, staff would try and encourage patients to agree to return to hospital without the use of the Act, commonly referred to as an informal admission. However, some patients and their families had concerns about returning to hospital informally due to the location of the Royal Glamorgan Hospital and the transport links. This was exacerbated for patients from locations further away from the in-patient settings at Royal Glamorgan Hospital and if families were reliant upon public transport. This reluctance of patients to return to hospital due to it's location had on occasions led to a patient's return to hospital being delayed until no other option was available to staff other than the use of CTO recall.

Based on community staff's experiences they held mixed views on whether the use of a CTO effectively prevented re-admission to hospital via recall, as opposed to a patient in the community not on a CTO. However, it was a commonly held opinion amongst community staff that the use of CTOs has allowed for easier intervention and a direct route for family, carers, etc. to contact the community teams involved with the patient to raise their concerns about patient welfare.

Staff spoke of the lack of availability of a service between patients being treated in the community and the acute in-patient service provided at Royal Glamorgan Hospital. They felt that to have a service that would be able to provide re-admission to hospital for respite or short-term crisis care, but not

---

[15] "The power of recall is intended to provide a means to respond to evidence of relapse or high-risk behaviour relating to mental disorder before it becomes critical and leads to the patient or other people being harmed. This is achieved by ensuring that the patient receives treatment quickly - increasing the likelihood that the patient's condition can be stabilised and that they can resume life in the community as soon as is practicable. The need for recall might arise as a result of relapse, or by a change in the patient's circumstances giving rise to increased risk." - Code of practice for Wales, paragraph 30.54.

[16] Following recall, "If the responsible clinician and the AMHP agree that the CTO should be revoked they must complete the relevant statutory form…. The patient's detention under their original treatment section of the Act will be re-instated from the date of revocation…" - Code of practice for Wales, paragraph 30.81.

the level of acuity provided at Royal Glamorgan Hospital, could be a benefit to providing care for patients in the least restrictive way. This is an area the health board should review.

Recall to Royal Glamorgan Hospital was facilitated through the health board's Crisis Teams, located in Royal Glamorgan Hospital and Prince Charles Hospital, Merthyr Tydfil. The Crisis Teams provide a 24 hours-a-day 7 days-a-week service and therefore allowed for easy contact for community patients, families and staff. The Crisis Team reviewed patients and considered whether any alternative approaches could be taken to continue to support the patient within the community, and therefore prevent hospital re-admission.

The Crisis Teams received the minutes from the weekly meetings held Outreach and Recovery Teams so that the members of the Crisis Team were kept informed of the patients currently being cared for within the community. This allowed for re-admissions of community patients to be planned as far in advance as possible.

The majority of re-admissions to hospital were to the Admissions Ward at Royal Glamorgan Hospital. However, if the patient's presentation required a higher level of support patients were admitted to the Psychiatric Intensive Care Unit[17] (PICU) at Royal Glamorgan Hospital.

When patients were required to be re-admitted to Royal Glamorgan Hospital there was a clear record of when the bed was booked and co-ordinated via the Crisis Teams; the date of re-admission was recorded in the patient's notes. There was a clear record of whether the patient had agreed to be re-admitted with or without the use of recall. When patients were recalled from their CTO it was evident that the recall was authorised by the patient's responsible clinician and the grounds for recall were compliant with Section 17E(1) of the Act. This was recorded in patients' notes.

When required, Section 135 warrants[18] were applied for, this was commonly undertaken by the patient's care co-ordinator who were either a member from the health board or the local authority.

To assist in transferring patients to Royal Glamorgan Hospital the health board have commissioned the services of St John's Ambulance to transport patients if required. The patient may also be accompanied by South Wales Police if their presentation deemed this necessary.

---

[17] Psychiatric Intensive Care Unit provide mental health care and treatment for people whose acute distress, absconding risk and suicidal or challenging behaviour needs a secure environment beyond that which can normally be provided on an open psychiatric ward.

[18] Section 135 allows for a warrant to search for and remove patients from any premises specified in the warrant in which that person is believed to be.

Reviewing patients' notes, it was evident that staff would attempt to recall the patient to hospital in the least restrictive way[19] and attempts to encourage patients to attend hospital were documented. When police involvement was require, the reasons for this requirement were documented within patient notes.

It was recorded in patient notes of the patient being given their recall notice. Staff documented whether they were able to provide this to the patient by hand, and if not the reasons why it was posted to the patient. The period of recall was always within the statutory time-limit of 72 hours. A record was always made in patients' notes as to whether the patient had returned to their CTO or if the CTO was revoked and that the patient had remained in hospital.

