Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

ACTION PLAN (2011 - 2014)

IN RESPONSE TO THE

DENTAL HOSPITAL INQUIRY

Updated July 2013

Contents **Page**

SECTION 1 – Background to the Dental Inquiry & Development of an Action Plan

Introduction

1.1 This document represents the DHSSPS Action Plan which was developed in response to the Dental Hospital Inquiry Report and its forty five recommendations **(Annex A**).

1.2 An executive summary of that Report was published in July 2011 (available at http://www.dhsspsni.gov.uk/executive_summary_dental_inquiry.pdf). The development of the Action Plan commenced shortly after this date but publication of the Plan, which was anticipated in August 2011, was deferred until the Inquiry closed and its final report published. The Inquiry has now concluded and the full report, which was published on 22 July 2013, is available at www.dhsspsni.gov.uk

1.3 Whilst circumstances pertaining to the Inquiry related to the treatment of patients in the Dental Hospital, it should be noted that the Dental Hospital and the School of Dentistry are co-located within the Royal Group of Hospitals. The Dental Hospital provides specialist dental services to the population of Northern Ireland and trains postgraduate dental specialists and consultants. It is mainly funded through the commissioning of services via the Health and Social Care Board. On the other hand, the School of Dentistry trains undergraduates and undertakes dental research. Of necessity, and as part of their training, dental students provide dental services to patients under supervision. The funding of the School of Dentistry is derived from the DHSSPS and the Department for Employment and Learning. Many of the senior consultants are, therefore, employed by both the Belfast Trust and the Queen's University of Belfast. This includes the consultant who was referred to as Dr X within the Inquiry Report.

Recall of Patients Attending the Oral Medicine Department in the Dental Hospital

1.4 Each year in Northern Ireland there are around 160 cases of oral cancer. Concerns regarding the care of a small number of patients, by one consultant in oral medicine in the Dental Hospital, were raised in late 2009. These centred on whether six patients who had been referred for surgery, following a diagnosis of oral cancer, could have been referred at an earlier stage. As a consequence of this the Belfast Trust initiated a review of 3062 charts of patients who had attended the oral medicine service in 2009. This look back exercise was a long complex task which was completed in November 2010. A number of major, intermediate and minor concerns regarding the standard of care provided by Dr X arose during the course of this exercise. A total of 22 cases in which there were major concerns about the standard of care provided by Dr X were identified at that time. 15 patients with cancers were identified – four of whom had died – three from oral cancer and one from other causes. (It should be noted that in the Addendum to the Inquiry Report, another patient who had been referred to the same consultant in June 2010 subsequently died of oral cancer in November 2011. This death was reported as a Serious Adverse Incident to the HSC Board. All of these deaths were reported to the Coroner's Office.

1.5 A number of cases (105) in which the standard of care provided to Dr X was classified as giving rise to “intermediate” concern were also identified. Subsequent to this case note review and the application of agreed recall criteria, on 05 February 2011, the Belfast Health and Social Care Trust delivered letters by courier to 117 dental patients, re-calling them for check-ups as a precautionary measure. Appointments were offered to 116 of these patients (one patient had died from an unrelated condition). 107 of the 116 patients who were offered appointments attended for review. 40 of these patients required a biopsy and no cases of oral cancer were detected as part of this recall exercise.

1.6 As part of the response to the Inquiry recommendation (44), the Belfast Trust reviewed a further 1500 patients who had attended the same consultant in oral medicine in 2010 (600 discharged patients and 900 under ongoing review). At that time the consultant was under supervision arrangements organised by the Belfast Trust. The review of these 1500 patients commenced in autumn 2011 and concluded in early 2012. The progress of this review was monitored by the Oral Medicine Clinical Governance Group formed between the Trust, PHA and HSC Board in response to the Inquiry. There were no untoward outcomes arising from these reviews.

1.7 As part of a validation process of patient records and administrative systems in the School of Dentistry, it was identified that the computer records of approximately 359 patients who were seen by the oral medicine service in 2010 were not updated to reflect that the patients had been discharged. This was subsequently reported to the DHSSPS as an Early Alert and these patients were also offered appointments in May 2012 with additional clinics run from June 2012 to early 2013. This further identification of patients was also raised as a Serious Adverse Incident with the HSCB. There were no untoward outcomes arising from the review of these patients. The Trust has compiled a detailed report on the entire recall procedure and presented this report to the HSC Board.

1.8 There had also been a formal complaint made by one patient who had a late diagnosis of oral cancer, and whose complaint about the treatment received was upheld by the NI Ombudsman. The individual went to the NI Ombudsman as he/she had not been satisfied with the outcome of the complaints procedure in the Belfast Trust.

Initiation and Remit of the Inquiry

1.9 On 07 February 2011, the then Minister for Health, Social Services and Public Safety, made a statement to the Northern Ireland Assembly, apologising to patients and their families and announcing that he would establish an urgent independent inquiry into these matters. The Inquiry Panel was chaired by Mr Brian Fee QC and comprised Mrs Margaret Murphy, External Lead, Patients for Patient Safety, WHO Patient Safety and Professor Stephen Porter, Institute Director and Professor of Oral Medicine at University College London.
Mrs Evelyn Cummins, retired Senior Civil Servant, was Assessor to the Inquiry Panel.

1.10 The Inquiry Panel's terms of reference were, broadly:

- to evaluate the quality of care provided to all those patients who were re-called for review,
- to evaluate the effectiveness of communications between and within the Dental Hospital (which includes the Royal School of Dentistry for the purposes of the Inquiry),
- Health and Social Care organisations, the Department, patients and the general public, and
- to make recommendations to improve quality and communications.

1.11 The conclusions of the Panel are contained in both the summary report (published in July 2011) and also in the full Report (22 July 2013). These are:-

i. *There were serious deficiencies in the quality of care provided by the oral Medicine Department of the Dental Hospital and Belfast HSC Trust to the patients recalled for review. These deficiencies may have impacted adversely on the health of some of them to a significant degree and certainly had the potential to do so*;

ii. *There was a failure by the Trust to communicate fully, effectively and promptly with the other HSC bodies in the appropriate manner and a failure by the DHSSPS to be proactive in seeking further communication from the Trust. These communication failures contributed to the risk of harm to these patients as they prevented wider knowledge of the problems and the allocation of appropriate expertise and resources to ensure they were addressed as quickly and effectively as possible*.

