Care Quality Commission

Northumberland, Tyne and Wear NHS Foundation Trust

Walkergate Park

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Outstanding ☆
Medical care (including older people's care)	**Outstanding** ☆
Outpatients and diagnostic imaging	**Outstanding** ☆

Summary of findings

Letter from the Chief Inspector of Hospitals

Walkergate Park Hospital is one of the hospitals providing care as part of Northumberland, Tyne and Wear NHS Foundation Trust. It is a neuro rehabilitation and neuro psychiatry centre located in Newcastle Upon Tyne. This hospital provides rehabilitation and assessment services on an inpatient, outpatient or community basis, for people with a disability caused by injury or disease affecting the brain, spinal cord or muscles. Walkergate Park Hospital does not provide accident and emergency services, surgery, critical care, children and young people services and diagnostic imaging services.

Northumberland, Tyne and Wear NHS Foundation trust serves a population of approximately 1.4 million, providing services across an area totaling 2,200 square miles and has 832 beds. The trust has operated as a foundation trust since December 2009. Walkergate Park Hospital has 65 beds.

We inspected Walkergate Park Hospital as part of the comprehensive inspection of Northumberland, Tyne and Wear NHS Foundation Trust, which included over 60 sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland. In addition, the trust provides a number of regional and national specialist services. We inspected Walkergate Park Hospital between 6 and 9 June 2016.

Overall, we rated Walkergate Park Hospital as outstanding. We rated it outstanding for being effective, caring, responsive and well-led, and good in providing safe care.

We rated medical care and outpatient services as outstanding.

Our key findings were as follows:

- The trust had a clear vision, strategic goals and core values to maintain the Centre for Neurorehabilitation and Neuropsychiatry as a centre of excellence, putting patients first in a service focused on safety, quality and pride in the care and treatment provided.
- The service has a very person centred focus and culture. Staff worked in partnership with patients, their families, carers and other stakeholders to ensure that individual needs were met to enable them to be as independent as possible.
- Staff took the time to meet the individual needs of patients and we were given examples of where staff had gone 'the extra mile' to make patients' hospital stay a positive experience. All patient feedback was extremely positive.
- Very effective multidisciplinary working (MDT) in the assessment, planning and delivery of patient care was apparent across services within the hospital.
- Services within the hospital had engaged and worked with a number of third sector organisations and agencies in order to develop their services or offer further information patients and carers. The services had close links with a number of charities.
- Clinics and services were developed to meet individual needs of people. The services were responsive to the needs of patients and carers and involved patients and carers in the care being provided. Outpatients had introduced a number of outreach services in response to patient need. Outreach clinics were either nurse led, consultant led or led by allied health professionals.
- A number of services provided vocational rehabilitation to patients to help them return to employment.
- Service leads and managers were available, visible within the hospital and approachable; leadership of the service was effective, there was excellent staff morale and they felt supported at ward level.

Summary of findings

- Staff and patient engagement was seen as a priority with several systems in place to obtain feedback. The hospital had an effective and well established Service User and Carer Forum.
- The hospital was accredited as a specialised level 1 rehabilitation service.
- The hospital had infection prevention and control policies in place, which were accessible, understood and used by staff.
- Patients received care in a clean, hygienic and suitably maintained environment.
- There was adequate personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this equipment during our inspection. Patients and carers told us that staff washed their hands and used gloves and aprons.
- The hospital routinely monitored staff hand hygiene procedures and compliance at the time of inspection was high.
- Patients were assessed regarding their nutritional needs using the Malnutrition Universal Screening Tool (MUST). Where necessary patients were referred to a dietician.
- There were effective arrangements for safely managing medicines, including medicines prescribed 'as required' and controlled drugs.
- No patient deaths had occurred within the last three years at this hospital. There were review processes in place should a death occur.

We saw several areas of outstanding practice including:

- A well established Service Users and Carers Forum was in place and social activities for service users and their families had been established with the Headway Charity.
- The hospital had established a Brain Injury Group providing opportunities for discussion of a variety of issues such as brain injury and sleep monitoring.
- The Social Therapeutic and Recreational Rehabilitation Team (STARRT) had been developed to promote independence and increase the quality of life of patients through taking part in social and leisure activities.
- The service had adopted best practice in support of the provision of care and treatment, for example 'Reducing the risk of deep vein thrombosis (DVT) for patients in hospital', functional independence measure (FIM) and functional assessment measure (FAM) scores.
- The establishment of a spasticity management clinic for individuals with spasticity following a neurological injury.
- The North East Drive and Mobility Service had worked with a number of external agencies to develop the services to service users, for example the Driver and Licensing Authority and the local police.
- Staff in outpatients had worked with a local university to develop a short course on the holistic management of spasticity and hypertonia. This was developed because a need for training was identified by staff.
- The hand hygiene clinic was a service developed in response to patient need and research by the outpatients department. The development of this work had led to additional support services available for patients with hand hygiene and contributed to staff development in outpatients.
- As part of the caring hands project, the trust had provided an additional two training sessions to home care managers and care staff in Newcastle. Information provided by the trust highlighted that they developing the education programme further.

However, there were also some areas of practice where the trust should make improvements.

The trust should:

- Ensure a consistent approach to displaying NHS safety thermometer data on wards at this hospital. This would assure patients that the hospital was improving practice, based on experience and information.
- Consider implementation of regular record audits within the outpatient department.
- Consider governance leads within the outpatients department.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating
Medical care (including older people's care)	Outstanding ☆

Why have we given this rating?

We rated medical care as outstanding because:

- Evidence-based techniques and technologies were used to support the delivery of high quality care, such as NICE Guidance on Urinary Continence Problems in Neurorehabilitation Inpatients, functional independence and functional assessment measures and a 'Modified Rivermead Mobility Index tool'.
- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE) and local policies were written in line with national guidelines and updated if national guidance changed. The group reviewed patient outcomes through a number of audits and also through the UK Rehabilitation Outcome Collaborative (UK ROC).
- The service has a very person centred focus and culture. All patients and family members said therapeutic input was relevant, co-ordinated and resulted in improvements. Staff took the time to meet the individual needs of patients and we were given examples of where staff had gone 'the extra mile' to make patients' hospital stay a positive experience.
- All patients who responded to the Friends and Family Test (FFT) said they would recommend the service. We were told that care had been individualised to ensure effectiveness and staff were '…fabulous', '...amazing' and '…conscientious'.
- Patients and family members had been involved in discharge processes. Staff had been to individual's homes to undertake assessments, gave full explanations and kept patients involved.
- Each patient received a welcome pack to 'Walkergate Park Centre for Neurorehabilitation and Neuropsychiatry'. A 'Patient Rehabilitation Journey Booklet' was also available for patients to complete and the centre produced a 'Resources for Carers' booklet that gave details of information available from the trust, carers resources and mental health resources.

Summary of findings

- All patients had a care plan and all were appropriately individualised from core standards and current to the needs of the patient. Patients and relatives informed us they felt involved in care options, decision making and planned treatment.
- Patients reported staff spent time with them and staff recognised the importance of time to care and support patients emotional needs. Care plans highlighted the assessment of patients emotional, spiritual and mental health needs.
- Staff said service leads and managers were available, visible within the division and approachable; leadership of the service was effective, there was excellent staff morale and they felt supported at ward level. Staff spoke very positively about the service they provided for patients and emphasised quality and patient experience as a priority and everyone's responsibility.
- Research and audit projects were being carried out for, for example the self-management of long term neurological conditions, speech and language therapy outcome measures, evaluation of current therapist to patient ratio and intensity of therapy intervention and spasticity management standards. A spasticity management clinic for individuals with spasticity following a neurological injury was provided for residents in the North East.
- We reviewed handover meetings and sheets used by ward staff and escalation documentation, which was effective in communication and decision making for those patients at risk of deterioration.
- The trust had formal nurse staffing review processes in place and the group had a funded establishment in place. The centre was accredited as a specialised level 1 rehabilitation service.
- The trust had a designated lead for safeguarding, a safeguarding strategy and held regular safeguarding board meetings. Staff understood their responsibilities and discussed safeguarding policies and procedures confidently and competently.
- Planning meetings to co-ordinate therapeutic input in to a patient's care and treatment were held each week.

Summary of findings

- Continued Professional Development Forums were in place on wards to assist in meeting training needs for speciality training. Education meetings took place each week and an education programme had been developed.
- We observed multidisciplinary working (MDT) in the assessment, planning and delivery of patient care on all wards and we observed effective interactions between various different teams and services.
- The group had developed a Social Therapeutic and Recreational Rehabilitation Team (STARRT) to promote independence and increase the quality of life of patients. The centre had developed work with the Headway Charity, the Brain Injury Group and the Service User and Carer Forum.
- The service designed wards in such a way to make optimum use of space to deliver patient care. Facilities and premises were designed for the access and availability of the specific patient profile using the centre. We observed the layout of the centre enabled patients to exercise within the corridors to aid their rehabilitation.
- There were examples of services planned in response to patient need e.g. a protocol for the management of foot-drop in patients with neurological conditions, specific protocols for all patients with acute pain and the prevention and management of harm from pressure ulcers, falls, and catheter associated UTIs.
- However, although all wards collected information relevant to the NHS safety thermometer, a consistent approach to display this data was not in place; wards displayed some information or no information at all. This would have assured people using the service that the ward was improving practice based on experience and information.

Outpatients and diagnostic imaging

Outstanding ☆

Overall, we rated this service as outstanding. We found that outpatients for safe was good, with caring, responsive and well led rated as outstanding because:

- There was very effective and clear multidisciplinary team working throughout the services visited and staff could describe working with a number of different professionals and external services to

Summary of findings

enhance services and patient outcomes. There was excellent access to a number of additional services within Walkergate Park Hospital and staff could sign post patients and carers to other services if required.

- Patient feedback for the services visited was consistently positive, friends and family test results were positive and patients felt supported. Confidentiality, dignity and privacy was respected by staff. The service provided strong person centred care that met people's individual needs.
- Clinics and services were developed to meet individual needs of people. The services were responsive to the needs of patients and carers and involved patients and carers in the care being provided.
- Outpatients had introduced a number of outreach services in response to patient need. Outreach clinics were either nurse led, consultant led or led by allied health professionals.
- A number of services visited had close links with third sector organisations to develop the service they offered and help provide further support to patients and carers.
- A number of services provided vocational rehabilitation to patients to help them return to employment.
- Staff we spoke with could describe the values of the trust. There was a clear leadership structure in place and staff felt supported by management. Staff were positive about working in their services and were proud of the service they provided to patients. There was a culture of staff completing training and development opportunities.
- Staff used evidence based care and treatment using National Institute for Health and Care Excellence guidelines (NICE) and local and national guidelines were in use. There were care pathways in place in the services visited and patient risk assessments and goal setting was in place for patients.

Summary of findings

- We found staff to be competent in their roles and a number of staff had completed further training and development. Staff could describe consent, the mental capacity act and deprivation of liberty standards.
- There was a commitment to supporting carers. Outpatients had a carer's charter in place. The services had been developed in response to patient need and developed to provide person centred care.
- Strong and effective governance processes were in place and management could describe how risks were escalated and managed. Risk registers were in place at the services visited which were proactively reviewed.
- The services visited had been involved in a number of innovative service developments.
- Staff we spoke with had a good understanding of how to report incidents and safeguarding concerns.
- All areas visited were visibly clean and tidy. Staff had access to personal protective equipment and hand gel dispensers were available in areas visited.
- Medicines were securely stored. Patient group directions were in place and signed. Records were found to be managed securely. Staffing levels were good and in line with trust planned levels in the services visited.

Walkergate Park

Detailed findings

Services we looked at
Medical care (including older people's care); Outpatients.

Detailed findings

Contents

Background to Walkergate Park

Walkergate Park Hospital is one of the hospitals providing care as part of Northumberland, Tyne and Wear NHS Foundation Trust. This hospital provides rehabilitation and assessment services on an inpatient, outpatient or community basis, for people with a disability caused by injury or disease affecting the brain, spinal cord or muscles. Walkergate Park Hospital does not provide accident and emergency services, surgery, critical care, children and young people services and diagnostic imaging services.

Northumberland, Tyneand Wear NHS Foundation Trust is one of the largest mental health and disability Trusts in England employing more than 6,000 staff, serving a population of approximately 1.4 million, providing services across an area totaling 2,200 square miles. It has a budget of over £300 million.

The trust provides care from over 60 sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland. It also has a number of regional and national specialist services. Walkergate Park Hospital is one of the regional specialist services offered. It has 65 beds. The hospital is the only specialist tertiary care neuropsychiatry and neuro rehabilitation service in the northern region. It provides level 1 tertiary specialised rehabilitation services, which provide for patients with highly complex rehabilitation needs that are beyond the scope of their local, and district specialist services.

Walkergate Park Hospital has in patient wards which offer post-acute rehabilitation care and all admissions are planned and the patients are medically stable in order that they are able to engage in their individually tailored rehabilitation programme. There are five wards within the hospital. These are Wards 1a and 1b (neurobehavioural) providing a service for patients who present with a range of physical, cognitive and emotional problems, and who are also exhibiting challenging behaviour. Ward 2 (neuro-psychiatry) provides a comprehensive resource for the assessment, investigation and treatment of specialist care for patients suffering from psychiatric, cognitive and emotional problems because of acquired brain injury or due to other organic and genetic neurological disorders. Ward 3 and Ward 4 (neurorehabilitation) provide a service for patients who have an acquired brain injury or another neurological condition.

Outpatient clinics within Walkergate Park Hospital were run by consultants, allied health professionals or were nurse led. The service provided clinics at this hospital and outreach clinics in Penrith, Durham and Sunderland. Outpatients provided clinics for continence, dystonia, medical and neuro-rehabilitation, sex and relationship clinic, multiple sclerosis, orthotics, splinting, hand hygiene, neuropsychiatry and spasticity.

The hospital did not provide diagnostic imaging services.

The trust also provided other services within the outpatients. These included the north east driving mobility services, community acquired brain injury services, Northumberland head injuries service , community multiple sclerosis team, regional communication aid service, regional disability team and the regional environmental control service.

Detailed findings

We inspected Walkergate Park Hospital as part of the comprehensive inspection of Northumberland, Tyne and Wear NHS Foundation Trust. We inspected Walkergate Park Hospital between 6 and 9 June 2016.

Our inspection team

Our inspection team was led by:

Chair: Paul Lelliott, Deputy Chief Inspector (mental health), Care Quality Commission

Head of Hospital Inspections: Jenny Wilkes, Care Quality Commission

The team included a CQC inspection manager, 2 CQC inspectors and a variety of specialists including: a director of nursing, deputy director of nursing and a physiotherapist.

How we carried out this inspection

To get to the heart of patients' experiences of care, 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?

The inspection team always inspects the following core services at each inspection:

- Urgent and emergency services (or A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging.

At Walkergate Park, the only core services provided were medical care (neuro- rehabilitation) and out patients. We inspected both core services during this inspection.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew with us. These organisations included the local clinical commissioning groups, NHS England, Monitor, Health Education England and Healthwatch.

We carried out an announced visit between 6 and 9 June 2016. We held focus groups with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the hospital, including from the wards and outpatient departments as well as other specialist services. We observed how people were being cared for, talked with carers and family members and reviewed patients' personal care or treatment records.

Facts and data about Walkergate Park

Walkergate Park Hospital is one of the hospitals providing care as part of Northumberland, Tyne and Wear NHS Foundation Trust. Northumberland, Tyneand Wear NHS Foundation Trust is one of the largest mental health and disability Trusts in England employing more than 6,000 staff, serving a population of approximately 1.4 million, providing services across an area totaling 2,200 square miles.

Between May 2015 and April 2016, there were 7154 outpatient attendances at Walkergate Park Hospital.

Detailed findings

The health of people in Northumberland is varied compared with the England average. Deprivation is lower than average, however about 17.6% (9,300) children live in poverty. Life expectancy for women is lower than the England average. Northumberland was ranked 135th most deprived out of the 326 local authorities across England in 2010.

The health of people in Sunderland is varied compared with the England average. Deprivation is higher than average and about 22.6% (13,070) children live in poverty. Life expectancy for both men and women is lower than the England average.