Where patients' CTOs were revoked it was clear that this was authorised by the patient's responsible clinician using the statutory form CP7[20] within 72 hour time-limit of the recall period. The reasons for revocation were compliant with Sections 17F and 17G of the Act. The authorisation was countersigned by an AMHP as required by the Act.

However, there was not always a record by the AMHP in patients' notes, held by the health board, stating their reasons the AMHP felt that revocation was necessary[21]. This was partly due to not all AMHPs having access to the health board's electronic computer system. The AMHPs should be recording their decision in the patient's notes.

When a CTO was revoked a referral to the Mental Health Review Tribunal was completed, either by the patient referring themselves or by the hospital managers on the patient's behalf.

Upon revocation there was a record of patients being informed of the change in their legal status and informed of their rights under the Act.

The Admission Ward at Royal Glamorgan Hospital had a dedicated clinician who overseen the care of all patients admitted to the ward, unlike the two treatment wards, Ward 21 and Ward 22, and the PICU; where patients would maintain their clinician from the community.

---

[19] Code of practice for wales, paragraph 30.70 "The patient should be taken to hospital in the least restrictive way possible, and if the responsible clinician thinks it appropriate, the patient might be accompanied by a family member, carer or friend."

[20] CP7 is the prescribed form completed by a patient's responsible clinician to revoke a patient's CTO http://www.wales.nhs.uk/sites3/docopen.cfm?orgId=816&id=105744

[21] "…The AMHP's decision and the full reasons for it should be recorded in the patient's notes…" - Code of Practice for Wales, paragraph 30.80

Some community staff felt that when patients were re-admitted to hospital on to the Admissions Ward that the change of consultant resulted in a lack of continuity of care for the patient. However, having a dedicated consultant for the Admission Ward allowed for the consultant to undertake daily ward rounds to monitor the patient. Some community staff felt that it may be beneficial for the continuity of care if the consultant did not change on the recall of a patient, and that due to the consultant's previous knowledge of the patient that dally ward rounds may not be required on recall. The health board should review the provision of consultant on the recall of patient to hospital, to ensure that patients receive the consistent and intensive care required to minimise in-patient stay.

Community staff stated that they did not always feel involved in the discussions about the patient's care once recalled to hospital. Particularly, if the community staff felt that the patient's re-admission had only been necessary to reintroduce the patient's current medication due to the patient stopping their medication which had resulted in the deterioration of health.

There were difficulties with electronic communication between the health board and local authority, both organisations run their own software and some staff spoke of limitations in accessing the other organisation's system to access up to date information for the patient. This is inappropriate, as stated above, the health board should review their systems so staff can access the most up-to-date information on the patient that they are involved with providing care for.

Recommendations

The health board should ensure that a record is made by the AMHP in patients' notes, held by the health board, stating their reasons the AMHP felt that revocation was necessary.

The health board should review the consultant arrangement for when a patient is recalled to hospital to ensure that a consistent approach to care is provided for the patient.

Reviewing a Community Treatment Order

From reviewing patient notes It was evident that CTOs were reviewed as a multidisciplinary team with the views of patients and their families sort and considered. All staff we spoke to were confident about raising their views whilst discussing and challenging other team members' opinions.

It was positive that the common view was that the extension of a CTO should only be authorised if required, in line with the Code of Practice's guiding principles. When a CTO had been extended to a period of two or three years there was very strong multidisciplinary team consideration to whether the CTO was still required.

Extension of CTOs were authorised by patients' responsible clinicians within the required time frames[22]. In each case the responsible clinician examined the patient within the two months of the CTO expiry as required by the Act. CTO extensions met the requirement of the Act and the responsible clinician's grounds for extension were clearly stated on the statutory documentation, CP3[23]. It was evident through reviewing the statutory documentation and speaking to staff that where possible the extension of the CTO was authorised by an AMHP that had been involved in the patient care; this provided continuity to the process.

There wasn't always an entry in patient notes on the health board computerised system to state that the CTO had been extended. It would be good practice if this was included so that staff reviewing patient notes were clear of the legal status of the patient.

It was noted that during conversations with staff it was common to for the incorrect term to be used for the extension of CTOs. Staff often referred to the renewal of a CTO; it would be beneficial if the health board encouraged staff to use the correct language of the Act of *extending* the CTO.

There were clear records of Hospital Managers' Hearing[24] recorded in the patient notes on the extension of patients' CTOs.

There were a number of steps available to staff to provide more support to a patient in the community prior to the use of CTO recall to hospital. Therefore, it was clear that even if the power of recall had not been used during a period of CTO it did not mean that a CTO was not required. Conversely, the use of recall did not mean that a CTO was necessarily inappropriate; it was evident

---

[22] The time periods for a CTO lasts initially for a maximum of six months, but can be extended for a further six months and thereafter can be extended for 12-month periods.