1.12 As identified above, in paragraph 1.4, an addendum was also added to the final report which highlighted that a further death in late 2011 gave rise to additional concerns regarding the late diagnosis of oral cancer.

The Inquiry Panel made 45 recommendations which are contained in (Annex A).

Regional Learning Emerging from the Inquiry Report

1.13 It is the Department's view that a number of regional learning points emerge from the findings of the Inquiry Report. These are pertinent to HSC organisations and teams in primary care. Much of this learning has commonality with other lessons learnt across UK health systems and elsewhere. Learning includes:-

i) The use of single handed practitioners creates particular difficulties in terms of clinical and social care governance; where such arrangements are an operational necessity, it is incumbent on the organisation(s) to provide an appropriate infrastructure that ensures the full integration of the individual within the parent organisation(s) and promotes continuity of care, especially during periods of absences;

ii) The safety and sustainability of vulnerable specialist services needs careful discussion and proactive management by both providers and commissioners of services, working in collaboration with other relevant organisations e.g. a university;

iii) Medical appraisal systems need to be robust and include information that reflects the totality of a doctor's practice, and the requirements of the regulator. Whilst appraisal provides an opportunity to review any health or performance concerns, it should not be seen as a substitute for processes that identify such concerns and address these as and when they arise;

iv) Where staff performance issues arise, they must be dealt with in a prompt, proportionate and systematic manner. Such issues may give rise to, or be associated with an adverse incident. Where this is the case, organisations must be clear on the differing (though inter-related) investigation, reporting and management accountability arrangements these give rise to, both within and between employing organisations;

v) Coherence of data sources is an essential component of the corporate management of concerns; for example, in the investigation of professional performance, complaints or adverse incidents.

vi) There is a need, across the HSC, for robust escalation arrangements and practice in managing risk based on informed, transparent decision making. The principle of "no surprises" is an important communication tool across organisations. The application of this principle will aid the appropriate escalation of information within and, where necessary, between organisations;

vii) Investigations of all adverse incidents, however serious, are an opportunity to learn from and, as appropriate, to share the learning widely. Investigations need to be carried out in accordance with best practice, using formal HSC escalation protocols, and with a degree of independence appropriate to the level of seriousness of the incident;

viii) Patients are partners in care and have the right to know when care has been found to be suboptimal, especially when harm has occurred; they should receive an apology and an explanation of what happened;

ix) Patients have a right to information about their clinical treatment and care and every effort should be made to provide timely information to inform decision-making. Patients should be informed of their right to access health records/notes taking account of the contents in *Your Right to Confidentiality Leaflet*", and the forthcoming Information Management Controls Assurance

x) Knowledge of patient outcomes and the patient experience within a particular service are pivotal aspects of clinical and social care governance,

in the commissioning and provision of services, and in the teaching of undergraduate students and post graduate training.

xi) Where, as a result of an adverse event, HSC organisations identify the need for a retrospective analysis of patient outcomes, there is a need to clearly define the nature of the analysis, its scope, agreed methodology and communication plan from the onset of the process. Such a plan must record how best to communicate with the public, and with individual patients to include the outcome of their investigations.

xii) Before undertaking a major retrospective analysis, a HSC Trust/ organisation should agree its methodology with HSCB/PHA or with relevant expert body.

xiii) Imaging should only take place where there is a clinical need i.e. in order to assist in investigation, diagnosis and treatment of the patient. All individuals should work within appropriate clinical governance arrangements for the justification of, and reporting, on radiographs, and organisations need to ensure compliance with IR (ME) R (NI) 2000 legislation.

xiv) Good record keeping and file management are essential components of patient care.

Strategic Links to the Inquiry Recommendations

1.14 It is acknowledged that a number of DHSSPS policies, strategies and guidance which were developed /reviewed in 2011/12 have the ability to contribute significantly to the implementation of Inquiry Recommendations which were published in July 2011. These are in addition to the many policies, strategies, guidance and legislation that had already been produced by the DHSSPS on clinical and social care governance, risk identification, assessment and management, appraisal and revalidation, the management of underperformance, adverse incident investigation and reporting, complaints management and patient and public involvement. Much of this existing policy, strategy and guidance relating to quality and safety are available on the DHSSPS website at www.dhsspsni.gov.uk.

1.15 The following paragraphs highlights a small number of documents/programmes from 2009 - 2011/12 which are pertinent to the implementation of the Inquiry's recommendations and general learning. These include:-

- *Confidence in Care Programme;* - ongoing since 2008;

- *A Report on the Dental School at Queen's University, Belfast and Belfast HSC Trust (The Saunders Report)*- published in March 2011;

- *Quality 2020 – A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland* - published by DHSSPS in November 2011;

- *Escalation of Risks within and Between Health and Social care organisations;* guidance cascaded by DHSSPS in November 2011;

- *Regional Review of Consultant –led Hospital Dental Services* – published by DHSSPS for consultation in July 2012;

- *Assurance and Accountability Framework for Arms' Length Bodies* - DHSSPS 2012

1.16. Due to the importance of these strategic documents, further detail is provided below on how they link to the general learning and recommendations emerging from the Dental Inquiry.

1.16.1 *The Confidence in Care Programme*– In December 2008, the DHSSPS established this programme to deliver on the recommendations of the UK White Paper *Trust, Assurance and Safety* and the outstanding actions of the DHSSPS report *Improving Patient Safety: - Building Public Confidence*

The programme is taking forward reform of professional regulation. Many aspects of this work are relevant to Inquiry recommendations, notably in the development of systems for appraisal and for intervention when concerns arise over the performance of an individual practitioner.

