The Hamptons

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We rated The Hamptons as **outstanding** because:

- The service had a person-centred approach to recovery. Patients were involved throughout their care and recovery plans. Individual goals and objectives were identified with each patient to help them achieve their preferred outcome. Staff respected and valued patients as individuals.
- There was a clear governance structure in place and the registered manager had a strong and thorough oversight of the service. This structure helped to drive improvements to create high-quality person-centred care. There was evidence that actions were taken to resolve issues and there were reporting processes in place. There was a full range of audits completed to monitor performance and to drive improvements.
- Staff at all levels displayed an understanding of the individual needs of patients and these were highly valued. Staff considered these needs throughout the care and treatment of patients. Patients and relatives were universally positive about the staff and how they would make time to assist patients.
- The morale of staff was high and they reported strong working relationships with their colleagues. Staff felt supported by management and that they were encouraged to raise concerns with them. Staff spoke highly of the culture. Staff felt that senior management listened to them and included them in the development of the service.
- The service encouraged feedback from patients and staff in a positive, innovative and inclusive manner. The 'Champions model' allowed all patients and staff to develop the service. This gave patients a true voice in how their care and treatment was being delivered. It promoted a culture of innovation and inclusiveness to provide a higher quality of care. The 360 degree patient appraisals also gave patients the opportunity to provide feedback about staff and highlight if there were any issues.

Summary of findings

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Background to The Hamptons

The Hamptons is a locked rehabilitation hospital for men with enduring mental health needs between the ages of 18 and 65 years old. It provides 14 beds and can admit both informal and detained patients.

The Hamptons has been registered with the CQC since 3 February 2011. It is registered for the following regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

There have been five previous inspections of The Hamptons. The most recent was conducted on the 17 and 19 August 2015 where The Hamptons was rated as Good across all domains.

The most recent Mental Health Act monitoring visit was on 17 May 2017. At this visit, we found good adherence to the Mental Health Act and Mental Health Act code of practice with some minor issues raised. The Hamptons submitted an action statement of how they would address these issues.

At the time of this inspection, there was a registered manager in place who was also the named controlled drugs accountable officer. This meant that there was a senior person in charge who checked that the hospital met the appropriate regulations and oversaw the arrangements for managing controlled drugs (drugs that require special storage with additional record keeping rules).

Our inspection team

Team leader: Alex Bostock

The team that inspected the service comprised three CQC inspectors.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information which was sent to us by the provider and considered the information we held about the service.

We completed an announced comprehensive inspection visit to this location on 13 and 15 November 2017. During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with the registered manager;
- spoke with seven other staff members including nursing staff and support staff, the occupational therapist, the assistant psychologist and the responsible clinician for the location;
- spoke with four patients who were using the service and three relatives / carers;

Summary of this inspection

- attended and observed a mini huddle, clinical risk strategy meeting and a patient multidisciplinary team meeting;
- looked at five care and treatment records of patients;
- carried out a specific check of the medication management in the hospital and looked at all relevant prescription charts; and
- looked at a range of policies, procedures, audits and other documents relating to the running of the service.

What people who use the service say

We spoke with four patients who used the service. Patients told us that staff were always approachable and would take time to speak with them. Patients explained that they were treated with respect by staff. They reported that they were included in their care plans and were able to help develop the service. All patients reported feeling safe on the ward and would raise any concerns if they needed to.

We spoke with three relatives of current patients at The Hamptons. All gave positive feedback about the service and the staff. They were complimentary about the level of care being given to their loved ones. They reported that they were all able to be involved in the care their loved ones received.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because:

- The hospital was clean and well-maintained.
- There were sufficient numbers of staff on duty to meet the needs of the patients.
- Staff completed thorough risk assessments and management plans of patients. Staff were aware of these risks and how to manage them appropriately.
- Staff understood safeguarding procedures. Safeguarding incidents were reported appropriately and recorded in a clear manner.
- All staff were aware of how to report incidents and when they were required to do so. There was a thorough process in place to review these incidents and identify any actions or lessons to be learnt.

However:

- The service target of 80% of staff having completed mandatory training had not been met for all courses.

Are services effective?

Good

We rated effective as **good** because:

- Care and support plans were developed with patients. The opinions and preferences of patients were reflected in the care and support plans.
- The Hamptons had a clear recovery focus. A range of recognised tools were used to assess and gain an understanding of each patient.
- A physical health check was completed on admission. There was evidence of ongoing physical health monitoring.
- Staff had access to specialist training and were able to request this when they identified gaps. The service supported them in accessing this.
- A new supervision and appraisal process had been introduced that gave a clear structure to the process. All staff had received an appraisal at the time of inspection.

Are services caring?

Outstanding

We rated caring as **outstanding** because:

- Patients at the hospital were thoroughly involved in their care. Patients were able to influence the care provided by the service

Summary of this inspection

through a variety of methods including the 'Champions model', patient focus groups and community meetings. The care records reflected that patients were included in discussions and decisions about their care. Patients were empowered as partners in their care.

- Feedback about the staff from patients and relatives was universally positive. Patients described that staff would always make time for them and would address any issues immediately. Staff truly respected and valued patients as individuals.
- The Hamptons had introduced 360 degree patient appraisals. This gave patients the opportunity to provide feedback on individual staff members in a confidential manner.
- Relationships between staff and patients were positive and person-centred. Staff spoke to patients in a supportive and considerate manner. Staff treated patients with dignity and respect and staff demonstrated a passion for helping the patients.

Are services responsive?

Good

We rated responsive as **good** because:

- Discharge planning began on admission and patients had clear goals and objectives.
- There was a complaints process and all complaints were managed appropriately and in a timely manner.
- Staff used the 'Modular Transitional Rehabilitation Programme' to support patient rehabilitation and was flexible to meet the needs of patients. Staff facilitated the programme but promoted patients to lead and deliver certain sessions.
- Patients had access to a range of information about the service.
- There was a positive atmosphere at the hospital and it had a homely feel. Patients were able to personalise their bedrooms and had access to a range of facilities.
- Improvements had been made to the menu which had been linked to the mental health foundation report on healthy eating and depression.

However:

- At the time of the inspection there were three delayed discharges. The service was not responsible for the delays and was working with partners to resolve them.

Are services well-led?