[23] CP3 is the prescribed form completed by a patient's responsible clinician and an AMHP to extend a patient's CTO http://www.wales.nhs.uk/sites3/docopen.cfm?orgId=816&id=105755

[24] Hospital Managers (non-executive directors of a hospital) review the detention of detained patients upon the extension of a CTO (or renewal of detention).

in patient notes that recall was used to provide assistance to the patient concerned. If required the revocation of the CTO was applied if a patient required a longer re-admission to hospital than the 72 hours period of recall allowed.

Patients' and family members' views of CTOs included that a CTO provided a framework for patients, families and staff for receiving care within the community, and that some patients liked the structure provided by the CTO. Other patients' views were less favourable feeling like the CTO and the power of recall to hospital was hanging over them. Where patients felt negatively towards a CTO staff attempted to provide reassurance to the patients and reinforce the positives of a CTO to the patient.

Staff felt that the Mental Health Review Tribunal for Wales had been positive in challenging the extensions of CTOs, particularly CTOs that have lasted over two years and/or the power of recall has not been used. As a result, community staff would ensure that they were able to defend their judgement for the extension of a CTO, prior to authorising the extension. Staff felt that this had meant staff were keen to take positive risk taking to ensure that patients were on a CTO for the least possible time and therefore cared for in the least restrictive method.

Recommendations

The health board should ensure an entry is made in patients' notes to state that a patient's CTO had been extended.

The health board should encouraged staff to use the correct language of the Act of *extending* the CTO.

6. Next Steps

The health board is required to complete an Improvement Plan (Appendix A) to address the key findings from the inspection and submit its Improvement Plan to HIW within two weeks of the publication of this report.

The health board's Improvement Plan should clearly state when and how the findings identified at the Community Treatment Order review will be addressed, including timescales.

The health board's Improvement Plan, once agreed, will be published on the Healthcare Inspectorate Wales website and will be evaluated as part of the on-going mental health/learning disability inspection process.

Appendix A

Mental Health/ Learning Disability: Improvement Plan

Health Board: Cwm Taf University Health Board

Hospital: Mental Health Community Treatment Orders

Date of Inspection: October 2015

Recommendation	Health Board Action	Responsible Officer	Timescale
The health board should ensure that any additional condition in relation to medication is written appropriately.	All Responsible Clinicians (RC) have been made aware that any additional condition in relation to medication is written within the wording of the Act and that CP2 Variation of Condition of CTO forms are completed as necessary. This will be clarified by the Clinical Director at the next Senior Medical Staff Meeting.	Mental Health Act Team Leader / Clinical Director	28th February 2016
The health board must ensure that that an appropriate system is in place so that all staff can access the most up-to-date information on the patient that they are involved with providing care for.	All staff within the Directorate are aware of the recording mechanisms within their teams and link in closely with inpatient services. The Health Board currently has multiple systems for recording patient information. The Directorate is aware of	Assistant Director of Operations	1st September 2017

	the associated risks and this is highlighted on the Directorate Risk Register. A possible solution will be the new All Wales CCIS which has an anticipated implementation date of 2017.		
The health board should ensure that all statutory documentation relating to patients CTOs are available on patients' community files.	The Mental Health Act Administration Team will carry out training for all CMHT administration staff on where to file CTO documentation in patients' files.	Mental Health Act Administration Team	30th May 2016
The health board should ensure that a record is made by the AMHP in patients' notes, held by the health board, stating their reasons the AMHP felt that revocation was necessary.	A form already exists for the recording of this information. This form is filed or scanned into the service user record. Further training will be given to CMHT administration staff as identified above.	Mental Health Act Administration Team	30th May 2016
The health board should review the consultant arrangement for when a patient is recalled to hospital to ensure that a consistent approach to care is provided for the patient.	At present when a patient is recalled the community Consultant assesses for revocation and, if revoked, transfers Responsible Clinician to the Admission Ward Consultant to allow daily ward rounds and reviews. The Admission Ward Operational Policy will be reviewed to ensure this arrangement is made explicit.	Clinical Director / Senior Nurse	30th March 2016
The health board should ensure an entry is made in patients' notes to state that a patient's CTO had been extended.	Mental Health Act Administration Team advises all clinicians to document in paper records. This will be clarified by the Clinical Director at the next Senior Medical Staff Meeting.	Mental Health Act Administration Team / Clinical Director	28th February 2016

The health board should encouraged staff to use the correct language of the Act of extending the CTO.	This will be clarified by the Clinical Director at the next Senior Medical Staff Meeting.	Mental Health Act Administration Team / Clinical Director	28th February 2016