A robust system of appraisal, together with the submission of a range of supporting information, will contribute to the revalidation of doctors by the General Medical Council. In preparation for revalidation, every HSC organisation in Northern Ireland has now nominated a Responsible Officer. They are lead doctors, who have a statutory duty to ensure that their organisation has the necessary processes in place to support medical revalidation and who will be required to make revalidation recommendations to the GMC about the fitness to practice of individual doctors who work there. Revalidation commenced for doctors in December 2012 and the vast majority of practicing doctors in Northern Ireland are scheduled to revalidate by 2016**.**

Through its *Confidence in Care Programme*, the DHSSPS has sought assurance from designated organisations, including HSC organisations, to advise it on readiness to meet GMC requirements for revalidation. All HSC organisations have indicated their readiness. The GDC's arrangements for revalidation of dentists are at an early stage of development. However, all employed dentists are part of the Trust's appraisal systems

The updating of the DHSSPS guidance on *Maintaining High Professional Standards* is also part of this programme of work. This guidance relates to procedures for the management of underperformance in employed doctors and dentists, e.g. by a HSC Trust.

The *Confidence in Care* Programme concluded in March 2013, remaining components of the work of the Programme have been allocated to the appropriate DHSSPS directorate.

1.16.2 *A Report on the Dental School at Queen's University, Belfast, and Belfast HSC Trust* (Saunders Report), Queen's University, Belfast and DHSSPS commissioned a Review of the School of Dentistry and Dental Hospital in Belfast, chaired by Professor W.P. Saunders, Dean of University of Dundee Dental School and Chair of the dental Schools Council. This review was published in March 2011. It included many proposals for the Dental School and Hospital, across the areas of education, research, and services, as well as generating high level imperatives. The relevant findings from this report have been considered as part of the Regional Review of Consultant –led Hospital Dental Services (see below).

1.16.3 Quality 20/20; The *Quality 2020 Strategy* sets the policy context for protecting and improving the quality of care over the next decade. Detailed work has begun on initiating a range of projects which will be a generic contributor to the implementation of learning arising from the Inquiry Report and many of its recommendations.

The projects include developing more robust processes to disseminate and monitor compliance with safety alerts, development of high level quality indicators, and development of annual quality reports for all HSC bodies, development of a standards policy framework, identification of culture assessment and change tools, and development of e-learning platforms.

The Strategy will also recognise and endorse initiatives across HSC which deliver quality improvement and comply with *Quality 2020* principles and values.

Since its launch in November 2011, a number of other initiatives have been progressed that focus on improving processes and systems to enhance patient safety. A review of guidance on incident investigations are presently being taken forward and are due to be completed by November 2013.

An Outline Business Case for the RAIL project (Regional Adverse Incident Learning system) was prepared by the Public Health Agency (PHA) at the request of the DHSSPS and this is currently under appraisal for investment approval. This system is aimed at establishing a unique region-wide system to monitor all adverse incidents (of all levels of severity) to better identify early indications of systems' failings so as to take appropriate immediate action, enhance learning and reduce the risk of serious adverse incidents arising in the future.

1.16.4 *Escalation of Risks Within and Between Health and Social Care Organisations* – In November 2011, the DHSSPS wrote to all HSC organisations on the need for robust processes within and between

organisations to escalate concerns and risk adequately, including to HSC Board level, if appropriate. In addition, this circular highlighted the related need to consider the wider impact of any identified risks across the HSC and Department and the resultant duty to address these adequately.

1.16.5 The *Regional Review of Consultant led Hospital Dental Services* has been completed by the DHSSPS and was issued for consultation in July 2012. This document presents evidence for change across specialist consultant led hospital dental services including the oral medicine service. The review focused on four key principles of quality, sustainability, timeliness and value for money. It also recognised the interface between hospital dental services and the School of Dentistry and the need to maintain sufficient expertise in consultant dental specialist services (including oral maxillo-facial services) to meet both service and academic needs. The final document is expected to be issued in September 2013. This Review has overlap with issues raised within the Dental Inquiry report including recommendations 2 and 3. Recommendation 2 of the Inquiry Report on how best to include non routine intra oral dental radiology should be undertaken and reported was considered by the Project Board. The advice of the Project Board was:-

- where a sialograph is required, the dental consultant should carry it out in conjunction with a consultant radiologist; and
- all radiography practice must be compliant with IR (ME) R (NI) 2000 legislation.

1.16.6 *Assurance and Accountability Framework for Arm's Length Bodies* (ALB's) In 2012, the DHSSPS finalised a new assurance and accountability framework for ALB's. The intention of the framework is to build on and strengthen the arrangements which already exist to further ensure that the Department discharges its sponsorship role in a consistent and proportionate manner with respect to all of the 16 Health and Social Care ALBs. Over the next year, the DHSSPS will further strengthen sponsorship of ALBs by developing guidance on; escalation of Special Measures to an ALB; and key elements of performance monitoring and reporting for all ALBs.

1.16.7 *Specials Measures – Belfast Trust,* In April 2012, Minister Edwin Poots, MLA, announced that specials measures, to monitor the Belfast Trust, were being put in place. These measures ceased in November 2012. During this time, the oversight arrangements between the Department and the Trust were enhanced under these arrangements with more frequent (monthly) governance and accountability meetings and a specific focus on progress against key milestones including the Dental Inquiry Recommendations.

Response to the Dental Inquiry – Development of an Action Plan & Update on Progress

1.17 The DHSSPS has co-ordinated the development of an Action Plan in response to the Dental Inquiry Report. This developmental work has adopted a collaborative

approach between the DHSSPS, and the HSC Board, Public Health Agency, Belfast HSC Trust, Queen's University, Belfast, and the Patient and Client Council. Where work has already started, as described in the above paragraphs (1.14 – 1.16) on Strategic Links to the Inquiry Recommendations, the Action Plan seeks to integrate the recommendations of the Inquiry into these existing strands of work.

1.18 The main objectives of the Action Plan are to promote patient safety, and to enhance both the patient experience and public confidence in the services provided by the Dental Hospital/School of Dentistry. However, and as identified in paragraphs 1.14 above, several of the Recommendations of the Inquiry have wider policy and HSC service implications.

1.19 The Action Plan (See section 2) is grouped under the seven headings contained in the Inquiry Report namely:-

- Quality of care;
- Supervision/ Appraisal;
- Administrative consideration;
- HR/Training/Workload Planning;
- Adverse Impacts on patients
- Communications; and
- Other recommendations.

1.20 The Plan sets out definitive and time-bounded actions which specify the benefits to patients and staff. Although it was not published in 2011, the relevant HSC organisations, DHSSPS and QUB senior officials have been aware of the general content of the draft Plan and its links to the 45 recommendations of the Inquiry Report.

