Inspection of Outpatient Departments Western Health and Social Care Trust

Hospital Inspection Programme (Phase III) 05 June 2023 – 07 September 2023

Type of service: Outpatient Services
Address: Western Health and Social Care Trust, MDEC Building, Altnagelvin Area, Hospital Site, Glenshane Road, Londonderry, BT47 6SB
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1.0 Service information

Responsible Person: Mr. Neil Guckian	**Position:** Chief Executive Officer
Person in charge at the time of inspection: Mr. Mark Gillespie	**Position:** Interim Director of Planned Care Services
Brief description of the accommodation/how the service operates: The Western Health and Social Care Trust (the Trust) provides inpatient, day case and outpatient healthcare services for up to 300,000 people across an extensively rural geographical area. The Trust supports up to 220,000 outpatient appointments annually, providing a range of treatments and services to meet the needs of the population it serves.	

2.0 Background

On 1 May 2018, the Belfast Health and Social Care Trust (Belfast Trust) announced a recall of 2,500 patients who were under the active care of a consultant neurologist. As part of the system response to this patient recall, RQIA was commissioned by the Department of Health (DoH) to undertake '*A Review of Governance of Outpatients Services in the Belfast Trust with a Focus on Neurology and other High Volume Specialties*' (the RQIA 2020 review). The report, published in February 2020, made 26 recommendations (Appendix 1) that if implemented, would strengthen the governance arrangements within and across the Belfast Trust's outpatient services.

Even though the RQIA 2020 review was focused on the Belfast Trust the learning arising from the review and the subsequent 26 recommendations were considered to be equally applicable to all HSC Trusts in Northern Ireland. Consequently, HSC Trusts have been providing updates to the Strategic Planning and Performance Group (SPPG) in relation to their Trust's progress at implementing the recommendations.

Following the publication of the RQIA 2020 review, the Western Health and Social Care Trust (the Trust) established a Trust Outpatient Oversight Group (TOOG). The TOOG includes representation from all service directorates that deliver outpatient services. The aim of the TOOG is to take the 26 recommendations from the RQIA 2020 review and seek to ensure they are implemented across the range of outpatient services in the Trust. The TOOG first met in December 2022; and at the time of this inspection, two meetings had taken place.

The aim of this inspection was to seek assurance that the Trust has appropriate governance systems in place capable of ensuring the quality and safety of care delivered in its outpatient services.

Outpatient departments at three hospital sites were selected for inspection:

- Omagh Hospital & Primary Care Complex (OHPCC)
- Altnagelvin Area Hospital (ALT)
- South West Acute Hospital (SWAH)

3.0 Inspection summary

An announced inspection of the Trust outpatient departments (OPD) commenced on 5 June 2023 across all three sites and was completed on 7 September 2023 when feedback was provided to Trust representatives.

Many areas of good practice were noted during the course of the inspection; these were visible at all levels within the Trust and warrant further commentary.

Positive feedback was provided by service users relating to the care that they received across the three OPD sites. They were particularly complimentary about the effective use of communication by OPD staff at all stages during their receipt of care. When asked to score their experiences out of five (excellent) the average score awarded was four (good). OPD staff were described as being kind, polite and supportive; and those spoken with voiced a common feeling of overall safety.

Inspectors noted progress on the implementation of the electronic e-Triage system across all outpatient services.

They found widespread awareness amongst OPD staff across the three OPD sites of safeguarding triggers and actions to be taken to escalate concerns.

It was also noted that General Practitioners (GPs) were informed when their patient referral has been downgraded. However, the issues associated with such communication have been noted in the Northern Ireland Public Service Ombudsman (NIPSO) report entitled *'Forgotten' An investigation into HEALTHCARE WAITING LIST COMMUNICATIONS* (2023); which suggests that further work in this area remains. The report may be accessed here.

There was evidence of compassionate care extending beyond the clinical care delivered by OPD staff. This was exemplified by the OPD staff's willingness to react swiftly and offer assistance when patients were witnessed to be experiencing difficulties checking-in using the automated system.

OPD staff reported, in the main, that they were happy in their work environment and that they felt well supported by their immediate manager. Overall, staff in outpatient departments stated that communication was consistently good.

The reports of good morale and a favourable work environment may be contributing to a good overall level of staff retention, with a number of staff having continued to work in outpatient services for many years. These may also be factors in the low use of bank staff and no reported agency staff throughout outpatient services.

This inspection resulted in six areas for improvement being made. These are detailed in the Quality Improvement Plan.

4.0 How we inspect

RQIA inspections form part of an ongoing assessment of the quality of Health & Social Care services in Northern Ireland. Our inspection reports reflect how services were performing at the time of our inspections, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

This inspection was underpinned by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and the DHSSPSNI Quality Standards for Health and Social Care (March 2006).

RQIA mapped the 26 recommendations made in the RQIA 2020 review against the following 12 high-level themes and developed key lines of enquiry for each theme:

- Vision for improving quality of care;
- Governance, leadership & accountability;
- Service planning;
- Quality assurance;
- Managing risk;
- Oversight and assurance of staff;
- Safeguarding;
- Medicines management;
- Records management;
- Access;
- Complaints, incidents and concerns; and
- Communication with stakeholders.

A pre-inspection information request was sent to the Trust affiliate for completion and return prior to the on-site element of the inspection. The returned pre-inspection information and supporting documentation, was reviewed to establish the Trust's progress to date and to identify gaps in assurance which further informed the inspection.

The Trust action plan detailing progress against the RQIA 2020 review recommendations (dated May 2023), which had been submitted to the Department of Health - Strategic Planning and Performance Group (SPPG), was also scrutinised prior to the on-site inspection phase. This information also assisted with the development of key lines of enquiry.

In advance of the on-site element of the inspection a number of regional and local policies and procedures were reviewed alongside minutes of meetings and Trust organisational charts.

The OPD across the three hospital sites were visited on the following dates:

- Omagh Hospital & Primary Care Complex (5 June 2023)
- Altnagelvin Area Hospital (6 June 2023)
- South West Acute Hospital (8 June 2023)

The on-site element of the inspection included direct observation; engagement sessions with patients, relatives and staff; and the review of relevant documentation. The documentation reviewed included nursing care records; medical records; management and governance reports; and minutes of meetings.

5.0 What people told us about the service

5.1 Service User engagement/patient experience

In total we spoke to 17 patients from a range of OPD clinics across all three sites. Overall feedback was very positive in relation to: care delivery; communication prior to, during and after attending OPD clinics; and patients reported that they felt safe at the OPD clinics.

We also reviewed patient feedback on 'Care Opinion' which is an online platform that enables patients to report on their experience of using health care services. The uploaded comments are shared with relevant service affiliates and therefore enables acknowledgement of positive feedback, and a means to address and respond to issues that contributed to poor patient experience.

The limitation of Care Opinion feedback for the purposes of the RQIA inspection, was that it was difficult to extrapolate patient responses which were solely aligned to outpatient services. However, the majority of patients who did comment on their experience of using an outpatient service made positive and complementary statements.

5.2 Staff engagement

We sought to understand staff experiences of working in OPD and to assess if they believed that care was delivered in a safe, effective, and compassionate manner; and also whether outpatient services were well led. During the inspection to each hospital site, posters were displayed with QR codes which linked to an online staff survey. This method would anonymise feedback online. However, we did not receive any online responses. Therefore, our approach was adapted and the Trust affiliate was asked to share an email to staff with a link to the survey and extended the response date in order to afford staff every opportunity to reply.

The staff responses varied; with some responses extending beyond outpatient services. Some responses indicated discontent, culture issues, lack of support, and concerns regarding the provision of one service (which the RQIA team addressed directly with the senior management of the Trust).