The health of people in Newcastle upon Tyne is varied compared with the England average. Deprivation is higher than average and about 26.1% (14,200) children live in poverty. Life expectancy for both men and women is lower than the England average.

The health of people in North Tyneside is varied compared with the England average. Deprivation is higher than average and about 19% (6,800) children live in poverty. Life expectancy for both men and women is lower than the England average.

The health of people in South Tyneside is varied compared with the England average. Deprivation is higher than average and about 24.6% (7,410) children live in poverty. Life expectancy for both men and women is lower than the England average.

The health of people in Gateshead is varied compared with the England average. Deprivation is higher than average and about 20.5% (8,195) children live in poverty. Life expectancy for both men and women is lower than the England average.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	Not rated	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Medical care (including older people's care)

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

Information about the service

Walkergate Park is a Neurorehabilitation and Neuro Psychiatry Centre located in Newcastle upon Tyne. The 65 bed purpose-built centre provides rehabilitation and assessment services on an inpatient, outpatient, day patient or community basis, for people with a disability caused by injury or disease affecting the brain, spinal cord or muscles.

Walkergate Park is home to the only specialist tertiary care neuropsychiatry and neuro rehabilitation service in the Northern Region and, at the time of opening, was the first centre of its kind in the UK to provide such integrated service delivery of specialist services.

The rehabilitation centre is post-acute and all admissions are planned and the patients are medically stable in order that they are able to engage in their individually tailored rehabilitation programme.

We visited all wards on site providing inpatient services. These were:

Wards 1a and 1b (neurobehavioural) providing a service for patients who present with a range of physical, cognitive and emotional problems, and who are also exhibiting challenging behaviour.

Ward 2 (neuropsychiatry) provides a comprehensive resource for the assessment, investigation and treatment of specialist care for patients suffering from psychiatric, cognitive and emotional problems because of acquired brain injury or due to other organic neurological disorders.

Ward 3 and Ward 4 (neurorehabilitation) who have an acquired brain injury or another neurological condition.

We spoke with 22 patients and relatives and 29 members of staff. We observed care and treatment, looked at 16 care records and reviewed data and performance information about the centre.

Medical care (including older people's care)

Summary of findings

We rated medical care as outstanding because:

- Evidence-based techniques and technologies were used to support the delivery of high quality care, such as NICE Guidance on Urinary Continence Problems in Neurorehabilitation Inpatients, functional independence and functional assessment measures and a 'Modified Rivermead Mobility Index tool'.
- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE) and local policies were written in line with national guidelines and updated if national guidance changed. The group reviewed patient outcomes through a number of audits and through the UK Rehabilitation Outcome Collaborative (UK ROC).
- The service has a very person centred focus and culture. All patients and family members said therapeutic input was relevant, co-ordinated and resulted in improvements. Staff took the time to meet the individual needs of patients and we were given examples of where staff had gone 'the extra mile' to make patients' hospital stay a positive experience.
- All patients who responded to the Friends and Family Test (FFT) said they would recommend the service. We were told that care had been individualised to ensure effectiveness and staff were '…fabulous', '...amazing' and '…conscientious'.
- Patients and family members had been involved in discharge processes. Staff had been to individual's homes to undertake assessments, gave full explanations and kept patients involved.
- Each patient received a welcome pack to 'Walkergate Park Centre for Neurorehabilitation and Neuropsychiatry'. A 'Patient Rehabilitation Journey Booklet' was also available for patients to complete and the centre produced a 'Resources for Carers' booklet that gave details of information available from the trust, carers resources and mental health resources.
- All patients had a care plan and all were appropriately individualised from core standards and current to the needs of the patient. Patients and relatives informed us they felt involved in care options, decision making and planned treatment.
- Patients reported staff spent time with them and staff recognised the importance of having time to care and support patients emotional needs. Care plans highlighted the assessment of patients emotional, spiritual and mental health needs.
- Staff said service leads and managers were available, visible within the division and approachable; leadership of the service was effective, there was excellent staff morale and they felt supported at ward level. Staff spoke very positively about the service they provided for patients and emphasised quality and patient experience as a priority and everyone's responsibility.
- Research and audit projects were being carried out for, for example the self-management of long term neurological conditions, speech and language therapy outcome measures, prescribing rehabilitation and spasticity management standards. A spasticity management clinic for individuals with spasticity following a neurological injury was provided for residents in the North East.
- We reviewed handover meetings and sheets used by ward staff and escalation documentation, which was effective in communication and decision making for those patients at risk of deterioration.
- The trust had formal nurse staffing review processes in place and the group had a funded establishment in place. The centre was accredited as a specialised level 1 rehabilitation service meeting BSRM medical and nursing staffing standards.
- The trust had a designated lead for safeguarding, a safeguarding strategy and held regular safeguarding board meetings. Staff understood their responsibilities and discussed safeguarding policies and procedures confidently and competently.
- Planning meetings to co-ordinate therapeutic input in to a patient's care and treatment were held each week.

Medical care (including older people's care)

- Continued Professional Development Forums were in place on wards to assist in meeting training needs for speciality training. Education meetings took place each week and an education programme had been developed.
- We observed multidisciplinary working (MDT) in the assessment, planning and delivery of patient care on all wards and we observed effective interactions between various different teams and services.
- The group had developed a Social Therapeutic and Recreational Rehabilitation Team (STARRT) to promote independence and increase the quality of life of patients. The centre had developed work with the Headway Charity, the Brain Injury Group and the Service User and Carer Forum.
- The service designed wards in such a way to make optimum use of space to deliver patient care. Facilities and premises were designed for the access and availability of the specific patient profile using the centre. We observed the layout of the centre enabled patients to exercise within the corridors to aid their rehabilitation.
- There were examples of services planned in response to patient need e.g. a protocol for the management of foot-drop in patients with neurological conditions, specific protocols for all patients with acute pain and the prevention and management of harm from pressure ulcers, falls, and catheter associated UTIs.
- However, although all wards collected information relevant to the NHS safety thermometer, a consistent approach to display this data was not in place; wards displayed some information or no information at all. This would have assured people using the service that the ward was improving practice based on experience and information.

Are medical care services safe?

Good

We rated safe as good because:

- Staff were confident in reporting incidents and provided us with examples of incidents they would report. Staff explained they received feedback on incident outcomes by e-mail, at team meetings, and through informal supervision to inform learning and improvements in care.
- All wards, therapy rooms, sluices and commodes were visibly clean and tidy. Cleaning rotas were in place and all equipment had been cleaned in accordance with schedules. Wards displayed posters at the entrance asking visitors not to visit the ward if they had been unwell. All wards had individual rooms, which enabled the isolation of patients when necessary, and all had bathroom facilities.
- There were effective arrangements for safely managing medicines, including medicines prescribed 'as required' and controlled drugs. All wards used electronic equipment for storage, recording and dispensing medication.
- Trust data showed mandatory training data for wards at Walkergate Park met overall compliance against a trust target of 85%. Ward managers were notified when staff needed to complete mandatory training sessions through online training systems and kept ward level lists of key mandatory training dates.
- The trust had formal nurse staffing review processes in place and the group had a funded establishment in place. A rota of six consultants was available on site during the day. Out of hours cover was provided by a second consultant on call.The centre was accredited as a specialised level 1 rehabilitation service meeting BSRM medical staffing standards.
- We looked at medical and nursing records on the wards and we saw they were complete, legible and organised consistently to reflect patient care, treatment and needs. Daily entries of care and treatment plans were clearly documented on the trust electronic system. Care

plans and charts we reviewed had completed patient assessment, observation charts, evaluations, and records examined included a pain score and allergies documented.

- We reviewed handover meetings and sheets used by ward staff and escalation documentation, which was effective in communication and decision making for those patients at risk of deterioration.
- The trust provided details of monitoring arrangements for pressure ulcers, falls, catheter associated urinary tract infections and venous thromboembolism. Data provided by the trust showed each was fully investigated and identified the cause, impact, details, outcome type and description of actions taken.
- However, although all wards collected information relevant to the NHS safety thermometer, a consistent approach to display this data was not in place; wards displayed some information or no information at all. This would have assured patients that the wards were improving practice, based on experience and information.

Incidents

- The directorate reported incidents through the trust electronic reporting system.
- Staff were confident in reporting incidents and provided us with examples of incidents that they would report. This included any incidences of falls, pressure ulcers, near misses and medication errors. Staff graded incidents according to a scale of level of harm ranging from no harm/insignificant to major/catastrophic events.
- There were 1840 incidents reported on the wards at Walkergate Park between April 2015 and April 2016. The majority of these (1116) related to violence and aggression (60%).
- The service had responded to these by increasing staffing levels, ensuring continuity of care and quality of care from staff permanently based on the ward and the provision of separate single sex lounges on wards.
- The trust reported 94 serious incidents between 1 January 2015 and 31 December 2015, none of these incidents related to acute medicine wards and none of these were Never Events.
- During the same period, the trust reported 149 serious incidents through its Serious Incidents Requiring Investigation (SIRI) reporting system. Of these, three related to medical wards and were classified as 'unexpected/avoidable death or severe harm'.
- Staff we spoke with explained they received feedback on incident outcomes by e-mail, at team meetings, and through informal supervision to inform learning and improvements in care.
- Staff reported all pressure ulcers (PUs) irrespective of grade or classification. Staff reported tissue viability nurses (TVNs) responded to incidents and there was appropriate availability of pressure relieving equipment because of proactive reporting.
- Staff we spoke with understood Duty of Candour requirements and that this involved being 'open and honest' with patients. Ward managers were aware of the Duty of Candour and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.
- The group did not hold mortality and morbidity meetings, no deaths had occurred within the last three years and the Service Manager detailed the process that would be undertaken through the SIRI process, should a death occur
- The group shared learning from incidents and when things went wrong and we saw evidence of good reflection on wards. Ward Managers discussed incidents at regular staff meetings and the trust held learning events to highlight themes and trends in patient safety.

Safety thermometer

- The trust provided details of monitoring arrangements for pressure ulcers, falls, catheter associated UTIs (C-UTIs) acquired during admission and venous thromboembolism (VTE) acquired during admission.
- These were reported through safety thermometer data to monitor the effectiveness of care in the service by giving a monthly snapshot of each area, and this was discussed, amongst other forums, in the physical health link nurse forum.
- Data provided by the trust showed there had been three pressure ulcers (grade 3) on the wards, 126 falls (one 'major harm'), 11 C-UTIs and 5 patient safety incidences between April 2015 and April 2016. Each incident was fully investigated and identified the cause, impact, details, outcome type and description of actions taken.

Medical care (including older people's care)

- Although all wards collected information relevant to the NHS safety thermometer, a consistent approach to display this data was not in place; wards displayed some information or no information at all. This would have assured people using the service that the ward was improving practice based on experience and information.
- Information was not displayed in ward entrances but staff had knowledge of the information and ward performance. This was used to measure, monitor and analyse patient 'harm free' care.
- The Braden Assessment Tool was used to monitor and manage pressure ulcers, falls risks and VTE assessments were identified at pre-admission assessment in order that any risk is identified and strategies are in place ready for admission and the development of C-UTIs was reported as an incident.
- The National Early Warning System (NEWS) and the Northwick Park dependency tool were used to monitor and record patient observations and escalation processes were in place for all patients.

Cleanliness, infection control and hygiene

- All wards, therapy rooms, sluices and commodes were visibly clean and tidy. Cleaning rotas were in place and all equipment had been cleaned in accordance with schedules.
- Wards displayed posters at the entrance asking visitors not to visit the ward if they had been unwell. This was in order to reduce the spread of infection.
- We observed that personal protective equipment (PPE) such as disposable gloves and gowns were available to staff. We saw these used appropriately, e.g., when staff were interacting with patients.
- We observed patients requiring isolation nursing cared for in side rooms. Staff displayed appropriate signage advising staff and visitors not to enter without appropriate protective clothing. We observed staff using and disposing appropriate protective clothing.
- Hand sanitizing gel was available on the entrance to all the wards we visited. We observed clear instructions to encourage visitors to sanitize their hands on entering clinical areas. We observed staff and visitors attending wards sanitizing their hands.
- We observed staff carrying out hand washing prior to and after patient contact. Staff adhered to the hand hygiene" and "Bare below the Elbow" protocols.
- Staff used clinical waste and sharps disposal appropriately on the wards we visited.
- The trust provided us with audits of Infection Prevention Control (IPC) Risk Assessments. These showed compliance with staff delivering clinical care were trained and supported to good infection prevention and control practice and understand their personal responsibility. (91%), general environment (100%), food hygiene (100%) and hand hygiene practice (100%).
- The group monitored staff knowledge surrounding Aseptic Non-Touch Techniques (ANTT) and IPC to support competence in infection control procedures.
- All wards had individual rooms, which enabled the isolation of patients when necessary, and all had bathroom facilities.
- The trust had a Healthcare Acquired Infection (HCAI) Prevention and Control Strategy underpinned by national guidelines and IPC policies to manage and monitor infection essential for patient and staff safety.
- IPC training was mandatory within the trust and staff accessed IPC staff for advice and guidance when required.

Environment and equipment

- Patient led assessments of the care environment (PLACE) are self-assessments undertaken by teams including members of the public. These focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness.
- The 2015 PLACE score for cleanliness within the trust was 99%, approximately 2% above the England average (97%) and Walkergate Park scored 100% for cleanliness.
- We checked the resuscitation trollies on all the wards we visited and these contained correct stock. Medication drawers were secured with tamper proof seals. Each resuscitation trolley had a log attached, which had been completed on a daily basis.
- Clinical Environmental Risk Assessments (May 2016) identified the numbers of incidents monthly by ward and type and listed areas of work required to achieve minimum requirements for safety in line with the Schedule of Safety Standards.
- Examples of improvements made included arrangements for locking doors to bathrooms, access to wards and clarity of bed provision requirements for different patient needs.

- The medical devices department coordinated the monitoring of equipment and calibration checks where necessary. All equipment we checked had been portable appliance tested.
- Staff identified patients at risk of developing pressure sores using the 'Braden Score' and provided appropriate pressure relieving support surfaces such as mattresses and cushions. Specific mattresses had been provided for patients with Huntington's disease.

Medicines

- There were effective arrangements for safely managing medicines, including medicines prescribed 'as required' and controlled drugs. All wards used electronic equipment for storage, recording and dispensing medication.
- We saw that patients' care plans included details of when 'as required' medicines should be offered to patients. Medicines were stored securely and were administered by qualified nurses. We looked at the records of administration of medicines for 16 patients and found these were completed correctly.
- Medicine prescription records for individual patients were clearly written and medicines were prescribed and administered in line with trust policy and procedures, reducing the risk of errors.
- Medication rounds were conducted with good practice principles and wards had dedicated and daily support from pharmacy.
- The storage of medication in refrigerated units was monitored and daily temperature checks recorded, these were within the correct limits on all wards.
- Medication audits on each ward showed full compliance with daily prescription sheet and pharmacists liaised with the ward team on a daily basis. We found allergies clearly documented.
- Ward managers were aware of the local microbiology protocols for the administration of antibiotics and liaised with pharmacy prior to prescribing for MRSA and C. difficile.
- Staff were required to attend mandatory updates on storage and recording of controlled drugs. Newly qualified staff were required to attend training and complete the safe medication training before being able to administer. Ward managers ensured training was in place to achieve trust targets.

Records

- We looked at 16 sets of medical and nursing records on the wards and we saw they were complete, legible and organised consistently to reflect patient care, treatment and needs.
- Patient medical notes were stored in lockable trolleys and patient care charts were kept at the bedside for ease of access to staff. We did not observe a breach in confidentiality during inspection.
- Daily entries of care and treatment plans were clearly documented on the trust electronic system. Care plans and charts we reviewed had completed patient assessment, observation charts, evaluations, and records examined included a pain score and allergies documented.
- We saw thorough completion of observation and monitoring charts including the national early warning score (NEWS) observation chart. Audits showed NEWS charts were completed in full for each set of observations and for actions taken based on escalation plans.
- We reviewed handover meetings and sheets used by ward staff and escalation documentation, which was effective in communication and decision making for those patients at risk of deterioration.
- Handover templates were in place, which identified a structure for these meetings, e.g. name, age, diagnosis, clinical observations, communication methods, behavioural issues, changes to care plans, meeting feedback.
- Admission procedures included comprehensive assessment of key areas of health needs including tissue viability and nutrition screening, assessment of personal care needs included infection and continence and risk assessments for falls, weight, fluid balance and venous thromboembolism. All wards used an inpatient audit tool to facilitate these assessments.

