Inspection of Outpatient Departments
South Eastern Health and Social Care Trust

16 September 2024 - 11 November 2024

Type of service: Outpatient Services
Address: South Eastern Health and Social Care Trust
Upper Newtownards Road, Dundonald, Belfast BT16 1RH
Telephone number: (028) 9048 4511

1.0 Service information

Responsible Person: Ms Roisin Coulter	**Position:** Chief Executive Officer
Person in charge at the time of inspection: Ms Mary Jo Thompson	**Position:** Assistant Director: Medicine and Cancer Services
Brief description of the accommodation/how the service operates: The South Eastern Health and Social Care Trust (the Trust) provides inpatient, day case and outpatient healthcare services for up to approximately 350,000 people across the local government districts of Ards, North Down, Down and Lisburn. The Trust supports approximately 235,300 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' (known as 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 focused upon the Belfast Trust, the learning arising from the review and the subsequent 26 recommendations were considered to be equally applicable to all Health and Social Care (HSC) Trusts in Northern Ireland. Consequently, HSC Trusts have been providing updates to the Strategic Planning and Performance Group (SPPG) of the Department of Health, in relation to their progress at implementing the recommendations.

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

Outpatient departments at five hospital sites were selected for inspection:

- Ards Community Hospital
- Bangor Community Hospital
- Downe Hospital
- Lagan Valley Hospital
- Ulster Hospital

3.0 Inspection summary

An announced inspection of the Trust outpatient departments (OPD) commenced on 16 September 2024 and was completed on 11 November 2024, 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.

Feedback from service users, relatives and staff was almost entirely positive and complimentary across the five OPD sites. Staff reported that there was sound visible leadership, governance and support from their managers across OPDs. Morale amongst medical teams was reported to be good, with positive working relationships expressed by nursing staff, clinical support staff and Allied Health Professionals (AHPs).

Governance and organisational structures were reviewed and found to be robust. The Trust had appropriate systems and processes in place for the oversight, monitoring and delivery of the quality of care to service users. A number of oversight groups had been established to monitor the implementation of recommendations arising from various reviews and inquiries.

Discussions between members of the inspection team and staff across all grades and from various directorates, together with observations and a review of a range of minutes of meetings, indicated that collective leadership was strong and indicative of a positive culture throughout the OPDs.

A significant development for the Trust is that it was the first in Northern Ireland to implement Encompass, a programme that seeks to create a single digital care record for every citizen in Northern Ireland who receives health and social care. Encompass means individual's health and social care records will be digitalised and can be accessed at the touch of a button; bringing together information from various existing but obsolete information technology (IT) systems which fail to communicate effectively with each other.

Further information on the benefits of Encompass can be found here.

The findings of this inspection were in keeping with the Trust's acknowledged position in relation to each of the 26 recommendations of the RQIA 2020 review.

This inspection resulted in two areas for improvement (AFIs) being identified; and these are detailed in the findings of this report and in the associated Quality Improvement Plan (QIP).

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.

Similar to all HSC hospital inspections, this hospital inspection was underpinned by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003; and care provision was measured against 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; key lines of enquiry were then developed 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 returned prior to the on-site element of the inspection. The Trust action plan detailing progress against the RQIA 2020 review recommendations (dated 8 August 2024), was also scrutinised prior to the on-site inspection phase. This information also assisted with the further 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; as were the Trust's organisational charts.

A folder of evidence was also shared with the RQIA inspection team on the first day of the on-site inspection phase, the content of which provided supporting evidence of Trust progress towards achieving the recommendations from the RQIA 2020 review.

OPD Clinics were selected systematically, e.g. clinics considered to have a high volume of service users; where there is a single consultant service provided by only one consultant working in a wider clinical team; or where concerns have been reported to RQIA.

The OPDs across five hospital sites were visited on the following dates:

- Ulster Hospital (16 September 2024)
- Lagan Valley Hospital (17 September 2024)
- Ards Hospital (18 September 2024)
- Downe Hospital (18 September 2024)
- Bangor Hospital (26 September 2024)

The on-site element of the inspection included direct observation; engagement with service users, relatives and staff; and the review of relevant documentation. The documentation reviewed included samples of evidence to support the Trust's progress with achieving the 26 recommendations from the RQIA 2020 review; management and governance reports; and the minutes of various relevant meetings.

