Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health Community Treatment Order (Announced)

Community Treatment Order: Aneurin Bevan UHB

March 2016

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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

Aneurin Bevan University Health Board provides community mental health services across localities of Gwent. These community mental health services include the provision 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 people. These services are delivered in partnership with:

- Blaenau Gwent County Borough Council
- Caerphilly County Borough Council
- Monmouthshire County Council
- Newport City Council
- Torfaen County Borough Council

In addition to the individual Community Mental Health Teams (CMHTs) across the health board, there are Assertive Outreach Teams & Home Treatment Teams providing crisis assessment services and home treatment services seven days a week between 9am and 9pm.

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.

For a CTO to be made, the responsible clinician must be satisfied, as 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 they agree that 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) sets out two conditions which are mandatory :

(a) That the patient make himself available for examination under section 20A; and
(b) 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

We reviewed 10 sets of patient notes and statutory documentation and spoke to staff at the health board and local authorities.

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. The views of staff from all disciplines and teams were considered and valued.

There was good communication between the different teams involved with the CTO process. With good record keeping maintained by the care teams. There were areas of positive practice of ensuring key entries in patient notes we prominent.

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). Conditions of CTOs were also clear and appeared consistent with the principle of being least restrictive. However, we noted that it was common practice to include an additional condition requiring the patient to take or comply with prescribed medication. The wording should be *to receive prescribed medication.*

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 CTO recall did not mean that a CTO was necessarily inappropriate; it was evident 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.

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. Staff spoke of good external review of CTOs by Hospital Manager Hearings and the Mental Health Review Tribunal.

[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

We concluded that a multi-disciplinary team approach, involving staff from inpatient and community services, was taken when considering whether a patient would benefit from the use of a CTO. 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. CTOs were also used 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.

In-patient 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. CTOs would be considered amongst other options such as Extended Section 17 Leave[7], Guardianship[8] or discharge from detention under the Act.

Individual patient notes evidenced that prior to commencing a CTO; patients would have trial leave to their own homes or supported accommodation within the community. The leave would be authorised under Section 17 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.

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 robust 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 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, thus supporting continuity of care. It was evident from reviewing patient notes and

[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. Section 17 Leave lasting 7 days or more is typically referred to as extended leave.

[8] The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people.

statutory documentation that in-patient and community teams ensured there was appropriate time to plan a CTO prior to it being authorised.

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

Good communication was reported between staff on the health board's in-patient mental health wards and the community teams; this was evidenced in patient notes. We saw evidence of regular meetings between in-patient staff and Community Practice Nurses (CPNs), including ward rounds. Staff said that this was easier to facilitate when the community teams were located at the same location as the in-patient service which benefited the professional relationships between teams.

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. Staff stated that CTOs were of benefit to enable some patients to receive care within the community. Staff felt that CTOs helped maintain patient engagement with the service due to the statutory responsibility.

Authorising a Community Treatment Order

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

During the review of statutory documentation, the authorisation form, CP1[9], was completed for the commencement of a CTO. The CP1 form had been completed by patients' responsible clinicians and an AMHP as required by the Act. It was evident from our review of patient notes that AMHPs were part of a multi-disciplinary team consideration for authorising a CTO.

Whilst there are two statutory conditions[10] of a CTO, the Act allows for the patient's Responsible Clinician, with the agreement of an AMHP, to attach additional conditions to the CTO[11]. Staff told us that patients' rights were at the forefront of the decisions they made regarding additional conditions, as

[9] 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

[10] 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.

[11] 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

any additional conditions may impact on them and their freedom of living in the community under a CTO.

Staff stated that any additional conditions that are authorised must be conditions that the patients can be expected 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.

However, we noted that it was common practice to include an additional condition requiring the patient *to take* or *comply with 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[12] 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 accept such treatment in the community.

Recommendation

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

Staff from varying disciplines spoke of how their views on additional conditions had changed 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.

Staff from across different disciplines would consider and challenge additional conditions that were suggested by members of the team; staff felt that their views were taken on board.

There was mixed practice by staff to recording in patient notes when a patient had commenced a CTO. It was positive to see that in some cases it was written that the patient had commenced their CTO and the entry had been made prominent in the notes by either highlighting it or writing it in a different colour. The health board should encourage staff across the health board to follow this practice. However, in a number of notes there wasn't a clear record that the patient had commenced a CTO.