Safeguarding

- The trust had a designated lead for safeguarding, a safeguarding strategy and held regular safeguarding board meetings. Minutes and action plans were clear and these meetings are well attended by senior staff from across the centre. This provided a forum for staff to discuss safeguarding concerns and share learning across the trust.
- Staff understood their responsibilities and discussed safeguarding policies and procedures confidently and

competently. Staff felt safeguarding processes were embedded throughout the trust and were aware of who to contact, where to seek advice and what initial actions to takes.

- Qualified staff were trained to an appropriate level for their role, for example level two for adults and children. Trust data (May 2016) showed 88% compliance across the wards with Safeguarding Adults training and 93% compliance across the wards with Safeguarding Children training.
- We spoke with members of the multidisciplinary team and they were confident staff knew how to respond to allegations or signs of abuse. All staff were aware of the phone numbers and procedure for escalating concerns.
- Information was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making. We saw that an audit tool was appropriately used by ward managers for 'Restrictive Practices' where necessary to ensure patients were not subject to unnecessary restrictions and to safeguard their rights.

Mandatory training

- The trust provided mandatory training data (May 2016) for wards at Walkergate Park. These showed overall compliance at 85% against a trust target of 85% (the target for information governance was 95%). Ward 1b achieved the highest compliance score of 91% and Ward 3 had the lowest aggregated rate of training of 80%.
- Compliance against 'records and record keeping' training had the highest rate of compliance with 100% and 'rapid tranquilisation' training the lowest overall training compliance of 57%.
- No ward achieved the trust target for clinical supervision training and overall compliance was 62%.
- Ward 4 failed to reach trust compliance targets in five mandatory training areas – 'clinical risk' training (64%), 'clinical supervision' (54%), 'dual diagnosis' training (44%), 'Prevention and Management of Violence and Aggression Breakaway' (65%) and 'rapid tranquilisation' training (13%).
- Ward managers were notified when staff needed to complete mandatory training sessions through online training systems and also kept ward level lists of key mandatory training dates. There were local action plans in place to ensure compliance with trust targets and address any shortfalls.
- Staff accessed mandatory training modules through the trust electronic learning system and face-to-face training sessions. This allowed staff to monitor training due dates when they logged onto the system.
- Staff explained they completed the majority of their mandatory training through protected time to complete training.

Assessing and responding to patient risk

- The trust used the National Early Warning Score (NEWS) risk assessment system. The strategy and processes for recognition and treatment of the deteriorating patient was embedded. We saw full completion of NEWS risk assessments and sepsis screening tools and staff were aware of escalation procedures.
- This allowed staff on the ward to record observations, with trigger levels to generate alerts, which identified acutely unwell patients. Protocols were in place to transfer patients to a neighbouring acute hospital where appropriate in emergency situations.
- Comprehensive risk assessments were in place in care records and included the completion of cognitive assessment tools, falls risks, pressure ulcer risks, and bed rails assessments.
- Care planning based on patients assessed risk was effective and individualised. We saw evidence of risk assessment for nutrition with the Malnutrition Universal Screening Tool (MUST) and this helped staff identify patient nutritional needs. Pain scores and diaries for patients were available.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and patient assessment and screening.
- Patients at risk of falls were identified and assessed on admission and an individualised plan of care was put in place. We saw planned care delivered, for example one to one nurse patient ratio, close observation, safety rails on beds, speciality beds, stickers to identify risk on display boards and nurse call system in reach.
- There were 198 incidents of restraint of nine different service users across the wards reported between November 2015 and April 2016. Seventeen incidents of restraint in the prone position were recorded, of which nine resulted in rapid tranquilisation.
- The trust had plans in place consistent with national guidance to mange and decrease the numbers of restraint in the prone position and incidents of rapid tranquilisation.

Medical care (including older people's care)

- There was one incident of seclusion and one incident of long-term segregation reported across the wards in the same period.

Nursing staffing

- The trust had formal nurse staffing review processes in place subject to regular review by the trust board. The group had a funded establishment agreement based upon agreed methodology and professional judgment triangulated through benchmarking, relevant national guidance and acuity information.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels and matrons told us shortfalls in nursing cover were managed day to day through regular senior nurse meetings to meet demands in ward activity.
- Staffing was in line with British Society of Rehabilitative Medicine (BSRM) standards and the centre had guidelines with clear escalation procedures in place. On-call senior nurses provided site cover at all times.
- Numbers of staff on duty was displayed clearly at ward entrances. During our inspection, all wards' actual staffing levels were consistent with planned staffing levels.
- Trust data (April 2016) showed Ward 3 had the highest nurse vacancy rate of 27% (above the trust nurse vacancy rate of 14%).
- Ward 2 had the highest number of shifts (178) filled by bank staff and Ward 3 the highest number of shifts (63) filled by agency staff and the highest number of shifts not filled (40).
- Ward 2 had the highest number of staff leavers in the last 12 months with 5.5%, under the trust average of 7.9%. Staff sickness in the last twelve months across the wards was 5.3%.
- Two of the wards operated below the lower fill level (less than 90%) for qualified nurses during the day, Ward 3 the lowest at 69% and Ward 4 (72%).

Medical staffing

- A rota of six consultants were available on site during the day. Out of hours cover was provided by a second consultant on call.
- Patients were admitted once they were medically stable; therefore, if an immediate acute response is required prior to the doctors being able to attend the ambulance and paramedics may be called.
- Annual leave and study leave arrangements were covered at consultant level ensuring that a consultant was always available.
- Job planning, on call rota and leave planning ensure that a consultant in rehabilitation medicine was always available for advice either by telephone and they were able to return to the centre if required. Junior doctors were able to attend the centre within 10-30 minutes, as were inpatient consultants.
- Within neuropsychiatry, there was a weekly daytime cover rota and out of hours the wards were covered by junior doctors working shifts. The senior cover was provided by the on call consultant psychiatrist.
- The centre was accredited as a specialised level 1 rehabilitation service meeting BSRM medical staffing standards.

Major incident awareness and training

- We saw that the trust had appropriate policies in place with regard to business continuity and major incident planning. These policies identified key persons within the service, the nature of the actions to be taken and key contact information to assist staff in dealing with a major incident.
- Major incident plans were reviewed and updated annually. Potential risks were taken into account when planning services and action plans were discussed and implemented as necessary.
- The impact on safety when carrying out changes to the service and staff, was assessed and monitored through robust, embedded assessments, staff engagement and ongoing service monitoring.
- Staff were clear on their specific role in the event of a major incident and were aware on how to access the major incident policy for guidance via the trust intranet.
- Service managers and senior staff considered seasonal demands when planning bed occupancy within the centre.

Are medical care services effective?

Outstanding ☆

We rated effective as outstanding because:

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE) and all local policies were written in line with

national guidelines and updated if national guidance changed. The group reviewed patient outcomes through a number of audits and through the UK Rehabilitation Outcome Collaborative (UK ROC).

- Evidence-based techniques and technologies were used to support the delivery of high quality care, such as NICE Guidance on Urinary Continence Problems in Neurorehabilitation Inpatients, functional independence and functional assessment measures and a 'Modified Rivermead Mobility Index tool'.
- These had been used to further assess patient self care, sphincter control, mobility/transfer, locomotion, communication, psychosocial adjustment and thinking function as well as clinical effectiveness of therapy intervention for neurorehabilitation inpatients and the confidence of staff in formulation skills. We also saw that audits had resulted in actions to update and ensure adherence to guidelines around endocrine screening and to educate nursing and medical staff on use.
- Research projects were well established at Walkergate Park. Specific examples had been developed to determine whether the provision of education to paid carers improved their confidence in managing complex hands in neurological patients, the self-management of long term neurological conditions using Therapy Outcome Measures and the development of a spasticity management clinic for individuals with spasticity following a neurological injury.
- Risk assessments, care plans and test results were completed throughout a patient's stay ensuring care and treatment was developed in line with the changing needs of individual patients. We saw these were available to staff enabling effective care and treatment.
- All patients admitted to the centre had a full medical history taken and each patient was individually assessed appropriately, including therapy assessments, medical and nursing assessments. The centre had direct links with the Acute Pain Service.
- We observed staff asking patients for their consent prior to care being delivered and procedures carried out and the trust had an appropriate policy informing staff about the consent process. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- Planning meetings to co-ordinate therapeutic input in to a patient's care and treatment were held each week. These were attended by all disciplines of staff involved in patient care and ensured a co-ordinated and multi-disciplinary approach for each individual patient.
- There was ongoing work addressing ways of improving assessments for those who are unable to communicate effectively, using the Disability Distress Assessment Tool and assessments of those with prolonged disorders of consciousness.
- Patient-led assessments of the care environment (PLACE) audit scored the trust consistently higher than the England average. Meal charts were completed comprehensively and reviewed.
- All staff had attended induction training at trust, group and ward level. A trust induction policy was in place, which identified responsibilities for the individual, and Staff Handbooks had been developed at all levels to support this process.
- Continued Professional Development Forums were in place on wards to assist in meeting training needs for speciality training. Education meetings took place each week and an education programme had been developed.
- We observed very effective multidisciplinary working (MDT) and interactions between teams and services in the assessment, planning and delivery of patient care on all wards.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE). Local policies were written in line with national guidelines and updated if national guidance changed.
- Staff referred to a number NICE Guidelines and quality standards and best practice guidelines in support of their provision of care and treatment, for example 'Reducing the risk of deep vein thrombosis (DVT) for patients in hospital'.
- Local policies, which were accessible on the wards and on the trust intranet site reflected up-to-date clinical guidelines. We reviewed a number of clinical guidelines on the intranet, all were current, and all had review dates.

- The group was actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment.
- Evidence-based techniques and technologies were used to support the delivery of high quality care. Staff actively monitored and improved patient outcomes and undertook opportunities to participate in benchmarking, peer review, accreditation and research proactively.
- An example of this was the audit of NICE Guidance on Urinary Continence Problems in Neurorehabilitation Inpatients. This audit had been designed to recognise the importance of recognising and treating the significant impact of urinary continence problems on patients.
- Functional independence measure (FIM) and functional assessment measure (FAM) scores were used on wards to assess self care, sphincter control, mobility/transfer, locomotion, communication, psychosocial adjustment and thinking function.
- A service evaluation report (May 2016) had audited the use of the 'Modified Rivermead Mobility Index tool' and provided evidence of clinical effectiveness for physiotherapy in inpatient neurorehabilitation.
- An evaluation of current therapist to patient ratio and intensity of therapy intervention for neurorehabilitation inpatients had been designed to assess physiotherapy, occupational therapy and speech and language therapy input over a six month period using FIM and FAM, goal attainment scale and discipline specific outcome measures.
- An audit in August 2015 measured the confidence of staff (therapists and nursing) in formulation skills to support the use of psychological skills with neurorehabilitation and neurobehavioural rehabilitation. The outcome from the audit was to develop frameworks for understanding patient's difficulties, enhanced clinical practice and alliance building with patients and families, a guide to intervention, a template for combining therapies in MDT discussions and enhanced team consistency.
- An audit (2013 - 2015) had been undertaken to establish the numbers of patients who had endocrine function checked at the time of injury, at three and six months post injury, the percentage of tests showing significant abnormalities and the percentage of patients with skull fractures. This resulted in actions to update and ensure adherence to guidelines around endocrine screening and to educate nursing and medical staff on use.
- A research project to determine whether the provision of education to paid carers improved their confidence in managing complex hands in neurological patients had been carried out. This covered the assessment and care of skin condition, cleanliness, infection and nails.
- A spasticity management clinic for individuals with spasticity following a neurological injury was provided for residents in the North East. This provided a medically led Botulinum Toxin Injection Clinic audited against national guidelines for 'Spasticity in adults: management using botulinum toxin (Royal College of Physicians)'.
- Research and audit projects were being carried out or had been proposed for the self-management of long term neurological conditions, speech and language therapy outcome measures, occupational therapy - Australian Therapy Outcome Measures, prescribing rehabilitation, spasticity management standards,
- The neuropsychiatry team had visited (May 2016) a comparable service at another trust to share good practice and benchmark services. This was used to develop an understanding the approaches to ward organization, relationships with other services, staffing levels, training and development, observation levels and links with psychology services.
- Planning meetings to co-ordinate therapeutic input in to a patient's care and treatment were held each week. Staff told us these worked well, identified therapeutic sessions and assure patients received the best care at the appropriate time.

Pain relief

- Patients were regularly asked about their pain levels and all patients reported their pain management needs had been met. Each ward had identified a pain link nurse and all patients we spoke with reported their pain management needs had been met.
- There was a pain assessment scale within the NEWS chart used throughout the centre. NEWS audits were in place and a review of records (16) showed 100% of NEWS charts had been correctly recorded.
- The group had adopted the key standard from the Faculty of Pain Medicine 2015 standards. The most

relevant to the post-acute neurorehabilitation unit at Walkergate Park (standard B) - all patients with acute pain must have an individual analgesic plan appropriate to their clinical condition that is effective, safe and flexible and a regular pain assessment using consistent, validated tools with results recorded with other vital signs.

- All patients admitted to the post-acute rehabilitation centre had a full medical history taken and each patient was assessed appropriately, including therapy assessments, medical and nursing assessments. If clinically required and pain was evident, the patient was able to use assessment tools and a validated analogue scale was used to record the pain.
- All patients had medical observations recorded on the NEWS chart and this was used together with the analogue chart to support the clinical assessment.
- This was implemented following an audit, the results of which were presented to the National British Society of Rehabilitation (BSRM).
- Referral to the Acute Pain Service was made following the acute trust's pathway. The centre had direct links with the pain service at the acute hospital with one of the Rehabilitation Medicine Consultants also working one session into the Chronic Pain Management Service based in the acute hospital.
- There was ongoing work addressing ways of improving assessments for those who are unable to communicate effectively, with working groups exploring the use of disability distress assessment tool (DISDAT) and assessments in those with prolonged disorders of consciousness (PDOC).

Nutrition and hydration

- Patients were screened using the Malnutrition Universal Screening Tool (MUST). Where necessary patients at risk of malnutrition were referred to the dietician. Staff reported that dieticians were accessible and visited wards regularly or when needed.
- We reviewed 16 records and saw nurses completed food charts for patients who were vulnerable or require nutritional supplements and the dietetic department provided support.
- Staff told us that they could access support from the speech and language therapy service (SALT).
- We observed nutrition and hydration recorded on fluid and food charts, which summarised periodic intake during the course of the day.
- Patients had protected meal times and staff allowed family members to attend during meal times where patients required help or support in eating or drinking.
- We observed staff feeding patients and saw they gave encouragement when required in a considerate way and at a relaxed pace. Staff updated care plans when a patient refused to eat.
- Patients reported their meals to be very good, with good choice and it was clear that staff prioritised nutrition for patients offering snacks and individualised choice for patients.
- Patient-led assessments of the care environment (PLACE) audit scored the trust consistently higher than the England average. Meal charts were completed comprehensively and reviewed.

Patient outcomes

- The group reviewed patient outcomes through a number of audits and through the UK Rehabilitation Outcome Collaborative (UK ROC).
- An example of this was the audit of NICE Guidance on Urinary Continence Problems in Neurorehabilitation Inpatients. This audit showed 98% of patients had their history taken as well as a physical examination (July to December 2015), 60% of patients had urinalysis performed and 49% had a fluid balance chart developed. The audit identified actions to ensure every patient had a bladder/catheter care plan in place.
- Functional independence measure (FIM) and functional assessment measure (FAM) scores were used on wards to assess self-care, sphincter control, mobility/transfer, locomotion, communication, psychosocial adjustment and thinking function.
- A service evaluation report (May 2016) had audited the use of the 'Modified Rivermead Mobility Index tool' and showed an improvement in Therapy Outcome Measures (TOM) from 0.6 at admission to 1.1 at discharge, an improvement of 0.5. Improvements were recorded in every measure, for example lying to sitting, sitting balance, standing, walking indoors.
- Data from the UK ROC (May 2016) showed the mean referral to assessment for patients in the last twelve months was 9 days (neurorehabilitation) and patients were then admitted, where appropriate, within an average of 51 days.
- The majority (79%) of patients admitted were classified as category A organic brain dysfunction, higher than the comparative group of providers (75%).