Outstanding

We rated well-led as **outstanding** because:

- All staff gave positive feedback about the teamwork that was displayed at The Hamptons. Staff felt supported by their

colleagues and by senior management. They felt that any concerns or issues could be discussed with managers and there was an open door policy. Staff spoke highly about the culture that was created by the senior management. Staff were committed to delivering high-quality care.

- The service had introduced innovative new procedures and ideas aimed at improving the level of care being provided.
- The 'Champions model' provided staff and patients with the opportunity to influence and develop the service and the way that care was delivered. Patients and staff gave positive feedback about this development and changes had already been made through this model. This gave the service a person-centred feel that gave individuals a clear voice.
- Patients completed 360 degree patient appraisals of staff. This process was used alongside the supervision and appraisal process to monitor staff performance and ensure that care and treatment was meeting the needs of the patient.
- The registered manager had a clear oversight of the service. They were passionate about innovation, continuous improvement and improving the quality of care provided to patients.
- Award schemes were in place to promote positive performance and successes.
- Lessons learnt following incidents were identified. The management took actions to ensure that any areas of improvement were addressed and resolved, such as the clinic room door being changed. Staff felt that issues got resolved quickly and that any changes implemented by management were well communicated to the staff.
- There was a clear governance structure to drive improvements and create high-quality person-centred care.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Eighty-six percent of staff have had training in the Mental Health Act.

The Hamptons had a Mental Health Act administrator who was responsible for ensuring all paperwork was completed correctly and stored in the appropriate place. They were also responsible for carrying out audits to become aware of any errors. This included an annual legal file audit and spot checks.

Patients' rights under the Mental Health Act were explained to them every two months and following any tribunal or manager hearing. This was monitored on a tracker and the administrator would prompt nurses to remind them to do this. When the rights were explained, this would be recorded in the patient's care notes and on an electronic record.

We reviewed the section 17 leave files of five patients. We found that these files were up to date and were comprehensive in the information recorded in them. A checklist was in place for staff to review when a patient was going on leave. A post leave evaluation was also recorded in the files.

Certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to medicine charts where appropriate. The Mental Health Act administrator regularly audited these.

At the time of the inspection there was one informal patient. The informal status had been documented in the support plan and care records. The patient had given their consent to care and treatment. Informal patients were free to leave and a sign on the door reflected this. It asked that any informal patient wanting to leave should make staff aware prior to doing so.

Patients had access to an independent mental health advocate. The advocacy service attended the hospital for two afternoons a week and on the days that the multidisciplinary team meetings were held. Information on how to contact the advocacy service was displayed on the Mental Health Act noticeboard in the main corridor. We observed staff offering advocacy support during the multidisciplinary team meeting that we attended. We observed patients accessing support from the advocacy service. Staff were aware of the advocacy service and knew how to contact if a patient requested support from an advocate.

Mental Capacity Act and Deprivation of Liberty Safeguards

Eighty percent of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

In all five care records reviewed, we found evidence that mental capacity had been assessed. Staff we spoke with showed an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. They were aware of their responsibilities and the procedures involved in this.

The Hamptons had a policy regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. One application for Deprivation of Liberty Safeguards had been made in the last six months. We reviewed this paperwork and found that the appropriate process had been completed and recorded in the patient's care record.

Long stay/rehabilitation mental health wards for working age adults

Outstanding ☆

Safe	Good
Effective	Good
Caring	Outstanding ☆
Responsive	Good
Well-led	Outstanding ☆

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

Safe and clean environment

The Hamptons provided rehabilitation to patients with enduring mental health needs. The hospital provided accommodation for male patients. There were 14 bedrooms all with en suite bathroom facilities across two floors. Three bedrooms were downstairs and were used for people with mobility issues. As the hospital was for male patients only, it complied with same sex guidance.

The Hamptons was originally built to a low secure specification. This meant that all bathrooms had anti-ligature fittings. The registered manager explained that the service would be removing the anti-ligature fittings in the bedrooms on the top floor to reflect the rehabilitation focus of the service and be a more welcoming environment for patients. In some bedrooms, this process had begun as fittings required repair or replacements. The three bedrooms on the ground floor were to remain anti-ligature should the hospital assess any patients as being at a high risk of self-harm.

A ligature audit had been completed in December 2016 and reviewed in July 2017. Ligature points are places to which patients intent on self-harm might tie something to strangle themselves. The audit identified a number of ligature risks and points throughout the hospital and described how these would be reduced. This included staff observation and awareness; monitoring access to certain areas and individually risk assessing patients.

Access to the top floor of the hospital was via an elevator or two staircases. The layout of the building meant there were some blind spots and areas of limited observation, such as the staircases. Staff were aware that each patient's individual risks had been assessed as well as the environmental risks. Staff described how risks were managed and how observations were completed.

In one bedroom, one of the window restrictors was recorded as missing in the monthly window restrictor audit. This was clarified with the registered manager who confirmed that the window restrictor was in place but was not working correctly. Maintenance were attempting to locate the correct part to fix the restrictor and had bolted that half of the window shut to ensure the safety of the patient. The second window restrictor in the room was reported to have no issues so the patient still had access to fresh air. We observed that this was recorded on the maintenance action plan. A store room was missing its handle. It was no longer in use whilst it was awaiting repair and had been locked so it could not be accessed. This was also listed on the maintenance action plan.

The hospital was clean and well maintained. Staff completed weekly environmental audits. These were weekly spot checks to observe any issues that needed resolving. Staff received training in infection control and there was a designated infection control lead. Cleaning records were kept and completed by the domestic staff. An infection control audit had been carried out and an action plan had been completed following this. One of the two

staircases was carpeted and this was stained. It was recorded on the maintenance action plan as requiring regular deep cleaning. The registered manager noted that this carpet was due to be removed.

Whilst checking one of the first aid kits we observed that a small number of the dressings were past the expiry date listed on them. This was highlighted to the registered manager and was resolved on that day.

The clinic room was situated off the main ground floor corridor. The door was locked and had a small hatch. Patients would not use the hatch to collect medicines but would come into the clinic room individually to collect their medicines. The clinic room had a weigh scale, pulsimeter, glucometer and blood pressure monitor. For patients requiring electrocardiogram, they would attend the local GP surgery. There was a schedule to check medical equipment for electrical testing and calibration. Records confirmed that the medical equipment had been checked and tested in March 2017. Fridge and room temperatures were checked daily. An air conditioner was available to regulate the room temperature. Staff were trained in standard infection control precautions including hand hygiene and sharps management. The equipment and premises were cleaned in line with local policies and adequate personal and protective equipment was available to staff. Hand washing facilities and antibacterial hand gel were available for staff to use. We observed staff using the antibacterial hand gel. There was no clinical couch and staff would examine patients in their bedrooms if needed. Laboratory specimens such as blood collection specimens were handled and stored in line with local policy. Medical waste bins and sharps disposal bins were located in the clinic room. Disposal procedures were in place and waste was stored in a locked area outside the building.