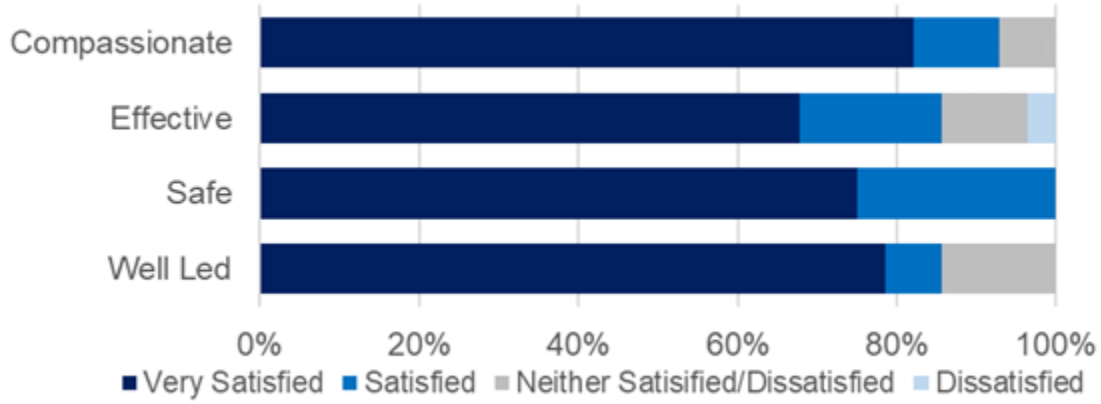
5.0 What people told us about the service

5.1 Service user engagement / patient experience

Inspectors met face to face with a total of 32 service users and their relatives during the inspection. Overall feedback was very positive in relation to the quality of care delivered, communication prior to, during and after attending OPD clinics, and service users reported that they felt safe at the OPD clinics.

As part of the semi-structured interviews, service users and their relatives were asked to score their experiences about a range of experiences relating to four domains: safety, compassion, effectiveness; and well led on a scale of 1-5 (1 being very dissatisfied and 5 being very satisfied).

Service user and relative satisfaction levels across the four domains are summarised in the graph below:



Positive feedback was provided by service users regarding how they were treated. OPD staff were described as being kind, polite and supportive; and those spoken with felt staff and consultants were respectful in their communication during appointments.

However, a small number of service users expressed their dissatisfaction about the length of waiting times for either their first appointment; or the prolonged gaps between follow up review/or subsequent appointments.

Care Opinion is a platform used by Trusts that allows service users to share their feedback and experiences of health and social care services. It was duly noted that service user feedback from Care Opinion was very favourable.

5.2 Staff engagement

We sought to understand staff experiences of working in OPDs and to assess if they believed that care was delivered in a safe, effective, and compassionate manner; and also to ascertain if they believed outpatient services were well led.

Inspectors met face to face with a total of 34 staff, which included doctors, nurses, pharmacists, managers, service leads, assistant directors and directors, and administrative staff. Three focus groups were also held with medical staff across the following staff groups: resident doctors[1] (formerly referred to as 'trainees'); SAS doctors[2]; and Consultants. There was representation across all relevant high-volume specialties: respiratory medicine, gastroenterology, neurology, diabetes / endocrinology, acute oncology, general surgery, breast surgery and paediatric surgery. In person discussions with staff, along with engagement with focus groups, provided rich, valuable information, which was triangulated with other evidence in order to inform the findings of the inspection.

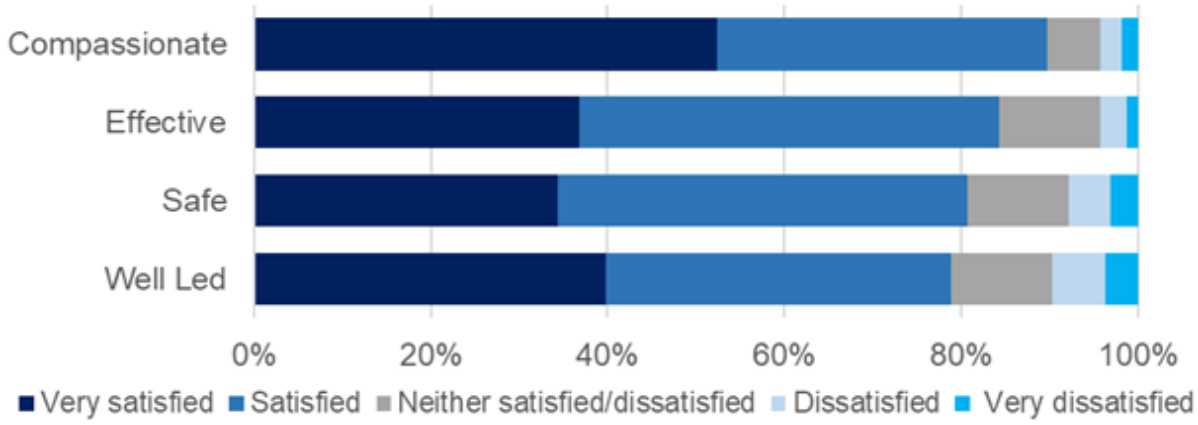
In person discussions and focus groups with staff were very encouraging with all staff groups describing the delivery of safe, effective and compassionate care both within OPDs and during other stages of the patient journey.

Staff morale across all staff groups working within OPDs was reported to be high, with positive working relationships described across differing staffing groups and disciplines, including clinical teams outside of OPDs.