- The mean motor gain during episode was 14 (16, comparative group of providers) and a cognitive gain during episode of six (10, comparative group of providers).

Competent staff

- Nursing staff told us that they had received information and support from the trust about Nursing and Midwifery Council (NMC) revalidation.
- Staff confirmed to us learning needs and development opportunities were discussed regularly through informal and formal discussions. These often translated into the opportunity to attend ward-based training, trust-wide training sessions or external courses in conjunction with academic partners.
- All staff had attended induction training at trust, group and ward level. A trust induction policy was in place, which identified responsibilities for the individual, contractors and agency workers and the service before employment, the first week of employment, within a month and within the first three months of employment. Staff Handbooks had been developed at all levels to support this process.
- Staff identified learning and training needs during annual appraisal and 1:1 sessions. Appraisal rates across the wards showed 88% of permanent non-medical staff had an appraisal within the last 12 months (as at 30 April 2016). Highest compliance was Ward 2 with 96% completion and the lowest Ward 3 with 86% completion.
- In the same period, 87% of medical staff across the wards had received an appraisal with Ward 3 and Ward 4 completing 100%.
- The Social Therapeutic and Recreational Rehabilitation Team (STARRT) had undertaken 100% of appraisals and monthly supervision sessions in the past year.
- Continued Professional Development Forums were in place on wards to assist in meeting training needs for speciality training. Training had been developed, for example, for mental capacity training for neurological services, core rehabilitation skills self assessment tool (CoRSSAT), neurological assessment, formulation and intervention and tracheostomy management, splinting in a neurological setting.
- Education meetings took place each Friday and included topics such as case presentation, amputee rehabilitation, pain and secretion management, intermediate life support, vision update and audit update.
- A MDT education programme had been developed and included sessions on vestibular rehabilitation, cognitive communication, motivational interviewing, returning to driving, wound assessment, mood disorders.

Multidisciplinary working

- We observed multidisciplinary working (MDT) throughout our visit to the wards. Standards had been developed to increase the effectiveness of MDT meetings, including prompt attendance recording of discussions, focus, timetables goals and objectives.
- MDT involvement in the assessment, planning and delivery of patient care was apparent on all wards and we observed interactions between various different teams and services. Records reviewed showed evidence of this input from the MDT.
- MDT working was embedded and fundamental to the effective running of the service. Nursing and medical staff, therapists, pharmacists and medical social workers attended MDT meetings where appropriate. All MDTs were well attended.
- Staff discussed each individual patient, their current medical condition, concerns and discharge plans. The MDT had an in-depth knowledge of each individual patient, his or her family and everyone contributed.
- The MDT process continued throughout the care and treatment of individual patients from admission to discharge. There were clear pathways to therapy and psychiatric services. Additionally, staff confirmed external referral to other services including social services worked very well and these attended MDT meetings when necessary.
- Multidisciplinary Team Education Programmes had been developed to increase common understanding, e.g. 'A Psychological Understanding of Medically Unexplained Symptoms' (June 2016).

Seven-day services

- Walkergate Park is a post-acute neurorehabilitation centre. All admissions were planned and the patients are medically stable in order that they are able to engage in the rehabilitation programme.

Medical care (including older people's care)

- All patients had a detailed assessment prior to admission and are only admitted once they are medically stable in order that they can undergo rehabilitation.
- Access to nursing and therapy staff was provided seven days a week.
- Consultants were available during the week on a daily basis and cover was provided out of hours and at weekends by a consultant on call.
- Job planning, on call rota and leave planning ensure that a consultant in rehabilitation medicine was always available for advice by telephone out of hours and at weekends.
- Within neuropsychiatry there was a weekly daytime cover rota and out of hours and at weekends the wards were covered by junior doctors working shifts. The on call consultant psychiatrist provided the senior cover.

Access to information

- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment and we saw these were available to staff enabling effective care and treatment.
- Handovers were thorough with detailed handover sheets providing key care need summaries for each individual patient. Medical handovers ran effectively and were comprehensive with detailed and relevant information shared. Medical staff informed us they received investigation results in a timely manner.
- Staff identified community services and on-going care needs that would be required for the patient on discharge. Staff involved the patient, their family and service providers in discharge planning. We reviewed discharge arrangements and planning started as soon as possible for patients and saw discharge arrangements were completed appropriately and shared relevant information with relevant services.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Staff had access to up to date information on ward performance against objectives and appropriate guidelines were available for staff to ensure they were working to best practice.
- All staff had access to policies, procedures and NICE guidelines on the trust intranet site. The staff we spoke to stated they were competent using the intranet to obtain information.
- Drug charts, blood results and x-rays were kept electronically and were available to both doctors and nurses as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff asking patients for their consent prior to care being delivered and procedures carried out.
- We saw that the trust had an appropriate policy informing staff about the consent process. This included reference to obtaining consent where patients may have capacity issues and included guidance on the Mental Capacity Act.
- Data provided by the trust (May 2016) showed that 83% of staff across the wards had received training in the Mental Health Act (1983) and 91% of staff across the wards had completed mandatory Mental Capacity Act training, against trust targets of 85%.
- Staff knew of the Mental Capacity Act and deprivation of Liberty Safeguards (DoLS). Staff provided us with examples of DoLS, explaining steps taken to identify and support patients who may not have the capacity to consent.
- Staff were confident in identifying issues in regard to mental capacity and knew how to escalate concerns in accordance with trust guidance. The consultant responsible for the patient's care undertook mental capacity assessments and DoLS were referred to the trust safeguarding team.
- There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- Consent, MCA and DoLS training was delivered as part of staff induction. Patients were consented in a timely manner and MCA and DoLS assessments were included in risk assessments.
- We looked at 16 records and all patients had consented in line with the trust policy and Department of Health guidelines. All records we reviewed contained appropriate consent from patients and patients described to us that staff took their consent before providing care.
- We reviewed the records of patients on the wards detained under the Mental Health Act (seven) and saw that these were well recorded with the exception of two

records where the capacity to consent was not documented. Immediate action was taken by the trust to ensure this was rectified and appropriate safeguards put in place.

Are medical care services caring?

Outstanding ☆

We rated caring as outstanding because:

- The service had a very person centred focus and culture. All patients and family members said therapeutic input was relevant, co-ordinated and resulted in improvements. Staff took the time to meet the individual needs of patients and we were given examples of where staff had gone 'the extra mile' to make patients' hospital stay a positive experience.
- All staff viewed the care and treatment of patients as a team responsibility and included the patient, family and patient carers in the planning and development of care. Changes to care and treatment were fully explained and adjusted depending upon individual preferences and circumstances. Staff worked consistently as a team to meet patient needs.
- All patients who responded to the Friends and Family Test (FFT) said they would recommend the service. We were told that care had been individualised to ensure effectiveness and staff were '…fabulous', '...amazing' and '…conscientious'.
- The group had developed a Social Therapeutic and Recreational Rehabilitation Team (STARRT) to promote independence and increase the quality of life of patients through taking part in social and leisure activities. The team consisted of a nurse team lead, a clinician, activities co-ordinator and volunteers.Patients and family spoke positively about the STARRT team and gave examples of interventions, which had promoted improvements.
- Patients and family members had been involved in discharge processes. Staff had been to individual's homes to undertake assessments, gave full explanations and kept patients involved.
- Each patient received a welcome pack to 'Walkergate Park Centre for Neurorehabilitation and Neuropsychiatry'. A 'Patient Rehabilitation Journey Booklet' was also available for patients to complete and contained individual information. Patient meetings were held on wards; minutes showed these discussed menus, environment, staffing, activities, and café arrangements.
- The centre produced a 'Resources for Carers' booklet that gave details of information available from the trust, carers resources and mental health resources.
- All patients had a care plan and all were appropriately individualised from core standards and current to the needs of the patient. Patients and relatives informed us they felt involved in care options, decision making and planned treatment.
- Patients reported staff spent time with them and staff recognised the importance of time to care and support patients emotional needs. Care plans highlighted the assessment of patients emotional, spiritual and mental health needs.
- The centre had developed work with the Headway Charity, the Brain Injury Group and the Service User and Carer Forum.
- Staff were aware of the impact that a person's care, treatment or condition may have on their wellbeing, both emotionally and socially. When they had concerns about a patient's emotional well-being, they referred to the psychiatry team and patients were offered professional therapy and support.

Compassionate care

- Wards had appointed link nurses to collate and action issues through the 'Points of You' patient feedback system. The group received positive comments that patients viewed staff as kind and compassionate, non-judgemental, respectful and considerate. Patients also responded they are made to feel safe and welcome; they are involved in deciding upon their care and staff promoted hope and positivity.
- All patients who responded to the Friends and Family Test (FFT) said they would recommend the service (83% extremely likely to recommend).
- Wards had action plans in place to benchmark essence of care for patients to promote patients and carers feel that they matter all of the time and patients experience of care in an environment that encompasses their values, beliefs and personal relationships.

Medical care (including older people's care)

- The group had developed a Social Therapeutic and Recreational Rehabilitation Team (STARRT) to promote independence and increase the quality of life of patients through taking part in social and leisure activities. The team consisted of a nurse team lead, a clinician, activities co-ordinator and volunteers.
- STARRT activities included (among others) cycling, pottery, swimming, crafts, golf, football, arts and orienteering. Risk assessments were carried out for all patients and included in care plans.
- STARRT provided services throughout the week and support at weekends. The team had developed a link nurse role on the wards, a relaxation group and a care pathway with defined outcomes using recognised tools (e.g. Warwick-Edinburgh Well-being Scale, Hospital Anxiety and Depression Scale).
- Patients and family spoke positively about the STARRT team and gave examples of interventions, which had promoted improvements. For example, the STARRT team had supported a patient with a traumatic brain injury to access the community on a regular basis for activities of his choice, worked on relaxation strategies with guidance from psychology services, resulting in the patient reporting increased confidence.
- A further example was a patient who had become completely isolated following a brain injury and would not get out of bed. Through a graduated approach with guidance from psychology services, the patient was encouraged to leave his room for short periods, which gradually increased and was then introduced to community access when ready.
- The patient began regular outings, attended football matches, began a vocational course and socialised with family members. The patient was discharged for longer term rehabilitation prior to returning to independent living.
- We were told that care had been individualised to ensure effectiveness and staff were '…fabulous', '...amazing' and '…conscientious'.
- All patients and family members said therapeutic input was relevant, co-ordinated and resulted in improvements. We were told that there were appropriate levels of staff.
- Patients and family members had been involved in discharge processes. Staff had been to individual's homes to undertake assessments, gave full explanations and kept them involved.
- Patients explained to us that staff maintained their privacy and dignity and always informed them of any care delivery or procedure in advance.

Understanding and involvement of patients and those close to them

- Each patient received a welcome pack to 'Walkergate Park Centre for Neurorehabilitation and Neuropsychiatry'. This gave a range of information useful to patients and family members. This included information about the admission process, working together with staff, one-to-one contact sessions, and access to pharmacy, changing consultant or getting a second opinion as well as general information about the trust.
- The pack contained details of how an individual's stay on the wards may be like, practicalities of staying on the wards (access to benefits, keeping in touch, treatment available, interpreters, safety and security) and importantly involvement in planning for moving on from the centre.
- A 'Patient Rehabilitation Journey Booklet' was also available for patients to complete. This recorded individual contact details, patient condition information, personal goals and achievements, appointments and team review meetings, discharge date and local contacts.
- We saw the journey booklet being used by staff and patients throughout our inspection and all patients said these helped them to feel involved in their care and treatment and they felt assured they were treated as individuals.
- The centre produced a 'Resources for Carers' booklet that gave details of information available from the trust, carers resources and mental health resources, for example, consent processes, Patient Advice and Liaison Services (PALS), how to cope as a carer, depression, bereavement, sleeping well, medication, how to manage stress.
- Further information was provided by the trust and group to involve patients and their carers or family in their care such as the 'Carers' Charter', a checklist for carers, useful contacts for carers, getting to know you and common sense confidentiality.
- Patient meetings were regularly held on wards; minutes showed these discussed menus, environment, staffing, activities, and café arrangements.

Medical care (including older people's care)

- All patients had a care plan and all were appropriately individualised from core standards and current to the needs of the patient. Patients and relatives informed us they felt involved in care options, decision making and planned treatment.

Emotional support

- Patients reported staff spent time with them and staff recognised the importance of time to care and support patients emotional needs. Care plans highlighted the assessment of patients emotional, spiritual and mental health needs.
- A multi-faith prayer room and facilities for ritual washing to be performed in preparation for prayer and worship were available on the main corridor at Walkergate Park. Patients and relatives said this was an extremely positive experience and individualised support.
- We were given information about support groups for patients. These included work with the Headway Charity, the Brain Injury Group and the Service User and Carer Forum. These facilitated the identification and provision of increased activities on wards, an opportunity for patients and families to influence service provision, request facilities and equipment and feedback directly to the service.
- Staff were aware of the impact that a person's care, treatment or condition may have on their wellbeing, both emotionally and socially. When they had concerns about a patient's emotional well-being, they referred to the psychology team and patients were offered professional therapy and support.
- Staff spoke with patients and family members to ensure they knew the details of their care and aftercare. Nursing staff felt this enabled patients to ask additional questions and address their fears.
- Staff explained to us, when caring for a patient they take into account all aspects of their individual physical, emotional and social needs that may affect their well-being.

Are medical care services responsive?

Outstanding ☆

We rated responsive as outstanding because:

- Individualised care was provided in line with patient preferences, individual and cultural needs and engagement with the local population took place when planning new services.
- The service designed wards in such a way to make the best use of space to deliver patient care. Facilities and premises were designed for the access and availability of the specific patient profile using the centre. We observed the layout of the centre enabled patients to exercise within the corridors to aid their rehabilitation.
- The group had developed the Social Therapeutic and Recreational Rehabilitation Team (STARRT) to promote independence and increase the quality of life of patients through taking part in social and leisure activities.
- The STARRT team had developed social groups to provide patients with opportunity to explore a range of social and leisure activities, such as agricultural, social skills, relaxation, impact of stress, wheelchair sports and independence.
- There were examples of services planned in response to patient need e.g. a protocol for the management of foot-drop in patients with neurological conditions, specific protocols for all patients with acute pain and the prevention and management of harm from pressure ulcers, falls, and catheter associated UTIs.
- Training had been developed for staff to assist patients with early and supported discharge and enabled a smoother and seamless transition to community services. Discharge co-ordinators were actively involved in each patient's care facilitating the process for discharge.
- The service was responsive to the needs of patients living with dementia and learning disabilities. Link nurses provided advice and support in caring for patients with learning disabilities and dementia.

Service planning and delivery to meet the needs of local people

- Commissioners, third party providers and stakeholders were involved in planning services, annual reviews of the service and discussion had been regularly held to provide an appropriate level of service, based on demand, complexity and commissioning requirements.