Safe staffing

The staffing establishment levels for the hospital was four qualified nurses and 12 recovery support workers. There was one vacant qualified nurse post although this had been appointed to. There were 2.5 whole time equivalent vacancies for recovery support workers. Recruitment was ongoing for these posts. In the period of 1 May 2017 to 31 July 2017, 175 shifts were covered by bank or agency staff. This equated to around 13 shifts per week. The provider reported to have a good team of bank staff and would try to use regular agency staff where possible. This ensured the staff were able to build relationships with the patients to maintain the levels of care.

The registered manager explained that the staff requirement was estimated by analysing the occupancy levels of the hospital alongside safe staffing guidance. They also took into account the needs and risks of the patients as well as feedback from the patients and staffing team.

In the last 12 months, five permanent members of staff had left the service. This was a turnover rate of 19%. The registered manager noted that the service had difficulty in retaining recovery support workers because of limited opportunities to progress within the role. The registered manager was hoping to create a pathway for recovery support workers who had been trained and upskilled to keep their knowledge and expertise within the service. Staff sickness over the last 12 months was 3%.

A two-shift system was in place with one qualified nurse and four recovery support workers during the day and one qualified nurse and two recovery support workers for the night shift. During the day, the hospital also had an additional recovery support worker between 9am to 5pm. Support for the qualified nurse on duty could be provided by the team leader, clinical lead and deputy manager. The Hamptons would also liaise with its neighbouring site, Brookhaven, who also had a qualified nurse on duty if additional support was required. The registered manager recognised that a flexible approach to staffing could be needed to manage the changing needs of patients and was confident that this could be managed appropriately.

Patients and relatives reported that there was always enough staff present at the hospital and that no leave or activities were cancelled due to low staffing numbers. Staff told us that the levels of staffing were adequate and that patients were always given regular one to one sessions with staff each week. There was a procedure in place to manage leave to ensure staffing levels were appropriately planned and cover could be arranged. The service had a specific key performance indicator for staff to have four meaningful one to one sessions a week with each patient. The registered manager used this indicator to check there were enough staff on duty. In October 2017, the actual

figure was 72% with a target of 80%. This had increased from a low of 40% in April 2017. An issue that was identified was that the sessions were happening but were not being documented correctly.

The consultant psychiatrist attended The Hamptons for one and a half days a week. They would be on call for the times when they were not present at the service and staff could contact them using telephone or email when necessary. On call cover at weekends could be sub-contracted to other consultants. In a medical emergency, the service would use the on call GP surgery or would use 999 to call an ambulance. The Hamptons had links with a local GP surgery for all physical health examinations and issues.

An on-call system was also in place for the management team to support the team with any staffing issues or incidents.

Managers monitored mandatory training using a training matrix that indicated the current percentage of staff that had completed each course. Mandatory training refers to training courses that the provider identifies as courses that are not optional for staff. The Hamptons had a target of 80% for mandatory training. This target had been set by the provider to ensure there was an allowance for new starters and refresher training. As of the day of the inspection, the majority of courses were above this level. The mandatory training that did not meet this target at the time of inspection were equality and diversity (75%), moving and handling (79%), record keeping (75%), information governance (71%) and mental health awareness (75%).

Assessing and managing risk to patients and staff

We reviewed five care and treatment records of patients. Every patient had a detailed pre admission assessment, a physical health assessment and a risk management plan. The staff used a recognised risk assessment tool. The risk assessments and management plans were reviewed regularly and were up to date in all five care records checked.

The Hamptons did not have seclusion facilities. Restraint had been used three times in the last 12 months. None of these were prone (face-down) restraint. Rapid tranquillisation had been used twice in the last 12 months. The provider had a policy on rapid tranquillisation that set out how the incident should be managed and the relevant checks and safeguards that needed to be in place following this happening. The registered manager explained how the policy had been followed during the use of rapid tranquilisation. The policy had been written taking into account the National Institute for Health Care and Excellence clinical guidelines regarding the short term management of disturbed / violent behaviour.

Staff were trained in breakaway and the management of violence and aggression. Staff described how they would use these techniques to de-escalate situations. Staff also explained that their relationships with patients allowed them to do this more successfully.

The Hamptons had an observation policy in place. The minimum level a patient would be seen during the day was once per hour. This could be increased based on individual risk. Night time observations were also based on an individual risk basis. The handover notes clearly documented the levels of observation that each patient was on.

There were no blanket restrictions in place at The Hamptons. Where restrictions were put in place, we saw evidence that individual risks were assessed and considered for patients. Patients did not raise any concerns about restrictions being placed on them.

Informal patients were informed of their right to leave at any time. A sign was placed on the locked door confirming that informal patients could leave, although did ask that they inform a member of staff prior to doing this.

Medication was dispensed to patients individually in the clinic room. There was a controlled drugs cupboard although no patients were prescribed controlled drugs at the time of the inspection. Blister packs were stored in a cupboard for daily prescription medicines and for those patients who self-administered medication. The clinic room contained locked cupboards for the storage of medicines and other medical equipment such as wound dressings, catheter bags and drug testing kits and also food supplements. Other stock medication was also stored in the clinic room such as, as required medication, liquids and creams.

There was an established quality checking system to ensure stock balances and expiry date rotation. Staff were trained in standard infection control precautions including hand hygiene and sharps management. Patients were

encouraged to attend local clinics for routine blood testing such as clozaril and lithium monitoring although some bloods were taken by the responsible clinician for those patients who preferred not to attend external clinics.

The service did not have any emergency drugs on site, although there was an EpiPen for the emergency treatment of anaphylaxis. There was a defibrillator in the entrance to the building.

A local pharmacy was used to supply medicines. The pharmacist would visit the service regularly to undertake audits and would send medicines alerts to the service. Staff told us that they were having some difficulties with the supply of medicines and had to undertake thorough checks that the medicines ordered corresponded to the medicines received. The provider was managing this situation and taking action to resolve the matter. Discussion was underway to review the use of this pharmacy.