Staff questionnaire

As part of this inspection RQIA extended an opportunity for all staff working across OPDs to share their thoughts and experiences by completing an online anonymous questionnaire. There were a total of 166 responses received across the five OPD sites.

Staff satisfaction across the four domains is shown in the graph below:



Comments from staff across all sites indicated there was good morale and working relationships and a strong focus on staff wellbeing. Overall staff reported effective communication and good support within their teams. Staff also stated that there are effective escalation and communication processes in place. However, the online / QR questionnaires concluded there was a small percentage of staff reporting lower morale as a result of reduced staffing levels. This predominantly related to the OPDs at the Ulster Hospital site.

Generally, staff reported there was good and visible leadership, governance and support from their managers across all OPD sites.

[1] Resident doctors are fully qualified doctors who are either currently in postgraduate training or gaining experience as locally employed doctors, to become the consultants, GPs or specialists of tomorrow.

[2] The term 'SAS doctor' includes specialty doctors and specialist grade doctors with at least four years of postgraduate training, two of which are in a relevant specialty.

Most staff reported there were also good opportunities to complete role-specific additional training. However, a small number of staff reported challenges accessing specific training and, in some cases, funding was limited.

Other issues that staff noted to be challenging largely related to the introduction of Encompass. The implementation of Encompass was characterised as being often perplexing, but firmly positive; and it was noted that issues were resolving as they became more familiar with the platform.

Staff also acknowledged that patients have expressed frustration in relation to waiting lists.

6.0 The inspection

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 documents were reviewed, including the Trust Quality Strategy, Quality 4 all: 2021-26, the "vision of which is to deliver the highest quality services for our population." Information was also directly provided through the inspection team's engagement with Trust staff. There was evidence of a range of quality improvement (QI) initiatives implemented across all OPDs.
The Safety, Quality and Experience (SQE) board displayed in all OPD areas highlighted quality improvement initiatives carried out by the Trust. An example involved improving patient experience when attending outpatient clinics for neurology speciality review. The aim of the initiative was to reduce the number of inpatients missing meals when attending outpatient speciality review by 50% within six months. There was a positive outcome in that there was a reduction noted in number of patients missing meals and the number of patients remaining in the OPD after 5.00pm.

A further QI initiative was the introduction of the Neurology Advanced Referral Management System (NARMS) which aimed to reduce clinic attendances using advice or investigations to provide a speedy response to around 50% of referrals.

Early indications highlighted positive feedback from GPs and service users such as timely advice and quicker investigations. Improvement was identified in communication between primary and secondary care, information included in referral letters, service user expectations, and clarity regarding who performs and follows up on blood investigations.

In other clinical areas there was an increased focus on dementia awareness, with changes to the clinical environment making it more user friendly for people living with dementia, such as, allocation of specific clinic rooms to review service users, an orientation board and updated signage.

There were also a number of innovative projects focusing on clinical capacity including identifying barriers that contribute to delays during clinic sessions and optimising 'on the day' clinic cancellations for cataract surgery.

The examples of QI work reviewed in OPDs demonstrated the Trust's ability to establish a vision for improving quality care in OPD and for communicating that work to service users and staff alike.

6.1.2 Governance, Leadership and Accountability

The Quality Standards for Health and Social Care 2006 state that organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care. The Trust's governance structures and leadership arrangements were reviewed and evidenced clear organisational, directorate and sub-directorate structures, and an integrated governance and assurance framework committee.

The governance and assurance committee structure outlined various meetings and forums which are informed by all directorates. Information reviewed evidenced appropriate representation of staff attending the relevant meetings (grades, specialities and directorates). Set agendas outlined data that gave an account of inpatient and outpatient activity, waiting list figures across red flag, urgent and routine triaged referrals, complaints, Datix (an electronic incident recording system), staff vacancies and significant event reports and reviews.

The range of convened meetings are designed to support governance reporting mechanisms from a top down and bottom up approach across the specialities and directorates. The review of meeting minutes evidenced shared learning from mortality and morbidity (M&M) meetings; serious adverse incidents (SAIs), complaints, information regarding new clinical guidelines, and new and reviewed policies and referral pathway updates.

In addition, the Trust had a number of oversight groups to monitor the implementation of recommendations arising from various reviews and inquiries such as the Neurology Independent Neurology Inquiry and Hyponatraemia Report of the Inquiry into Hyponatraemia related Deaths inquiries. There was appropriate representation across the directorates and specialities, and appropriate terms of reference (TOR) stipulating the aims, objectives, and reporting responsibilities of each group were in place.

Throughout the inspection, discussions between the members of the inspection team and staff across all grades from various directorates, together with observations and a review of a range of minutes of meetings, indicated that collective leadership was strong and indicative of a positive culture throughout the OPDs.

Leadership and Management of the Clinical Area

There was a clear organisational structure in place and staff were able to describe their roles and responsibilities; managers were visible in the clinical area; and managers described operating an open door policy for all staff.