Medical care (including older people's care)

- Individualised care was provided in line with patient preferences, individual and cultural needs and engagement with the local population took place when planning new services. This ensured flexibility, choice and continuity of care.
- Facilities and premises were designed for the access and availability of the specific patient profile using the centre. We saw individual patients using the environment to exercise as part of their standing and walking rehabilitation.
- The service designed wards in such a way to make optimum use of space to deliver patient care. We observed the layout of the centre enabled patients to exercise within the corridors to aid their rehabilitation.
- The group had developed the Social Therapeutic and Recreational Rehabilitation Team (STARRT) to promote independence and increase the quality of life of patients through taking part in social and leisure activities. The team consisted of a nurse team lead, a clinician, activities co-ordinator and volunteers.
- The STARRT team had developed social groups to provide patients with opportunity to explore a range of social and leisure activities, such as agricultural, social skills, relaxation, impact of stress, wheelchair sports and independence.
- Equipment was provided on an individual basis depending upon patient need, for example the provision of specific mattresses for patients with Huntington's disease.
- An example of a specific service planned in response to patient need was a protocol developed for the management of foot-drop in patients with neurological conditions to explore soft and shelf orthotics where foot-drop had been identified as affecting walking patterns and causing falls.
- The group had developed specific protocols for all patients with acute pain. We saw patients had an individualised analgesic plan appropriate to their clinical condition that was effective, safe and flexible. All in-patients with acute pain had regular pain assessment using consistent and validated tools, with results recorded with other vital signs. There were clear guidelines for communication with the Acute Pain Service.
- The group had developed protocols for the prevention and management of harm from pressure ulcers, falls, catheter associated UTIs (C-UTIs) acquired during admission and venous thromboembolism (VTE) acquired during admission.
- For example, pressures ulcers were identified at pre-admission assessment where the patient's skin integrity was assessed, what pressure relieving equipment was required based on the Braden Assessment Tool and any input needed from the tissue viability nurse. The management of continence status and dietary needs were considered as part of the assessment.
- Upon admission, the Braden score was completed again to ensure care needs had not changed. Care and risk management plans were developed in relation to pressure ulcer prevention, moving and handling requirements, dietary needs and continence management.
- All wards displayed information for patients and carers on a variety of topics such as trust information, quality standards, ward and staff contact details, a who's who of staff on the ward and useful signposting on where to get further information such as PALS, complaints and support groups.
- The North East Driving Mobility service offered assessment, practical advice on driving, car adaptations and car choice for people with a condition, which may affect their ability to use a car as a driver or passenger. This included patients with mild cognitive impairment.

Access and flow

- Data from the UK Rehabilitation Outcomes Collaborative (May 2016) showed the centre admitted 94 patients in the last three years, 30 in the twelve months to March 2016 with 27% of patients admitted for more than 180 days.
- The mean referral to assessment for patients in the last twelve months was 24 days and patients were then admitted, where appropriate, within an average of 52 days (36 days for a comparative group of similar providers).
- The majority (79%) of patients admitted were classified as category A organic brain dysfunction and the mean motor gain during episode was 14 (increase from 60.6 on admission to 74.6 on discharge) and a cognitive gain during episode of 6.1 (increase from 65.8 on admission to 71.9 on discharge).

- Trust data showed the average length of stay across the wards for current patients (30 April 2016) was 109 days (92 days for a comparative group of similar providers) between 1 May 2015 and 30 April 2016.
- Trust data (six months to 30 April 2016) showed 93% bed occupancy across the wards. Ward 4 had the highest bed occupancy rate in that period of 98% and Ward 1a the lowest rate of 77%.
- There had been one readmission within 90 days (Ward 3) to the wards between 1 November 2015 and 30 April 2016.
- The group had developed a 'Discharge Pack' to detail the patient's background, medical summary, future appointments, nursing summary , behaviour clinical risk assessments and social care needs to facilitate effective discharge.
- Training had been developed for staff to assist patients with early and supported discharge – transition from ward to community. This covered ongoing rehabilitation needs within the current pathway to enable a smoother and seamless transition to community services with ongoing specialist support.
- Discharge co-ordinators were actively involved in each patient's care once initial assessment had been completed and typically between three and six weeks following admission. The discharge co-ordinator was responsible for explaining the process for discharge to the patient, liaise with social services, access appropriate teams, attend MDT meetings, maintain patient contact and deal with patient queries.
- Following team review meetings, the co-ordinator liaised with community teams and social services to identify placements in line with the patient's preferences and needs and kept the MDT, patient and family informed. Staff, patients and family members said this role and process worked well and had speeded up the process.
- A discharge planning meeting was held approximately two weeks before the planned discharge date to finalise discharge arrangements.
- All inpatient referrals reported to a single point of contact (SPA), based in the Outpatient department, regardless of referral source. Details were then uploaded to the electronic system and input onto the monitoring list. Clinicians reviewed the waiting list on a regular basis to identify actions to be taken.
- Referrals were then triaged as behavioural issues (Ward 1 or Ward 2) or no behavioural issues (Ward 3 or Ward 4).
- New referrals were discussed at the allocation meeting on Mondays and agreement made on patient assessment (consultant only, consultant and nurse, consultant and therapist). The standard was for patients to be seen within ten days of referral
- A nursing assessment was arranged prior to admission, the outcome of assessment was discussed at the allocation meeting, and if appropriate for admission, and medically stable, the patient was moved to the waiting list and agreement made on the appropriate ward for admission.
- Trust data (six months to 30 April 2016) showed 16 delayed discharges across the wards, Ward 4 had the highest number (six).

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. Link nurses provided advice and support in caring for patients with learning disabilities and dementia.
- We saw suitable information leaflets were available in pictorial and easy read formats and described what to expect. For example, 'Do you need an independent medical health advocate', 'Care co-ordination, a guide for people with mental health and their carers' and 'Information about consent (easy read)'.
- These were complemented by leaflets on each ward about complaints guidance from the Patient Advice Liaison Team (PALS), nutrition guidance, stop smoking support, infection prevention and control guidance, and hand hygiene information. Nursing staff and specialist nurses were available to ask questions about care and treatment at any time.
- These were available in languages other than English on request. Wards had access to interpreters as required, requests for interpreter services were identified at the pre-assessment meeting.
- Interpreter services were available to staff, both in person and on the telephone. The trust's interpretation (including British Sign Language) and translation services provided face to face and telephone interpreting services.

Learning from complaints and concerns

- We saw that the trust had a complaint policy and staff were able to outline the process and how to guide patients through the process.

Medical care (including older people's care)

- The group had received one formal complaint (Ward 4) regarding care and treatment in the twelve months to 30 April 2016. This complaint had been fully investigated and not up held.
- The wards displayed leaflets and posters outlining the complaints process. We also saw posters displayed on wards advertising the process.
- Feedback from complaints and lessons learnt were discussed either on an individual basis with the staff member concerned where applicable or general observations was provided at ward meetings and staff forum.

Are medical care services well-led?

Outstanding ☆

We rated well led as outstanding because:

- The trust had a clear vision, strategic goals and core values to maintain the Centre for Neurorehabilitation and Neuropsychiatry as a centre of excellence, putting patients first in a service focused on safety, quality and pride in the care and treatment provided.
- The vision and strategy had been communicated throughout the group and staff at all levels contributed to its development. Staff demonstrated the values of the trust during the inspection were clear about the trust vision and understood their role in contributing to achieving the trust wide and group goals.
- There were effective and comprehensive processes in place to monitor risk and performance.
- Staff said service leads and managers were available, visible within the division and approachable; leadership of the service was effective, there was excellent staff morale and they felt supported at ward level. Staff spoke very positively about the service they provided for patients and emphasised quality and patient experience as a priority and everyone's responsibility.
- Staff morale was very high on wards, staff were enthusiastic about their work, the service they provided and about the group and trust they worked for. Staff explained that morale remained high due to leadership support and excellent MDT working.
- A well established Service Users and Carers Forum was in place and social activities for service users and their families had been established with the Headway Charity. The centre had also established a Brain Injury Group providing opportunities for discussion of a variety of issues such as brain injury and sleep monitoring.
- All wards had a community meeting on a weekly or fortnightly basis where views from patients were sought and ideas or concerns acted upon.

Vision and strategy for this service

- The trust vision, strategic goals and core values highlighted its desire to maintain the Centre for Neurorehabilitation and Neuropsychiatry as a centre of excellence, putting patients first in a service focused on safety, quality and pride in the care and treatment provided.
- We met with senior managers who had a clear vision and strategy for the centre and identified actions for addressing issues within the Specialist Care Group. The vision and strategy had been communicated throughout the group and staff at all levels contributed to its development. Staff were able to repeat this vision and discuss its meaning with us during individual interviews.
- Staff demonstrated the values of the trust during the inspection were clear about the trust vision and understood their role in contributing to achieving the trust wide and group goals.
- The group had a commitment to an individualised approach delivering high quality care with robust assurance and safeguarding and saw this in practice during the inspection.
- The service had a clear and planned strategy in place to help it to achieve its vision statement. This included reference to the importance of quality clinical governance, encouraging an open culture, and listening to patients, carers and staff.

Governance, risk management and quality measurement

- A clear management structure was in place and the Specialist Care Group reported directly to the Executive Director of Nursing and Operations and then to the trust board.
- A directorate manager, senior clinical nurses and a service manager managed services.

- The group managed the service and held governance meetings for neurological services. Governance issues were standing agenda items at the divisional management group, clinical management team, business team leads, ward managers and team leads, lesson learned group and professional nurse forum.
- Although the centre did not hold a specific mortality and morbidity group, a trust group was in place. This reviewed the benchmarked mortality rates of the trust in conjunction with other qualitative clinical data and identified areas for investigation. No deaths had been reported at the centre within the last twelve months.
- Service level agreements were in place for the provision of services (e.g. biochemistry, haematology, microbiology, histopathology, radiology) from a neighbouring acute trust.
- Joint clinical governance and directorate meetings were held each month. We saw agendas and minutes with evidence of audit activity, learning from complaints and clinical risk management issues. The trust held monthly mortality and morbidity case review meetings that were well attended.
- The group's risk register was updated following these meetings and when needed. Risks were assigned to specific staff responsible for the monitoring of actions and the revision of the risk assessment as required.
- The risk register included corporate and local risk ratings, current controls, actions, target risk, date added, last review and next review. We saw that action plans were monitored across the group and the risk register was updated with any progress or new risks.
- We saw risks had been identified (April 2016) and actively managed through the risk management process, including recruitment difficulties, consultant cover, assessment waiting times, staff alarms, delayed discharges and hydrotherapy pool functioning and infection control management.
- The group had developed a template for senior nurse meetings to ensure consistency across the wards. This identified managing off-duty, payroll, appraisals, training and development, absence management, risk register, audits and ward rounds.
- We observed staff promote responsibility, accountability and improvement of patient care.
- The governance framework and management systems were reviewed annually and improved where necessary.

Leadership of service

- During interview, senior managers expressed their understanding of the challenges associated with good quality care and identified actions needed. Senior staff were motivated and enthusiastic about their role and had clear direction with action plans in relation to improving patient care. Senior managers and clinical leads showed knowledge, capability, skills and experience to lead effectively.
- Staff said service leads and managers were available, visible within the division and approachable; leadership of the service was effective, there was excellent staff morale and they felt supported at ward level.
- Monthly speciality meetings were held and discussed financial and clinical performance, patient safety and operational issues.
- Staff spoke very positively about the service they provided for patients and emphasised quality and patient experience as a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers. We were told they could access one-to-one meetings, which were mostly informal, as well as more structured meetings and forums.
- Medical staff stated that they were supported by consultants and confirmed they received feedback from governance and action planning meetings.
- Staff understand the value of raising concerns and were encouraged to do so. All staff spoken to were confident that action taken was a result of concerns raised.
- Trust data (April 2016) showed completion of clinical supervision across the wards ranged from 84% on Ward 2 to 96% on Ward 3. Individual records showed these had taken place on a monthly basis.

Culture within the service

- Staff morale was very high on wards, staff were enthusiastic about their work, the service they provided and about the group and trust they worked for. Staff explained that morale remained high due to leadership support and excellent MDT working.
- Staff were motivated and enthusiastic and told us they felt valued, appreciated and listened to by colleagues and senior staff. Staff described the teamwork as one of the best things about working for the trust.

Medical care (including older people's care)

- We saw staff worked well together on all wards and there was respect between specialities and across disciplines. We saw examples of effective and patient centre MDT working on the wards between staff of different disciplines and grades.
- All staff we spoke with felt that they received good support from management to allow them to complete their jobs effectively. Staff reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- All staff explained that they would be happy to approach senior staff to raise concerns and that they were confident issues were dealt with in a timely manner.
- All staff spoke with spoke extremely positively about their line managers and felt that they provided excellent support and guidance.
- Staff reflected on the strong leadership and visibility of senior members of the trust board. This motivated staff and staff felt that senior leadership reflected the vision and values that they shared with the organisation.
- Ward managers were given dedicated management time. This allowed them to focus on management and administrative issues. They told us they had appropriate access to senior staff members.

Public engagement

- A well established Service Users and Carers Forum was in place for the centre and was supported by a member of occupational therapy staff who acted as secretary provided by the trust. The forum met on a regular basis and minutes went to the Service Manager for action and/or information.
- The forum undertook 'Family 'Carer' Feedback interviews and met with group management to discuss issues raised. The forum interviewed people at six weeks into their stay and again at the end of their stay and write a quarterly report which is fed in via the Clinical Nurse Managers to the Ward Managers and a 'you said-we did' poster developed in response.
- Staff met with the forum twice a year to develop a two way engagement event to share ideas or concerns and to look at how best to develop services. Issues highlighted included improvements to the patients welcome pack, discharge planning (introduction of discharge coordinators) and the underutilization of outdoor space, which was rectified with plants and furniture.
- Members of the forum attended the Walkergate Park site group and were actively involved in the services provided at the site and wider trust issues.
- Opportunities for social activities for service users and their families had been established with the Headway Charity. This offered opportunities to develop relationships and social support networks with other individuals with a neurological condition and their families.
- The centre had an established Brain Injury Group which discussed issues such as psychotropic prescribing in a neurobehavioural unit, psychosis and brain injury and sleep monitoring.
- All wards had a community meeting on a weekly or fortnightly basis where views from patients were sought and ideas or concerns acted upon.
- Family meetings with relatives within the first couple of weeks of admission had been introduced on Ward 1 so that contact was made with the consultant and other members of the multi-disciplinary team early in their relative's admission rather than until the first team review at week six. For wards, 3 and 4 relatives were invited to the first ward round.
- A member of staff who had completed the Foundation in Family Therapy (FFT) had completed work to establish if they and clinical staff valued early meetings with families. The purpose of this was to establish the structure of the family, their own specific needs and how these were best supported.

Staff engagement

- The trust undertook a staff survey (2015) which led to action plans at both a trust level and at Specialist Care Group level.
- The results of the Staff Family and Friends Survey (2015, quarter 4) showed 89% of staff were extremely likely or likely to recommend the organization as a place to work.
- Further issues identified the evaluation of outcomes of the appraisal system, continuation of 'Speak Easy' and 'Conversations' forums, embedding of 'Freedom to Speak up' guardian' and champions as well as a co-ordinated campaign to address the issue of harassment/bullying/abuse not being reported. These included work around induction, training and the importance of communications.

- The trust had introduced a 'Positive and Safe Strategy' and local reviews to address issues of violence and aggression.
- Specialist Care Services scored worse than the average for the trust on a number of areas and had identified actions to address these. The group launched a strategy (December 2015) bringing together a range of previous action plans to put engagement with staff as a core theme throughout the priority areas:
  - Improved engagement and cultivating a culture of context and relevant information sharing to encourage openness and reporting and understand personal responsibility;
  - Monthly group engagement sessions;
  - Each service to own their own needs log;
  - Line managers to feedback to staff concerns raised through supervision and appraisal;
  - Group engagement in positive management behaviours.
- Staff said all senior managers were available to lead the service and provide advice and direction. Without exception, staff believed they provided a 'first class' service that met the needs of patients and resulted in improvements to individual's living circumstances. Staff told us they were 'inspired to work here'.

Innovation, improvement and sustainability

- Staff identified patients at risk of developing pressure sores using the 'Braden Score' and provided appropriate pressure relieving support surfaces such as mattresses and cushions.
- The service had adopted best practice in support of the provision of care and treatment, for example 'Reducing the risk of deep vein thrombosis (DVT) for patients in hospital', functional independence measure (FIM) and functional assessment measure (FAM) scores.
- A spasticity management clinic for individuals with spasticity following a neurological injury.
- Referral to the Acute Pain Service where appropriate.
- A 'Patient Rehabilitation Journey Booklet' had been developed and was used for each patient.
- The development of support through the Headway Charity, the Brain Injury Group and the Service User and Carer Forum.
- The group had developed the Social Therapeutic and Recreational Rehabilitation Team (STARRT) to promote independence and increase the quality of life of patients through taking part in social and leisure activities.
- Discharge co-ordinators had been appointed.
- The group was actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment such as:

- The audit of NICE Guidance on Urinary Continence Problems in Neurorehabilitation Inpatients;
- The use of the 'Modified Rivermead Mobility Index tool', an evaluation of current therapist to patient ratio and intensity of therapy intervention;
- The confidence of staff in formulation skills to support the use of psychological skills with neurorehabilitation and neurobehavioural rehabilitation;
- the numbers of patients who had endocrine function checked at the time of injury;
- A research project to determine whether the provision of education to paid carers improved their confidence in managing complex hands in neurological patients;
- The self-management of long term neurological conditions, speech and language therapy outcome measures.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Outstanding
Responsive	Outstanding
Well-led	Outstanding
Overall	Outstanding

Information about the service

Walkergate Park is a Neuro Rehabilitation and Neuro Psychiatry centre in Newcastle upon Tyne. The hospital is part of the Northumberland, Tyne and Wear NHS Foundation Trust. The centre provides care to people with a disability caused by injury or disease affecting the brain, spinal cord or muscles.