Staff responses from the online survey are presented in the tables below and are attributable to each of the three sites inspected.

During face-to-face discussions, overall verbal staff feedback was positive. One persistent theme was identified in relation to a lack of regular staff meetings and the need for better communication specifically on shared learning. There was reportedly good morale across all sites; good support from line managers and staff felt they were listened to. There was reportedly good post-incident communication; and available support from colleagues. Supervision (where applicable) and staff appraisals were largely up-to-date; and in the main mandatory training was also up-to-date. Staff at the OHPCC stated they would be keen for more senior management presence at the Omagh site.

Table 1.

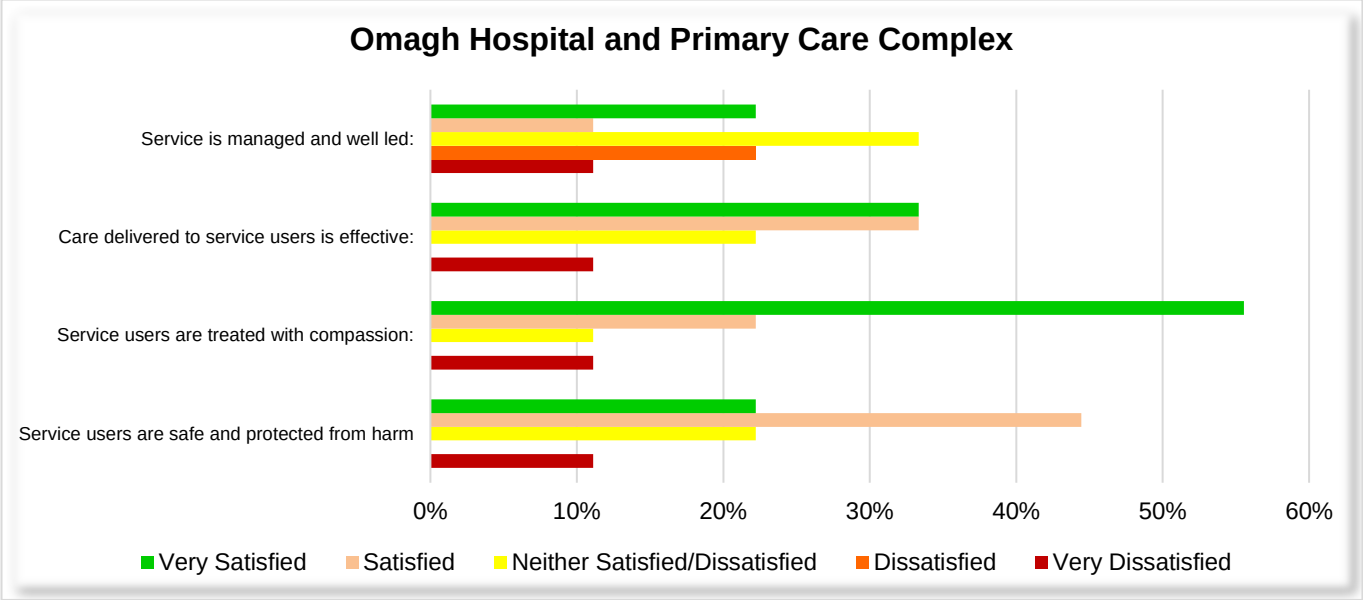


Table 2.

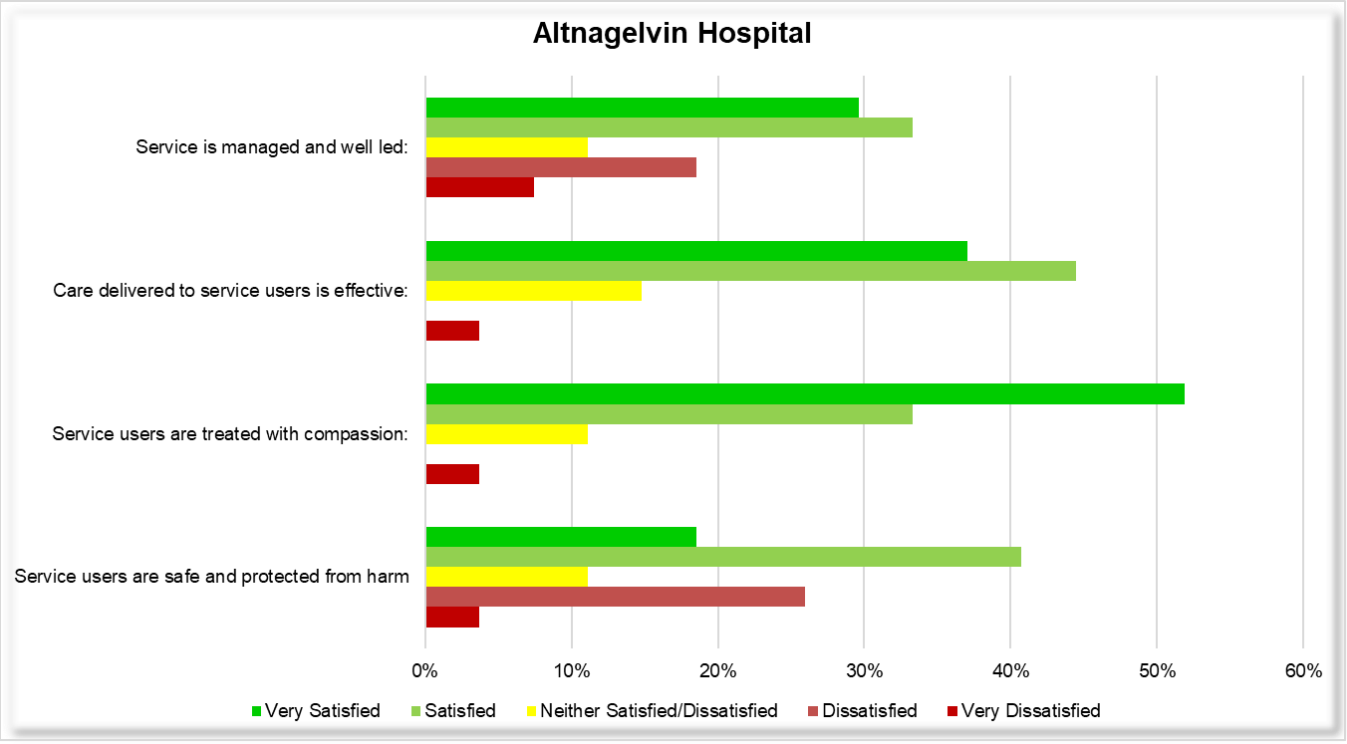
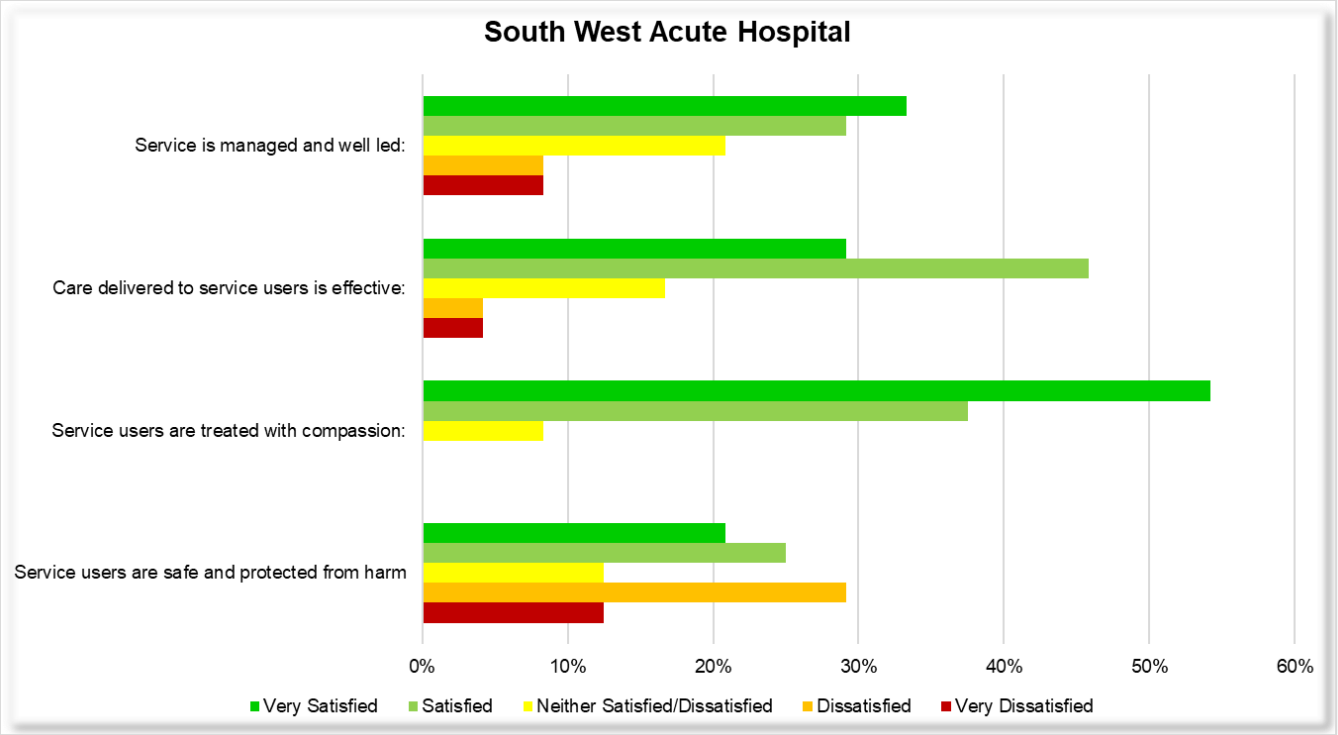