1.21 The following paragraphs provide a summary overview of developments and actions completed since the publication of the Inquiry's Executive Summary Report in July 2011. For ease of reference these have been documented under the seven headings of the Inquiry report. These same seven headings form the basis for the Action Plan and its contents.

Progress to date on implementation of the Action Plan includes:-

1.22 <u>Quality of Care</u>

1.22.1 *Regional Learning arising from the Dental Inquiry Report.* The DHSSPS has cascaded the high level regional learning, arising from this Report, within its own organisation and to HSC organisations and relevant Arms Length Bodies, primary care teams and Queen's University, Belfast. A reminder letter will be issued in July 2013 on foot of the publication of the Inquiry's final report. Local organisations are responsible for the internal cascade of that learning which is included in paragraph 1.14 of this document. It addresses many of the Inquiry Recommendations but sets the learning in a wider context than that of the Dental Hospital/School of Dentistry.

1.22.2 *Revision of DHSSPS policy circulars.* The DHSSPS is revising policy circulars on patient service reviews/look back exercises, and templates for incident investigation. This work will be completed by November 2013.

Throughout this interlinking work, the importance of transparency, openness and information sharing will be highlighted. This will also assist in the consideration of which investigation pathway to take; for example, incident investigation, complaints procedures, or disciplinary procedures (including Maintaining High Professional Standards (MHPS) for the management of potential underperformance of employed doctors and dentists.

1.22.3 *Review of Maintaining High Professional Standards*- a working draft of this document was completed in December 2012 and shared with key stakeholders for consideration.

1.22.4 C*linical Governance arrangements between Belfast Trust and QUB.* A formal Dental Governance Committee was re-established with new terms of reference within the Dental Hospital and School of Dentistry in December 2011. The purpose of this committee is to provide a robust integrated mechanism to support the Belfast Trust's governance framework and to ensure that effective governance systems are established, monitored and maintained within the dental services, in both clinical services and the teaching programmes.

The Committee also addresses internal health and safety issues involving staff, students and patient safety. The Terms of Reference are attached at Annex C. The committee meets on a quarterly basis. Any concerns raised are communicated through the governance arrangements within the specific organisation. In the Belfast Trust, this is to the Trust Assurance Committee via the Directorate Assurance Committee. This facilitates a regular, objective review of dental activities by the multidisciplinary management team. The reporting pathway through QUB is to the School Management Board. Each speciality and sub speciality within the dental Hospital now have regular meetings with the Dental Services Manager to review and discuss any clinical, service or management issues and identify opportunities to improve the delivery and the efficiency of the service.

1.22.5 *Redesign of the Oral Medicine Clinic in the Dental Hospital*- The Trust is progressing well with the refurbishment of the physical infrastructure of the Dental Hospital/School of Dentistry. As part of this programme, the existing layouts are being reviewed, and where possible, areas are created to enable confidential discussions with patients. However, given the physical environment and the nature of teaching within the service clinics, the Trust/QUB advise that it is difficult to absolutely assure patient confidentiality.

The first stage of the refurbishment programme was completed in September 2012. The phasing of the business case for the next stage of the programme is being

reviewed in conjunction with Health Estates Investment Group with a view to including a revision of the layout of the area used in oral medicine. However, due to the demand for space, it is unlikely that an area solely for oral medicine will be created; but improvements could be made to the current environment.

1.22.6 *Improvement in patient outcomes*

Preparatory work to develop a PPI process and questionnaire has been ongoing. The questionnaire will be issued to patients attending the Dental Hospital/School of Dentistry from October 2013. In addition a, face to face interviews will also be organised.

A further group of patients who regularly attend the Dental Hospital/School of Dentistry across the dental sub-specialties will be identified to establish a focus group to discuss the services provided and recommend areas for development. This process will be undertaken using Experience Based Design methodology. Consideration is also being given to the development of clinical indicators specifically for the oral medicine service.

The Belfast Trust has committed to the Investors in People methodology; as part of this, a detailed staff survey was completed across the Trust. Final submission for IIP assessment took place in March 2013 and the Trust was reaccredited with this standard.

A dedicated biopsy clinic has been established with available capacity reviewed on a regular basis. Where appropriate, additional capacity for biopsy clinics is made available to ensure that there are no unnecessary delays in diagnosis. All biopsy results are reviewed by the referring consultant. Where appropriate these are reviewed, together with other clinical information at the head and neck multi-disciplinary meeting.

1.23 <u>Supervision of Appraisal</u>

1.23.1 *Appraisal* - Consultant appraisal was introduced for all employed doctors in 2001. This requirement also applies to dentally qualified practitioners who are employed as consultants. The DHSSPS has revised this appraisal guidance which now aligns to the requirements of medical revalidation. The revised appraisal guidance and documentation were published on 14th February 2013.

1.23.2 *Joint appraisal between Belfast Trust and QUB* - A new protocol was approved in 2010 to govern the operation of appraisal, job planning and academic workload and performance review. There is a process in place to ensure the completion of appraisal of clinical academic staff and fed through to respective governance committees in both organisations.

1.23.2 Appraisals and job planning for clinical academic staff are carried out jointly by the University and Trust. Completion of appraisals are recorded and reported annually to the University management and Senate.

1.23.3 For practitioners in the School of Dentistry who are contracted solely by Queen's University (i.e. non-consultant clinical lecturers and Clinical Teaching Fellows), the University is developing an appraisal framework.

1.23.4 Further work is on-going by both organisations (BHSCT and QUB) to ensure that the process of appraisal is working effectively including for those at sub consultant level working in the Dental Hospital/School of Dentistry – for example, for sessional doctors and dentists and for those Clinical Teaching Fellows who work in a supervisory capacity of dental students treating their own patients.

1.24 Administrative Consideration (specific to Dental Services)

1.24.1 *Prioritisation of workload/cases* – A protocol for oral medicine needs to be developed to ensure effective prioritisation of all cases and to maximise use of the resources of the clinical team. The Trust states that oral medicine clinic timetables have been amended, and are in line with recommended practice and those used in other centres. All appointments meet the requirements of the regional Integrated Elective Access Protocol (IEAP) guidelines. Referral letters are graded by the consultant, based on the information provided by the referring clinician. Patients are offered appointments in priority of Red Flag, Urgent and then Routine referral.