There was an evident strong focus on staff wellbeing with a number of activities being described such as team building and celebration activities, alongside specific Trust programmes such as 'Live Well'.

Collective leadership was evident throughout, staff provided examples of their participation in QI projects, attending a variety of meeting forums and they felt comfortable to respectfully challenge colleagues, and to raise any concerns.

Nursing staff, AHPs and clinical support staff described feeling well supported and valued within their day-to-day work, by the multi-disciplinary teams and by the Trust. Resident doctors and SAS doctors also described positive support mechanisms and feeling valued by senior colleagues and the wider clinical team. Staff advised that they have no issues raising concerns and believe the culture within the OPDs is both positive and supportive.

Consultant staff, on the whole, reported feeling supported by the Trust and acknowledged a leadership commitment to nurturing staff wellbeing. It was highlighted that strengthening a proactive and preventative approach to staff wellbeing may be helpful; such as enhanced provision of support to staff involved in complaint and incident investigations.

Staff reported that they felt supported by their managers and they were encouraged to develop their skills and expertise. Staff also viewed the clinical educator as a positive support mechanism.

Recent developments have included the creation of a forum for deputy nurse managers from across the hospital sites to meet to discuss matters relating to their role, share learning, and to develop their leadership and management skills. These meetings were seen as a mechanism to promote staff development and career progression.

There were systems in place to promote effective communication with staff and across multidisciplinary teams. There was evidence of daily safety briefs across OPDs, and dissemination of information through a number of formats; face to face, via email, and through additional meetings. Some nursing staff also participated in M&M meetings which they found beneficial and any learning was shared. Nevertheless, there were variances in how frequently OPD team meetings were held and in how they were conducted. The Trust may wish to consider a standardised approach to conducting team meetings across its outpatient services.

There are a range of policies and procedures which are available for staff to access through the Trust IT system. A number of OPD managers described retaining paper copies of policies and procedures for their staff to access in the clinical area. Managers confirmed that staff have access to the most up-to-date policies and procedures at all times.

There were effective arrangements for ensuring evidence-based practice through staff education, training and Trust policies and procedures.

6.1.3 Service planning

Evidence was sought 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 service users, 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, team, and by consultant) to enable robust capacity planning and to inform future service development and modernisation of outpatient services across the Trust.

Encompass can provide real-time data on the number of appointments in an outpatient clinic; how many of them are new or review appointments; and under what category they are such as red flag, urgent or routine. It has the ability to accelerate service users' journey through the hospital system by affording the function for doctors to order diagnostic tests, imaging, or requesting bloods in a more expedient manner.

Medical staff described effective delivery of outpatient services within existing budgetary constraints and workforce challenges which have been impacting on waiting times regionally. Within the Trust, infrastructure issues resulting in a lack of physical space were reported (by medical and nursing staff) to be impacting on capacity to see service users within some outpatient services. This was particularly in relation to maxillofacial and paediatrics outpatient departments.

Discussions with senior management responsible for maxillofacial services highlighted a number of issues in relation to the growth and development of the service, the increased number of service users and the commissioning of staff complement to meet the current needs of the service. Senior staff reported that work is in progress to reconfigure the service at regional level and it was confirmed that meetings with the Strategic Planning and Performance Group (SPPG) have taken place to progress this work.

A number of non-medical staff also highlighted concerns with the lack of clinical space within the Paediatric OPD which had remained static for a number of years despite significant growth in the service. It was noted that plans were being progressed to expand the Paediatric OPD into an adjacent area, however staff advised that plans were slow to progress.

Recent service development and innovative working was described, such as the development of Rapid Access Clinics and Ambulatory Hubs along with enhanced clinical triage processes, greater emphasis on service user self-management and, where appropriate, use of other methods of service user engagement, such as online video, telephone or email, rather than face-to-face service user appointments.

The enthusiasm of medical staff for these service user centred improvements was commendable. However, it was reported that some innovation was borne out of good will, with no additional funding or time set aside within consultant job plans. Medical staff also reported specific challenges with the delivery of outpatient services that were difficult to address without a concerted strategic direction, accompanied by additional funding.

One regional challenge cited was the lack of a DoH-led strategy specific to outpatient care to set out the vision and strategic direction for outpatient care within a post-COVID landscape[3].

A legacy of longstanding challenges with workforce planning and workforce strategy implementation was reported to be impacting on service efficiency, contributing to long waiting lists across specialties. Whilst the number of consultant staff has risen over the last decade, the number of trainees allocated to specialty training programmes within the Trust was described as largely static; this was reported to have impacted both on service provision and also the Trust's ability to make the best use of training opportunities within its outpatient services. Multidisciplinary working within the Trust was highlighted as a strength by all medical groups but it was reported that further consideration could be given to how other professionals, such as specialist nurses and AHPs could be trained to deliver specific aspects of outpatient care, lessening the reliance on medical staff.