Table 3.



6.0 The inspection

This inspection was focused on the governance and oversight arrangements for OPD in the Trust.

Areas for improvement which have been identified as a result of this inspection, were made to support the work of the TOOG in implementing the recommendations from the RQIA 2020 review.

RQIA acknowledge the delay created by the challenges of managing the Covid-19 pandemic and its impact on the Trust to implement the recommendations from the RQIA 2020 review. However, the Trust must support, expedite and strengthen the momentum of the work undertaken by the TOOG to ensure full implementation of the recommendations are realised without any further delay.

6.1 Inspection findings

6.1.1 Vision for improving quality of care

In order to understand the Trust's vision for improving the quality of outpatient care, a range of relevant meeting minutes were reviewed; information was also directly provided through the inspection teams engagement with senior Trust staff.

The Trust had formed a TOOG to progress work on the implementation of the recommendations made in the RQIA 2020 review. Two meetings had been convened at the time of the inspection.

There was evidence that those in attendance, recognised that further work was required to ensure that operational arrangements for all outpatient services are appropriately aligned across service directorates and divisions, so that outpatient care is consistency well governed.

Whilst this group had only met twice at the time of the inspection, they had developed a questionnaire as a means of obtaining baseline data to inform them how different specialities across directorates reviewed, reported and escalated performance relating to outpatient services.

During the onsite element of the inspection, the inspection team met with staff from different disciplines, specialities, and grades. The majority of staff [up to and including consultant level] were not aware of the RQIA 2020 review or that the recommendations contained within it were applicable to all HSC Trusts. As such, many staff were unaware of the rationale for this inspection.

It is RQIA's determination that the TOOG was in the early stages of understanding how all specialities operated and governed their outpatient services and the terms of reference of the TOOG acknowledged the scope of the work to be undertaken to implement the recommendations and thus it was yet to determine how improving the quality of care could be realised. In alignment with recommendation 12 of the RQIA 2020 review, further work is required to establish a vision for improving quality care in outpatients and communicating that to all staff.

6.1.2 Governance, Leadership & Accountability

Governance

On day one of the inspection (5 June 2023) the Trust informed the inspection team that the acute directorate had been split in two; one directorate for unscheduled care and one for planned care. Email communication was issued to all Trust staff to inform them that the new directorates were coming into effect on the 6 June 2023 and that there would be a six to eight-week period for the new directorates to embed. However, having spoken to a number of staff of all grades and disciplines across all sites it was apparent that staff were not aware of the new structures or directorates.

For each outpatient clinic, responsibility for governance oversight remained within each speciality. Staff were unaware of the impact of the new directorates on the current governance arrangements. The Trust shared the new governance structure which outlined lines of accountability and role and responsibilities for the respective planned and unscheduled care directorates.

Leadership and Accountability

As already referenced above, OPD staff across all grades, disciplines and sites had no knowledge of the recommendations that arose from the RQIA 2020 review or that they were applicable to all HSC Trusts. Nevertheless, staff morale was good and there were good working relationships throughout each clinic and site.

All staff were aware of the *Whistleblowing Policy* and many staff described the good support from their managers, Having reviewed minutes of a selection of meetings there was evidence that structures were in place to support a collective leadership approach; however, a clear communication strategy to ensure that relevant staff are informed of recommendations arising from RQIA reviews and their role and contribution in implementing them, would lend itself to further support any collective leadership model.

No reference was made in the reviewed minutes, to evidence that the Trust had an action plan to strengthen the delivery of safe, effective and compassionate care in OPD. Front line staff were not aware of the measures used to demonstrate safe, effective and compassionate care, but believed that their service was good; and this was reflected in the feedback from patients.

An area for improvement has been made.

The Trust needs to develop a communication strategy to ensure relevant staff are informed of recommendations arising from RQIA reviews. This would support the collective leadership model and ensure that staff are aware of their role and contribution to implementing the recommendations. The communication strategy for each project should outline the Trust's action plan and the key performance indicators which will be monitored.

6.1.3 Service Planning

We sought evidence that the Trust had service planning processes in place which promoted an equitable pattern of service based on assessed need, having regard to the particular needs of patients, the availability of resources, and local and regional priorities and objectives.

This requires the Trust to collect, and analyse information relating to outpatient activity (by service, by team, by consultant) to enable robust capacity planning and to inform future service development and modernisation of outpatient services across the Trust.

Savience-Clarity (SC) an electronic Outpatient Management System has been used within the Trust since 2012. The SC system facilitates patient check-in, tracking patient flow and recording of patient outcomes. Staff can view clinic lists on this system. Appointment times, arrival times and notes can be recorded at all stages in the patient visit.

The SC system does not support real-time monitoring of waiting times for OPD on any of the three sites. Additionally, there was inconsistent use and adoption of the SC system by OPD medical staff in recording activity and outcomes. As such the Trust did not use it for reporting on waiting lists but instead used data from the Patient Administration System (PAS).

The inconsistent use of the SC system may incur a risk of losing activity and outcome data. Although the SC system manager confirmed that there has been an increased focus on usage compliance; this has not been verified.

Nonetheless, the Patient Access Team provide specific measures for OPD services which focus on referrals, scheduled appointments, triage categories, hospital initiated clinic cancellations and validation reports of duplication of referrals on the PAS systems and long waits. This information provides relevant data to service groups to inform service planning and development. The Trust's Elective Care Group meet regularly to review the elective data to allow actions to be expedited at specialty level and validation reports are discussed at Business Speciality Meetings. Minutes of the business speciality meetings are not recorded. Therefore, there is no record of decision making to evidence action taken.
The TOOG will progress this matter in line with recommendation 17 of the RQIA 2020 review.