1.24.2 *Demand – capacity analysis in Oral Medicine* – In June 2012, the HSC Board carried out a demand and capacity exercise for oral medicine services in the Belfast Trust. This revealed that if historical referral volumes persisted then the service would not have sufficient capacity to see all patients within the agreed DHSSPS performance waiting times. However, the HSC Board subsequently identified that oral maxillo-facial surgery services in the South Eastern and Western Trusts and their respective outreach sites, also provided significant levels of oral medicine services. Therefore, the demand –capacity analysis was extended to all HSC Trusts. The analysis found that if primary care practitioners referred oral medicine cases to their local Trust provider, be that an oral maxilla-facial surgery service or a dedicated oral medicine service, and an additional oral medicine consultant was recruited to BHSCT, then the service for these patients should meet access targets.

1.24.3 *Review of Clinical Administration Processes*- The Review of Clinical Administration Processes within the Dental Hospital commenced in April 2011. This Review included all aspects of clinical administration, staffing, skills mix, training, and the use of technology with reference to best practice elsewhere. A total of 65 recommendations for change were made following the Review with an implementation group established in December 2011. Of these, 43 recommendations have been fully implemented with the remaining 12 partially addressed and work is ongoing to complete these.

An Administrative Quality Co-ordinator with responsibility for the development of audits, protocols and staff training was appointed in February 2012. The Coordinator has a lead role in the implementation of

the recommendations from the clinical administration review. A new structure for administration management has been agreed and was implemented in September 2012. This development provides a more inclusive and specialised approach to the management of appointments and health records.

A number of audits have already been carried out which detail significant improvements in the following areas:

- An increase in completed clinical outcome forms from 75% in January 2012 to 84% in April 2013. The use of these forms has enabled the Trust to provide a more robust administration and management system of a patient as well as ensuring that the patient administrative system (PAS) is updated.
- A significant increase in accurate case note tracking following random audits from 67% in May 2012 to 100% in July 2012. This process ensures that all patient charts can be located when required for a patient attendance. The medical records facility has recently been completely upgraded and reorganised. This involved a temporary relocation of medical records which are now being returned to the medical records store. A re-audit of case-note tracking is scheduled for August 2013.
- The filing of clinical correspondence has greatly improved and continues to be monitored on a weekly basis.
- Patient letters are now dictated using advanced digital technology and turnaround of transcribed letters is within two weeks of dictation. This is monitored on a weekly basis.
- In total eight clinical administration protocols have been developed and implemented, greatly enhancing the systems and processes for all clinical administration.
- The telecommunication system within the School of Dentistry; Hospital has improved and the opening times of the appointments office has been extended.
- Capital funding has been secured to modernise and improve the Health Records Department. This will enhance the security of patient records.

1.24.4 A*ccess to clinical notes by patients* –Throughout Northern Ireland, hospital patients are not routinely given a copy of correspondence that is sent to the referring practitioner following a consultation. However, as a general principle, patients have a right to see their records. A patient attending the Dental Hospital has the same rights as any other patient who attends a HSC service for treatment. The Department published a revised Code of Practice on Protecting the Confidentiality of Service User Information in January 2012 and an associated leaflet. *Your Right to Confidentiality* was issued to all relevant organisations so that they could make it available to service users. The leaflet includes a section “Your Right to see what is held about You.” The Department is currently finalising an Information Management Controls Assurance Standard which includes a proposed standard which contains a requirement for Trusts to respect an individual’s right to access their health records.

1.25 Human resource/training/workload planning

1.25.1 *Referral protocols* – The HSC Board, Belfast Trust and the oral and maxilla-facial surgery teams in the Western and South Eastern Trusts have worked together on the development of referral guidelines for oral medicine services. The HSC Board also ran workshops in April 2012 with key regional stakeholders on oral medicine and oral surgery referrals. This work is linked in with the demand- capacity exercise to lead to the creation of an oral medicine referral guidance package which allows each primary care dental and medical practitioner to understand the referral pathway to their local oral medicine services. The package clarifies what conditions are appropriate for Trust services and provides practitioners with a referral pro-forma. Particular emphasis is given in the package to management of cases of suspected oral cancer. Whilst ready to be issued immediately, waiting until after the oral surgery pilot in the Southern Trust area concludes on 30 September 2013 will minimise the possibility of the package causing confusion among referring practitioners.

1.25.2 *Use of Single handed Practitioners* - The Review of Consultant-led Hospital Dental Services advises against single-handed consultant working and that any future model should ensure that service delivery is not reliant on a single individual. The Review proposes service models for all the specialities within its remit which will result in a sustainable solution when considering the European Working Time Directive, lone working, and staff recruitment and retention. In recognition of the significant service reliance on dental joint appointment posts, Recommendation 3 of the Review states that "t*he commissioning of dental joint appointment consultants should be reviewed. The future model must ensure full involvement of the HSCB in the structure and allocation of these posts".* The Department has already completed work to establish the guiding principles underpinning the future model for joint appointments. Further work is now planned to implement a new process for appointing dental joint appointment consultant posts.

1.25.3 *Recruitment of joint appointment consultants* –The DHSSPS provides funding through the Supplement for Undergraduate Medical and Dental Education (SUMDE) funding stream to employ sufficient numbers of joint appointment consultant posts to deliver the undergraduate programme for dental students in Northern Ireland. Although there have been difficulties in the recruitment of consultants, the DHSSPS will continue to make available the funding to support a full complement of consultant staff.

The University had already attempted on several occasions to recruit into some of the unfilled posts but with limited success**.** Two appointments in restorative Dentistry (at Professor and Clinical Lecturer levels) were made and candidates took up positions in September and November 2012 respectively.

A further six appointments have been made – one in restorative dentistry, three in oral surgery and two in paediatric dentistry – with successful candidates taking up post during the Summer of 2013.