The catchment area covered by the Trust was leading to some service users travelling further for care, in some cases, despite living closer geographically to hospitals such as Royal Victoria Hospital; this was reported to be a particular issue for children's outpatient services. Capacity issues within HSC services external to the Trust was also reported to be impacting on Trust services; for example, it was reported that there were difficulties in children and adolescents accessing specialist Eating Disorder Services within the Belfast Trust.

[3] It should be noted that subsequent to the inspection visits, the NI Health Minister has published a framework document 'Hospitals – Creating a Network for Better Outcomes' (1 October 2024) to support consultation on the reconfiguration of HSC hospitals, to include modernisation of outpatient services.

An increase in service user complexity without commensurate investment in services was also highlighted as a challenge. Service accessibility issues and, in particular, long waiting lists for first appointments was reported to be impacting on the ability of some outpatient services to provide care in accordance with national standards. This has led to 'work-arounds' in some specialties; for example, service users triaged as 'red flag' may instead be assessed at the Pleural Hub rather than within the dedicated outpatient clinic.

It was reported that consultants have time set aside within consultant job plans to triage referrals and, in some specialties, SAS doctors also participate in referral triage. The importance of time available within medical job plans for administrative and governance duties was recognised. It was stated that there are ongoing efforts to review consultant job plans in accordance with service and population need.

One consultant reported undertaking singlehanded outpatient practice by virtue of being the only oncology consultant within the Trust providing a subspecialist outpatient Lung Cancer service. Adequate mitigations were reported to be in place, with good peer support described within the wider specialty team and regional specialist networks, and appropriate arrangements for oversight and assurance through consultant participation in MDT, clinical audit and peer review. The Trust reported that an arrangement is in place with NI Cancer Centre to ensure consultant cover for planned periods of leave. Nonetheless, the vulnerability of the specific outpatient service should unexpected leave arise, was highlighted as a concern by medical staff. Digital transformation through implementation of the Encompass system, has brought benefits to outpatient services, however a consistent view expressed by medical staff was that there has been an increase in the administrative requirements for each appointment and length of time needed to see each service user. Medical staff expressed concerns that clinic capacity would remain reduced in the longer term and wanted this to be taken account of in the planning, commissioning and staffing of outpatient services going forward.

Encompass has the ability to support service planning based on an equitable pattern of assessed need. Environmental constraints regarding core clinical space and also the growth of services are being addressed at local and regional level.

6.1.4 Quality Assurance

A robust and holistic approach to assurance was described within OPDs with governance and oversight of each OPD facilitated through the collation of a monthly assurance document.

This document was completed and overseen by senior managers in OPDs throughout the Trust and included information such as key performance indicators (KPIs), QI projects, risk assessments, service user feedback, incidents, and information on staffing, staff supervision and appraisal.

Evidence was sought of the systems in place which will enable the Trust to collate and analyse KPIs within outpatient services to drive service improvement; to include the identification and management of risk to promote learning and prevent reoccurrence.

A range of KPIs were collated and displayed in the clinical areas, these included Infection Prevention and Control (IPC), such as adherence to hand hygiene compliance, and environmental audits; and feedback from service users. Overall, the results displayed were positive.

One of the initiatives in place to drive quality improvement was a 'focus of the month' which was also displayed in OPDs.

Quality Board displayed in Lagan Valley Hospital

There were effective systems and processes in place to monitor and improve the quality and safety of the service.

6.1.5 Managing Risk

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

Local risk registers are in place across OPDs and within the administrative teams' structures. Identified risks are escalated through relevant structures and incident reporting processes are followed. Risks are managed and discussed through a number of avenues; safety huddles, speciality team meetings, directorate meetings and forums.

Staff were able to discuss incidents which had occurred and the resulting actions and mitigations taken by the Trust. Good clinical governance and best practice dictates that all staff must complete Datix training. Not all OPD managers were aware of this requirement for their staff; they agreed to ensure all their staff undergo Datix training.

It was confirmed there were a number of effective mechanisms across each OPD, to identify, mitigate, record and review risks. These mechanisms were sufficient to manage and escalate risks as required. There was evidence that incidents were reported, analysed, and appropriate actions taken to implement any identified learning.

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 service user outcomes achieved across its outpatient services**.**

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 M&M meetings and other meetings where clinical incidents, complaints, waiting lists and high risk "red flag" service users are discussed. Regional specialist nurse forums were also attended which provides an opportunity for sharing of good practice and continuous professional development.

Senior Trust representatives reported that they are developing rollout of audit and peer review processes for specialist nurses to drive quality of care outcomes for patients.

Supervision arrangements are in place for nursing staff, and managers confirmed professional/clinical supervision sessions are carried out across all OPD's. Supervision sessions are collated through the electronic staff rostering system and managers have oversight of compliance through completion of the monthly assurance document.

Generally, staff reported they are receiving regular supervision and some stated it mainly consisted of 'group debrief' type sessions' as opposed to one to one supervision.