There was a system in place with locked cupboards in each bedroom to store medication for those patients with individual responsibility to administer their own medication. This was individually assessed and staff demonstrated a good system to help patients understand how to use the blister packs. Patients were subject to a thorough assessment of understanding their own medication and how and when to take this. Approval was needed from the multidisciplinary team before a patient could self-administer their medication. The responsible clinician would explain the risks and benefits of each prescription and ensured patients had a thorough appraisal of these and any possible side effects when looking at choice in treatment.

Staff were trained in safeguarding adults and children. They were able to describe what a safeguarding concern was and the process they were required to follow if identified. The service had a designated safeguarding lead. A safeguarding file was available to staff which provided essential information about how to make a safeguarding referral and the service policy. We saw evidence that safeguarding incidents were being reported to the Local Authority. All safeguarding referrals were recorded on a spreadsheet to monitor and record any updates. The registered manager explained how safeguarding incidents were managed at a senior level and how they had oversight of this. An annual safeguarding audit was completed to review the full safeguarding process.

There was a designated room for when children visited patients at the hospital. This was the meeting room, which was locked and had two entry points, one of which was in the entrance hallway of the hospital. This meant that children could go straight into the room without having to enter the main hospital. Visitors were asked to notify the hospital if they were attending with children so that the appropriate arrangements could be put in place.

Track record on safety

We reviewed the incidents that had occurred recently at The Hamptons. The hospital had notified us of relevant events including safeguarding notifications. Between September 2016 and September 2017 the provider sent us 11 safeguarding notifications. In the 12 months prior to the inspection, there had been 16 serious incidents. Staff and management had taken actions to resolve these incidents and ensure they were managed appropriately. Actions and lessons learnt were identified following incidents where necessary. We saw evidence that these actions had been completed or progressed to reduce the risks and appropriately safeguard staff and patients. Staff we spoke to were aware of these incidents and learning.

Reporting incidents and learning from when things go wrong

Staff were aware of the systems used to report incidents and what type of incidents were reported. Incidents were reported using a local incident report form. These would be reviewed by the relevant manager who would set any actions required and notify any relevant external agencies. All incidents were logged on an electronic database that was monitored by the registered manager to ensure all necessary reporting had been completed. The incidents would also be reviewed at the weekly clinical risk summary meeting. The company director would be made aware of all incidents within 24 hours of them occurring.

Staff reported that debriefs took place after any incident had happened. These sessions looked at what had taken place, if anything could have been done differently, what did not go well and what did go well. These would be held as soon as possible after the incident. Following an incident, staff would organise a one to one session with the patient involved to reflect on the incident and ensure they had the right support following the incident. Staff reported that lessons learnt from incidents would be fed back to the team through team meetings.

Long stay/rehabilitation mental health wards for working age adults

Outstanding ☆

We reviewed handover notes and saw evidence that incidents were discussed during these sessions. We also attended the clinical risk strategy meeting where we observed that incidents from the past week were discussed. The meeting also reviewed the actions taken following the incident and if there was anything further that needed to be done.

Where a serious incident had occurred, we saw evidence that the relevant actions had been taken to reduce the risk of the incident happening again.

Duty of Candour

Staff were aware of their responsibilities around the duty of candour. The registered manager had completed training in the duty of candour. The registered manager explained this training to staff to ensure they were aware of their responsibilities. A file was available providing further information on the duty of candour. No incidents had met the threshold for duty of candour. The registered manager had identified one incident that had the potential of meeting the threshold and managed this alongside the provider's policy on duty of candour. Following the investigation and further information being provided it was established that the incident did not meet the threshold.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

During the inspection we reviewed five care plans. Each contained a comprehensive pre-admission assessment. Care and support plans had been developed with the use of a recovery based assessment tool, the mental health recovery star. This tool assessed and provided guidance on recovery based support to people with mental health needs. The mental health recovery star is a collaborative tool and allowed patients to set goals and map their own progress against these goals. In the records reviewed we saw evidence that this tool had been used with patients to identify individual goals and recovery needs. Staff developed care plans with patients and their voice was included throughout. Staff used the recovery star in the patient multidisciplinary meeting to monitor progress and review the patient's individual goals and targets.

Four of the five care plans reviewed indicated that staff had given a copy of the care plan to the patient or that the patient had declined a copy. One care plan did not state either of these options and had been left blank, however, there was evidence that the patient was involved in their care plan throughout.

Physical health was assessed on admission and there was evidence in the care plans that staff continued to monitor patients' physical health. Patients were registered at a local GP practice and were booked in for a physical examination upon admission. Patients had a 'my physical health check' plan which was a recognised tool formulated by a national charity to improve physical health outcomes for people affected by mental illness.

Patients would meet with the occupational therapist during the first week following admission. An assessment would be completed using the Model of Human Occupation Screening Tool to allow the therapist to have an oversight of the patient's occupational functioning. The occupational therapist would also complete an initial assessment for people who struggled to communicate. Staff would complete an interest checklist with patients to gain an understanding of the patient's likes and dislikes to allow for care and treatment to be focused on the individual's preferences.

Care records were kept in a paper format and were stored in a locked office. The care records were kept up to date by staff and were of a high quality. During the inspection, the inspection team had some difficulties locating some information within the paper records. Staff were able to direct the inspection team to the correct place quickly and efficiently. The registered manager told us that the service were assessing the possibility of introducing an electronic system for care records.

Best practice in treatment and care

We reviewed five care records during the inspection. Staff at The Hamptons used a range of measures to record and assess outcomes for patients. The main tool used was the mental health recovery star. We saw evidence that this tool was used during the multidisciplinary team meeting to evaluate how the patient was progressing with their own

set goals. There was a range of other outcome measure tools used for different areas. These tools would be used for patients on an individual basis if it was identified that they required that tool. For example the Liverpool University Neuroleptic Side Effect Rating Scale was used to show improvement in drug related side effects. The service also used the Health of the Nations Outcome Scales to monitor patient outcomes. Staff used this scale to rate the patient against a wide range of health and social domains. These ratings were monitored and assessed to highlight if a patient's health or social status had changed.

The registered manager explained that one of the targets of the service was to ensure the support plans were all of the highest quality and for there to be consistency across all of them. They explained that during their spot checks, the best support plans made reference to the National Institute for Health Care and Excellence guidance throughout. This was believed to reflect best practice and the registered manager wanted to improve training and knowledge around this to improve the quality of care delivered.