The DHSSPS has also been informed that a staffing strategy, with defined targets, has been agreed by the Belfast HSC Trust and the University through a Dental School Project Group. The need to expedite recruitment and appointment of consultant is seen as a key priority and has already been emphasised by recent General Dental Council reports[1]

1.25.4 *Continuing professional development in Oral Medicine* – The General Dental Council has included the topic of 'improving early detection of oral cancer as a recommended core subject in its continuing professional development requirements for all members of the dental team. The DHSSPS has written to the Northern Ireland Medical and Dental Training Agency in September 2012 to ask that continuing professional development in oral medicine is included as a recurrent element in the postgraduate dental calendar of education events.

1.25.5 *Teaching needs for specialist dentists* - There is an established process in place to identify the future service and teaching needs for dental specialists and to provide training pathways for this specialist training in order to produce specialists of consultant standard. Since 2004 the DHSSPS has provided funding for an additional four specialist training registrar posts to ensure a sufficient supply of specialists for service and training needs. However, due to the historical problems of recruiting a sufficient number of consultants at the Dental School/Hospital (highlighted at 1.25.3 above), there was a capacity issue for training specialists in certain dental specialities. With the recruitment of more senior staff, creative ways of training the future specialist workforce will be looked at.

1.25.6 *Induction of staff* - A new induction programme has been developed and introduced for all administrative staff in the Dental Hospital. This programme is routinely reviewed to assess its suitability for new staff members and their role in patient safety.

A monthly administrative team meeting was established in September 2011 with "governance" a standing item on the agenda. This gives management and staff an opportunity to raise any area of concerns. The Administrative Services Co-ordinator is also now an active member of the Dental Governance Committee.

An induction programme is also being developed for new consultant staff.

1.26 Adverse Impacts on patients

1.26.1 *Biopsy arrangements* – The locum consultant in Oral Medicine in the Dental Hospital provides a separate and dedicated biopsy clinic within his weekly job plan. Any patients who are deemed to need a biopsy are, where practical, offered an opportunity to have this done immediately. If this is not feasible, then a range of appointment options are available to patients each week, including appointments in other clinics or a dedicated biopsy clinic.

1

1.27 Communication

1.27.1 *PPI review and the patient experience* – The DHSSPS produced guidance on Patient and Public Involvement (PPI) in 2007. This guidance was revised in September 2012 to take account of changes which occurred as a consequence of the Health and Social Care (Reform) Act (NI) 2009. This Act placed a statutory duty of public involvement on Health and Social care organisations. The revised circular will link to the *Quality 20/20* arrangements, as PPI is seen as a key element of clinical and social care governance. Each HSC organisation will be expected to include action plans for PPI in their organisational Annual Reports and/or Annual Quality reports to be developed as part of Quality 20/20 implementation.

The Belfast Trust is in the process of establishing a formal Patient and Public Involvement User Group for dental services taking account of both the service and teaching elements of the Dental Hospital /School of Dentistry.

In order to improve the patient experience, the Oral Medicine clinics in the Dental Hospital are run from a small unit often without any other clinic running at the same time.

1.27.2 *User experience within the teaching environment*

The dental curriculum has been revised to allow increased feedback on the patient experience. Since 2012/13, patients are invited to talk about their dental problems and health care experience in a new Second-Year module within the revised curriculum. In Final Year all students have a presentation case and part of the assessment process is that the patients are given the opportunity to speak to the External Examiners about their treatment. This is in addition to the routine questionnaire- based patient feedback to staff and students concerning their experience and satisfaction.

1.27.3 *Communication with patients as a consequence of the Dental Inquiry*
The Belfast Trust has stated that it has completed its communications programme with individual patients. All of those patients who were called back for review were communicated with verbally by the consultants in oral medicine. They advised the patients on their condition, on any treatment necessary, and on any recommendations to improve oral health. After each appointment, a letter was also sent to the patient's general dental practitioner advising them of the outcome of the appointment. Once discharged from the service, the consultants communicated this verbally to the patients and again in writing to the general dental practitioner, as per normal practice.

1.27.4 *Letter to all dental staff from DHSSPS.* – In August 2012, a letter was issued from the Chief Dental Officer to all dental professionals. This letter drew attention to the General Dental Council (GDC) standards with particular reference to keeping accurate and complete patient records, including medical history, at the time they treat patients. It drew attention

to the DHSSPS Minimum standards for Dental Care and Treatment which also require good record keeping in primary care.

1.28 Other Recommendations

1.28.1 *Mission statement of Dental Hospital* – This has been addressed through the Review of Consultant led Hospital Dental Services, issued for consultation in July 2012 where the role of the Dental Hospital/School of Dentistry has been made clear within the context of needs assessment and specialist service redesign.

1.28.2 *Audit of biopsy results* – In response to recommendation 43 of the Dental Inquiry recommendations, a laboratory management information report was produced using relevant diagnostic coding to show patients with a clinical diagnosis of epithelial dysplasia and related conditions. The report identified that 15 biopsies were carried out on a total of 12 patients who attended the oral medicine service during the period January 2009 - August 2011 under the care of Dr X. All 12 patients have been followed up by the Oral Medicine service or have been referred on for treatment to an appropriate clinical practitioner since their initial diagnosis.

1.28.3 *Recall of patients* – as per recommendation 44 of the Inquiry Report. As identified in paragraphs 1.6-1.7 above, the Belfast Trust recalled 1500 patients (completed in early 2012). An additional 359 identified as a result of a validation process of patient records and administrative systems in the School of Dentistry in June 2012. The review of this latter group was completed in early 2013. The identification of this patient group was raised as an Early Alert with the DHSSPS and as a Serious Adverse Incident with the HSCB. The Trust has advised that there were no untoward outcomes arising from these reviews. A detailed report on the exercise was presented to the HSC Board.

Further Implementation of Action Plan

1.29 The preceding paragraphs (1.17- 1.28) highlight that significant progress has already been made in the implementation of actions within this Action Plan. However, the DHSSPS expects to see this Action Plan implemented in full.

1.30 Many of the actions require the commitment of a range of organisations, including the DHSSPS itself. Each HSC organisation will be required to submit to the Permanent Secretary of the DHSSPS a full report on progress towards implementation of respective actions until full implementation is achieved in 2014.

