Healthcare Inspectorate Wales

Arolygiaeth Gofal Iechyd Cymru

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health Community Treatment Order (Announced)

Community Treatment Order: Cardiff & Vale UHB

December 2015 and January 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

Cardiff & Vale University Health Board provides community mental health services across localities of Cardiff and the Vale of Glamorgan. 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 The City of Cardiff Council and the Vale of Glamorgan Council.

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

- Two Crisis Resolution & Home Treatment Teams providing crisis assessment services 24 hours a day and seven days a week, and home treatment services seven days a week.
- Assertive Outreach Service providing seven days a week support in addition to the support provided by patients CMHT.

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 11 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 a unified computer system between the health board and the local authorities, up-to-date information was readily available for staff involved with the patient's care.

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. 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.

However, staff raised concerns with the process of transporting a patient back to hospital when required. The process could be lengthy, and without a standardised process within the health board, on occasions it could difficult to facilitate between different agencies.

[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, a patient would have trial leave at settings within the community or their own homes. 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

[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.

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. 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 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.

Community staff spoke positively that the patient's clinician would be the same clinician on the health board's in-patient mental health wards 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. Staff stated that some patient stays within hospital would be prolonged if they were unable to use a CTO and 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.

AMHPs reported that they felt that their role was considered an important one within the CTO authorising process and their views considered. 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 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.

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. As a test of the appropriateness of a condition, some staff stated that they considered what action would be taken if that condition was breached. If staff thought no action would be taken, the inclusion of the condition would not be appropriate.

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[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

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.

It was positive that when a condition was made in respect of medication, the wording used in the sample of documentation reviewed was *to receive prescribed medication* reflecting the legislation of the Act. It is important that any condition in regard to medication is phrased correctly as a patient should be recalled to hospital under Section 17E[12] if they refuse to accept medical treatment for their mental disorder. It is not possible for a CTO condition to be used to compel a patient to receive such treatment in the community.

The health board had one electronic record system for the in-patient and community services which enabled staff from different services to input and review patient case notes. This meant up-to-date information was available to staff as and when they required it. For the sets of documentation we reviewed, it was clear that a patient had commenced a CTO and it was stated within patient notes.

[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.

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 Assertive Outreach Service[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 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. This provides a record for documenting the progress patients are making on their CTO. We found 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.

Care and Treatment Plans were available on the health board's computerised records system which could be accessed by health board and local authority staff.

[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.

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 Service, 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 placements 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. 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 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.

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.

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.

Based 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.

Staff spoke of the lack of availability of a service between patients being treated in the community and the acute in-patient service provided within the health board's current in-patient settings. 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 the level of acuity provided at within the current in-patient settings, 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 hospital was facilitated through the health board's Crisis Teams located in Whitchurch Hospital. 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 community 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.

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[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 required to be re-admitted to hospital, 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[17] were applied for. This was commonly undertaken by the patient's care co-ordinator who was either a member from the health board or the local authority.

Staff reported that there have been difficulties with transporting patients unwilling or unable to go to hospital by themselves. The health board does not provide transport for patients to return to hospital and we were informed that accessing a service via Welsh Ambulance Service Trust can be difficult due to the demands on this service.

Recommendation

The health board should review the provision of transport for facilitating the recall of patients to hospital.

It was evident from reviewing patient notes and speaking to staff that staff would attempt to recall the patient to hospital in the least restrictive way[18]; attempts to encourage patients to attend hospital were documented. The patient may also be accompanied by South Wales Police if their presentation deemed this necessary. When police involvement was required, the reasons for this requirement were documented within patient notes.

Patient notes stated when the patient had been given their recall notice. Staff documented whether they were able to provide this to the patient personally, 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 therefore the patient had remained in hospital.

[17] 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.
[18] 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."

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.

In general, 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. However, staff from the Forensic Community Mental Health Team[20] expressed that they experience difficulties in admitting patients to the Forensic Ward at Whitchurch Hospital due to the demand on the service and the number of in-patient beds available.

Recommendation

The health board should review the provision of beds for forensic patients to assist with the provision of CTO recall when required.

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.

With health board and local authority staff using the same computer system there were good electronic communication between both organisations.

[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 Forensic Community Mental Health Team services are offered to service users who have a diagnosed mental disorder, which is associated with a serious risk to others, most often seen in serious offending behaviour and for which appropriate treatment is available and can be met through community service provision

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[21]. In each case the responsible clinician examined the patient within the two months of the CTO expiry, as required by the Act.

Five sets of documentation reviewed were for CTOs that had lasted five years or more. In these cases, the responsible clinician's grounds for extension were clearly stated on the statutory documentation, CP3[22]. Where other CTOs had been extended, the responsible clinician involved had stated the grounds for extension. However, for one CTO extension, the reasons listed related to historic risks, but the need for the power of recall was not clearly stated but alluded to within the reasons. The grounds for extension should state that the power of recall may be required.

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.

However, on a number of occasions the responsible clinician had stated on the CP3 statutory form that the other profession was the AMHP involved in extending the CTO. Whilst this is legal under Section 20A(9), it would be beneficial if responsible clinicians sought opinions from a range of staff involved in the extension of the CTO and that this is reflected on the statutory documentation.

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

[21] 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.
[22] 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

However, it was noted that during conversations with staff it was common 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.

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[23] 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 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, as they felt that 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.

[23] 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: **Cardiff and Vale University Health Board**

Hospital: **Mental Health Community Treatment Orders**

Date of Inspection: **December 2015 & January 2016**

Recommendation	Health Board Action	Responsible Officer	Timescale
The health board should review the provision of transport for facilitating the recall of patients to hospital.	The Crisis Service or the Community Mental Health Team will provide transport to facilitate the recall of patients who do pose a significant risk of harm. The Health Board is also able to book taxis; however, for patients unwilling to accept the recall, police or WAST assistance is required.	Senior Nurse Manager for Community Services	Complete
The health board should review the provision of beds for forensic patients to assist with the provision of CTO recall when required.	The Mental Health Service will move to new facilities in April 2016 and whilst there is no opportunity to increase the provision of forensic beds, the Psychiatric	Clinical Director	June 2016

	Intensive Care Unit bed provision could be increased and would be available in emergency situations.		
The health board should encouraged staff to use the correct language of the Act of *extending* the CTO.	A briefing has been sent to staff regarding the use of the correct language of the Act of extending the CTO.	Mental Health Act Manager	Complete