The SC system has the potential to inform service planning and development but currently is unreliable due to the aforementioned inconsistencies.

An additional area for improvement has been made.

The Trust must strengthen its assurance arrangements to support improved compliance with SC usage by medical staff across all specialties.

6.1.4 Quality Assurance

We sought evidence of the systems in place which will enable the Trust to collate and analyse Key Performance Indicators (KPIs) within outpatient services to drive service improvement; to include the identification and management of risk to promote learning and prevent reoccurrence.

We noted that on a monthly basis KPI data is collated and reported on the number of cancelled appointments and the rationale for their cancellation. A separate quarterly report is also produced noting the longest wait for appointments across each speciality for red flag, urgent and routine appointments. In addition, the number of appointments where patients "did not attend" (DNAs) and any new cases are also reported quarterly across the specialities.

The current reporting includes activity levels, numbers of complaints, incidents and adverse incidents. These were submitted through lines of management and considered as measures of the delivery of safe, effective and compassionate care. The minutes of the elective performance meetings evidence discussion occurred to address operational issues identified.

Mortality and Morbidity (M&M) meetings are forums to support a systematic approach to the review of patient deaths or care complications to improve patient care and provide professional learning. M&M meetings give ownership to clinical teams and offer a direct opportunity to improve care delivery in a timely manner and promote research and scholarly activity and opportunities to improve quality. M&M meetings and bench marking arrangements do not take place in relation to outpatient services as a whole, rather they are conducted within each speciality group/service. There were significant variances on the level of detail recorded and learning identified across the speciality M&M meetings. The system could be improved by ensuring the learning points are consistently recorded to facilitate sharing the learning more widely with relevant staff and to clearly identify the clinical and/or system changes that should be considered if applicable.

An area for improvement has been made.

The Trust should agree a recording template across all specialities that evidences the learning identified at M&M meetings; and should detail how that learning will be disseminated.

6.1.5 Managing Risk

Evidence was sought in relation to the Trust's systems to prevent, identify, assess and manage risk; including the review of adverse incidents and near misses within each outpatients' service, and to ensure that the Trust were collating, analysing and learning from adverse incidents/near misses, and sharing the knowledge to prevent reoccurrence.

There were a number of effective mechanisms across each OPD department, hospital, speciality and directorate to identify, mitigate, record and review risks. These mechanisms were

sufficient to manage and escalate risks as required. However, it was too early to determine if the separation of the acute directorate into unscheduled and scheduled care will have any impact on the current assurance framework/reporting structures to manage and escalate risks. The TOOG are encouraged to make a periodic assessment of any impact following the structural change.

6.1.6 Oversight and Assurance of Staff

Evidence was sought to demonstrate that the Trust had appropriate systems and processes in place for the oversight and monitoring of the quality of care delivered by medical and nursing staff and the related patient outcomes achieved across its outpatient services.

The Trust had good governance systems with respect to oversight of nursing staff, notably with regard to specialist nurses. Specialist nurses are supported with clinical supervision, annual appraisal, professional development and revalidation by their individual speciality lead nurse/line managers. They also work closely with relevant speciality consultants which supports clinical review, learning and development opportunities. Specialist nurses are integral within their speciality multidisciplinary team (MDT) and attend meetings where clinical incidents, complaints, waiting lists and high risk “red flag” patients are discussed.

Regional specialist nurse forums may be attended which provides an opportunity for inter-Trust sharing of good practice, and local nurse specialist forums are available for local network support, continuous professional development and the sharing of good practice and experience.

We were assured that if any issues were raised regarding a specialist nurse practice within the OPD, then these would be directly escalated to the staff member’s professional line manager.

Whilst specialist nurse care delivery is informed by recognised quality standards there is no formal system to centrally collate patient outcomes delivered by specialist nurses across the OPD setting.

The Trust recognises that this requires further action and the TOOG will seek to address this matter in keeping with recommendation 18 of the RQIA 2020 review.

There was no system for specialist nurses, practising as lone workers in speciality outpatient clinics, to have their work peer-reviewed. Yet, specialist nurses advised that they would routinely have the opportunity to discuss cases with the consultant-in charge if they required advice or direction on a particular case.

Following the onsite visit, inspectors were contacted by representatives from the Trust who advised that they were examining ways to introduce a peer review mechanism for specialist nurses. The Trust are encouraged to continue with this work. Future updates on progress will be welcomed.

Practice appraisal and revalidation are processes through which consultant medical staff evidence their continuing professional development and maintain their licence to practice with the General Medical Council. These processes are facilitated through a system of established medical appraisers and responsible officers (ROs), who validate that the required standards have been achieved.

Oversight of appraisal was noted within Trust governance reports and there was also evidence of discussions held at a senior management team (SWAH & OHPCC) governance meeting, in relation to a work efficiency dashboard that monitors mandatory training and appraisal scores. There was also evidence that some information (e.g. information relating to the number of complaints received or adverse incidents reported) was made available by the Trust to inform practice appraisal and revalidation. However, it was not evident that established data and intelligence systems [used to record patient outcomes] were being linked to individual clinicians. This was discussed with the Trust SMT who confirmed, that although this had not yet been progressed, it would be in the near future.

The TOOG will progress these matters in line with recommendations 18 and 19 of the RQIA 2020 review.

6.1.7 Safeguarding

Evidence was sought to demonstrate that the Trust had systems in place for appropriate patient safeguarding systems across the OPDs.

A significant objective of the TOOG is to review processes around adult and child safeguarding; and whilst we acknowledge that the Trust has made some progress in this regard, further work is required to provide robust assurances in relation to safeguarding knowledge, awareness and compliance with policy & procedures across all grades of OPD staff.

During the inspection, a range of staff demonstrated good knowledge and awareness of their roles and responsibilities in regards to raising concerns and completing referrals. However, while staff were largely able to advise who the child protection champion was, they were not always aware of the adult counterpart. That said, aide memoires were visible in areas to support staff and the Trust's computer system had displayed an icon to support easy access links and information for the safeguarding of children.

Some staff reported difficulty accessing safeguarding training as this had been impacted during the pandemic. Medical staff confirmed during an engagement session that safeguarding training was part of their mandatory training and that a record of safeguarding training is maintained as part of their appraisal process.

Notwithstanding that the Covid-19 pandemic significantly reduced opportunities for training throughout HSC; the Trust risk registers, including outpatients did not specifically refer to any risks associated with child protection and adult safeguarding training.

The TOOG will progress this matter in line with recommendation 16 of the RQIA 2020 review.

6.1.8 Medicines Management

Evidence was sought to demonstrate the Trust had developed a system or systems to enable appropriate oversight and assurance of prescribing and prescribing advice across the Trust outpatient services including the development and implementation of an interim electronic system to replace the current paper based Treatment Advice Notes.

While there was robust oversight of prescribing of specialist medicines and cancer medicines in the outpatient service; there was limited oversight of other prescribing. The Treatment Advice Note (TAN) system employed by the Trust was paper-based and the Trust had no effective method for oversight or assurance of prescribing and prescribing advice, aside from GP and practice pharmacist review.

The Trust pharmacy team did have input into the development and design of the TANs. However, an Outpatient Treatment Advice Note Policy which includes details of the arrangements for the oversight and assurance of prescribing and prescribing advice across the Trust outpatient services was not in place at the time of inspection.

No private prescriptions were found to be being issued in any of the outpatient services visited during this series of inspections.