OPD managers confirmed that they review current practice in line with the Trust Supervision Policy which highlights that staff can avail of either group or one to one supervision opportunities.

Whilst a policy and procedure for supervision in nursing was available, not all staff were able to locate the policy through the staff intranet system, this was discussed with senior staff. Additionally, the Trust acknowledged that the present supervision policy was under review, and confirmed that this was being progressed. There were reportedly satisfactory arrangements for medical governance in terms of oversight of medical appraisal and revalidation. Appraisal compliance rates were reported to be high.

Medical oversight of outpatient services was reported to be strong. Resident doctors reported feeling well supported with both clinical decision making and training needs. SAS doctors reported having their professional autonomy respected and receiving an appropriate amount of support, when required. Morale amongst medical teams was reported to be good, as well as positive working relationships with nursing staff, clinical support staff and AHPs.

Staff appraisals were largely up-to-date and, in the main, mandatory training for nursing and administrative staff relevant to the RQIA 2020 Review recommendations was also up-to-date.

It was reported that outpatient services regularly participated in clinical audit. Some services such as cancer services reported having participated in peer review in the past; i.e. as part of the National Cancer Peer Review programme. However, with the exception of internal peer review of consultant triage as part of a specific service improvement initiative[4], there was no evidence of Trust-initiated peer review having been undertaken within the last three years. As such, RQIA determined that there was a need to strengthen a systematic approach to peer review of outpatient services within the Trust. RQIA notes that the Trust's position in response to this recommendation[5] is that further scoping is required to develop and implement a specific regional outpatient peer review across all specialties. RQIA considers that in order to demonstrate robust assurance of quality and safety of its outpatient services, the Trust should progress these plans at the earliest opportunity.

The Trust had appropriate systems and processes in place for the oversight, monitoring and delivery of the quality of care to service users.

[4] Neurology Advice and Referral Management System
[5] Recommendation (19) *'South Eastern Trust should develop, implement and assure a systematic approach to clinical peer review across its outpatient services'*

6.1.7 Safeguarding

Safeguarding is the term used for actions taken to protect the health, well-being and human rights of individuals, especially children, young people and adults at risk.

RQIA assessed the Trust's arrangements for oversight and delivery of service user safeguarding systems and training across the OPDs.

In February 2019, following an RQIA inspection of Belfast Trust outpatient services, NI Chief Medical Officer wrote to remaining HSC Trusts advising them to ensure that all staff working in outpatient settings have good awareness and a working knowledge of safeguarding matters, they know how to identify and escalate concerns and staff have received training on safeguarding, appropriate to their role and seniority.

During the inspection, a range of staff demonstrated good knowledge and awareness of their roles and responsibilities with regard to recognising and raising safeguarding concerns. The majority of staff had completed their safeguarding mandatory training and were aware of the types and indicators of abuse, how to respond, take action in reporting and escalating concerns.

Knowledge and awareness of child protection procedures was found to be good amongst medical staff working within the Trust paediatric services. In relation to adult safeguarding, medical staff indicated a degree of uncertainty around Trust arrangements for delivery of training and monitoring of compliance rates.

Northern Ireland Medical and Dental Training Agency (NIMDTA) mandate that all foundation doctors and GP trainees undergo adult safeguarding training.

For resident doctors in specialty training, child protection training is mandatory but not adult safeguarding; therefore, it is the responsibility of HSC Trusts to be assured that all medical staff working within outpatient services, including resident doctors, SAS doctors and consultants, have the appropriate level of awareness and training.

The Trust confirmed that all staff, are required to complete Level One adult safeguarding training. Those with direct contact with adults at risk of harm are also required to complete Level Two adult safeguarding training every three years. Despite Trust requirements, training compliance rates with medical staff were found to be low. Overall rates of medical and dental staff completion of Level One training were just 19%; Level Two was reported to be 8%. Specialty-specific compliance rates were not available.

Staff had access to safeguarding policies and procedures, and safeguarding information boards were displayed in each OPD providing information to all staff and service users on pathways to raise concerns. The boards also displayed relevant safeguarding contact numbers. Departments had a designated safeguarding champion, and staff reported they felt confident in raising any concerns and they were aware how to seek any additional support which was readily available.

An area for improvement has been made.

To mitigate the potential risk to service-users, the Trust must take steps to improve and assure the compliance of medical staff with adult safeguarding training.

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.

There is robust oversight of prescribing of specialist medicines and those dispensed in hospital pharmacy in the outpatient service. There is some oversight of medicines prescribed to be administered in the outpatient service via the inventory list.

The Trust does not currently monitor or have oversight of medicines recommended to be prescribed (electronic treatment advice notes, eTANs) in the outpatient clinics. The system currently operating is based on eTANs issued electronically to GPs. It is expected that eTANs are reviewed by the GP and their practice pharmacists and that medicines optimisation and prescription review occurs before a prescription is issued. The identification of 'unusual' recommendations to prescribe and/or trends is reliant on issues being identified in primary care by the GP who has responsibility for signing the prescription.