Physical health checks were carried out on admission. A physical examination was carried out by a GP. Further specialist medical care was arranged through local GP referrals. The service would also liaise with the local hospital in respect of any medical conditions. In the records we saw evidence that physical health was monitored, such as monthly weights being recorded and diabetic monitoring in place for those patients with diabetes. Falls risk assessments were also completed.

Staff carried out a range of audits including medication, clinical files, infection control and a variety of Mental Health Act audits. Where actions were identified as part of these audits we observed that action plans had been put in place to address any issues. These audits were also discussed and reviewed at governance meetings. Staff were able to describe their involvement in audits and the reasons why they were required.

Skilled staff to deliver care

The Hamptons had access to a full range of staff. This included the registered manager, deputy manager, clinical lead, team leader, consultant psychiatrist, staff nurses and recovery support workers. They also had an occupational therapist and assistant as well as a psychologist and assistant.

A new supervision and appraisal process had recently been introduced by the service. At the time of the inspection, all staff had received an appraisal. The frequency of supervision was agreed between the line manager and member of staff. A signed supervision agreement was present in all five staff supervision files reviewed. There was evidence in the supervision files that performance was monitored. Management addressed any performance issues with staff and supported them in these situations.

Specialised training was identified as part of the supervision and appraisal process. Staff were encouraged to highlight any areas where additional training was required and the provider supported them in accessing this. A range of specialised training had been organised by the provider, including risk formulation, catheters, diabetes and clozaril and lithium training. The staff we spoke to gave positive feedback about being able to access specialised training and noted this was useful in helping them to do their jobs to a higher standard.

Multi-disciplinary and inter-agency team work

Multidisciplinary meetings were held every Wednesday. We observed a multidisciplinary meeting during our inspection. The meeting was attended by the consultant psychiatrist, the clinical lead, the occupational therapy assistant, the care co-ordinator and an advocate as well the patient and their family members. The meeting had a clear structure. The patient was able to have as much as involvement in the meeting as they wanted. Staff gave positive support to the patient to enable them to have a voice during the meeting and give their opinions. Family members also had the chance to give their opinions. The meeting reviewed the patient's progress and their physical health, along with updates from the disciplines involved with the patient.

We were informed that care co-ordinators were invited to all multidisciplinary meetings. The care co-ordinator was in attendance at the multidisciplinary meeting that we attended. The registered manager reported that improvements had been made in involving care co-ordinators.

A clinical risk strategy meeting was also held every Wednesday. All patients were discussed as part of this meeting to review any incidents or issues from the previous week. We observed that patients were discussed with respect and in a positive manner. Staff displayed

knowledge of each patient and their preferences. These were considered when deciding the next actions to be taken. All staff were given a chance to give their opinion and those in attendance listened to them.

Handovers were held at the beginning of each shift. We reviewed the handover notes. These were detailed and documented any incidents that had occurred for each patient on that shift. It also clearly stated the current levels of observation that each patient was on. The service also held a mini huddle mid-way during the day shift. We attended a mini huddle and observed that patients were discussed in a positive and respectful manner. Staff were given a chance to reflect on what had gone well and any issues they had encountered. All staff were encouraged to participate. Support and advice was given when needed during this meeting.

Adherence to the MHA and the MHA Code of Practice

Eighty-six percent of staff had training in the Mental Health Act.

The Hamptons had a Mental Health Act administrator who was responsible for ensuring all paperwork was completed correctly and stored in the appropriate place. They were also responsible for carrying out audits to become aware of any errors. This included an annual legal file audit and spot checks.

Patients' rights under the Mental Health Act were explained to them every two months and following any tribunal or manager hearing. This was monitored on a tracker and the administrator would prompt nurses to remind them to do this. When the rights were explained, this would be recorded in the patient's care notes and on an electronic record.

We reviewed the section 17 leave files of five patients. We found that these files were up to date and were comprehensive in the information recorded in them. A checklist was in place for staff to review when a patient was going on leave. A post leave evaluation was also recorded in the files.

Certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to medicine charts where appropriate. The Mental Health Act administrator regularly audited these.

At the time of the inspection there was one informal patient. Staff had documented the informal status in the support plan and care records. The patient had given their consent to care and treatment. Informal patients were free to leave and a sign on the door reflected this. It asked that any informal patient wanting to leave should make staff aware prior to doing so.

Patients had access to an independent mental health advocate. The advocacy service attended the hospital for two afternoons a week and on the days that the multidisciplinary team meetings were held. Information on how to contact the advocacy service was displayed on the Mental Health Act noticeboard in the main corridor. We observed staff offering advocacy support during the multidisciplinary team meeting that we attended. We observed patients accessing support from the advocacy service. Staff were aware of the advocacy service and knew how to contact if a patient requested support from an advocate.

Good practice in applying the MCA

Eighty percent of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

In all five care records reviewed we found evidence that mental capacity had been assessed. Staff we spoke with showed an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. They were aware of their responsibilities and the procedures involved in this.

The Hamptons had a policy regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. The service had made one application for Deprivation of Liberty Safeguards in the last six months. We reviewed this paperwork and found that the appropriate process had been completed and recorded in the patient's care record.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Outstanding ☆

Kindness, dignity, respect and support

We spoke with four patients who used the service. Patients reported that staff treated them with kindness and dignity.

Patients felt that staff listened to them and respected their opinions and preferences. Patients told us that staff would always make time to talk to them and would address any issues or requests that they may have. This was evident during our time at the hospital, as we observed positive interactions between staff and patients. Staff engaged patients in conversation and responded to any questions or concerns immediately.

We observed a mini huddle involving staff members where they spoke about patients in a respectful manner. They reflected on some of the positive things that had happened for patients on that day and addressed any issues that had occurred. We also observed a clinical risk strategy meeting where it was evident that staff had a good understanding of each patient. Staff were thoughtful and reflective when discussing issues that had occurred over the previous week. Actions were put in place to address any concerns and the meeting identified the most appropriate person to do this, for example, a particular member of staff was identified to discuss some difficult topics with a patient due to them having a good relationship. During the patient multidisciplinary team meeting we attended, we observed the patient being offered positive support and being given time to reflect on the discussions.

Staff we spoke to displayed an understanding of the needs of individual patients. This allowed them to provide appropriate support to each patient.