The Trust had explored the development and implementation of an interim electronic system to replace the paper-based TANs. However, funding was withdrawn before any interim system was able to be realised. The Trust advised that the planned introduction of the HSC digital Encompass system will address the issues of oversight and assurance for prescribing and prescribing advice in the OPDs.

The majority of medicines observed during site visits were stored appropriately. However, issues were identified with medicines which required cold storage. Refrigerator temperatures were outside the recommended range in two of the sites visited and staff had not taken appropriate corrective action. This was escalated to the management teams and assurances were provided that robust checking daily refrigerator monitoring regimes would be implemented.

An area for improvement has been made.

While awaiting the implementation of the HSC digital Encompass system, the Trust should develop and implement an Outpatient Treatment Advice Note Policy which includes details of the arrangements for the oversight and assurance of prescribing and prescribing advice across the Trust's outpatient services.

6.1.9 Records Management

Record management was reviewed to assess compliance with best practice.

There was evidence of both electronic, paper based referral and outcome systems in operation. Internal referrals come from consultant to consultant, ED and other departments; and externally, there were a small number of paper based referrals received by the Trust from opticians and dentists. All paper based referrals are required to be managed through the central booking system team. Staff have been discouraged from sending paper based referrals directly to consultants and/or their secretaries, in order to facilitate traceability, prevent referrals getting misplaced and ensure activity data relating to referral triage/grading and waiting times is accurately captured. Whilst the majority of referrals are received via Clinical Communication Gateway (CCG) which is a system for electronic exchange of clinical information from GPs and Northern Ireland Electronic Care Record (NIECR) E-referral facility; compliance with this approach was not currently measured. NIECR is an electronic system which enables health and social care staff to access records of investigation requests, appointments, encounter and discharge letters and information relating to patients' medical history.

An example of how clinics operate without paper based medical notes was provided by a member of the respiratory team. Staff used a mixture of electronic and paper-based records when delivering care in outpatient services. Paper based patient care records were used in many of the clinics visited. Digitally recorded data such as laboratory reports and radiological images/reports can be viewed on NIECR. Staff reported if notes were not available for the clinic staff used loose pages known as continuation sheets and stick a printed patient identification label to the page. Therefore, there is a risk that loose pages could be misplaced.

The availability of patients' care records was not audited by the OPD staff but staff reported they have on occasions been running clinics when patient's notes were not available. Despite the ability to record patient outcomes information on the electronic SC system in use within the OPDs, there was poor compliance to do so by a number of clinicians. This creates a risk to delivery of safe and effective care when records are not easily accessible for other teams/clinicians to access.

A sample of patient care records were reviewed during each site. We noted variation in the standard of recording across all sites and by clinicians.

Staff advised that the introduction of Encompass, will facilitate a new regional single electronic care record for use across Health and Social Care(HSC) services in Northern Ireland and it is envisaged this will reduce the risks.

The TOOG will progress these issues in line with recommendations 12,13,14, 17 and 22 of the RQIA 2020 review.

6.1.10 Access

Evidence was sought of an evidence-based model of care applied to the delivery of outpatient services with a particular focus on ensuring positive outcomes for patients.

The Department of Health, Social Services and Public Safety (now the DoH) updated the Integrated Elective Access Protocol (IEAP) in September 2023. The IEAP provides a standardised approach in respect of arrangements for access to elective services across Northern Ireland. HSC Trusts in Northern Ireland are required to plan and deliver services in line with the IEAP. It specifies the approved processes for managing patients access to outpatient, diagnostic, elective admissions and elective Allied Health Professional (AHP) services.

The IEAP provides guidance on the management of referrals, booking and cancellations of appointments, organisation of clinics and management of waiting lists with a view to ensuring timely, equitable and appropriate treatment for all patients. The Patient Access Team work within the IEAP guidance. Staff are made aware of IEAP at induction and a resource folder containing this information was available for staff.

The main referral routes into outpatient services across the Trust were examined and it was noted that the Trust have established systems that all referrals should be managed by the central booking team within the Patient Access Team. However, there are some variations in this, for example staff in the stroke team receive direct referrals and they ensure these are captured onto the patient administrative system (PAS). The PAS information technology system captures patient data in relation to referrals, appointments, and waiting lists. Reports can be collated using this system and shared with the relevant teams with oversight and assurance responsibilities.

There was a system in place to ensure re-designation of patients from the independent sector. Referral information was captured on the PAS system. When a patient is seen privately a specified document is required to be completed and submitted to the Patient Access Team, this team ensures the patient is coded correctly on PAS in order to facilitate the Trust's oversight arrangements.

Most external referrals were made through the Clinical Communication Gateway (CCG). Paper and email referrals continue to be received internally for example from Emergency Department (ED) or from Consultant to Consultant via their secretaries. This internal and informal referral process has inherent risks in the referral not being logged on the appropriate electronic system. It was good to note the Trust was working towards an internal electronic referral system via NIECR E-referral facility. This should reduce the risk of paper referrals being misplaced and not actioned. The strengthened system should also ensure traceability and support governance and oversight arrangements.

The Patient Access Team linked directly with speciality service managers who utilise the Trust's OPD service and provide reports generated from the PAS to provide data relating to outpatient activity. Staff told us these reports were then followed up with the service managers at monthly meetings, however these meetings were not recorded therefore we were unable to find evidence to demonstrate the effectiveness of these oversight arrangements.

It was confirmed systems were in place to provide assurance that all patients have an appointment and to identify delays in triage.

The Trust operate two PAS systems and staff stated this can lead to duplication and in turn inaccurate information relating to waiting lists. To mitigate the risk a quarterly duplication validation report was collated and reviewed by appropriate individuals.

There was evidence the Trust was working towards reviewing and streamlining its systems and processes for receiving and managing referrals to its outpatients' services; however, there are still paper based referrals internally which are not managed through an electronic system. Whilst the Trust provided evidence of validation of waiting lists these processes could be improved to strengthen the governance and oversight arrangements.

The TOOG will progress these matters in line with recommendations 1, 22 and 23 of the RQIA 2020 review.

Additionally, a new area for improvement has been made.

The Trust should:

- *Ensure accurate records of monthly meetings between service managers and the Patient Access Team are maintained to evidence discussions and agreed actions; and.*
- *Strengthen the oversight and assurance in relation to the Trust's referral processes (both paper and electronic).*

6.1.11 Complaints Incidents and Concerns

Evidence was sought to demonstrate that effective complaints, representation procedures and feedback arrangements, were operating and available to patients, carers and staff, to inform and improve care, treatment and service delivery.

Incidents and complaints were reviewed through the Trust governance assurance processes within relevant directorates. Risks were raised and reported through individual OPD departments and specialities which is appropriate. There was no over-arching report specific to all complaints and risks that informed all outpatient staff of a plan to improve the quality and safety of outpatients. During conversation with staff there was an appetite for all OPD across the three sites to work more collaboratively to strengthen and improve service delivery in OPD based on the intelligence they hold.

OPD staff had good awareness of the need for, and mechanisms to, report incidents and near misses, although they stated that the did not always receive feedback on the outcome of investigations. Additionally, feedback primarily given to them was limited to nursing related complaints and not those related to for example waiting times.

The Trust have established an TOOG with clear terms of reference outlining roles, responsibilities and objectives in relation to reviewing incident and complaints themes/trends relating to outpatient provision and agree on wider sharing of learning. Through this approach it is anticipated this will drive improvement in quality and safety within OPDs. However, this group was in it's infancy at the time of inspection and will require time to embed before effectiveness can be fully assessed.