Outpatient clinics were run by consultants, allied health professionals or were nurse led. The service provided clinics at Walkergate Park Hospital and outreach clinics in Penrith, Durham and Sunderland. Outpatients provided clinics for continence, dystonia, medical and neuro-rehabilitation, sex and relationship clinic, multiple sclerosis, orthotics, splinting, hand hygiene, neuropsychiatry and spasticity.

The hospital did not provide diagnostic imaging services.

Between May 2015 and April 2016, there were 7154 outpatient attendances at Walkergate Park Hospital.

The trust also provided other services within the outpatients. These included the north east driving mobility services, community acquired brain injury services, Northumberland head injuries service , community multiple sclerosis team, regional communication aid service, regional disability team and the regional environmental control service.

We inspected the outpatients department at Walkergate Park Hospital, North East Drive Mobility Services, community acquired brain injury service, Northumberland head injuries service, regional communication aid service, regional disability team, regional environmental control service and the multiple sclerosis team.

During the inspection, we spoke with 34 members of staff. We spoke with 11 people who used the service and carers. We looked at 5 records during the inspection. We also reviewed performance information about this hospital.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated this service as outstanding. We found that outpatients for safe was good, with caring, responsive and well led rated as outstanding because:

- There was very effective and clear multidisciplinary team working throughout the services visited and staff could describe working with a number of different professionals and external services to enhance services and patient outcomes. There was excellent access to a number of additional services within Walkergate Park Hospital and staff could sign post patients and carers to other services if required.
- Patient feedback for the services visited was consistently positive, friends and family test results were positive and patients felt supported. Confidentiality, dignity and privacy was respected by staff. The service provided strong person centred care that met people's individual needs.
- Clinics and services were developed to meet individual needs of people. The services were responsive to the needs of patients and carers and involved patients and carers in the care being provided.
- Outpatients had introduced a number of outreach services in response to patient need. Outreach clinics were either nurse led, consultant led or led by allied health professionals.
- A number of services visited had close links with third sector organisations to develop the service they offered and help provide further support to patients and carers.
- A number of services provided vocational rehabilitation to patients to help them return to employment.
- Staff we spoke with could describe the values of the trust. There was a clear leadership structure in place and staff felt supported by management. Staff were positive about working in their services and were proud of the service they provided to patients. There was a culture of staff completing training and development opportunities.
- Staff used evidence based care and treatment using National Institute for Health and Care Excellence guidelines (NICE) and local and national guidelines were in use. There were care pathways in place in the services visited and patient risk assessments and goal setting was in place for patients.
- We found staff to be competent in their roles and a number of staff had completed further training and development. Staff could describe consent, the mental capacity act and deprivation of liberty standards.
- There was a commitment to supporting carers. Outpatients had a carer's charter in place. The services had been developed in response to patient need and developed to provide person centred care.
- Strong and effective governance processes were in place and management could describe how risks were escalated and managed. Risk registers were in place at the services visited which were proactively reviewed.
- The services visited had been involved in a number of innovative service developments.
- Staff we spoke with had a good understanding of how to report incidents and safeguarding concerns.
- All areas visited were visibly clean and tidy. Staff had access to personal protective equipment and hand gel dispensers were available in areas visited.
- Medicines were securely stored. Patient group directions were in place and signed. Records were found to be managed securely. Staffing levels were good and in line with trust planned levels in the services visited.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe in outpatients as good because:

- Staff we spoke with were aware of how to report incidents and safeguarding concerns.
- All areas visited were visibly clean and tidy. Staff had access to personal protective equipment and hand gel dispensers were available in areas visited.
- The environment was suitable for the services offered. Equipment we checked had been portable safety tested.
- Medicines were securely stored. Patient group directions were in place and signed.
- Records were managed securely.
- A resuscitation trolley was available in outpatients and had been checked daily.
- Care pathways were in place for the services visited.
- Staffing levels in services visited were in line with the planned staffing levels.

Incidents

- The trust used an electronic incident reporting system. Staff we spoke with understood how to report incidents and training about how to use the system had been cascaded to staff. Staff were aware of what type of occurrence would require an incident report to be completed.
- Incident reports were automatically sent to the manager of the service involved where they would investigate the cause of the incident and close the online form once a section on action taken to prevent the occurrence happening again was completed.
- Management told us learning from incidents was cascaded to staff through team meetings.
- The strategic executive information system (STEIS) allows trusts to report serious incidents that have occurred. The hospital was required to report serious incidents to STEIS. These included 'never events'. Never events are serious patient safety incidents that are wholly preventable. The trust reported 94 serious incidents between 1st January 2015 and 31st December 2015. One of these incidents related to Acute Outpatient services.
- The outpatient department had no never events between 1st January 2015 and 31st December 2015.
- In the period 1st January 2015 to 31st December 2015, the trust reported 149 serious incidents through its' SIRI (serious incidents requiring investigation) reporting system. Of these, one related to acute outpatient services.
- The duty of candour was introduced as a legal requirement for National Health Service (NHS) trusts in November 2014. It is about trusts informing and apologising to patients if they have made a mistake in their care, which led to a moderate or significant harm to the patient.
- The trust had a duty of candour policy in place and in date. Staff were able to access this policy whilst using the electronic reporting system.
- Staff we spoke with understood duty of candour and management were able to provide examples of where duty of candour had been applied. Staff we spoke with could describe being open, honest and apologising to patients if an incident had occurred. Management could provide example documentation of where duty of candour had been implemented after an incident and in response to a complaint.

Cleanliness, infection control and hygiene

- Within outpatients and other areas we visited, all areas were visibly clean and tidy.
- Staff were able to access an infection prevention link nurse within outpatients and had access to a hospital infection prevention and control nurse when further information was required.
- Staff adhered to the bare below the elbow policy.
- Hand gel dispensers were available for use within the department. Sinks with hand washing facilities were available in each clinic room in outpatients.
- Domestic services were provided by in house cleaning services and were available 7 days a week.
- An infection prevention and control policy was in place and in date.
- A hand hygiene and the use of gloves policy was in place and in date. Hand washing technique posters were also visible.
- A patient led assessment of the care environment (PLACE) audit is a system for assessing the quality of the patient environment.

Outpatients and diagnostic imaging

- A PLACE audit had been completed which showed mostly positive results. An action plan had been developed in June 2016 to address any outstanding actions on the audit.
- An infection, prevention and control audit had been completed in 2016 in neuro-rehabilitation outpatients, we viewed this audit and all sections were green and compliant.
- Management had access to an environmental assurance system, which allowed them to check if legionella checks had been completed weekly.
- Staff had access to personal protective equipment (PPE) such as aprons and gloves and could describe when they would use PPE.
- A hand hygiene clinic was in place located at neuro-rehabilitation outpatients to assist patients in hand hygiene management. This clinic was developed from a piece of work on caring hands in neuro-rehabilitation outpatients.

Environment and equipment

- The environment was calm, clean, tidy, and suitable for the services offered.
- Access to the departments within Walkergate Park Hospital was via stairs or lift access. The reception area in outpatients was spacious and had adequate seating. Reception was clearly identified and staff were welcoming.
- The Neuropsychiatry outpatients department was clean, tidy with adequate seating available.
- A clean utility room held medicines, medical gases and other equipment for use in the neuro rehab department. This was locked and keys held by a staff member.
- There were seven clinic rooms in neuro-rehabilitation outpatients and five of these had access to a hoist. A manual hoist was available for the other two clinics rooms. Each clinic room had a refrigerator to store medicines during clinics.
- A resuscitation trolley was available in the neuro-rehabilitation outpatients department. The equipment on the resuscitation trolley had been checked daily and daily check logs were signed and up to date. The trolley was clearly identified in an area of outpatients. Neuropsychiatry outpatients would use this resuscitation trolley if required. Neuropsychiatry outpatients and neuro rehabilitation outpatients were located side by side with double doors separating them.
- A COSHH file was in place, which included safety data sheets for products held within the department. Staff would update this as and when required.
- A PLACE audit had been completed and results were positive for the environment of neuro rehabilitation outpatients. An action plan was in place and actions had been mostly completed.
- All equipment checked had been portable appliance tested (PAT).
- Staff told us they had suitable equipment for patients and we saw equipment stores, which were organised, and equipment securely stored if required.

Medicines

- Patient Group Directions (PGD) are written instructions that permit the supply or administration of medicines to patients.
- PGDs were in place and were signed and in date. We checked a PGD and this had been authorised by senior members of staff within the trust and the staff members using the PGD had signed the document. Each staff member had access to the required PGD for reference.
- Safe and secure medicines handling and supply policy was in place and in date. A controlled drugs policy was also in place and in date.
- Medicines we checked were in date and stored securely. Medical gases in outpatients were stored securely and in a locked room, which only staff had access to. Medicines cupboard keys were held during the day by a registered nurse and were locked in a neighbouring ward overnight for security.
- A medical gas safety data sheet was stored close to the medical gases.
- Refrigerator temperature checks were in place and temperatures were checked daily. A stock control log was in place to check for expiry checking of medicines.
- Management had access to an environmental assurance system, which allowed them to check if expiry dates on medicines had been checked.
- Risk assessments had been completed for use of medicines within the neuro-rehabilitation department where required.
- Outpatient's staff told us they had access to pharmacy advice via telephone and a weekly visit from pharmacy to the department.

Records

Outpatients and diagnostic imaging

- A management of records policy was in place and in date.
- Patient records were a mixture of electronic and paper records. Patient records stored on the electronic system were password protected. Some clinics used paper records during the clinic as the electronic system did not allow for certain assessments to be recorded, staff then transcribed and scanned these notes onto the electronic system once the clinic had finished.
- We checked five records during our inspection and found them to be appropriately completed.
- A medical record store was available within the outpatients department and this was locked and secure.
- Records were stored centrally on an electronic record system and staff had access to these via computer in the clinics or laptops during outreach clinics. Where notes were required for outreach clinics, staff would store these in a locked bag to transport them to the outreach service.
- All standard operating procedures viewed were found to be in date. Procedures were in place for a number of processes, for example, a patient's journey and setting up a clinic room refrigerator.
- There was no current process for record audits.

Safeguarding

- Safeguarding adults and safeguarding children policies were in place and in date.
- Staff we spoke with were aware of how to report safeguarding concerns. A trust safeguarding team was available for advice when required.
- Staff were able to describe the types of concerns where they would contact safeguarding for further advice. Staff told us they had received feedback for safeguarding concerns.
- Safeguarding children training and safeguarding children training level 2 was overall 98% compliance. All services were 100% compliant except the complex neurodevelopment disorders service, which was at 81% compliance, and the neuropsychiatry community service, which was at 99%.
- Information provided by the trust highlighted that only the complex neurodevelopment disorders service completed safeguarding level 3 training. The service had a 44% compliance rate.
- Safeguarding adults training compliance was 99% overall. The trust target was 85%.

Mandatory training

- The training compliance for Acute Outpatients was 88%. This figure included all outpatient services and all mandatory training courses. The trust target was 85%.
- All services met the 85% mandatory training target except the complex neurodevelopment disorders service, which was at 78% compliance, and the regional communication aid service, which was at 76% compliance.
- Neuropsychiatry Community achieved the highest compliance score of 97%. The Regional Communication Aid Service had the lowest aggregated rate of training of 76%.
- Five mandatory courses achieved the highest completion rate with 99% each, this included Equality & Diversity, Health & Safety, Infection Prevention & Control - Inoculation Incidents – Hand Hygiene, Records and record Keeping and Safeguarding Adults.
- Dual Diagnosis training had the lowest aggregate training score with 41%, seven of the eight services failed to reach the 75% benchmark for dual diagnosis training with the Regional Communication Aid Service scoring the lowest for this course with 11%. Some areas within outpatients told us they were not required to complete the dual diagnosis training; therefore, the training completion rates were low.

Assessing and responding to patient risk

- A resuscitation policy was in place and up to date. A resuscitation trolley was available in neuro rehabilitation outpatients.
- Staff told us they would call 999 if a patient deteriorated in their care.
- Staff could describe the criteria for patients who could be referred to neuro-psychiatry and neuro-rehabilitation clinics.
- The teams within outpatients were multi-disciplinary and were able to seek advice from other healthcare professionals in response to patient needs and risk. For example, Staff could receive input and guidance from physiotherapy, occupational therapy and nursing staff along with access to psychology services. Staff told us because of the integrated team approach, access to this advice was quick and referral to these internal services was efficient.

Outpatients and diagnostic imaging

- The electronic patient record system allowed staff to complete narrative risk assessments, for example care stability reviews and orthotic reviews.
- Staff in neuro-rehabilitation carried out narrative risk assessments through the electronic patient's record system. We reviewed narrative risk assessments and found that they had been completed appropriately.

Nursing and allied health professional staffing

- There was a fixed requirement for staffing in neuro-rehabilitation outpatients. The fixed staffing level required was seven staff, which included registered nurse, assistant practitioners and allied health professionals.
- Rotas were completed weekly and staff allocated to the relevant clinic. Clinics were nurse led or consultant led. The hand hygiene clinic was assistant practitioner led. Allied health professionals ran clinics for neuro-rehabilitation in outpatients. There were no vacancies in neuro-rehabilitation outpatients.
- Staffing levels at the services visited were fixed staffing levels; there was no formal acuity tool to establish staffing levels in the services.
- Actual staffing levels in most services visited were mostly in line with the planned staffing level. Some services had vacancies, for example the community; multiple sclerosis team had four vacancies. Senior managers told us they had set up a stall at a local shopping centre to highlight the opportunities available at the trust to assist with recruitment to the services. The type of clinic being run determined skill mix within outpatients. Many staff were competent in different specialities within outpatients, for example some specialist nurses ran dystonia clinics but were also able to work in the continence clinic.
- The Community Multiple Sclerosis Team had 100% qualified nurse vacancy rates, although the team only had a 0.6 WTE qualified nurse establishment.
- Information provided by the trust highlighted that the north east drive mobility service, the regional communication aid service, the regional environmental control service and the regional disability service had no vacancies during our inspection.
- The north east drive mobility service had the highest number of staff leavers in the last 12 months with 20.62%, it is one of four services above the trust average of 7.9%. This service also had the highest sickness rate of 8.94%, which is also above the trust average of 5.51%.
- The Regional Communication Aid Service had the highest vacancy rate in the last 12 months with 25.54%, it is one of four services above the trust average of 2.76%. The service had the highest sick rate with 6.36%, which is above the trust average of 5.40%.
- No shifts were covered by bank and agency staff for any of the teams.

Medical staffing

- There was consultant on-call for out of hours cover in psychiatry services between 5pm and 9am daily.
- Medical staffing data for neuropsychiatry showed that the planned whole time equivalent was 1.04 and the actual whole time equivalent was 1.04.
- Medical staffing data for the outpatient and community rehabilitation clinic showed that the planned whole time equivalent was 2.93 and the actual whole time equivalent was 3.07.
- Bank, agency and locum medical staffing were not used in outpatients.

Major incident awareness and training

- A Walkergate Park Hospital resilience plan was in place. This covered a number of incidents, for example flooding, loss of electricity and loss of staff.
- Staff told us that during adverse weather they would receive e-mail updates, for example during a heatwave.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We are unable to provide a rating for effective in outpatients, however we found that:

- Staff used evidence based treatment and guidelines including National Institute for Health and Care Excellence (NICE), local and national guidelines.
- The services visited had care pathways in place and could sign post patients and carers to other services.
- There was further information available to patients about their care and some clinics had information packs they could provide to patients.
- Staff could describe how they worked with patients to set goals.