The involvement of people in the care they receive

Patients reported feeling involved in their care and were included in decisions about their care and treatment. Patients described that staff would spend time with them to discuss their care plans. This included getting their opinions, talking through the details and explaining this to the patient. Staff would then offer a copy to the patient and would ask them to sign. Of the five care plans reviewed, four had either been offered to the patient and signed or was signed to say the patient had refused a copy. One care plan had not been signed and did not state that the patient had either accepted or refused a copy. All five care plans were written with the involvement of the patient and reflected their individual goals.

The hospital had recently launched the 'Champions model'. All patients and staff were involved with this model and were assigned to one of five groups, based around the five CQC domains. This gave patients the chance to be involved in the development of the service and how their care was provided. Patients that we spoke to understood the purpose of the groups and could give examples of projects that they were involved in. One of these projects was to create a 'positivity tree' in the patient lounge. This gave patients and staff the opportunity to write a positive comment and display it on the wall so others could read about it. We observed that a number of patients and staff had taken part in this. We were provided with further examples of projects that were ongoing or due to be started by the five groups in developing the service.

A community meeting was held every week. A patient representative chaired the meeting and all patients had the opportunity to attend. Staff members would also attend to gather the views of the patients. This included the registered manager when they were available. The meeting gave the patients the opportunity to discuss the activities that were taking place in the hospital, along with raising any concerns or issues. A member of staff recorded the minutes of the meeting. The most recent minutes were displayed on the community notice board in the corridor. Any issues raised during the community meeting were discussed at the local governance meetings.

The hospital asked patients to complete 360 degree patient appraisals. This gave the patients the opportunity to provide feedback in relation to a staff member. The appraisal asked the patient to rate the member of staff in a number of different competencies, including communication, relationship and privacy and dignity. The patient could also add any additional comments or feedback at the end of the form. Of the five staff supervision and appraisal files reviewed, all five had a completed 360 degree patient appraisal form included. The majority of the feedback given was positive, saying staff were going the extra mile, passionate, kind and considerate.

We observed a multidisciplinary meeting. The patient was in attendance at the start of the meeting and had opportunities to speak and reflect upon what was being discussed. Staff offered advocate support to the patient at the start of the meeting as well as during the meeting when the discussion became more complicated. Family members of the patient were in attendance and had the chance to offer their opinions. The mental health recovery star was discussed as part of this meeting. Staff had completed the recovery star with the patient to reflect their

individual goals and aims. Staff provided an update about the patient's progress with their goals. Staff explained the purpose of the recovery star to the relatives present so that they understood what it meant and why it was used.

We spoke with three relatives who all gave positive feedback about The Hamptons. All spoke positively about the service and the care that their loved ones received. They reported that they were able to be involved in the care and treatment of their loved ones. One relative noted that it could at times be difficult to contact the service on the telephone and when messages were left these were not always responded to.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

Average bed occupancy at The Hamptons over the last six months was 80%.

The Hamptons had a target discharge time of 18 months to two years. The average length of stay for patients discharged in the last 12 months was 405 days (one year and one month). The average length of stay for patients who were currently at the hospital was 600 days (one year and eight months). Three patients had been discharged in 2017.

At the time of the inspection, three patients were subject to delayed discharge. Staff were aware of these and were actively working towards finding the patients an appropriate placement. The reasons for these were either due to lack of suitable placements in the local area for the needs of the patient or legal delays. The service reported that they were working with the care co-ordinators to resolve these delayed discharges.

The registered manager reported that there were positive relationships with the care co-ordinators for each patient and that the service had got better at communicating with them. Care co-ordinators were invited to care programme approach and multidisciplinary team meetings. A care co-ordinator was present at the multidisciplinary team meeting that we observed. Discussions were held about the patient's discharge and all present at the meeting were given the opportunity to give their opinions.

Discharge planning was evident in the care records that we reviewed and patients were involved in this. At pre-admission, discharge planning would be discussed with the patient about what goals they wanted to achieve and the potential pathway of moving on from The Hamptons. The service recognised that the discharge process was individual for each patient and the level of support given would reflect this. Staff supported patients pre-discharge with any transitional work such as supporting to buy furniture.

The facilities promote recovery, comfort, dignity and confidentiality

There were a range of rooms at The Hamptons including a lounge, dining area, skills kitchen, quiet room and activity room. All patients had access to their own bedroom throughout the day. Patients were able to personalise their bedrooms and were given a choice as to what colours the bedroom was painted. All patients had keys to their own bedrooms so could lock these when they left.

There was access to a telephone in the quiet room that would ensure privacy. Patients also had access to mobile phones. Patients were asked to sign a contact agreeing to a set of rules to follow when using mobile phones, such as being respectful of the other patients present and not taking pictures. Patients had access to a computer in the activity room with access being granted following an individual risk assessment. Certain inappropriate websites were not allowed to be accessed which staff monitored. Patients also had wi-fi access and were given a code to access this on their mobile phones following a risk assessment.

Patients had access to the outdoor space at all times. A shelter had been built to allow cover when outside and there was plenty of seating available. There was a small garden available to patients with a greenhouse so patients could grow their own vegetables. This was accessed by leaving the front entrance and walking around the back of the building. The registered manager explained that the service was planning to develop the outside space further and was considering the removal of the fence.

Long stay/rehabilitation mental health wards for working age adults

Outstanding ☆

The service introduced the 'Modular Transitional Rehabilitation Programme' in 2016. It was developed by the clinical team and was based on psycho-social intervention and cognitive behaviour therapies to improve health and social care functioning. Sessions were delivered on areas such as risk management and medication management. These sessions were facilitated by staff but gave the patients the opportunity to deliver and lead the sessions themselves. The programme had been adapted following patient feedback to allow patients to start a module at any time and to make the programme less structured.

Patients felt that they had access to a variety of activities and these were rarely cancelled. These activities were discussed during community meetings. There were two noticeboards that gave information about activities. There was a "what's on today" board that listed the activities occurring on that day. This was updated first thing in the morning. In the dining room there was a noticeboard that listed what activities were happening across seven days. We observed that activities were happening throughout the day and that patients were engaging in them.

Further noticeboards were displayed throughout the main corridor and dining room. A health information board was updated regularly to inform patients about a specific health subject, such as influenza, with information about what symptoms there may be and how to be aware of it. When the information was changed, the old information was stored in a folder for the patients to access. There was also a noticeboard regarding food for The Hamptons. This displayed menus for the next four weeks and information about how the menu had been created.