RQIA acknowledges that some progress had been made by the Trust, in strengthening its use of information and intelligence relating to OPD incidents and complaints however this could be further strengthened by ensuring staff are kept informed of all relevant complaints and incident information including outcomes relating to OPDs, in addition to the nursing-specific complaints that they already received.

6.1.12 Communication with Stakeholders

Evidence was sought in respect of the effectiveness of systems to communicate and manage information, to meet the needs of patients and carers; the organisation and its staff, partner organisations and other agencies.

We reviewed the communication with stakeholders specifically communication with GPs who make referrals to OPD and with patients. Engagement took place with the GP Associate Medical Director (GP AMD) whose role it is to facilitate routine communication on system-wide issues with the GP practices in the Trust's geographical area and the various specialities in the acute sector.

The GP AMD works one day per week in this role and for the remaining days of the week they work in general practice. The role of the GP AMD had recently incorporated the management of two GP Practices that the Trust took control of which has had a significant impact on the time they have to fulfil the original duties of this role. At the time of engagement, the GP AMD had no knowledge of the RQIA 2020 review or that the recommendations contained within it also pertained to the other four Trusts. RQIA recommends the GP AMD receives regular briefings on the work of the TOOG.

The GP AMD advised of the challenges they face namely; maintaining an up-to-date list of email addresses for GP Practices in the northern and southern sectors of the Trust and low attendance from GPs at the quarterly GP interface meeting.

The GP AMD advised that GPs also experience the following challenges:

- Navigating the Trust's referral guidance/flowchart on their IT system as certain specialities may have different sub speciality referral forms which are not readily identifiable;
- If GPs need to speak to a consultant about a referral or if the grading of the referral has been changed there is no single point of contact to manage these types of calls and so members of the PAS team refer GPs to the consultant's secretary. This can be time consuming for both parties;
- GPs do not routinely look at NIECR and whilst letters are available for viewing, GPs do not view until such time as they are verified by the consultant. The verification of letters on the system can take significant time; and
- The GP AMD was unsure if Encompass would link to GP IT systems.

The GP AMD was aware that there had been incidents within another Trust in relation to a number of outcome letters not being issued to GPs from outpatient clinics and that their line manager, a consultant in Emergency Medicine was undertaking a fact finding exercise to ascertain if a similar issue was occurring in the Trust.

Administrators reported challenges that contributed to delays in the typing of outcomes letters namely the variances in the dictation system used and whether or not the consultant chooses to copy the patient into the same letter as the GP or compose a separate letter to the patient while others do not issue an outcome letter to the patient at all. The Trust made efforts to streamline letters by devising a template however, all consultants/specialities do not comply. Administrators were aware of a Trust KPI set in relation to the timing of typing outcome letters and acknowledged these differ according to the triage rating of the patient.

The Trust had not implemented a system to evaluate the impact and effectiveness of directly including patients in clinical correspondence following outpatients review.

Not all clinicians were aware of KPIs for turnaround of dictated letters/sign off or validation regarding clinical outcomes letters for patients. We learned that the corporate management team are in the early stages of working on an assurance framework which will address KPIs and monitoring processes.

The TOOG will progress these matters in line with recommendations 7, 20 and 21 of the RQIA 2020 review.

An area for improvement has been made.

The Trust should:

- *Develop a set of KPIs in relation to discharge letters across all outpatient services ahead of the roll out of Encompass;*
- *Provide more user friendly guidance for GPs on referral pathways for subspecialties;*
- *Strengthen the Trust's assurance system of the clinical validation of outcome letters; and*
- *Develop and test a system which evaluates the impact of directly including patients in clinical correspondence*

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Standards
Total number of Areas for Improvement	6

Six new areas for improvement have been stated for the first time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the Quality Standards for Health and Social Care DHSSPSNI (March 2006) as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)	
Area for improvement 1 **Ref:** Standard 4 Criteria 4.3 (d) **To be completed by:** March 2024	The Trust needs to develop a communication strategy to ensure relevant staff are informed of recommendations arising from RQIA reviews. This would support the collective leadership model if staff were aware of their role and contribution to implementing the recommendations. The communication strategy for each project should outline the Trust's action plan and the key performance indicators which will be measured. Ref: 6.1.2
	Response by registered person detailing the actions taken: The WHSCT has established a Trust Wide OP Oversight group to continue to consider the perfromance, communication and governance frameworks across all aspects Outpatient (OP) services Trust Wide. The Oversight Group, in conjunction with the WHSCT Communication Department, will be responsible for the provision of senior leadership to provide regular updates and ensure these are appropriately disseminated throughout relevant Trust service areas. Published information should be aligned to the RQIA recommendations, good practice and cognisant of the NISPO "Forgotten Report" with associated implementation plans and compliance updates. The Oversight Group will be the appropriate authority to promote collective and meaningful leadership in the consistent implementation and application of the associated recommendations in line with relevant KPI's. All Outpatient KPI information will be reported on a monthly basis to the

	WHSCT Elective Care Board for review and consideration thereafter. The Tust OP Oversight Group is Asssistant Director led to ensure there is scope for senior decision making and the provision of clear guidance and communication across the WHSCT directorate structures. It is envisaged that the Trust will issue a revised acute structure (s) across the WHSCT towards the end of 2024 as there are number of changes in structure at tier 4 currently being implemented, these are at an advanced stage at this time. The Trust Oversight Group will move to work with the WHSCT Comminucation Team to communicate the recommendations of the RIQA report but also take note of the further recommendations cited in the NIPSO "Forgotten Report" and monitor to compliance on same. The WHSCT as at July 2024 are compliant with the NIPSO recommendations. The communication strategy will also include a roll out of associated training to both the clinical and administrative teams who suport and deliver OP services across the WHSCT.
Area for improvement 2 **Ref:** Standard 5 Criteria 5.3.1 (f) **To be completed by:** March 2024	The Trust must strengthen its assurance in relation to compliance with SC usage by medical staff across all specialties. Ref:6.1.3
	Response by registered person detailing the actions taken: A review of Savience (SC), utilised in secondary care, is currently ongoing across the WHSCT with a view to all specialties being compliant in application across medical teams Trust wide. It is recognised whilst SC provides good governance, streamlined services and efficiency that SC is not suitable for all services i.e. Fracture clinics. In these instances alternative control measures from a governance perspective are in place. It is also acknowledged that the WHSCT is now less than one year until systems migration to Encompass (EPIC) at which

	time systems and processes will significantly change. However it is accepted that the Ehealth systems, well embedded in WHSCT processes, do provide a controls governance assurance in terms of efficiency and patient safety. A report on medical compliance, to SC by specialty, will be submitted to the Trust Oversight Group in September 24 and thereafter to the WHSCT Elective Care Board (ECB). Whilst there has been significant progress made to this regard there a number of specialties where further work, development and training is required in some areas. The compliance to SC will continue to have a focus in the run up to Encompass implementation and will remain a fixed item, by exception, to both WHSCT Core Elective Group and Elective Care Board.