Recommendation

The health board should ensure there is a record of a patient commencing a CTO.

[12] 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.

There were records of patients being provided with information regarding their CTO and the provision of their rights whilst on a CTO. Some staff had made their recording prominent in the notes by either highlighting the entry in patient notes or writing it in a different colour.

Patient notes were maintained in physical paper-based files and held by the care team currently involved with the patient. The majority of staff entered their involvement with the patient (and other associated persons involved with the patient's care) directly into the paper files. However, staff also had access to the health board's electronic system where staff could enter their involvement with the patient, along with other patient care documentation, such as risk assessments and care plans. This information was printed off and placed into the physical files.

The electronic system would allow staff to review patient care without the requirement to view the physical file. However, not all information was being inputted electronically, therefore staff still relied on the paper-based files. The staff we discussed this with felt that an electronic system would benefit staff and patient care. However, staff felt that an electronic system would need to be implemented systematically to ensure consistency of use by staff, so that up-to-date information was available in one place as and when staff required it.

Recommendation

The health board should review the systems in palace for maintaining patient notes so that information is inputted consistently by staff and that up-to-date information is available in one place.

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, risks and previous behaviours. Where required, patients could have daily contact from the health board's Assertive Outreach Team[13] for short periods of daily contact or independent providers for long term arrangements. Staff spoke positively about these services and the support they provided in monitoring patients.

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). Where patients were at independent accommodation placements, staff from those placements would provide 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.

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

Staff commented that the frequency of engagement with patients was determined by individual patient needs. There was a requirement to balance between the regularity of contact to provide assurance on patient welfare to staff and to ensure that contact wasn't too regular that may result in a patient to disengage.

Staff from the health board and local authority spoke of good open communication between the services, and patient notes reflected this. 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.

Patients' CTOs and the patients' Care and Treatment Plans were monitored together. Care and Treatment Plans were written to assist patients with receiving care in the community on a CTO. 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.

The overarching theme for monitoring the CTO conditions and compliance with medication was to engage the individual patient and where possible discuss 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 Assertive Outreach Teams, when required, was spoken of positively by community staff. The team provided regular support to patients in an attempt to prevent re-admission to hospital. Where patients required less 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 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 settings where 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 which was also recorded in patient notes. When required, a patient's Care Co-ordinator would be contacted by the staff at the independent settings to discus any concerns regarding the patient.

Monitoring whether patients took their oral medication could be difficult for staff. From reviewing patient notes and speaking to staff we found that 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 or independent services 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 seen by health board staff 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.

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 patient 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.

Based on experience, community staff 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.

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[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.

[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.

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 and it was positive to note that in some patient notes that staff would ensure that the entry was prominent by highlighting the entry, the health board should encourage staff across the health board to follow this practice. There was also a record of the patient being provided with the reason for recall and their rights; again, some staff highlighted these entries in the patient notes to make them prominent.

Whilst staff stated that they always attempt to provide the recall notice by hand to the patient, as opposed to posting it, staff didn't always document in patient notes how the recall notice had been delivered. However, in some patient records the reasons why staff were unable to provide the notice by hand were documented in patient notes.

Recommendation

The health board should ensure staff document in patient notes how the recall notice was provided to the patient, to evidence their compliance with the Code of Practice, paragraph 30.64.

Staff stated that they would attempt to recall the patient to hospital in the least restrictive way[17]; however, reviewing patient notes it was not always evident from how the patient was returned to hospital.

Recommendation

The health board should ensure staff document in patient notes how the patient was taken to hospital, to evidence their compliance with the Code of Practice, paragraph 30.70.

On occasions staff required the assistance of Gwent Police when a patient was unwilling to return to hospital and the patient was posing a risk to themselves or others. When required, Section 135 warrants[18] were applied for. When police involvement was required, the reasons for this requirement were documented within patient notes.

However, community staff raised concerns regarding the consistency of response by the police service. Whilst staff were mindful of the police service's differing priorities, it was felt amongst health board staff that the liaison between the health service and police service needs to reviewed to ensure the safety of patients, staff and the public.

Recommendation

[17] 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."
[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.

The health board should liaise with Gwent Police to review the procedures for recalling CTO patients when police assistance is required.

The period of CTO 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 therefore 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[19] 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.

Staff in the community mental health teams said that they do not have difficulty in accessing hospital beds for patients being recalled from a CTO.

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.