- Staff were competent in their areas and a number of staff had completed further training and development.
- Multidisciplinary team working was embedded in the services visited. Staff had access to alternative services for advice if required.
- Staff we spoke with were aware of consent, the Mental Capacity Act and the deprivation of liberty standards.

Evidence-based care and treatment

- Staff we spoke with were able to describe the guidelines and policies they worked with and were applicable to their practice. For example staff could describe working to the multiple sclerosis NICE guidelines and NICE guidelines on spasticity management.
- Staff had access to procedures and policies. These were in date and available in paper format in the departments. There was no electronic access to procedures in outpatients.
- Patient risk assessments were in place, for example, the Northumberland Head Injuries Service used a referral risk assessment. The service had in place initial assessments, which included a section on consent. Internal referral forms were also in use.
- Care pathways were in place for the different services offered. Pathways documented included the regional communication aid service, spasticity integrated care pathways and continence pathways.
- Audits had been carried out in the outpatients departments and services visited, for example outpatients had completed an infection, prevention and control audit.
- Patients were provided with additional information during their treatment in a number of services we visited. The multiple sclerosis team provided further information from the multiple sclerosis society and the dystonia team provided information from the dystonia society.

Pain relief

- Pain relief medication was not kept in outpatients. Staff had access to pain assessment forms and a pain assessment visual guide; however, patients who required pain relief would be referred to other relevant services such as their GP.

Patient outcomes

- The trust used an anxiety and depression scale tool and a fall assessment tool.
- Staff told us patient goals were regularly reviewed in clinics using methods such as reviewing satisfaction forms completed by patients. Staff told us they empowered patients to set their goals and the teams in outpatients worked with them to achieve their goals.
- Staff in outpatients told us they would use goal attainment scaling to assess patient outcomes. Patients kept these and completed them as required; patients and staff then reviewed the document during appointments.
- The multiple sclerosis service provided a holistic model of care that was self-managed using goal based interventions. The Multiple sclerosis team and regional disability team used an outcome measure for people with long term conditions which was self-rated by patients.
- The regional environmental control service measured therapy outcomes, which considered a number of factors such as activity prior to assessment and activity following intervention. Therapy Outcome Measure Data from April 2015 to March 2016 showed that there was an increase in activity following intervention by the service against activity prior to assessment.
- The North East Drive Mobility Services measured patient outcomes through assessment outcomes.

Competent staff

- All staff were required to undertake a corporate induction. An induction policy was in place and in date along with an induction checklist that was completed by each staff member. The outpatient department had an induction process and arrangement policy in place for bank nurses.
- A new induction competency pack had been developed. We checked one of these and it was in the process of being completed and signed off. Not all staff had a completed the induction competency packs because it had been developed recently.
- Staff told us they had yearly appraisals and these enabled them to discuss training opportunities and their aims for the next year.
- Appraisal rates for non-medical staff in the outpatient department (correct as at April 2016) showed a total completion rate of 95%.
- Appraisal rates for medical staff in the outpatient department (correct as at April 2016) showed a total completion rate of 100%.

Outpatients and diagnostic imaging

- A number of staff had accessed further training and development within outpatients. Staff told us training offered was good and if training was relevant to their practice, they were generally able to attend it.
- Some staff had completed foundation degrees, attended external training opportunities and been able to implement this development into their practice. Staff had access to a trust leadership course.
- The department had developed a core rehabilitation skills self-assessment tool (CoRSSAT) to highlight the basic skills and knowledge that staff working clinically with patients with neurological conditions had to know.
- Administrative staff completed basic life support training and clinical staff completed intermediate life support training.
- The occupational therapy service within outpatients had developed a new short course in conjunction with a local university and offered the course to a number of healthcare professionals.
- Staff told us they had regular clinical supervision. Clinical supervision was bi-monthly in dystonia and spasticity clinics and a rota was in place for clinical supervision. Clinical supervision records for each speciality within neurorehabilitation outpatients showed that staff had regular clinical supervision and once a year were signed off as competent by the relevant consultant.
- Clinical supervision rates varied between the services, the lowest rate of clinical supervision was the North East Drive Mobility service with 71%. The overall clinical supervision rate was 86% between May 2015 and April 2016.
- Staff at the North East Driving Mobility service had completed further training to assist them in the services they provide. For example, some staff were driving advisors.
- Link nurses were available in neuro-rehabilitation outpatients, for example, there was an infection, prevention and control link nurse, carers champion and tissue viability link nurse.

Multidisciplinary working

- There was clear multidisciplinary team working in outpatients and other services visited. Some clinic appointments consisted of allied health professionals, nursing staff and doctors if required and staff could describe working with a number of teams to improve patient care.
- Staff in outpatients had access to dietician services and psychology services and we were told these were accessible and responsive.
- Orthotic clinics were held with a physiotherapist, an Orthotist and a podiatrist to ensure a multidisciplinary approach.
- Patients attending for their first appointment in neuro-rehabilitation outpatients were seen by a team consisting of a physiotherapist, occupational therapist and doctor.
- The Northumberland head injury service provided a multidisciplinary team approach. The service had access to physiotherapists, occupational therapists, speech and language therapists, clinical psychology, rehabilitation consultants and rehabilitation assistants. Staff told us the team was focused on a holistic approach. The head injury service had links with a number of brain injury charities.
- The community acquired brain injury service worked alongside the stroke service.
- The neuropsychiatry community team included consultants, mental health nurses, Huntington's disease specialist liaison nurse, neuropsychologists and support workers.
- The North East Drive Mobility Service had worked with the Driver and Vehicle Licensing Agency to implement their services. The service had worked with a local police force to assess older people's fitness to drive as part of a new initiative.
- The North East Driving Mobility service would carry out joint assessments including a driving advisor and a driving clinician if required.
- Some of the teams in outpatients had close links with the relevant societies and charities, for example the multiple sclerosis team had worked closely with the multiple sclerosis society.
- Staff were able to describe working with other services in the hospital. Staff told us they could refer patients to the relevant ward if required and wards were able to refer patients into the outpatient's teams.

Seven-day services

- Walkergate Park Hospital outpatients operated Monday and Friday between 08:30 and 17:30. Outreach clinics were provided at a number of locations between Monday and Friday.

Access to information

Outpatients and diagnostic imaging

- Referral criteria and processes were in place. The community acquired brain injury services had a single point of referral. If the referral was not appropriate, the service would signpost patients to other agencies.
- Outpatient staff had access to patient records through a mixture of electronic records and in some clinics, paper copies. Patient risk assessments were held in either paper format or on the electronic patient record system.
- Management could access online logs to check if medication expiry checks had been completed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A Mental Capacity Act 2005 policy was in place and in date. The trust had Mental Capacity Act assessment forms in place and a record of actions taken to make a best interest decision form.
- As at May 2016, Acute Outpatients scored 83% overall compliance for the number of staff who had received training in the Mental Health Act (1983).
- North East Drive Mobility scored 61% compliance for staff training in the Mental Health Act (1983). The Community multiple sclerosis team scored 59% for overall compliance.
- As at March 2016, acute outpatients scored 87% for Mental Capacity Act training.
- Staff we spoke with were aware of the Mental Capacity Act and deprivation of liberty standards.
- Staff were able to describe when they would get consent and where this was documented.

Are outpatient and diagnostic imaging services caring?

Outstanding ☆

We rated caring for outpatients as outstanding because:

- The service had a very person centred focus and all staff provided person centred care with patients and carers involved in their care. There was a commitment to supporting patients and carers and a focus on patient centred care from staff in all areas visited. Staff would sign post patients and carers to alternative services if required. A carer's charter was in place.
- There was a clear commitment to carers and the trust had developed a carer's charter to highlight how they would involve carers and provide further information to carers. Outpatients had carried out carer's surveys to seek the views of carers. Feedback from this survey was positive.
- Patients felt supported and staff provided compassionate care. Confidentiality and dignity was respected by staff.
- Friends and family test information and other patient satisfaction surveys completed by the service was extremely positive. Positive patient feedback was consistent in the areas visited.
- Patient goals were discussed with patients and staff discussed treatment and rehabilitation with patients. Staff worked in partnership with people who used services and empowered patients to work with staff to set their goals.
- Staff could request input from psychology and counselling services for patients in outpatients. Emotional and social support needs were taken into account by staff
- Staff took into account social and religious needs when delivering services to patients.

Compassionate care

- Patients told us that staff were caring and compassionate. Patients we spoke with were consistently positive about the services provided and told us that staff were supportive and they were treated as individuals in their care.
- A neuro-rehabilitation outpatient carer survey highlighted that 96% of respondents stated 'yes all the time' to highlight the person they cared for was treated with dignity and respect while they were in the outpatients department. The survey had a 93% response rate.
- A neuro outpatient survey in April 2016 for people who used the service and carers asked the question 'were we respectful in our approach to you?' There were 16 respondents to the survey and 100% agreed.
- The Northumberland head injury service had carried out a satisfaction questionnaire in October 2015. One hundred percent of patients felt listened to and staff understood their concerns. The response rate was 38.7%.
- The North East Drive Mobility service used 'Points of You' cards to gather feedback from service users.

Outpatients and diagnostic imaging

Between January 2016 and March 2016, 100% of people who used the service who responded felt they were listened to. There were 25 respondents in the January 2016 to March 2016 'Points of You' cards.

- The trust undertook a friends and family test in quarter 2 of 2015. The neurology rehabilitation and neuropsychiatry services were part of the specialist care directorate. Seventy-four percent of people were likely to recommend the services in the specialist care group.
- Reception staff were able to speak with patients and carers without being overheard thus preserving patient dignity and confidentiality.
- Posters for chaperone assistance were displayed in areas of outpatients and staff told us they were able to provide a chaperone if patients requested it.
- Neuro-rehabilitation clinics would offer longer appointment times if patients required further support.
- Confidentiality, privacy and dignity was respected by staff. Staff spoke with patients in clinic rooms and told us they would close blinds if required and use the curtains provided in each clinic room to ensure confidentiality is maintained.
- Staff took into account social and religious needs when delivering services to patients.

Understanding and involvement of patients and those close to them

- Friends and family test data was positive. In February 2016, Neuropsychiatry outpatient's friends and family test data showed that 38 patients were extremely likely to recommend the service, four patients were likely to recommend the service and 1 stated neither. In March 2016, nine patients were extremely likely to recommend the service and one was likely to recommend the service.
- Neuro-rehabilitation carried out regular goal reviews of patients and patients were able to use a patient satisfaction score sheet to allow therapists, nurses and medical staff to assess the changes in the patient's condition. These were reviewed at each clinic. Staff in neuro-rehabilitation told us that patients set their own goals and the team within outpatients worked with that patient to achieve the goals set.
- Staff could describe how they would communicate with patients to ensure they understood their care and treatment. Staff would respond to the individual requirements of the patients, for example by checking they understood what had been said and providing time for patients to ask questions. First appointments were an hour long and provided time for patients and carers to ask questions.
- Patients and carers had access to information packs when attending outpatients, for example a multiple sclerosis treatment pack or dystonia pack.
- A carers charter board was located in outpatients and had information about the patient advice and liaison service (PALS) and useful contacts for carers.
- Staff told us they would discuss the condition being treated with patients; discuss the options available and patient goals. Staff in neuro-rehabilitation outpatients told us they reviewed goal setting at each appointment and provided patients with a goal attainment scaling document to complete. Patients and staff at appointments reviewed the goal attainment scaling documents jointly.
- In August 2015, outpatients carried out a carer experience and satisfaction survey. The survey had a 93% response rate. The survey considered a number of questions, for example 96% of respondents felt involved in the consultation, 93% of respondents stated 'yes definitely' that they had enough time to discuss the health or medical problems for the person they care for and 85% of carers responded that within the consultation their needs as a carer were addressed.
- The North East Drive Mobility service used 'Points of You' cards showed that between January 2016 and March 2016, 100% of service users felt involved in the assessment process. There were 25 respondents in the January 2016 to March 2016 'Points of You' cards.

Emotional support

- A carer's charter had been developed at the trust and outpatients had information for carers displayed throughout the seating areas and reception areas. The charter detailed how the trust would work in partnership with carers and provide support and help.
- The multiple sclerosis service and dystonia service provided information packs on the condition to patients. These information packs included information on societies and charities where further information could be sought.

Outpatients and diagnostic imaging

- Outpatients had access to trust psychology and counselling services if required. Staff were able to seek psychology assistance for patients and carers from Walkergate Park Hospital. Staff were able to discuss examples where they may seek psychologist assistance.
- Clinical nurse specialists were available in some specialities offered in outpatients, for example, there were clinical nurse specialists within the multiple sclerosis team and dystonia teams.
- Staff could discuss examples where they had provided further support to people who use the services, for example, the north east drive mobility service arranged for people who use the service to visit a national racing track and the head injury service had provided additional multidisciplinary support to other services when requested.
- The Northumberland head injury service had carried out a satisfaction questionnaire in October 2015. 92.% of patients felt involved in setting their goals. The response rate was 38.7%.
- We spoke with patients during our inspection and feedback was consistently positive.

Are outpatient and diagnostic imaging services responsive?

Outstanding ☆

We rated responsive for outpatients as outstanding because:

- Clinics and services were developed and planned to meet the needs of patients and the local population. Services took into account the needs of patients and carers and were flexible to meet these needs.
- Nurse led clinics had been implemented in some clinics to enhance the services and allowed people to access services in a way and time that suits them. The service had introduced new clinics or enhanced services where there was demand. Outreach clinics had been implemented in some areas to provide additional services. The service also offered some home visits to patients who were physically unable to attend outpatient clinics.
- Neuro-rehabilitation and neuropsychiatry outpatients were achieving the 18 week referral to treatment indicators.
- Management had implemented changes such as text reminder services to address did not attend (DNA) rates.
- Services visited had engaged and worked with a number of third sector organisations and agencies in order to develop their services or offer further information patients and carers. The services visited had close links with a number of charities.
- A number of services provided vocational rehabilitation to patients to help them return to employment.
- Interpreter and sign language services were available if required.
- The number of complaints was low in the services visited. When a complaint occurred these were managed, responded to in a timely way and improvements made if required.

Service planning and delivery to meet the needs of local people

- Many clinics in outpatients were multidisciplinary and different services worked together to provide care to patients.
- The service provided a number of outreach clinics. These had been developed in response to patient need and were provided in Durham, Penrith and Sunderland. Staff from Walkergate outpatients would run these clinics and when an annual review was required for patients, a consultant would attend. Staff were able to provide clinics at Walkergate Park Hospital, the outreach clinics if appropriate for the patients and in certain circumstances would attend home visits if required.
- Outreach clinics for outpatients were provided for dystonia.
- A number of services visited had worked and engaged with third sector organisations to help provide further support to patients and carers. This further support often included providing patients and carers with information on relevant charities and services where they could get further support or information.
- Neuro-rehabilitation outpatients had identified that there was a lack of support for patients in the care of their hands. This had led to a piece of research and multidisciplinary work between staff in outpatients called 'caring hands'. The research project considered hand hygiene and education provision to paid care staff involved in the care of patients with a neurological diagnosis. As part of the project, staff provided education sessions to care staff and patients. The trust

had provided two more specific training sessions to home care managers and care staff in Newcastle and were planning on developing the education programme further.
- The caring hands research work had led to a hand hygiene clinic being developed within outpatients. This clinic ran weekly.
- The North East Drive Mobility service helped people retain or regain independence as drivers and passengers. The service provided independent assessment and advice to people with a medical condition, or disability, which may affect their ability to drive or use a vehicle as a passenger. The service provided services such as advice on vehicle adaptations and specialist driving tuition.
- The North East Drive Mobility service offered an outreach service in Penrith to allow people who use the service to access the service closer to home if appropriate.
- An area of Walkergate Park Hospital car park had been specifically designed to provide the north east drive mobility service. The service included mobility clinicians who were occupational therapists or physiotherapists and driving advisors who were qualified driving instructors. The service had access to 14 vehicles, a garage and a driving track on site.
- Orthotic clinics had been increased due to an increased demand for the services.
- The Northumberland Head Injury Service had developed a dizziness assessment document to improve services to patients with vestibular disorders related to their neurological condition. The service had developed education groups for new referrals. The service was in the process of planning further education sessions.
- The Neuropsychiatry community team had implemented nurse led clinics within their service. Information provided by the trust highlighted that these clinics are still being evaluated and improved and are seeking the views of patients as part of this.
- In May 2016, the neuropsychiatry service had visited another provider to share best practice and benchmark services. The benchmarking and sharing best practice considered how services were organised, staffing levels and policies and procedures.
- Ambulance transfers were available for patients if required.