Area for improvement 3 **Ref:** Standard 5.3 Criteria 5.3.1 (f) and Standard 5.3.2 Criteria 5.3.2 (a), (b) and (c) **To be** completed by: March 2024	The Trust should agree a recording template across all specialities that evidence the learning identified at M& M meetings which details how the learning will be disseminated. Periodic audits should be undertaken to determine if the method of sharing the learning has an impact on reducing similar incidents from occurring. Ref: 6.2.4
	Response by registered person detailing the actions taken: M&M Teams hold regular meetings to discuss all patients that have passed away within the WHSCT Hospital setting. At these meetings they record any learning identified on the M&M Pathway on NIECR and if there are any necessary actions. This learning is sent to the M&M Co-ordinator on a monthly basis as part of the BSO extract from NIECR which is then recorded and discussed at RRG & necessary Directorate Governance Meetings. This learning is also added to a monthly M&M report and sent to Directors for sharing within their remit & discussed at M&M Outcome Review Group Meetings & M&M Lead Meetings. There is no audit currently in place for ensuring these methods have had an impact in reducing incident reoccurring but the Trust monitors trends in incidents across a number of forums and escalates any issues or concerns identified. In addition KPI's are monitored across a broad number of safety indicators to ensure progress is made in reducing recurrence of known risks. The WHSCT is currently developing a Learning policy and will include this recommendation in improving processes for sharing learning and assurance on same. The WHSCT are working towards the introduction of a standard learning template as a mechanism for shared learning across specialties Trust wide. This work will will be progressed with a view to implementation by late 2024.

Area for improvement 4 **Ref:** Standard 4.3 Criteria (a), (f) and(g) and Standard 5.3.1 Criteria (f) **To be completed by:** December 2023	While awaiting the implementation of the HSC digital Encompass system, the Trust should develop and implement an Outpatient Treatment Advice Note Policy which includes details of the arrangements for the oversight and assurance of prescribing and prescribing advice across the Trust's outpatient services. Ref 6.2.8
	Response by registered person detailing the actions taken: The Trust shares RQIA's vision for transferring information digitally to GPs. At the minute, the focus for ICT,Pharmacy, Medical and Nursing teams is the rollout of Encompass. The Trust will use this as an opportunity to have oversight of prescribing in a more robust way. The Trust will add a section to its Medicines Code/ Policy which includes reference to the NI Formulary, HSS MD26 2022 and a link to the recommendation to prescribe form, asking prescribers to complete this fully. It will be a challenge to audit practice. To date, adherence to the NI Formulary is regularly encouraged at MDT meetings and using digital sharing platforms eg Eolas. HSS MD26 2022 was tabled at the D&T subgroup meeting and shared with all outpatient medical and non- medical prescribers, to clarify prescribing responsibilities and associated transfer of information. To provide oversight and assurance of prescribing and prescribing advice across the Trust's outpatient services a robust audit would need to take place using the paper copies of the TANs. Unfortunately with the increased workload associated with assisting other Trusts with their encompass golive and preparing for the WHSCT golive in Spring 2025 we have no capacity to conduct this audit. However, as mitigation, the Trust has an a level of assurance by reviewing the quarterly Trust area prescribing Compass reports that are shared by SPPG. Areas for improvement are noted and where secondary care may influence the prescribing patterns the appropriate actions are taken. For example Lidocaine patch prescribing memo issued to all prescribers and pharmacists in July 2024. Our Trust Medicines Code has been updated in relation to prescribing in the outpatient setting: "Prescribers must not prescribe or recommend to GPs new medicines that have not been approved through the regional NI Medicines Managed Entry process or by the WHSCT Drug

	and Therapeutics Committee unless prescribing is for an individual patient presenting with a clinical need for a new medicine not previously approved and they have secured peer support for prescribing the new medicine".
Area for improvement 5 **Ref:** Standard 4.3 Criteria (a), (b), (e) and (g) and Standard 5.3.1 Criteria (f) **To be completed by:** December 2023	The Trust should: • ensure accurate records of monthly meetings between service managers and the Patient Access Team are maintained to evidence discussions and agreed actions. • Strengthen the oversight and assurance in relation to the Trust's referral processes (both paper and electronic). Ref: 6.2.10
	Response by registered person detailing the actions taken: Patient Access Team Leads, band 4, meet with the Service Managers on a monthly basis with standing agenda items. These meetings are also an opportunity for the escalation of any presenting issues. All discussions and actions are recorded on the attached template, see appendix 1, and revisited at subsequent meetings to ensure actions have been expedited or remain open for further consideration and subsequent closure. Team Leads collectively discuss these at their monthly Patient Access Team meetings with their immediate line manager, band 7, and records are saved on a Sharepoint site as a reference point and audit trail. In addition, Service Managers attend Core Elective on a monthly basis at which there is senior representation from Patient Access at Assistant Director level. This ensures that any escalated issues and/or concerns are cited and formally minuted for follow up action. The Patient Access Service Manager, band 8b, also meets individually the Service Managers on a monthly basis to review a number of pertinent aspects of service provision and management of waiting lists. This includes the level of open registrations, hospital initiated cancellations, duplicate referrals, delay in triage, DNA rates and review backlogs.

	See attached current processes for electronic and manual referrals managed within the Patient Access Team at appendix 2. Weekly Patient Targets Lists (PTL's) and twice weekly cancer PTL's are issued at specialty level which highlight any outstanding triage i.e. > 72 hours in line with IEAP. Issues are escalated to Service Managers and Clinical Leads for immediate attention and action. The Western Trust has consistently escalated to WLMU in relation to the implementation of the paper and internal referral module for Etriage which has been delayed since 2021/22 - this is currently with BSO. This module will facilitate paper referrals to be dropped electronically to Etriage processes on ECR, therefore providing the same level of assurance and accountability for the management of these referrals as those received via CCG. However in the interim period, there is oversight and control measured in place to manage paper referrals at Team Lead level with subsequent escalation for any delays and or operational challenges that present thereafter.
Area for improvement 6 **Ref:** Standard 4 Criteria 4.3 (n) Standard 8 Criteria 8.3 (b), (c), (d), (f) **To be completed by:** June 2024	The Trust should: • Develop a set of KPIs in relation to discharge letters across all outpatient services ahead of the roll out of Encompass; • Provide more user friendly guidance for GPs on referral pathways for subspecialties; • Strengthen the Trust's assurance system of the clinical validation of outcome letters; and • Develop and test a system which evaluates the impact of directly including patients in clinical correspondence
	Response by registered person detailing the actions taken: Patient Access have a standardised suite of discharge letters for patients who fail to respond to the partial booking process and also for those who DNA or cancel twice. KPI - Patient Access issue the discharge letter within 48 hours of the date of non-attendance or cancellation. KPI - Secretarial teams will send a discharge letter to patients and GP's if the consultants have dictated same.

	A further range of KPI inline with RQIA recommendations and NIPSO "Forgotten Report" to be reviewed and imbedded to core services, for example: 1. Referral to Traige outcome i.e. 72 hours 2. Text reminder to patients on receipt of OP referral 3. Text reminder to patients waiting 52 weeks 4. DNA / CNC rates and application of IEAP The link between Secondary Care and Primary care is promoted and maintained by close working relationships with the Deputy Medical Director for Primary Care with whom there is ongoing communication and updates as required. The "Forgotten Report" highlighted the need to improve links and communication with Primary Care colleagues - this is facilitated, in the WHSCT,through secondary representation at LCG and other Primary Care forums. There are designated sub-specialty pathways available with the Electronic Triage system on CCG which GP's access when referring a patient to secondary care services. There are clear CCG hospital destinations by Speciality and sub-specialty in line with referral criteria based on clinical priority. Any changes in referral pathways are communicated to Primary Care to ensure there are no unnecessary delays incurred for our patients. There are consistent pockets of good practice in relation to patient clinical letters going directly to the patients in a number of specialities within the Western Trust, however an action plan will be developed to roll this practice out in a consistent manner throughout all specialities within the Western Trust 24/25. Whilst there is currently a KPI for discharge letters generated from the Patient Access Function and secretarial functions, the monitoring of same is being reviewed to ensure there is consistency in application and monitored thereafter. The current medical secretary secretariats are currently in the process of being de-centralised to be aligned and managed thereafter at specialty level. Each specialty team will have a band 5 team lead who will have reponsibility for complaince to KPI's across their relevant area. It is envisaged that this secretarial support model will provide increased capacity to monitor and improve compliance to KPI's, for example discharge letters. The re-evaluation of KPI's will be undertaken in September - December 2024 when the new structures will be in place. It is anticipated monitoring and reporting of same will be in place for January 2025.