1.31 Where actions fall outside the scope of the DHSSPS, an update on progress towards implementation will be sought from the relevant organisation. A composite report will then be sent to the Minister for Health, Social Services and Public Safety and published on the departmental website – by 2014.

1.32 The DHSSPS will seek independent assurance regarding implementation of the Action Plan and on improving the quality of dental care commissioned by HSC

Board and provided by the Belfast Trust. This will be led by the Regulation and Quality Improvement Authority, and carried out during 2015/16.

SECTION 2 - The Action Plan

How to read the Action Plan

2.1 The action points listed in the Plan in section 2.3 below are grouped under the headings contained in the Dental Inquiry Report. These are:

- Quality of Care
- Supervision/ Appraisal
- Administrative Considerations
- HR/Training/Workload Planning
- Adverse Impacts on Patients
- Communications
- Other Recommendations.

Before looking at the detail of the attached Action Plan, you will need to read the Recommendations of the Dental Inquiry Report as grouped under the above headings as listed in Annexe A. For ease of reference, the recommendations have been numbered sequentially.

You may also wish to refer to the Glossary of Terms below, and the Bibliography (Annexe D), as a large number of references and acronyms are used in the Plan.

Against each action point in the Plan, and where appropriate, the interlinked Dental Inquiry Report recommendation(s) is identified by its number(s). In addition, the timeframe for delivery of the specific action, together with the benefits to patients and staff, are identified.

Each action identifies the lead organisation(s) responsible for reporting back to the DHSSPS on progress towards implementation. It is envisaged that all of the actions should be completed or ongoing by 2014.

Red/Amber /Green Analysis of Action Plan

2.2 The report takes the form of a red/amber/green (RAG) assessment: The purpose of the RAG assessment is to provide a transparent overview of progress against each of the Actions within the Plan.

RED constitutes a formal alert that a milestone has not been delivered or will not be delivered by the agreed date and urgent action is required.

AMBER constitutes a caution that some adjustment may be required to bring progress back on track to deliver the milestone

GREEN indicates that the milestone has already been delivered or is fully on track for delivery. Delivered milestones will be removed from the business area reporting template but will continue to feature in the overall reporting matrix.

2.3 **Glossary of Terms**

BHSCT	Belfast Health & Social Care Trust
CAB	Clinical Academic Board
CiC	Confidence in Care programme
CDE	Centre for Dental Education
CDS	Community Dental Service
CDO	Chief Dental Officer, DHSSPS
CPD	Continuing Professional Development
CTF	Clinical Teaching Fellow, QUB
DCMO	Deputy Chief Medical Officer, DHSSPS
DHSSPS	Department of Health, Social Services and Public Safety
GDC	General Dental Council
GMC	General Medical Council
HRD	Human Resources Directorate, DHSSPS
HSC	Health & Social Care
HSC Board/HSCB	Health & Social Care Board
IMB	Information Management Branch, DHSSPS
IEAP	Integrated elective Access Protocol (i.e. how waiting lists are managed)

MHPS	*Maintaining High Professional Standards in the Modern HPSS* (DHSSPS, 2005)
NCAS	National Clinical Assessment Service
NMAG	Nursing and Midwifery Advisory Group, DHSSPS
PHA	Public Health Agency
PPI	Patient and Public Involvement
PCC	Patient and Client Council
QUB	Queen's University, Belfast
SCD	Secondary Care Directorate, DHSSPS
SAI	Serious Adverse Incident
SLA	Service Level Agreement
SMDB	School of Medicine, Dentistry and Biomedical Sciences at Queen's University, Belfast
SUMDE	Supplement for Undergraduate Medical and Dental Education
SQSD	Safety and Quality Standards Directorate, DHSSPS

2.3 Detailed Action Plan

Section	Action(s)	Timeframe for Delivery	Benefit to patients/staff	Responsibility for Delivery	Link to Recommendations
Quality of Care	**1. Cascade the generic learning emerging from the Inquiry to all HSC Organisations**	Reminder letter to be issued once Inquiry report is published.	Highlight the important lessons for the benefit of patients, staff and organisations	DHSSPS (SCD)(CMO Group)	All
	2. Review the layout of clinical areas as part of the refurbishment programme planned over the next two years.	Phase 1 Completed September 2012; 2nd Phase September 2014	Increased patient and staff satisfaction/patient confidentiality.	**Lead:** BHSCT	1
	3. Incorporate into the Review of Consultant-Led Hospital Dental Services how best non-routine intra-oral dental radiology should be undertaken and reported.	Report issued for consultation in July 2012; Issue discussed and agreed by Project Board. This matter will be incorporated into the final Review Report September 2013	Consistent approach to patient care across NI.	**Lead:** Project Board of Review Group* (Chair CDO) **Support:** BHSCT at a local level	2
	4a. Identify and develop patient and staff outcome measures, building on the work of the Belfast HSC Trust, e.g. Patient Experience Design methodology, and a staff wellbeing survey through IIP.	IIP staff surveys completed PPI Preparation ongoing with initial survey to be distributed in	Improved patient care and Increased patient and staff satisfaction. Promotes regular audit of patient outcome measures.	**Lead:** BHSCT **Support:** HSC Board	3

* This refers to the Consultant-Led Hospital Dental Services Review Group

	4b.Measures to be audited on a regular basis	October 2013 Action plan and regular audit			
	5. Review, combine and re-issue policy circulars HSS (SQSD) 18/2007 (Conducting Patient Service Reviews/Look-back exercises) and HSS (SQSD) 34/2007 (HSC Regional Template and Guidance for Incident Review Reports), taking account of established governance arrangements and escalation of risk.	Serious Adverse incident procedures being revised by HSC Board October 2013	Clarity on conducting incident reviews, escalation policy and differentiation of incident types.	**Lead:** DHSSPS (SQSD) **Support:** HSC	4-10, 12, 28, 35
	6. Review *Maintaining High Professional Standards* and associated guidance - ensure that the processes in the framework complement those under Action Point 5 and HSCB Serious Adverse Incident (SAI) protocols.	Working draft completed December 2012 Full implementation December 2013	Assurance in relation to processes for managing concerns arising from the practice of individual doctors or dentists.	**Lead:** DHSSPS (HRD/CMO Group)	4 -8, 10, 12, 35
	7. Implement *Quality 2020* (a 10-year strategy to protect and improve quality in the HSC in NI), taking into account relevant guidance on governance arrangements.	Implementation commenced June 2012.	This will contribute to a range of quality issues and training in patient safety.	**Lead:** DHSSPS (SQSD) **Support:** HSC bodies/all DHSSPS directorates	27,29, 35,37
	8(a) Review and revise the Service Level Agreement between the Department and NCAS for the provision of services in Northern Ireland. **8(b) Conduct a further review of SLA in line with the Government's Review of Arm's Length Bodies, when NCAS will become self-funding.**	Action Completed for 12/13 and 13/14 SLA reviewed and agreed Mar 2013	Expert input into the investigation and management of underperformance of medical, dental and pharmaceutical practitioners.	**Lead:** DHSSPS (SQSD) **Support:** HSC bodies	8,9, 12, 40
		December 2013			6, 9, 10,12