The Trust is not currently funded to provide pharmacy resource in the majority of outpatients' clinics. Whilst the Trust has moved to Encompass, the reports have not been built and tested which will allow information to be pulled retrospectively to monitor recommendations to prescribe/eTANs.

The majority of medicines identified on site visits were found to be stored appropriately however, one oxygen cylinder was found to have no clear signage in place, this was escalated to management. Patient Group Directions (PGDs) were in use for the supply and administration of medicines, three PGDs were out of date.

This was escalated this to Trust management for immediate action.

An area for improvement has been made.

The Trust should develop a 'prescribing and recommendation to prescribe policy' which includes details of the arrangements for the oversight and assurance of prescribing and prescribing advice across the Trust outpatient services.

6.1.9 Records Management

Records management was reviewed to assess compliance with best practice.

Following the launch of Encompass, the Trust advised that only a small number of hard copies of service users' notes are required, for a small number of clinics.

Encompass systems enable medical staff to write outpatient letters on clinic templates which can be addressed to the service user and copied to the GP, in keeping with NICE Guidance on Shared Decision Making (NG197)[6]. Facilitated by Public Health Agency (PHA), with oversight arrangements in place by SPPG, regional work is ongoing to progress implementation of NICE Guidance NG197.

[6] NICE Guidance NG197 on Shared Decision Making:

1.2.20: When writing clinical letters after a discussion, write them to the patient rather than to their healthcare professional, in line with Academy of Medical Royal Colleges' guidance on writing outpatient clinic letters to patients. Send a copy of the letter to the patient (unless they say they do not want a copy) and to the relevant healthcare professional

In respect of requirement relating to clinical letters, a Task and Finish Group has been established with representation from the Trust. The Trust provided RQIA with a copy of their action plan; RQIA notes that the Trust is committed to achieving compliance with this standard, in line with regional efforts.

Notwithstanding this commitment, RQIA found that at the time of the inspection there was an inconsistent approach to providing service users with outpatient letters.

Medical staff reported that it was clinic-dependent and sometimes clinician-dependent on whether a letter would be typed, dictated, sent to the GP and/or to the service user; not all medical staff reported using lay language in outpatient letters. There was no local policy or guidance available to ensure a standardised approach to the sharing of information with service users. Although the new 'My Care' platform will serve to improve service user access to medical information, it is important that a consistent approach is adopted to the recording of lay language correspondence available to service users. The Trust confirmed that all letter templates were reviewed prior to Encompass going live and are stored within the Encompass system.

6.1.10 Access

RQIA assessed if the Trust used an evidence-based model of care to the delivery of outpatient services with a particular focus on ensuring positive outcomes for service users.

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 service users access to outpatient, diagnostic, elective admissions and elective 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 central booking team work within the IEAP guidance. A number of administrative managers advised that staff had received awareness training on IEAP a few years ago with refresher training now in progress. A copy of IEAP is available and can be accessed on Sharepoint. The principles underpinning it are discussed at team meetings.

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 and triaged by the central booking team electronically. Small pockets of referrals are still received via paper and these are now scanned into EPIC via the central booking team. Reports are collated for un-triaged referrals over three days and an escalation process is in place as service users cannot go onto the waiting list unless triaged through EPIC.

Processes and system prompts were in place for administrative staff to detail the type of appointment required, for example: priority, face to face, virtual and nurse led. A partial booking system is in use. This is where a letter is sent to the service user inviting them to ring into the booking team to arrange their appointment.

Some of the challenges discussed were that due to the lengthy waiting lists there is an increase of secondary referrals which can mean a service user is on a queue a number of times. The Trust are currently working with the encompass team for a resolution with a number of options being considered.

Processes are in place for the transfer of service users from the private sector to National Health Service (NHS). A paper based form ensures the appropriate process is followed for the consultant transfer of service users from private to NHS, with governance arrangements in place to approve this. Letters received for private sector service users are triaged with all other letters and added to lists in chronological order and clinical priority. Administrative staff have aide memoires to follow the correct process. Spot checks are carried out to ensure compliance with the process.

The Trust are able to extract and interrogate data from Encompass and produce reports across some data sets, for example, understanding the number of appointments where patients did not attend (DNAs) or cannot attend (CNAs).

However, to understand some of the reasons why patients missed their appointments, requires the Trust to build a software programme that will enable them to report on and interrogate that level of detail. The Trust are aware of the further actions required to progress this and have communicated these issues with the SPPG in the DoH who monitor performance.

Text message reminders are sent to service users prior to appointments which did result in a reduction of DNAs.

Trust staff advised that the introduction of Encompass challenged them beyond their initial expectations and their resilience across all disciplines and grades. The Trust envisaged that (over time) once service managers, clinicians and directors become more familiar with its capability, they will be able to more readily and easily monitor and scrutinise service KPIs and other aspects of their service which will ultimately enable them to plan and improve their services from a more readily available evidence basis.