The provider had recently developed informative placemats. These were on the tables in the dining room. The topics on them at the time of the inspection were eight things to enhance every day mental health and foods that help with the loss of appetite. The placemats had been developed as part of the responsive 'Champions model' group.

A letter was provided to patients on admission explaining that some areas of the hospital may have to be locked at certain times due to clinical need. These were the laundry room, upstairs communal bathroom and the downstairs toilet. The situation would be risk assessed and reviewed on a daily basis and staff would inform patients if the rooms needed to be locked. On the day of the inspection the rooms were not locked. Staff explained the letter to patients and asked the patients to sign it to confirm that they understood and that they were happy with this arrangement. The letter also detailed that access to the skills kitchen would be assessed on an individual basis. The skills kitchen remained locked at all times. Following individual risk assessments and a kitchen risk assessment patients would be given a key to allow them to access when they wanted. They could then cook and prepare their own meals.

Meeting the needs of all people who use the service

The Hamptons had two floors. There were two staircases and a lift to access the top floor. Three bedrooms were on the ground floor and the registered manager explained that patients with mobility issues would be allocated one of these rooms as required. All bedrooms had wet room style bathrooms, which meant people with mobility issues could use these without difficulty.

An accessibility audit had been completed in January 2017 to ensure that the hospital was adequately equipped and to highlight where any improvements could be made to assist patients with mobility issues.

On admission, patients received a guide that detailed useful information. This included information about the service itself, the complaints procedure, patient's rights, useful addresses and contact numbers and information about the care and treatment programme. At the front of the guide it stated that a copy of the handbook could be made available in large print or another language if required.

The registered manager explained that the hospital did not have a stock of information leaflets in other languages. If this was required, it would be identified during the pre-assessment and the appropriate materials would be ordered. Staff had access to interpreters when required. We observed that staff had provided an easy read document to a patient with a learning disability in respect of the medication they were taking.

Patients gave positive feedback in respect of the food. This was prepared on site and patients had a choice of three meals at each meal time including a vegetarian option. Menus were displayed on a noticeboard in the dining room for a four week period. One patient noted that halal meat had been provided on request by the service although they no longer asked for this.

Long stay/rehabilitation mental health wards for working age adults

Outstanding ☆

There was one designated night a month where a specific theme was chosen. The food was prepared fresh on site rather than being bought in. Plans were in place to base these theme nights on patients' culture and background to involve them more in these nights and to introduce the other patients to their culture. Improvements to the menu had been made following patient food surveys. The chef had linked the new menus to the mental health foundation report on healthy eating and depression.

The patients were also able to access the skills kitchen and prepare their own meals. This was based on individual risk assessments. Patients were able to buy their own food and this could be stored in the skills kitchen or in lockers in the dining room. Patients reported that snacks and drinks were available at all times.

As the service had a rehabilitation focus, patients were encouraged to access spiritual support in the community. We were informed that two patients attended a local church.

Listening to and learning from concerns and complaints

A complaints, comments and compliments box was located in the main corridor. The forms to complete were stored next to the box. The box was checked on a regular basis and passed on to the registered manager. We observed that a complaints policy was in place and up to date. The policy detailed how staff should process the complaint and the relevant timescales involved. We were also informed that patients at the community meeting could raise any complaints or concerns.

The Hamptons had received a total of 10 complaints between October 2016 and October 2017. The provider had upheld three complaints and partially upheld a further three. The provider processed these complaints in line with the complaints policy. Staff recorded the complaints appropriately. Each complaint had a summary of the actions taken to review and address them. Two of the upheld complaints were external from local residents. We saw evidence of actions that had been taken to resolve upheld complaints.

Staff members were aware of the complaints process and could describe how complaints had been managed. Examples were also given as to when complaints had led to service changes. Patients reported that they knew how to complain. Staff felt that senior management would listen to their complaints and deal with them appropriately. Relatives were also confident that The Hamptons would manage any complaints or issues appropriately.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Outstanding ☆

Vision and values

The Hamptons' vision was 'that each service user and each member of staff is entitled and will have, their own individual and unique pathway designed by them with the support of the organisation to get from their current situation to their desired situation. Each service user is supported to be an expert in their own mental health and each member of staff is supported to be an expert in their own development, with everyone's voice heard, respected and acted upon.'

The values were

- Quality of our care
- Safety of our people
- Passion for recovery.

Staff were aware of the visions and values. They felt that they were used on a day to day basis by the team. During the inspection, we observed staff displaying these values by treating patients as individuals and being aware of their likes and dislikes. Both staff and patients were given opportunities to have a voice within the service. When staff and patients raised concerns or issues, it was clear that senior management made changes based on these in a proactive manner. A staff member noted that staff had complained about feeling understaffed the previous year. The service reviewed staffing and altered the levels of staffing to ensure that there were enough staff on the unit when people went on leave. Staff did not raise any concerns about staffing levels at the time of the inspection and we observed the service had processes in place to manage staffing levels.

Staff knew who the senior managers of the hospital were and praised the availability of them. Staff felt that they

could take any issues to the senior management team and that they would be listened to. We observed strong working relationships between the team and the management that had a positive impact on the running of the hospital.

Good governance

The hospital had systems in place to ensure regular monitoring of care and treatment. There was a clear and comprehensive audit plan. We observed that a range of audits had been completed including incidents, supervision records, medication, Mental Health Act, health and safety. Where the audits indicated that improvements could be made, we saw evidence that actions had been created to address this with a timescale attached. Audits were discussed at governance meetings to ensure the senior management team had oversight of the findings, actions and how they were progressing.

A clear governance structure was in place that allowed efficient reporting. There were designated leads for areas such as safeguarding and infection control. The registered manager told us that the governance structure helped them to delegate and have a good oversight of the service. Positive feedback was given about the openness of the senior management and that any issues could be taken to them.

The Hamptons had recently introduced a new supervision and appraisal process. There was a clear structure to this process and we saw evidence that staff were involved. At the time of inspection, all staff required to have an appraisal, had one in place. These reflected clear objectives and development goals for each member of staff, based on the staff member's own needs, the requirements of the hospital and the visions and values. Staff reported no issues regarding supervision and stated they were able to have a say in how often they required supervision. The levels of supervision, appraisals and mandatory training were monitored and audited monthly.