Reviewing a Community Treatment Order

It was evident from our review of patient notes that CTOs were reviewed on a multidisciplinary team basis, with the views of patients and their families sought 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.

CTO extensions were authorised by patients' responsible clinicians within the required time frames[20]. In each case the responsible clinician examined the patient within the two months of the CTO expiry, as required by the Act. Where CTOs were extended the responsible clinician's grounds for extension were stated on the statutory documentation, CP3[21].

It was evident through reviewing the statutory documentation and speaking to staff that where possible the extension of the CTO was authorised by an

[19] 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

[20] 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.

[21] 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

AMHP that had been involved in the patient care; this provided continuity to the process.

In the documentation reviewed, there was an entry in patient notes to state that the CTO had been extended.

However, it was noted that during conversations with staff and reviewing health board documentation it was common for the incorrect term to be used for the extension of CTOs. CTO extensions were 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.

Recommendation

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

There were clear records of Hospital Managers' Hearings[22] recorded in patient notes on the extension of patients' CTOs. It was evident from reviewing patient notes that Hospital Managers' Hearings were challenging CTO extensions, particularly if the CTO had been in place for a number of years. In response to the challenge, staff documented their reasons why a CTO was still required.

There were also records of referrals to Mental Health Review Tribunal. Staff stated that the Mental Health Review Tribunal keenly contested the extension of CTOs and this encouraged staff to strongly consider the requirement of threating a patient on a CTO and extending a CTO.

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

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 within 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

Community Treatment Order: **Improvement Plan**

Health Board: **Aneurin Bevan University Health Board**

Hospital: **Mental Health Community Treatment Orders**

Date of Inspection: **March 2016**

Recommendation	Health Board Action	Responsible Officer	Timescale
The health board should ensure that any additional condition in relation to medication is written appropriately.	Will ensure training covering these points is included in current training practice. Implementation of new guidelines covering treatment of patients subject to Part 4 and Part 4a (consent to treatment), including form for Responsible Clinicians to complete. E-mail regarding appropriate wording associated with receiving prescribed medication to go to relevant staff.	Training Leads, MHA Admin Lead, Clinical Leads	May 2016 April 2016
The health board should ensure there is a record of a patient commencing a CTO.	MHA Admin department send letters to patient and relevant care team informing them of new CTO and any current	MHA Admin Lead, CMHT Leads	Completed

	extension periods for CTO. Mental Health Act Department, Audit and Community Mental Health Team Leads to ensure correspondence is kept and recorded in relevant patient notes in Community. Electronic records of CTO start dates and extensions already kept, ensure this is continued and followed.		
The health board should review the systems in place for maintaining patient notes so that information is inputted consistently by staff and that up-to-date information is available in one place.	Relevant training is available to staff to use current recording systems, such as EPEX. CMHT's to ensure relevant staff is trained in using these systems and that information is properly recorded. Health Board to take review of current systems to Information Development Group and where possible improve current systems. Health Board to ensure that the new integrated electronic Welsh Community Care Information (WCCIS) will support the recording of necessary and up-to-date information regarding CTO's.	Training Leads, CMHT Leads, IDG Lead	Completed May 2016 May 2016 June 2017
The health board should ensure staff document in patient notes how the recall notice was provided to the patient, to	Email regarding recall information recording to go out to relevant staff and partners, training to be made available	CMHT's Training Leads	April 2016

evidence their compliance with the Code of Practice, paragraph 30.64.	regarding recording of relevant information, also to be audited.		
The health board should ensure staff document in patient notes show the patient was taken to hospital, to evidence their compliance with the Code of Practice, paragraph 30.70.	As above point.	CMHT's Training Leads	April 2016
The health board should liaise with Gwent Police to review the procedures for recalling CTO patients when police assistance is required.	Health Board to take issues to Gwent Police / Health Liaison Group for review and clarification. Feedback of any reported issues to continue.	Perry Attwell to Liaison Group	May 2016
The health board should encouraged staff to use the correct language of the Act of *extending* the CTO.	Review of current documentation and language used, alter where necessary, include any relevant points in current training. Mental Health Act Administration Team to monitor through audit the use of language in relevant documentation, specifically CP1's and CP2's where conditions are of particular importance. E-mail flow chart to CMHT's regarding process of the extension of CTO's and highlighting the importance of using the correct language of the Act.	Training Leads MHA Admin	May 2016 April 2016 Ongoing April 2016