Access and flow

- Between May 2015 and April 2016, 100% of patients were seen within 18 weeks for the Neuropsychiatry Community service.
- Between May 2015 and April 2016, 100% of patients were seen within 18 weeks for the Community Multiple Sclerosis Team except for June, July and August 2015 and February 2016 where the lowest figure was 89%.
- Between May 2015 and April 2016, 18 week indicator varied for the Northumberland Head Injuries Service. The lowest percentage for the 18 week indicator was 25% in October 2015, however the trust achieved 100% of patients seen within 18 weeks between February 2016 and April 2016.
- Between May 2015 and April 2016, the trust were at 100% for the patients being seen within 18 weeks for the Outpatient and Community Rehabilitation Clinic.
- Between May 2015 and April 2016, the Regional Environmental Control Service, the Regional Communication Aid Service and the Regional Disability Team were 80% or above for patients seen within 18 weeks.
- Between May 2015 and April 2016, the trust were at 100% for the percentage of patients provided with loan equipment within 18 weeks of referral.
- Management told us there were no current concerns with appointment waiting times or follow up times.
- Audits for length of time people wait in outpatients had not been completed, however staff told us patient generally were seen on time and no longer than 20 minutes after arrival to the department. If clinics were running late, staff would speak with the patient and apologise for the delay. Delays to clinics were highlighted on an electronic information board at reception.
- Did not attend (DNA) rates were at 8% during the inspection. Management told us they had implemented a text reminder service in the last 18 months, reminder letters and highlight within outpatients the cost of did not attend appointment cancellations in neuro-rehabilitation outpatients to address the DNA rate. Management told us the DNA rate was on the improvement plan and this plan was reviewed monthly.
- Clinics were run on set days each week; patients were able to choose the time of their appointment at reception.

Outpatients and diagnostic imaging

- Staff told us they would try to offer dual appointments, both on the same day to patients if they were required to attend different speciality clinics.
- Staff told us they would decide on the length of time before a next appointment according the needs of the patient.
- The Northumberland head injury service had carried out a satisfaction questionnaire in October 2015. One hundred percent of patients were offered a flexible choice of appointments. The response rate was 38.7%.
- In April 2016, there were 225 cancellations in neuro-rehabilitation outpatients and in May 2016, there were 150 cancellations in neuro-rehabilitation outpatients. These cancellations were a mixture of client cancellations and clinician cancellation. The multiple sclerosis team had a clear referral process in place. This process included a pathway, which assessed what services the patient required and determined whether a referral was accepted or it was accepted with a triage. A community multiple sclerosis team (CMST) referral patient prioritisation document was in place.
- The Northumberland Head Injury Service had a referral pathway in place, which included a telephone risk assessment.
- The Northumberland Head Injury Service had introduced a new mild traumatic brain injury pathway.
- The community acquired brain injury service had implemented a duty protocol to ensure that referrals were triaged by a senior clinician when received. This triage was in place to ensure an appropriately timed response to the patient was in place.

Meeting people's individual needs

- Outpatients had a clear commitment to understanding the needs of patients and those close to them. They were able to provide a variety of information and guidance to patients and carers. Staff were able to provide examples where they had assisted carers in finding further support and sought support from Walkergate Park Hospital for carers if required.
- Management told us they would adjust patient's appointment times according to the individual requirements of the person. For example, Staff would provide longer appointments if the acuity of the person was high or dependant on the social circumstances of the person.
- Staff told us interpreting services were available if required. They would try to pre-book these services if they were aware a patient was attending who may require interpreter assistance.
- Staff told us they would refer patients to an alternative service if it were identified during their treatment that additional support would help. Staff told us they were able to signpost patients and carers to a number of services if required.
- The North East Drive Mobility service offered specialist driving tuition to people who use the service who may need further support. People who use the service were able to use the centres' adapted vehicles to support this tuition. The service told us they were in the process of working with local police to develop and offer additional services.
- The North East Drive Mobility service offered complex driving solutions, which involved high tech driving assessments in a specially constructed vehicle to assess people with a high level of physical disability. The service was involved in partnership working with a local university to support a framework for professionals working in the field of driving and dementia.
- A number of services provided vocational rehabilitation to patients to help them return to employment. These services included the community acquired brain injury services.
- The hand hygiene clinic provided care to patients with hand hygiene management.
- The regional communication aid service had implemented communication technology to support patients in their service.
- There were seven clinic rooms in neuro-rehabilitation outpatients. Five had hoists integrated in the room and there was a manual hoist available for the other two rooms. Clinic rooms were available for staff to speak with patients to ensure confidentiality.
- Neuro-rehabilitation outpatient staff told us that first appointments were always an hour long and follow up appointments were 30 minutes. The head injury service offered initial one and half hour comprehensive assessments.
- In neuro-rehabilitation and neuropsychiatry outpatient reception areas, there was adequate seating areas, a television and a number of information leaflets and boards for patients.

Outpatients and diagnostic imaging

- The community acquired brain injury service had implemented nurse and psychology led mild head injury clinics in Gateshead and Sunderland.
- The regional communication aid service had implemented technology to assist people using the service with communication and provided communication aid or speech aid if required.
- The regional disability team and multiple sclerosis team had worked with employers to provide assistance in the education and management of conditions. Staff told us this helped increase the well-being of people.
- The regional environmental control service assisted people with physical disability to operate equipment or appliances in their desired environment.
- A hearing loop was available in outpatients reception, staff told us they were awaiting a sign to be attached to make patients aware of the hearing loop.
- Information leaflets were available to provide further information for carers, for example useful contacts for carer's information leaflet and a checklist for carers information leaflet was available.
- The outpatient environment was appropriate for the services being delivered. There was adequate seating in the waiting areas with magazines and information available to patients. There was a water dispenser available in neuro-rehabilitation outpatients. Wheelchair accessible toilets were available in the outpatient areas. The departments at Walkergate Park Hospital were clearly sign posted and a reception desk was available at the reception of the hospital and within departments.
- A television was present in the seating area along with a number of patient and carer information leaflets and advice posters.
- Beverage bays were available for staff to make drinks.
- The brain injury service had access to a gym, treatment rooms and medical treatment rooms.
- A multi-faith room was available at Walkergate Park Hospital.

Learning from complaints and concerns

- The trust had a comments, compliments and complaints process in place.
- The service received five complaints with one complaint either fully or partially upheld during the last 12 months (1 November 2015 – 30 April 2016).
- Three complaints related to an adverse drug reaction, one complaint related to dispute over diagnosis and one complaint related to neglect. This complaint was partially upheld.
- Learning from complaints was included in the follow up action on complaints document used by the trust.
- The North East Drive Mobility service had not received any formal complaints for the last three years.
- The head injury service had not received any formal complaints in the last 12 months.
- Management provided an example of where they had responded to a complaint and implemented the duty of candour arrangements within this complaint.
- Patient advice and liaison service (PALS) information was available for patients in the waiting areas of outpatients. This information provided information on how to complain about services.

Are outpatient and diagnostic imaging services well-led?

Outstanding ☆

We rated well led in outpatients as outstanding because:

- The individual services had engaged with the public and staff and sought feedback from patients, carers and staff. The service sought patient feedback in different services in a number of different ways such as patient surveys and feedback cards. Walkergate Park had an active service user's forum and engaged with the public in different ways.
- A new approach to staff engagement had been implemented in 2015 called 'Speak Easy' events which provided a way for staff to meet with senior managers and discuss what is going well and where there were challenges.
- The service had implemented a number of innovative services and developed these to meet patient's needs. Staff had been involved in innovative work and contributed to developing and improving services.
- The trust had a clear vision and set of values in place and staff we spoke with could describe the values of the trust. Senior managers were able to describe the challenges of the services, actions taken to address challenges and their aim of maintaining a service, which provides the best care to patients.

Outpatients and diagnostic imaging

- There was strong governance processes in place and management could describe how risks were escalated when required. Risk registers were in place for the individual services visited and were reviewed regularly.
- Management had access to quality data, which allowed them to review DNA rates and cancellation rates.
- There was a clear leadership structure in place and roles and responsibilities were clear at the services visited.
- Staff feedback regarding management and leadership was positive and staff felt supported by management. Staff told us managers were visible and approachable.
- Staff were positive about working in their areas and were proud of the services provided. Staff satisfaction was high.
- There was a culture of enhancing training and development opportunities for staff and enhancing services offered to patients.

Vision and strategy for this service

- The trusts vision and values highlighted the trusts aim to provide the best care and deliver the best services to patients. We met with senior managers who described the group strategy, which was to maintain the centre as a service, which provided the best care to patients.
- The strategy for the service was integrated into the specialist care group strategy. Management could describe the challenges faced by the group and the actions taken to address the challenges.
- Staff we spoke with were able to articulate the values of the trust and staff demonstrated the trust values during our inspection.
- Management and staff in outpatients and other services we visited could describe ideas for future plans to develop the services offered. Management told us their aim was to be the provider of choice in the North East.
- The North East Drive Mobility service had service transformation plans in place to enhance the service they offered, for example to reduce waiting times by achieving higher assessment numbers and improved productivity.
- A nursing strategy was displayed in outpatient's areas.

Governance, risk management and quality measurement

- The trust operated an integrated governance model with four assurance committees attached. The four committees were the Quality and Performance Committee, the Mental Health Legislation Committee, Resources and Business Assurance Committee and the Audit Committee
- The trust had a clear management structure in place and the Specialist Care Group reported directly to the Executive Director of Nursing and Operations and then to the trust board.
- Operation management group meeting minutes highlighted that performance, procedures, risk assessments and staffing were discussed at these meetings.
- A risk management policy was in place and in date.
- Individual risk registers were in place in each of the services we visited. Management were able to describe risks highlighted on the registers and what action they were taking to mitigate the risk. Risk registers were reviewed monthly.
- Management were able to describe the arrangements for escalating risks identified through the different governance groups and structures.
- Outpatient management had access to information, which allowed them to check on quality data such as DNA rates and appointment cancellations.

Leadership of service

- Outpatients had a clear leadership structure in place. Staff told us management were visible, approachable and staff felt listened to. Staff we spoke with were aware of their responsibilities and could describe their roles clearly.
- Service line managers, senior nurses and a directorate manager managed services. Senior managers could describe the challenges of providing high quality services and what actions were taken to address challenges. Senior managers told us there had been challenges following an administrative service review and this had been highlighted in the staff survey.
- Staff we spoke with were positive about management and felt supported. Staff told us management were open to ideas.
- Clinical supervision was embedded within outpatients with staff aware of when supervision was due. Clinical supervision rotas were displayed with dates due in the department.

Culture within the service

Outpatients and diagnostic imaging

- Staff told us they felt valued and respected by management and the trust.
- Staff we spoke with were positive about working in outpatients and were proud about the service they provided. Staff in other services we visited spoke positively about the services they provided and described good team working.
- We found there to be a culture of team work and supporting each other to provide patient centred care to patients. Staff were positive about developing their skills and there was a good culture of training and development.
- Outpatients and other services provided had a culture of developing services to meet the needs of patients and progressing ideas of service improvement. Different staff groups had been involved in service development.
- There was effective multidisciplinary team working across the services visited with person centred care taken into account.

Public engagement

- Walkergate Park Hospital held a service users forum. Management told us they were often involved in the patient forum group. This forum was supported by a member of occupational therapy staff who acted as secretary provided by the trust. This forum was well established and met on a regular basis.
- A points of view board was displayed in outpatients. Comments cards were available for patients to complete and give feedback to the trust.
- Staff from Walkergate Park Hospital had hosted a recruitment stall locally to highlight the trust's recruitment opportunities.
- The multiple sclerosis team had held an open day to promote their services. This open day had involved the multiple sclerosis society.
- The Northumberland head injuries service carried out annual satisfaction questionnaires. The service had gathered patient feedback to assist in the development of their new referral education sessions. The service had attended national conferences to present and had links with a number of brain injury charities.
- The North East Drive Mobility Service held open days to promote the service. The service had implemented the 'Points of You' system, which allowed service users to provide feedback. The service had plans to take their high tech vehicle to a national mobility roadshow.
- Staff from neuro-rehabilitation outpatients had provided education sessions in care homes on hand hygiene to staff and patients.

Staff engagement

- The trust held speak easy events at Walkergate Park Hospital, which were staff engagement events. These events allowed staff to work in small groups with a senior manager to discuss items such as what is working well and what is not working so well? These events allowed senior managers to listen to the views of staff throughout the trust and had been developed in 2015 to increase staff engagement.
- Staff told us they received email updates and trust bulletins to keep them up to date and aware of trust wide information.
- The neuropsychiatry team had organised a neuropsychiatry conference to raise the profile of the team and educate other healthcare professionals about neuropsychiatry.
- Regular team meetings were held in outpatients and other services, for example the North East Drive Mobility held regular team meetings. We reviewed these minutes and found that service user feedback and the chief executives bulletin were regular items on the agenda.
- The Regional Communication Aid Service had hosted a communication matters road show to staff from local teams.

Innovation, improvement and sustainability

- The trust had implemented a North East Drive and Mobility service. This service was developed to retain or regain independence as drivers or passengers. The service provided independent assessments and advice to people with a medical condition or disability, which may have affected their ability to drive or use the vehicle as a passenger.
- The North East Drive and Mobility Service had worked with a number of external agencies to develop the services to service users, for example the Driver and Licensing Authority and the local police.
- Staff in outpatients had worked with a local university to develop a short course on the holistic management of spasticity and hypertonia. This was developed because a need for training was identified by staff.
- The hand hygiene clinic was a service developed in response to patient need and research by the

outpatients department. The development of this work had led to additional support services available for patients with hand hygiene and contributed to staff development in outpatients.

- As part of the caring hands project, the trust had provided an additional two training sessions to home care managers and care staff in Newcastle. Information provided by the trust highlighted that they developing the education programme further.
- Some staff had been involved in the development of national guidance. Staff had worked with a local university to develop a course for healthcare professionals.
- Staff had provided a splinting course in March 2016 for external applicants and the trust's own staff.
- Walkergate Park Hospital had been successful in gaining funding to assist in providing further support to the allied health professional team to allow capacity for staff to be involved in research and develop research skills. This work had led to the development of the Neurological Research and Development Forum.
- The Northumberland head injury service were reviewing exit interviews when discharging patients to enhance discharge planning. This work was being progressed with assistance from a local university to explore engaging service users to help develop an exit interview form.

Outstanding practice and areas for improvement

Outstanding practice

- A well established Service Users and Carers Forum was in place and social activities for service users and their families had been established with the Headway Charity.
- The hospital had established a Brain Injury Group providing opportunities for discussion of a variety of issues such as brain injury and sleep monitoring.
- The Social Therapeutic and Recreational Rehabilitation Team (STARRT) had been developed to promote independence and increase the quality of life of patients through taking part in social and leisure activities.
- The service had adopted best practice in support of the provision of care and treatment, for example 'Reducing the risk of deep vein thrombosis (DVT) for patients in hospital', functional independence measure (FIM) and functional assessment measure (FAM) scores.
- The establishment of a spasticity management clinic for individuals with spasticity following a neurological injury.
- The North East Drive and Mobility Service had worked with a number of external agencies to develop the services to service users, for example the Driver and Licensing Authority and the local police.
- Staff in outpatients had worked with a local university to develop a short course on the holistic management of spasticity and hypertonia. This was developed because a need for training was identified by staff.
- The hand hygiene clinic was a service developed in response to patient need and research by the outpatients department. The development of this work had led to additional support services available for patients with hand hygiene and contributed to staff development in outpatients.
- As part of the caring hands project, the trust had provided an additional two training sessions to home care managers and care staff in Newcastle. Information provided by the trust highlighted that they developing the education programme further.

Areas for improvement

Action the hospital SHOULD take to improve

- Ensure a consistent approach to displaying NHS safety thermometer data on wards at this hospital. This would assure patients that the hospital was improving practice, based on experience and information.
- Consider implementation of regular record audits within the outpatient department.
- Consider governance leads within the outpatients department.