Appropriate systems were in place to ensure an evidence-based model of care to the delivery of outpatient services was in use.

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 service users, 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.

Staff had good knowledge of the Trusts complaints process and how to manage complaints at a local level. There was evidence of shared learning and actions taken as a result.

OPD staff had good awareness of the need for, and mechanisms to report incidents and near misses, and confirmed that they received feedback on the outcome of relevant investigations.

Robust governance arrangements were described for deriving and sharing learning from incidents, complaints and clinical audit through monthly M&M meetings. It was reported that learning from M&M meetings is utilised to inform staff education and service improvement; this was evidenced by meeting minutes provided to RQIA.

Medical staff were knowledgeable on the mechanisms for raising concerns, and reported feeling comfortable raising safety concerns, if required.

There was evidence to confirm that the Trust used information and intelligence relating to complaints, incidents and concerns occurring in the context of outpatients services to promote a proactive approach to identifying risk and improving the quality and safety of outpatients services.

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. The inspection team met with the Clinical Director of Primary Care (CDPC) who among other roles facilitates the communication with local medical councils (LMCs) who have representatives from the GP federations. This forum aids two-way communication from GP practices and the Trust. The CDPC advised that there is a formal meeting with a set agenda that occurs every two months with local medical councils. Outside this formal meeting GPs can also contact the CDPC to discuss any issues.

The CDPC advised that there is a culture of mutual respect and trust between the LMCs and GPs. They reported there is a shared understanding that when issues are raised, they are addressed, and any concerns that are raised directly by GPs with SPPG, GPs copy the CDPC into the communication. This understanding assists them in their role and enables them to track and trend any matters over time.

The CDPC stated that GPs respect consultant decisions on the triage of referrals and they are only aware of one instance where there was a complaint from a GP who was not made aware of the triage outcome. The decision itself was not the issue, rather the lack of communication that a downgraded outcome was made.

In relation to Encompass, the CDPC advised that GPs did not have specific training targeted to them although in hindsight it proved that this was not required as GPs needed support rather than specific training using the digital programme. The CDPC advised that Encompass has aided the speed of communication between GPs and consultants as it makes it easier to ask questions on clinical management and treatment advice as all service user information is available to view. The CDPC also advised that Encompass supports the quality and range of information to help consultants make informed decisions. The previous system was reliant on what GPs included in the referral whereas now, consultants can access more data if needed to help them make a decision.

With the introduction of Encompass, the CDPC advised that the transfer of communication from consultant to the GP is also expedited. With the use of “smart tools”, a function built into Encompass, outcome letters can be more readily available to GPs and service users, post appointment. The smart tool enables consultants to populate letters to the GPs on the service user’s non – invasive procedures and self-management options, and advises what to look out for and do, should the service user’s condition worsen. These smart tools are pre-populated narratives that cover a range of specific conditions.

This means that regardless of which consultant a service user sees the outcome letter should contain advice under each of these headings therefore providing consistent management advice on specific conditions. The CDPC advised that consultants will require time and confidence to understand the application of smart tools however, over time, it is envisaged that this function will provide assurance of consistency.

There were effective systems to communicate and manage information, to meet the needs of service users and carers; the organisation and its staff, partner organisations and other agencies.

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	2

Two 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 5.1 Criteria 5.3.1 (c) **To be completed by:** 14 February 2025	To mitigate the potential risk to service-users, the Trust must take steps to improve and assure the compliance of medical staff with adult safeguarding training. Ref: 6.1.7 **Response by registered person detailing the actions taken:** 1. Agreed action: Communication to all medical staff to remind everyone and highlight the need to complete safeguarding training. Progress update against action: Issue discussed at the medical directorate on 12.11.24 Issue discussed at surgical directorate on 10.12.24 Issue discussed at WACH directorate on 10.12.2024 Email correspondence has been issued from Medical Director to all consultant staff on 14.11.2024 Follow-up email from Medical CD/ACD to consultants 15.11.24 Follow-up email from Surgical CD/ACD to consultants 25.11.24 2. Agreed Action: Monitor training compliance on a monthly basis to demonstrate increase in compliance 3. Agreed Action: Ensure safeguarding training requirements are highlighted through the education sessions provided at Trust level for resident doctors.

Area for improvement 2 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **To be completed by:** 14 February 2025	The Trust should develop a 'prescribing and recommendation to prescribe policy' which includes details of the arrangements for the oversight and assurance of prescribing and prescribing advice across the Trust outpatient services. Ref 6.1.8
	Response by registered person detailing the actions taken: 1. Agreed Action: To establish a working group to take forward the writing of a policy and agree oversight arrangements for prescribing and prescribing advice within outpatients departments (1st meeting scheduled in early January) 2. Scope out other Trusts in regards their arrangements for oversight arrangements for prescribing and prescribing advice within outpatients departments

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

10. Appendices

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 recor*
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.*

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews