Inspection of Outpatient Departments

17 February 2025 - 15 May 2025

Northern Health and Social Care Trust

Type of service: Outpatient Services
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1.0 Service Information

Responsible Person: Ms Jennifer Welsh	**Position:** Chief Executive Officer
Person in charge at the time of inspection: Rebecca Getty	**Position:** Assistant Director: Diagnostic and Clinical Services
Brief description of the accommodation/how the service operates: The Northern Health and Social Care Trust (the Trust) is one of six health and social care Trusts in Northern Ireland. The Trust provides a range of health and social care services to a population of approximately 479,000 people across a geographical area of 1,733 square miles, making it the largest geographical Trust in Northern Ireland. The Trust also provides services on Rathlin Island.	

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 Trust has appropriate governance systems in place capable of ensuring the quality and safety of care delivered in its outpatient services.

Outpatient departments at four hospital sites were selected for inspection:

- Causeway Hospital
- Antrim Area Hospital
- Whiteabbey Hospital
- Ballymena Health and Care Centre

3.0 Inspection summary

An announced inspection of the Trust outpatient departments (OPD) commenced on 17 February 2025 and was completed on 15 May 2025, 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 outpatient services.

Feedback regarding the experiences of those using outpatient services was largely complimentary; as was the mainly positive feedback from outpatient staff.

During the onsite element of the inspection, staff across the different outpatient sites described availing of good support from within their respective teams and from management. They reported there are good multidisciplinary working relationships and effective escalation and communication processes in place.

Following the on-site element of the inspection, additional feedback was received via an online staff survey. A small number of staff highlighted issues around poor culture and low staff morale at one hospital site. This information was subsequently shared with senior Trust representatives for their consideration and required action.

The Trust's OPD governance and organisational structures were reviewed and found to be robust. It was determined that the Trust has in place systems and processes for effective oversight and monitoring of the quality of the care provided across their outpatient services.

Throughout the course of the inspection numerous areas of good practice were noted; however, three areas for improvement were made. Two related to aspects of medicines management and the third related to the oversight and recording of staff safeguarding training.

Significantly, in November 2024 the Northern Trust became the third HSC Trust in Northern Ireland to introduce Encompass, HSC's new digitally integrated healthcare system. 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 Trust outpatient inspection resulted in a total of three areas for improvement (AFI) being identified; these are described in associated sections of the report and are stated in the Quality Improvement Plan (QIP) in Section 7.

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.

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 four hospital sites were visited on the following dates:

- Causeway Hospital (17 February 2025)
- Antrim Area Hospital (18 & 20 February 2025)
- Whiteabbey Hospital (20 February 2025)
- Ballymena Health and Care Centre (5 March 2025)

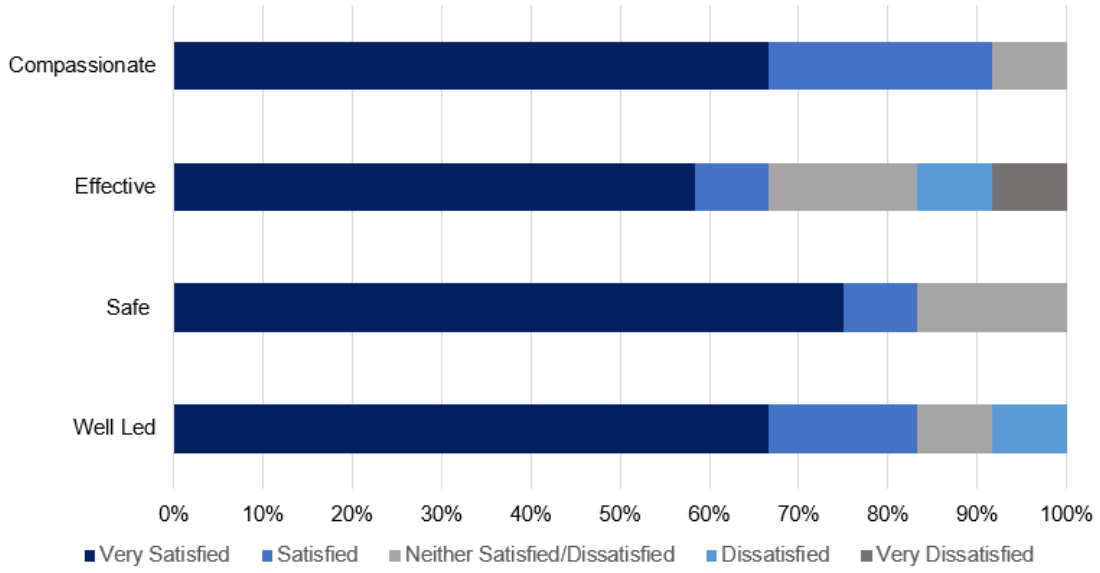
The on-site element of the inspection included direct observation; engagement with service users, relatives and staff; and the review of relevant documentation. The documentation reviewed included samples of evidence to support the Trust's progress with achieving the 26 recommendations from the RQIA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

A total of 39 service users and their relatives provided feedback throughout the inspection. During the inspection inspectors met face to face with 16 service users and their relatives and used a semi-structured interview to illicit their feedback. A further 23 responses were received from service users and their relatives who completed postal questionnaires or an online survey.

As part of the semi structured interviews respondents were asked to rate the service provision in terms of its safety, compassion, effectiveness and service management (**Graph 1).** 92% of service users/relatives were satisfied or very satisfied that the service provision was compassionate, however only 67% of service users/relatives expressed the same level of satisfaction with the service being effective.



Graph 1: Service users'/relatives satisfaction across the four domains.

Overall feedback was very positive in relation to the quality of care delivered, staff were described as being “very professional and competent.” Service users reported that staff put them at ease for their appointment, they felt listened to and were given opportunities to ask questions; and that they felt safe in the OPD clinics.

A small number of service users expressed their dissatisfaction about the length of waiting times for either their first appointment, or the prolonged wait between their initial appointment and follow up or review appointments voicing fears that their clinical condition could worsen in the meantime. In addition, changes to appointment notification and appointment check in system as a result of the implementation of Encompass to the Trust, were highlighted as issues by a minority of service users.

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 in relation to OPDs 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 range of staff, which included doctors, nurses, health care assistants, pharmacists, managers, service leads, assistant directors, directors, and administrative staff. Two focus groups were also held with medical staff across the following staff groups: specialty and associate specialist doctors (SAS); and consultants. There was representation across the following high-volume specialties: gynaecology, dermatology and general surgery.

Overall face-to-face discussions with staff reported that they felt supported by their managers and they were encouraged to develop their skills and expertise.

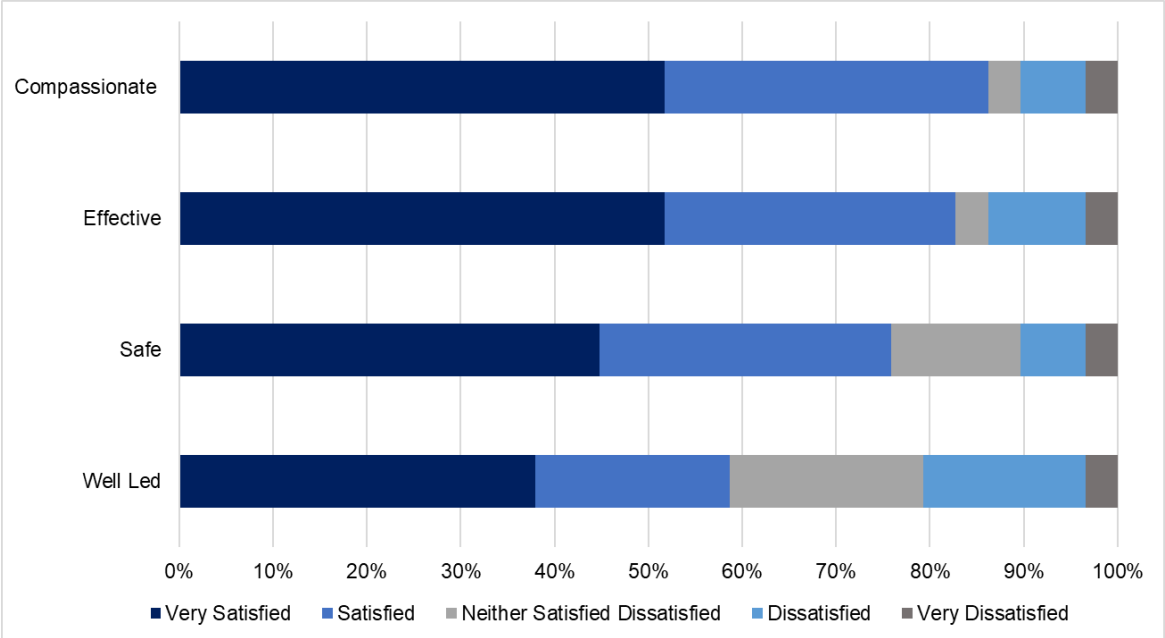
In person discussions and focus groups with staff were very positive with all staff groups describing the delivery of safe, effective and compassionate care both within OPDs and other periods of the patient journey.

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 **29** responses received across the four OPD sites.

Respondents were asked to rate the service provision in terms of its safety, compassion, effectiveness and leadership (**Graph 2**). 86% of staff were satisfied or very satisfied that the service provision was compassionate, however only 59% of staff expressed the same level of satisfaction with leadership and management.

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



Graph 2: Staff satisfaction across the four domains.

Comments from staff across most sites indicated there was good morale and good working relationships and support within their teams. Overall, staff confirmed that there were effective escalation and communications processes in place. Training was reported to be up to date with opportunities for role specific additional training in some clinical specialities.

However, the online/ QR questionnaires completed anonymously highlighted that a small percentage of staff reported lower morale relating to management issues and culture. This predominantly related to the OPDs at one hospital site and was discussed with Trust senior management at a separate meeting prior to formal feedback to the Trust. The Trust agreed to engage with the appropriate team to address the management issues and culture.

Other challenges raised by staff included the implementation of Encompass into the Trust. Medical staff in particular felt they were at risk of becoming overwhelmed as a result of the additional administrative workload associated with Encompass, reducing face to face time with their patients. Overall, staff reported that issues with Encompass were resolving as they were becoming more familiar with the platform.

Staff reported that they would be happy for a member of their family to be cared for in all OPDs visited.

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.

In January 2019, the Trust set up a task and finish group to prepare for the RQIA inspection of its outpatient services. This followed a letter from the Chief Medical Officer advising HSC Trust Chief Executives that the early learning from the RQIA 2020 Review identified that learning surrounding culture and safeguarding was equally applicable to all Trusts. The terms of reference for the task and finish group were provided to the inspection team, along with minutes of an internal Trust meeting held in February 2019.

The minutes of the meeting evidenced there was good representation across surgical and clinical services, medicine and emergency medicine specialities; with representation from infection prevention and control (IPC) teams and administration and support services. The minutes also indicated that the Trust was striving to maintain a coordinated approach for the embedding of learning and to develop their governance oversight framework for outpatient services. However, the task and finish group and its functions were suspended due to the outbreak of Covid-19 and its designation as a pandemic.

In November 2023, the Trust established an "Outpatient Modernisation (OM) and Renewing our Vision (ROV)" group. The terms of reference were reviewed along with minutes of associated meetings. The purpose of the Outpatients Modernisation Group is to determine a whole-systems phased approach to the implementation of Active Clinical Triage (ACT) and Patient Initiated Follow-Up (PIFU); and clinical validation across the Trust aligned with regional strategic direction and the Elective Care Framework. The Elective Care Framework was published in 2021 and is a DoH five-year plan which outlines a number of proposals that aim to reduce healthcare waiting lists and address the backlog of patients waiting for assessment and treatment across Northern Ireland.

ACT is an enhanced vetting process of referrals to secondary care by a senior clinician. By changing the way in which referrals are managed, value is added at the start of a patient's secondary care pathway.

The main objectives of ACT are; to improve triage accuracy; reduce overall waiting times; improve patient care by reducing time to treatment/diagnosis; and to reduce reliance on limited resources.

PIFU enables patients to initiate a follow-up appointment when their symptoms and individual circumstances necessitate. PIFU can be used with patients with long or short-term conditions in a broad range of specialties. The main objectives of PIFU are to; personalise outpatient care; enable flexibility for patients in follow up care; match clinical resources with patient needs; and reduce waiting times for patients needing appointments.

Minutes evidenced that the Trust were liaising with SPPG in relation to the specific conditions that were suitable for PIFU across a range of specialities; and reporting arrangements were also discussed. Minutes also evidenced discussion on the impact of reporting/recording figures when Encompass was activated. The review of meeting minutes and reports showed that the Trust had good oversight of waiting lists across the specialities, including red flag, urgent and routine referrals; and demonstrated that concerted efforts were being made to process referrals and reduce waiting times.

Reviewed documentation also referenced the Northern Ireland Public Service Ombudsman Report entitled; 'Forgotten': An investigation into Healthcare Waiting Lists; and this was linked to the Trust's action plan to address relevant regionally-applicable recommendations.

The inspection team was presented with a Trust briefing paper relating to Neurology Services, which suggested a range of contributing factors likely to challenge the ability of the Trust to meet the demands placed upon outpatient services. These factors included: sustained difficulties recruiting into consultant posts; and an increase in the number of neurology referrals year on year. Inspectors also considered an Early Alert that was issued to DoH in August 2024 which reported concerns about the fragility of Trust neurology services, due to the ongoing difficulties recruiting consultant neurologists. The Trust has had discussions with SPPG who convened a regional meeting to establish what further actions could be taken. At the time the briefing paper was shared with RQIA, the Trust was awaiting an indication of short and medium term plans from SPPG.

During focus group discussions with medical staff groups: SAS doctors and consultants reported that there was no apparent Trust vision or strategy for the development of outpatient services; and stated that there was a need for modernisation of outpatient care across the region. During a clarification meeting with senior Trust representatives on 6th May 2025, RQIA were informed that the OM and ROV group meetings had been suspended in May 2024 (in preparation for the roll out of Encompass) but were being reinstated, with meetings already scheduled in members calendars.

RQIA are encouraged by the recommencement of these meetings which will augment the Trust's collective leadership approach in the management of outpatient services.

The Trust shared a document with the inspection team detailing a list of ten quality improvement initiatives that were being considered across a range of outpatient specialities; including gynaecology, podiatry, children's mental health team, physiotherapy, ear nose & throat (ENT), rheumatology, and nephrology.

One of the ten projects had been suspended due to a lack of funding, another had just commenced; two were ongoing; and four had been completed. Five were related to the implementation of active clinical triage (ACT). There were no updates available for the inspection team regarding progress on the two active projects.

The effectiveness of one quality improvement initiative was shared with inspectors and related to ENT services. Prior to the initiative commencing, 94% of referrals went straight to OPD appointments.

However, when the ACT trial was undertaken to gather a baseline of potential triage options, against referrals received, triage straight to OPD appointment levels were reduced to 64%, with 19% being discharged with advice, 8% discharged without advice, and others being appropriately redirected.

These quality improvements initiatives demonstrated an ongoing commitment to improve the patient experience and access to care and treatment.

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 governance reporting structures were reviewed and it was noted that each directorate had a number of reports produced across three main themes: Finance and Performance; Safety and Quality and Workforce and Engagement.

Minutes of governance meetings were reviewed to ascertain if the reporting structure enabled the escalation of risks and issues and to determine if there was robust oversight of Trust activities. The minutes evidenced the following areas were reported on: the numbers of referrals received across specialities; how long patients were waiting for appointments (new and review); workforce vacancies and recruitment efforts; the percentage of staff having completed their appraisals; the numbers of incidents and the top five incident themes; and the number of Serious Adverse Incidents (SAI) (inclusive of new and ongoing SAIs). Some minutes detailed staff training compliance figures, and cases to be discussed at Morbidity and Mortality (M&M) meetings. There was evidence that discussions took place around risk management. Minutes also evidenced progress in implementing recommendations arising from internal audits and new polices, including those that were to be reviewed. In more recent meetings, the capacity downturn as a consequence of the launch of Encompass ‘go live’ was noted.

A number of Directorate risk registers and the Trust’s principal risk register were reviewed alongside a selection of the Trust Board Committee Assurance Meeting minutes. The review of minutes evidenced appropriate escalation of risk from a bottom-up approach and there was appropriate challenge and discussion on risks and emerging issues.

The Trust’s governance structures and leadership arrangements evidenced clear organisational, directorate and sub-directorate structures, and an integrated governance and assurance framework.

Leadership and Management of the Clinical Area

Within the OPDs there were clear organisational structures in place and staff were able to describe their roles and responsibilities; managers were visible in the clinical area.

OPD managers reported receiving good support from their senior management team (SMT) and respective teams, and described supportive team working arrangements across OPDs.

A monthly OPD managers meeting takes place which strengthens connectivity, governance arrangements and collective leadership across the Trusts outpatient services. OPD managers described robust induction programmes for new staff, and this was corroborated by the staff the inspection team spoke with.

Staff have access to policies and procedures which are accessible through the Trust IT system; and arrangements are in place for communication of any new or revised policies or procedures.

There were systems in place to promote effective communication with staff and across multidisciplinary teams, such as the 'Team North Brief 'monthly communication. There was evidence of regular safety briefs across OPDs, and dissemination of information through a number of formats; face to face, via email, and through additional meetings. Enhanced communication processes were described for staff to assist patients attending OPDs who require additional or specific support, for example for patients with dementia. This is considered good practice.

Staffing and skill mix across the OPDs is continually reviewed to ensure safe staffing and this is overseen by the Trusts designated Safer Staff Lead. Trust bank staff with experience of working in OPDs are used when there are shortfalls and this is continually monitored by OPD managers.

There was evidence of good communication and oversight of staffing within OPDs.

6.1.3 Service Planning

Evidence was sought that the Trust had service planning processes in place capable of promoting an equitable pattern of service, based upon the specific needs of service users; the availability of resources; and local/ 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.

From discussions with staff and the review of minutes and reports, there was evidence that the Trust SMT are aware of the challenges facing outpatient services which impact upon the ability to meet the demand for services.

Medical staff described the challenges in delivering outpatient services within existing budgetary constraints and workforce issues, which have been impacting on waiting times regionally.

Within the Trust, infrastructure issues restricting the availability of physical space were reported by medical staff which they felt hampered their capacity to see patients in the outpatient departments. It was reported that capacity issues have been exacerbated not just by the limited footprint, but also by the introduction of Encompass.

Medical staff also acknowledged that an increase in patient complexity without commensurate investment in services was also a challenging. 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.

Waiting lists for Red Flag dermatology appointments, and surgical appointments were highlighted as unacceptable. With regards to general surgery outpatient waiting times, it was reported that even for benign conditions the waiting list is a significant issue, as by the time the patient is assessed at the first appointment, booked for surgery and then attends for surgery, their condition is often more severe and complex than it would have been if earlier intervention had been facilitated. This was said to be impacting on the surgical team, causing a degree of moral injury, given that this is not the standard of care they would wish to provide.

A number of steps have been taken to improve capacity across various outpatient services: enhanced clinical triage processes, such as photo triage within dermatology services; virtual clinics; the introduction of PIFU; and the utilisation of non-medical staff. Medical staff stated that additional efforts could be taken in this respect, which may lead to further improvement; however, ultimately they felt that challenges remain with a lack of physical space, funding, and the difficulties of recruitment.

An increase in the number of phlebotomy hubs across the Trust was considered a positive development for patient access to facilitate bloods for patients under clinicians in secondary care. In response, the Trust developed a Standard Operating Procedure (SOP) for patients attending phlebotomy hubs. In addition, a further SOP is being developed for those oncology patients who require a separate phlebotomy appointment prior to their oncology review.

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 by medical staff, for each appointment and the length of time needed to see each patient. Medical staff expressed concerns that clinic capacity would remain reduced in the longer term and wanted this to be taken account of in the future planning, commissioning and staffing of outpatient services.

There was reported to be particular challenges for procedure-based specialties, where an ultrasound or biopsy may be required as part of the same consultation appointment, but with no additional time allocated to take account of these procedures, or the associated administrative duties demanded by Encompass. Encompass has reduced capacity for venesection procedures as they are now classed as a day case which requires logging the patient as an admission on the system which lengthens the administration process for staff. Staff reported that there are a series of ongoing meetings to address these issues and further administrative support staff is being scoped.

Representatives from the Trust SMT advised that the recommencement of the previously mentioned OM/ROV group meetings will address service planning needs.

6.1.4 Quality Assurance

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 staff and the related service user outcomes, achieved across its outpatient services**.**

A range of Key Performance Indicators (KPI) 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 and managers described action plans were in place for any deficits that were identified through audit.

At the time of inspection Encompass had been operational in the Trust for approximately three months. The inspection team are aware of the capability and functionality of Encompass not only as an electronic patient recording system, but also in its ability to produce reports and assist the senior management team in having governance oversight in real time.

On the 18th February 2025, the Trust held a Post Live Readiness Assessment event during which attendees were provided with a PowerPoint update on how Encompass has been embedded within the Trust; what impact it was having; what issues still needed to be resolved; and what mitigations are in place in the interim. Seven aspects of each division were assessed. These included: Post Live Governance; On Boarding & training; People transition; Business Continuity Planning; Reporting; Operational Processes and Digital Safety. An overall RAG-rated assessment was assigned to each division and aspect.

The RAG-rating format refers to Red, Amber and Green, a colour coded method used to assess and communicate the status of services. Red signals a serious issue or serious risk that needs immediate attention; amber highlights areas that require monitoring or further investigation; and green indicates performance is meeting expectations.

Within each Division a number of specialities were highlighted and their particular Encompass issues noted with nominated Trust personnel who were then responsible to drive forward the issues with the corresponding Encompass software team.

It was evident that the senior leadership team in the Trust were aware of the issues and what needed to be done to rectify them. Some issues were service-specific operational issues and others related to management at all levels being confident in using the system effectively, so that they were able to maintain robust oversight of the service which they managed. In some specialities, until the Encompass operational issues were resolved, the service could not be wholly reported on from a governance/oversight perspective.

The Trust provided a further PowerPoint presentation to the inspection team that indicated ongoing engagement occurs between the Trust and SPPG, where the Trust provides an update on the Service Delivery Plan (SDP) and submits regulatory returns on Trust activity. The presentation also noted the ongoing work within the Trust to validate data that is presented to the SPPG.

These factors evidenced that the Trust had robust oversight of Encompass implementation and its associated impact on service delivery.

6.1.5 Managing Risk

The inspection team sought evidence that the Trust had systems to prevent, identify, assess and manage risk; including the review of adverse incidents and near misses across its outpatient services; and to also ensure the Trust had mechanisms to share any associated learning.

Inspectors noted that local risk registers are in place across OPDs, and that these are systematically reviewed by SMT and discussed at monthly OPD management meetings.

Identified risks are escalated through relevant structures and incident reporting processes are followed. Staff were able to discuss incidents which had occurred and the resulting actions and mitigations taken by the Trust. Risks are discussed and managed by a number of means; safety huddles, speciality team meetings, directorate meetings; and forums.

The restricted physical footprint of outpatient services was reported to negatively impact service provision and this has been identified as a risk which features within both the local and corporate risk registers.

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 staff, and the related service user outcomes achieved across its outpatient services.

The Trust's supervision policy states that nursing staff are to have supervision twice yearly; and whilst supervision arrangements are in place for nursing staff across all OPDs, compliance figures identified a large deficit in one outpatient service. Senior managers confirmed this has been recognised and an action plan was in place to monitor and resolve the deficit.

Generally, nursing staff reported that they are receiving regular supervision and some stated it mainly consisted of 'group debrief' type sessions as opposed to one-to-one supervision. Staff feedback identified some confusion surrounding how supervision was delivered, however current Trust policy highlights that staff can avail of either group or one-to-one supervision opportunities. This was discussed with senior managers who agreed to further engage with nursing staff to reinforce that both forms of supervision are available.

Nursing staff appraisals were largely up-to-date and managers provided assurances that plans were in place to follow-up any outstanding appraisals.

The Executive Director of Nursing provided a comprehensive overview of a rigorous annual review of permissions granted to nurse prescribers. Appropriate oversight mechanisms are in place which provide assurances to SMT that nurse prescribers are adhering to the Trust's guidelines and operating within their scope of practice.

There were satisfactory arrangements for medical governance, including oversight of appraisal and mandatory training. Appraisal compliance rates were reported to be high at approximately 99%.

On the whole, medical staff reported generally good morale. However, ongoing issues with waiting lists, staffing capacity and recruitment and retention, were reported to be a source of frustration. The medical staff were keen to point out that the Trust undertakes a more proactive approach to recruitment, particularly in circumstances where the Trust has advance notice that a staff member is retiring or leaving. The impact of vacancies on the patient population for smaller services in particular, was reported to be significant.

Multidisciplinary working within the Trust was highlighted as a strength by the medical staff; positive working relationships were described with nursing staff, clinical support staff and Allied Health Professionals (AHPs).

Medical oversight of outpatient services was reportedly strong; and resident doctors felt that they are well supported with both clinical decision-making and training needs. SAS doctors described having their professional autonomy respected, and receiving an appropriate amount of support when required.

It was reported that outpatient services regularly participated in clinical audit; and even though cancer services participate in peer review; i.e. as part of the National Cancer Peer Review programme, there is currently no strategy for Trust-initiated peer review within outpatient services. The Trust reports challenges with capacity and a lack of clarity around the expectations as specific barriers.

RQIA believes that there is a need to develop a systematic approach to peer review of outpatient services within the Trust. RQIA considers that in order to demonstrate robust assurance of quality and safety of its outpatient services, the Trust should commence scoping work to consider how peer review could be developed for Trust outpatient services.

6.1.7 Safeguarding

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

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

RQIA assessed Trust arrangements for the oversight and delivery of service user safeguarding systems and training across outpatient services.
Staff had access to safeguarding policies and procedures, and safeguarding information boards were displayed in each OPD which provided helpful information to all staff and service users on pathways to raise concerns.

During discussions with staff they demonstrated good knowledge and awareness of their roles and responsibilities with regard to recognising and raising safeguarding concerns. Staff reported they felt confident in raising any concerns and that they were aware how to secure readily available support when required.

Overall staff feedback confirmed that the majority of staff had completed their safeguarding mandatory training (Adults and Children) and were aware of the types and indicators of abuse; how to respond; and how to take action in reporting and escalating concerns. However, records requested to evidence staff safeguarding training compliance levels were incomplete, difficult to navigate and the inspection team were unable to ascertain a reliable picture of actual compliance levels.

An area for improvement (AFI) was made.

AFI: To enable an easily accessible and accurate measurement of compliance levels, the Trust should introduce a robust mechanism for recording safeguarding training for all staff grades across all directorates.

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 paper based Treatment Advice Notes (TANs).

The Trust had developed the use of an electronic Treatment Advice Note (eTAN), using the Patient Centre system, during the Covid pandemic with partial transfer from paper based TANs to eTANs. The Trust has moved to Encompass; the use of paper based and Patient Centre eTANs have been replaced by the TAN functionality in Encompass.

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.

However, the Trust does not currently monitor or have robust 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 prescribing responsibility for the recommendations that have been accepted.

Encompass facilitates reports to be produced which allow information to be ‘pulled’ retrospectively to monitor recommendations to prescribe/eTANs. However, at present there is no regular schedule of producing or reviewing this data to provide appropriate oversight. In addition, the prescribing data reports do not include the indication for the medicine. The Trust is not currently funded to provide pharmacy resource in all outpatient clinics.

A medicines management interface group consisting of the following representatives: GP, GP practice pharmacist leads, community pharmacy, SPPG Pharmacy co-ordinator, SPPG pharmacy advisors, a consultant and lead pharmacists from NHSCT meet to provide a cross-organisational strategic approach to medicines management issues and clinical decision-making with due regard to clinical and cost-effectiveness and to promote seamless and cost-effective medicines management across organisational boundaries. This forum is used to address any issues or concerns of inappropriate prescribing identified in primary care in relation to prescribing or recommendations to prescribe from prescribers in the NHSCT. These meetings had been paused over Encompass Go-Live and Implementation period. The last meeting was on 3 July 2024.

The majority of medicines identified on site visits were found to be stored appropriately however, expired medicines were identified in two outpatient clinics. This included medicines stored in the cupboards, medicine refrigerator and on the emergency trolley, this was immediately escalated to Trust management.

Mandatory medicines management training had expired for the majority of nurses in one outpatient clinic. This was escalated to Trust managers who were aware of the expired training and were prioritising staff to be released for mandatory training in order to address this.

Stock supplied by the hospital pharmacy department for both top-ups and ad hoc inventory requests via Encompass is automatically received into the department without any check or intervention, with the exception of controlled drugs. RQIA pharmacy inspectors escalated this to the Trust Head of Pharmacy who agreed to review and risk assess this at the optimisation phase of Encompass implementation.

Two AFI have been made;

AFI: 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.

AFI: The Trust should review the systems in place for monitoring expiry of medicines in outpatient departments.

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 small numbers of hard copy service users notes are required. Inspectors were told that the reduction of hard copy notes has freed up some storage space in the clinic areas. Staff were able to describe the process for obtaining medical notes if required, and secure storage areas were available to hold these.

Encompass systems enable medical staff to write outcome patient letters on clinic templates which can be addressed to the patient and copied to the GP, in keeping with NICE Guidance on Shared Decision Making (NG197)[1]. Regional work is ongoing to implement NICE Guidance NG197; and this is being facilitated by the Public Health Agency (PHA), with oversight arrangements in place from SPPG.

Medical staff reported variation in the approach to providing patients with outpatient letters. Some reported good practice where patients are sent letters in lay language with the GP copied in. However, this practice was reported to be 'clinician-dependent' and there was no local policy or guidance available to ensure a standardised approach for the sharing of information with patients. Although the new patient accessible 'My Care' platform will serve to improve patient access to medical information, it is important that a consistent approach is adopted to the recording of lay language correspondence available to patients.

6.1.10 Access

RQIA assessed whether the Trust employs an evidence-based model of care for 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; as it specifies the approved processes for managing service user 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.

Administrative managers advised that staff had received IEAP training with refresher training provided by managers on an annual basis. The principles underpinning this protocol are embedded in their decisions and practice.

The main referral routes into outpatient services across the Trust area were examined, and it was noted that the Trust have established systems that mean 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 the Encompass system via the central booking team. Reports are collated for un-triaged referrals waiting more than three days and an escalation process is in place as service users cannot be added to the waiting list unless triaged.

[1] 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

Processes and system prompts are 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 where a letter is sent to the service user inviting them to contact the booking team to arrange their appointment had been in place; however, this was paused for the launch of Encompass in October 2024 and is currently being reinstated on a phased basis.

Procedures are in place for the transfer of service users from the private sector to National Health Service (NHS), with a specific team overseeing this process to ensure governance arrangements are in place. Referrals received for private sector service users are triaged with all other referrals and added to lists in chronological order and clinical priority. Administrative staff have aide memoires to follow the correct process.

The implementation of Encompass has impacted the Trust's ability to extract and produce reports across some data sets for example, understanding the number of appointments where patients did not attend (DNAs) or cannot attend (CNAs), as well as cancellations. The performance team are currently addressing this to enable the generation of this data. The Trust also continue to liaise with and report to the SPPG on Trust activity in relation to outpatient referrals; review appointments; and other KPIs around outpatient attendance

A total of eight clinics were followed across the multiple sites. These were evidenced to have a mix of urgent, new, review and red flag patients attending, with a mix of time slots allocated. Patients are able to check-in at reception and on some sites at the self-check in kiosk. Staff were observed to show respectful and compassionate care, and good engagement between nursing and medical colleagues was evident.

When trying to determine why a clinic had a non-attendee during the inspection, it was observed that the administrative team were able to see that this was a patient coming from a ward or other hospital/care home as denoted by a bed symbol, however the nursing team were not aware of this. This was raised with management who agreed to address this to ensure that the two systems provided the same necessary information. This may assist the Trust to track and trend DNAs.

During the inspection of one clinic it was noted the Encompass system was temporarily unavailable and staff were unclear of the continuity plan in this event; stating that they would not have the ability to carry out venepuncture practices. The inspector intervened and staff were directed promptly by the manager to implement continuity measures. Subsequently it was noted this was a planned downtime, but it had not been communicated to department staff. This was escalated to Trust management who agreed to address it.

The inspection team determined that appropriate systems are in place to ensure an evidence-based model of outpatient care delivery was in use.

6.1.11 Complaints, Incidents and Concerns

Inspectors sought to evidence that effective complaints, representation procedures, and feedback arrangements, were in place and available to service users, carers and staff.

Inspectors reviewed relevant reports and documents are determined that incidents and complaints are collated and reviewed through the Trust governance assurance processes within their associated directorates.

OPD managers were able to describe to the inspection team the mechanisms for robust oversight of incidents and complaints, how they are themed, and how associated actions ensure that derived learning is shared, or triggers instances where additional training may be required.

OPD staff also had sound knowledge of the Trust's complaints process, and ably described the management of complaints at a local level. There was evidence of effective use of shared learning from complaints and incidents; and staff demonstrated good awareness for the reasons and mechanisms for reporting complaints, incidents and near misses.

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

Robust governance arrangements were described for deriving and sharing learning from incidents, complaints and clinical audit through regular audit and governance meetings. It was reported that learning from these meetings is utilised to inform staff education and service improvement; examples of which were provided to inspectors.

Patient views are collated through; Care Opinion; a bespoke OPD Trust survey; and additional feedback mechanisms. Examples were provided when patient feedback had been used to develop actions plans to make improvements.

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 two GPs who have a role in facilitating communication between GP practices operating within the NHSCT area, and Trust consultant doctors. The purpose of this meeting was to understand the two-way flow of communication from primary care services to speciality clinics; and to ascertain what is working well and what needs to improve from point of referral, to the discharge of patients.

The GP representatives expressed that there are very good working relationships between the GPs and consultants within the Trust; and added that any issues they did encounter were mostly generic in nature and certainly not unique to the Northern Trust. An example was provided relating to the timeliness of review appointments; where within some specialities following the initial consultation, the patient may be advised by the consultant they will be reviewed within four months; however, in actual fact it could be up to two years later before they are reviewed.

The GP representatives also noted that at the point of triaging a referral, there is no clinician to clinician discussion about the patient, and GPs have no way of noting who triaged the referral.

This is problematic when the patient's condition/presentation changes or deteriorates in the interim period or when a red flag referral is downgraded, and the GP needs to understand the rationale for downgrading in order to inform the patient. Under these circumstances, GPs contact the patient access team. This process is time consuming thereby creating further delay before discussion can occur.

The GP representatives acknowledge it is the responsibility of the GP to hold the clinical risk of patients in the interim period; however, due to prolonged waits for first appointments, some conditions worsen and require to be regraded.

The GP representatives advised it would be helpful if the actual waiting list timeframes were accessible to GPs. Currently the average wait times are published which they report is not meaningful. The one exception is the Children's Autism Service. It was suggested that sometimes they are told the waiting times for Children's Autism Services when they phone the patient access team directly.

One service identified where patients are routinely discharged from is radiology, when the referrals are returned asking GPs to send more information. This is a frustration experienced by GPs. This point was raised at the feedback session when a senior Trust representative advised that this related to the legal requirement under 'The Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018'. If a referral does not contain sufficient information to allow the justification of the referral then the referral is returned to the referrer seeking more information. GPs reported that the situation continues to improve, consequently a reduced number of referrals are being returned month on month.

An area of concern expressed by GP representatives was in relation to patients being discharged from care into the independent sector who are subject of waiting list initiatives. The question of who is responsible for archiving this period of care on the patient's electronic record is unclear. This matter was raised with a member of the Trust's senior management team who acknowledged that patient care delivered in the independent sector is scanned on to patient electronic records, so GPs can now have access to it.

GP representatives acknowledged there are target lists set for first appointments; however, there are none for review appointments and this metric is particularly significant for patients with chronic life limiting diseases. Another concern for GPs arises when consultants retire and this is not communicated either to patients or GPs, leaving uncertainty about who is overseeing care from a consultant perspective. Examples were provided when GPs made efforts to have patients reviewed with no success and patients subsequently required hospital admission, when perhaps admission could have been avoided if they had received a review.

GP representatives noted that a number of patients are discharged when they don't arrive in time to their appointment, regardless is this may not necessarily be the patient's fault. A number of patients have reported that they do not receive an appointment letter on time, or at all; and this perpetuates a revolving door type experience where GPs continually have to re-refer patients. This is particularly problematic for patients living in apartments or flats where post is delivered to a communal hall; especially if the intended recipient suffers from with debilitating long-term chronic illnesses, mobility issues or has mental health issues. It is apparent that the Trust's discharge policy in this respect, does not serve these patient groups well.

Another concern the GP representatives had was in relation to the My Care app particularly in relation to providing context around results. If the consultant does not review the results within a specified time (usually 15 days) the results are automatically released to the patient who may not understand the results in the context of their clinical presentation/condition and this has the potential to be misinterpreted and raise patient anxiety. During the design/ consultation phase of My Care, GPs had asked for the following sentence to be included in the patient result page.

"If you have any queries about your results please contact your specialist." This was not included and therefore patients seek clarity from their GP which impacts upon GPs allocated time for appointments with patients.

The GP representatives welcomed participation in the SPPG workshops held in January 2024 in relation to the guiding principles outlined in Working Well Together paper which was designed to break down interface issues between primary and secondary care providers. They welcome a final version of the draft document and are keen to see this work through to completion.

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	3

Three 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 is 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 (f) **To be completed by:** 15 August 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 (Section 4.8).
	Response by registered person detailing the actions taken: Accepted - Head of Pharmacy to draft policy in collaboration with Medical Director and Executive Director for Nursing. Policy to be taken for ratification in line with Trust Policy Process. Completed within 6 months (February 26)
Area for improvement 2 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **To be completed by:** with Immediate Effect	The Trust should review the systems in place for monitoring expiry of medicines in outpatient departments (Section 4.8).
	Response by registered person detailing the actions taken: Accepted- Weekly checks to be integrated into the role of a nominated individual in each department. Outpatient Managers (Band 7) to oversee compliance. Implemented immediately
Area for improvement 3 **Ref**: Standard 5.1 Criteria 5.3.1 (c) **To be completed by:** 15th August 2025	To enable an easily accessible and accurate measurement of compliance levels, the Trust should introduce a robust mechanism for recording safeguarding training for all staff grades across all directorates.
	Response by registered person detailing the actions taken: Accepted - Process to be established for capturing data on safeguarding training at a corporate level to be led by Assistant Director of Social Work in conjunction with the Assistant Director of HR. Completed by December 2025

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 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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