	Technical Guidance for PAS has now been approved and issued to ensure there is a formal record of clinical validation - all clinical outcome letters now have a facility to be linked to an episode in NIECR. Processes have been designed within the Patient Access function to support clinical validation by issuing a data set on which outcomes are recorded by the clinician. This is subsequently returned to Patient Acess and outcomes are recorded on PAS using the PAS Technical Guidance for same. It is envisaged that the WHSCT will udertake a pilot test of a cohort of patients who currently receive a copy their clinical correspondence issued to their respective GP. The Trust will survey patients via QR Code linked to an agreed questionnaire, with WHSCT communications, to evaluate the impact of receiving same. It would also be the intention to collate and evaluate feedback from Primary Care on the impact of clinical letters being issued to patients. It is anticipated this will be undertaken September - December 2024 with outcomes of same presented to ECB disseminated thereafter.

Please ensure this document is completed in full and returned via the Web Portal

Appendix 1.

Recommendations arising from the "RQIA Review of Governance of Outpatient Services in the Belfast Health and Social Care Trust with a focus on Neurology and other High Volume Specialities" (February, 2020)

1	Belfast Trust should review and streamline its systems and process for receiving and managing referrals to its outpatient's services. Accurate data and intelligence arising from streamlined referral systems should be used to inform oversight and assurance of the Trust's referral processes.
2	Belfast Trust should develop and implement a wider team approach to assure best practice in the triaging of referrals received for its outpatient services; a team approach is particularly important for referrals received to high risk specialties such as antenatal obstetric care.
3	Belfast Trust should strengthen its systems for validation of lists of patients currently awaiting review and / or assessment through outpatient services; validation should include risk stratification, by clinical need and priority, of patients currently on waiting lists.
4	Belfast Trust should review its systems for identifying and recording information on patients transferring from the Independent Sector to Trust services; the Trust should ensure there is robust governance and oversight of all processes relating to transfer.
5	a) Belfast Trust should ensure that all outpatients services receive and actively use up-to-date information relating to productivity lost through clinics which are cancelled and / or not attended (DNAs and CNAs); b) The Trust should expedite its work to improve productivity and reduce the impact of cancellations and non-attendances at outpatient clinics.
6	Belfast Trust should urgently review the content and format of appointment letters issued to patients attending orthopaedic outpatient services.
7	a) Belfast Trust should review its current practice in relation to communication with General Practitioners and other referrers, following patients' attendance at outpatient services; b) The Trust should agree, implement and monitor a standard set of key performance indicators across its outpatient services to underpin improvement in its written communication following outpatients review; and c) The Trust should evaluate the impact and effectiveness of directly including patients in clinical correspondence following outpatients review, to determine if implementing this approach would be of benefit across all its outpatient services.
8	Belfast Trust should identify and strengthen mechanisms to engage Sisters / Charge Nurses across outpatient services in its work programmes addressing collective leadership and organisational accountability.

9	a) Belfast Trust should complete a mapping exercise to understand in detail the operational, management and governance arrangements across all outpatient services it delivers; and b) The Trust should assure itself that operational arrangements for all outpatient services are appropriately aligned across service Directorates and divisions, so that care delivered in outpatients is consistency well governed.
10	a) Belfast Trust should specify how its collective leadership strategy and model will specifically strengthen the delivery of safe, effective and compassionate care across outpatient services; and b) The Trust should identify key measures to demonstrate the impact of its collective leadership strategy and model on outpatient services.
11	Belfast Trust should develop and implement a set of key indicators to assure its performance in relation to the care it delivers through outpatient services. The Trust should not limit these indicators to activity data; these should be shared with the Trust Board and the Executive Team on a regular basis.
12	Belfast Trust should adopt a strategic approach to audit and quality improvement work involving outpatient services, to align with the Trust's organisation-wide approach to quality improvement and to focus on both specific service or site improvement and system level improvement.
13	Belfast Trust should strengthen its approach to the identification and management of risk within and across the outpatient services it delivers by necessity this will include: a) A mechanism to ensure sharper focus for the known risks across the full range of Trust services delivered in outpatient settings; b) Progressing work to understand and mitigate new or previously unidentified risks, such as those described in this review; c) Ensuring that all staff delivering outpatients services are proactive in their approach to identifying risks as they emerge and to implementing systems to manage these risks; and d) Ensuring that the Executive Team and Trust Board are regularly updated and receive robust assurance regarding risks as they relate to outpatient services.
14	Belfast Trust should expedite work to develop its internal information systems so that data on clinical activity and patient outcomes (by service, by team and by consultant) are routinely reported and shared; this information should be available to support annual whole-practice appraisal and revalidation, as well as service planning and development.

15	Belfast Trust should strengthen its use of information and intelligence relating to incidents and complaints occurring in the context of outpatients services it delivers; the Trust should analyse this data and intelligence in a way that promotes a proactive approach to identifying risk and improving the quality and safety of outpatients services.
16	a) Belfast Trust should develop and implement a targeted action plan to improve knowledge and awareness of staff in relation to the safeguarding of adults and children receiving care and treatment in its outpatient services; b) The Trust must ensure it receives robust assurances in respect of compliance with best practice as advised by regional and local policies in this regard; and c) The Trust should review its risk register to ensure it is accurately capturing current risks relating to the knowledge and awareness of staff safeguarding roles and responsibilities.
17	Belfast Trust should ensure information relating to outpatient activity (by service, by team, by consultant) is collected, analysed and routinely shared; this data should be used to enable robust capacity planning and to inform future service development and modernisation of outpatient services across the Trust.
18	a) Belfast Trust should ensure it develops and implements a robust system for oversight and monitoring of the quality of care delivered by Specialist Nurses and the related patient outcomes achieved across its outpatient settings; b) Specialist nurses should be appropriately supported to undertake their roles through effective supervision, professional development and support for annual appraisal and revalidation.
19	Belfast Trust should develop, implement and assure a systematic approach to clinical peer review across its outpatient services.
20	Belfast Trust and the Health and Social Care Board should establish clear mechanisms by which the Trust and General Practitioners can engage and communicate in relation to outpatient services delivered by the Trust. The Trust should also assure itself that General Practitioners who may have a concern relating to services delivered have been provided with clear information regarding how to raise their concern.
21	Belfast Trust should develop a system or systems to enable appropriate oversight and assurance of prescribing and prescribing advice across the Trust's outpatient services. This should include the development and implementation of an interim electronic system to replace the current paper based Treatment Advice Notes.
22	Belfast Trust should cease the practice of retaining separate paper-based notes for particular outpatient specialities; the Trust should develop a system whereby patient notes for all specialities as retained as part of an integrated hospital-wide record.

23	a) Belfast Trust should agree a range of key performance indicators across all its outpatient services; b) It should assure and govern these systems for service improvement; and c) It should communicate these to services through specialty level dashboards.
24	Belfast Trust should further develop and expedite new models of working in outpatient services, such as the use of telephone and video appointments, remote monitoring, outreach clinics; new models for service delivery should be agreed with commissioners and consistently evaluated to demonstrate impact.
25	Belfast Trust should optimise various communication media as a means of providing information about conditions, procedures and treatments to patients across its outpatient services.
26	Belfast Trust should develop and implement arrangements to obtain patient feedback in a co-ordinated and systematic way across all outpatient sites. Feedback received should be used to evidence quality of care delivered and to underpin service improvements as required.

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