The registered manager had a clear oversight of the running of the hospital and was aware of the various monitoring systems and audits. A monthly key performance indicator report was produced to enable the manager to have oversight of how the hospital was running. The registered manager explained that this was an important part of the governance cycle to identify targets and trends. These would then be reported to senior management. Key performance indicator data was also on display in the staff office, enabling all members of staff to be able to view it and monitor the progress.

A risk register was in place to monitor high level risks to the hospital. These risks were identified by using a risk matrix assessment. This assessment was reviewed every eight weeks through the health and safety committee. Any risks identified as high risk in this assessment would be added to the site risk register.

We saw evidence that incidents, safeguarding and complaints were managed using defined processes and recorded in a manner that gave the registered manager oversight. Where a complaint had been made, it was investigated appropriately with feedback given to the complainant. Any actions identified were also recorded and completed to resolve the issues. Incidents were also investigated and had a clear process for ensuring any external agencies that needed to be contacted would be. Debriefs were held to reflect upon any incidents and lessons learnt were fed back during team meetings. We observed that any identified actions and lessons learnt following incidents were acted upon by the service. The clinic room door had been re-designed following an incident where a staff member was assaulted by a patient in the clinic room. The service had identified that the previous clinic room door had contributed to the incident. A secure fob system was now in use for the door and the door now opened outwards, rather than in. The registered manager noted that the learning from this incident had been shared externally with other hospitals, which had led to the other services making similar changes.

Leadership, morale and staff engagement

The Hamptons had a sickness rate of 3% in the 12 months prior to the inspection.

There were no reported bullying or harassment cases at the time of our inspection. Staff were aware of the processes involved in either making complaints or raising concerns. They reported that there was an open door policy with management and that they would have no issues with discussing concerns with management. All staff reported that they had a strong sense of job satisfaction and that they were empowered to make suggestions about the

running of the service. Staff explained that they could provide feedback on the service through supervision, team meetings, the 'Champions model', handovers and the mini-huddles.

Team morale was reported as high and staff felt they received appropriate levels of support from management and colleagues. Where staff identified additional training needed to improve their work or knowledge, this was provided by the service. We saw evidence that this had happened and staff reported that this had been of benefit when treating patients.

The Hamptons had a local awards scheme called 'step up and stand out' to highlight positive performances by staff and patients. Any member of staff or patient could nominate someone for an award. The nominees for each month were discussed by senior management and winners chosen. The managing director or registered manager presented the winner with a certificate. The pictures of the winners were displayed on a noticeboard in the main corridor to highlight their achievements.

A 'you say we did' board was located in the staff office. This noted where staff had made suggestions or comments about the running of the service and explained what the management had done about them.

The provider launched their 'Therapeutic and Clinical Strategy 2017/18' in March 2017. An action plan was created and monitored against to assess the progress being made by the provider. The registered manager assessed the impact of this strategy by completing staff focus groups in July 2017 and a staff survey in October 2017. The survey results indicated that staff felt more engaged following the introduction of the strategy and that communication had improved. In the July focus groups, the proposal of the 'Champions model' was included to get staff feedback on the idea. Staff were positive about the proposal and felt it would further embed the therapeutic strategy.

The 'Champions model' was launched in September 2017. This was designed to enable all levels of staff and patients to have a voice in how the hospital would be developed in the future. It focused on the five CQC domains and focus groups were held every month. The staff and patients were allocated a place in one of the five groups based on specific values and behaviours that the service expected the members of the groups to display. These were linked to the vision and values of the hospital. When allocated to a group, the staff and patients were known as 'champions' in that particular domain.

The registered manager noted that this had empowered staff and patients in being able to make suggestions and decisions about the service and the care being delivered. Positive feedback was received from both staff and patients in relation to this. They were able to describe what tasks the groups were currently working on and their involvement in them. We observed that a number of areas were being developed through these groups and a number of changes had already been implemented because of them. For example, a 'positivity tree' had been created in the lounge. This gave patients and staff to write down positive comments and display them on the wall. This highlighted where things had gone well and what people were pleased with about how the service was running.

The registered manager recognised that getting patients and staff engaged in the service was an important aspect of developing the service and producing a higher standard of care. This was reflected in staff attitudes and presentation of being a person-centred service, focusing on the patients and their needs. We observed staff offering support to each other and there was a real commitment to teamwork.

The Hamptons had a defined management structure, which provided clear roles and responsibilities. The registered manager reported that this had improved the running of the service and improved efficiency.

Commitment to quality improvement and innovation

At the time of the inspection, The Hamptons did not participate in any national quality initiative programmes. The provider had identified this as one of the actions for the effective group in the 'Champions model' to progress. The 'Champions model' itself promoted a culture of quality improvement and innovation at a local level. Staff and patients were encouraged to participate and give suggestions as to how the service could be improved. Patients and all levels of staff gave positive feedback about this model. There were examples of improvements that the service had introduced by using this method, such as the positivity tree and the informative patient placemats, with a number of future developments also identified.

The Hamptons used the Mental Health Safety Thermometer to measure certain areas against national

statistics. The Safety Thermometer is a national tool designed to measure commonly occurring harms in people that engage with mental health services. This covered areas such as self-harm, omissions of medication and violence and aggression. Managers were able to assess the performance of The Hamptons against national statistics to highlight where they were performing well and where work was required. Data provided at the inspection indicated that medication omissions were higher than the national average. The provider had taken actions to reduce the numbers of omissions and ensure staff gave medication to patients safely. The registered manager told us that the safe group were going to look at this in further detail to assess why this might be the case and what actions could be taken to reduce this.

Outstanding practice and areas for improvement

Outstanding practice

The Hamptons had introduced 360 degree patient appraisals. This gave the patients the opportunity to provide feedback in relation to a staff member. The appraisal asked the patient to rate the member of staff in a number of different competencies, including communication, relationship and privacy and dignity. The patient could also add any additional comments or feedback at the end of the form. Managers could then use this feedback as part of the supervision and appraisal process.

The 'Champions model' was designed to enable all levels of staff and patients to have a voice in how the hospital would be developed in the future. It focused on the five CQC domains and focus groups were held every month. The staff and patients were allocated a place in one of the five groups based on specific values and behaviours that the service expected the members of the groups to display. These were linked to the vision and values of the hospital. When allocated to a group, the staff and patients were known as 'champions' in that particular domain.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that they continue to work towards meeting their 80% target for all mandatory training.