	9. Take forward a Regional Adverse Incident Learning (RAIL) system.		Improved arrangements for sharing learning from adverse incidents.	**Lead:** PHA **Support:** DHSSPS/HSC	

Section	Action(s)	Timeframe for Delivery	Benefit to patients/staff	Responsibility for Delivery	Link to Recommendations
Supervision/ Appraisal	**10. Further develop Appraisal Guidance in line with requirements of the revalidation process.**	Completed in December 2012	Improved quality, consistency and data collection of evidence for the appraisal process and to inform revalidation.	**Lead:** DHSSPS (HRD/CMO Group) **Support:** HSC and other organisations including academic institutions	10,11
	11. Implement medical revalidation to include evidence of annual participation in appraisal.	Commenced in December 2012	Assurance that medical practitioners are up to date and fit to practise (also linked to the role of the Responsible officer).	**Lead:** DHSSPS (HRD/CMO) **Support**: HSC and other organisations including independent sector, academia and GMC	6,-10, 11
	12. Establish a Clinical Academic Board (QUB) and seek assurance on the robustness of the processes that are in place for the completion of academic workload/performance review, appraisal and job-planning. These processes should include an agreed minimum dataset to inform appraisal, performance review and job planning.	Completed Joint QUB/Trust appraisal documents, also joint performance group with Deputy Medical Director	Assurance that rigorous processes for joint appraisals are in place and that appraisals, performance review and job-planning are undertaken on a timely basis.	**Lead:** QUB/ BHSCT	11
	13. a)Comply with the current CDE management structure in QUB which ensures that sub-consultant staff who are supervising dental students receive annual appraisal, including	completion of 12/13 appraisal cycle on-going.	Assurance that a more rigorous management of joint appraisals is in place.	**Lead:** QUB/BHSCT	11, 18

	the responsibilities of the registered practitioner when supervising dental students treating their own patients. **b) Consider the consultant appraisal system's applicability to the needs of sessional dentists, as has been carried out for the Community Dental Services.**	June 2013 – for implementation of new framework for dentists/doctors (non-consultant clinical lecturers/Clinical teaching Fellows)			

Section	Action(s)	Timeframe for Delivery	Benefit to patients/staff	Responsibility for Delivery	Link to Recommendations
Administrative Considerations	**14. Develop and implement a protocol for oral medicine services to ensure effective prioritisation of all patients and to maximise the use of the resources of the clinical team.**	Completed All appointments are managed in accordance with the regional IEAP	Timely appointments for patients-as defined by the clinical urgency of their symptoms/signs.	**Lead:** BHSCT **Support:** Staff of Dental Hospital, HSCB and other organisations	13 (1), (2), (3), 14, 15; also further links to 19
	15. a))Long-term staffing arrangements within the Dental Hospital to be agreed **b) Implement the recommendations of the Regional Review of Consultant-Led Hospital Dental Services Group (final document, post consultation in early 2013.**	From March 2013 onwards	Improved management of patients and clinical leadership	**Lead:** BHSCT/HSCB/QUB/ other HSC trusts **Support:** DHSSPS	20, 21,22,23,
	16. Agree actions/recommendations arising from the Administrative Review in Dental Hospital, to include records management, and audit to ensure effective implementation.	Completed Regular audits take place	Assurance that records management and administrative support are in line with best practice.	**Lead:** BHSCT **Support**:- staff in Dental Hospital, QUB	15, 16, 17
	17. Ensure that patients are made aware that they have a right to see correspondence regarding their care. (*See para 1.24.4 in text)*	New guidance issued to HSC in January 2012 New Information Management controls Assurance Standards – July 2013	Improved transparency, and patient involvement. Improved information governance	**Lead:** DHSSPS **Support:**- implementation in all HSC organisations	16

18. **a) Review clinical governance arrangements to ensure that there is a robust, integrated mechanism to support the Belfast Trust governance framework within the Dental Hospital Service and School of Dentistry.** **b) CDE Director to report to the School Management Board in QUB, on any issues regarding clinical governance as it relates to teaching/student activity, and risk registers to be shared between the sponsor units in QUB and BHSCT.**	December 2011 and ongoing Director of Centre for Dentistry reports every 2 months through School Management Board.	Assurance that governance arrangements are adequate and robust.	**Lead:** BHSCT/QUB **Support: S**taff in Dental Hospital and QUB	18

Section	Action(s)	Timeframe for delivery	Benefit to patients/staff	Responsibility for delivery	Link to Recommendations
HR / Training / Workload Planning	**19. Include within the Review of Consultant-Led Hospital Dental Services referral and care pathways of patients to and within Oral Medicine; clinical demands and training needs of local primary healthcare providers and Oral Surgery specialists regarding Oral Medicine in Northern Ireland.**	Review issued for consultation in July 2012 These matters will be incorporated into the final Report: September 2013	Patients seen in right setting, by the right clinician at the right time with the right outcome.	**Lead:** Project Board of Review Group* (Chair CDO-DHSSPS) **Support:** HSC organisations, primary care practitioners and NIMDTA	19 & 20 and further links to 23, 24
	20. a) Determine and benchmark the regional demand and capacity for Oral Medicine. **b) Examine referral pathways with a view to networking where appropriate. Until this work is complete, produce interim guidance to inform practitioners of current arrangements.** **c) Recruit and maintain a consultant led Oral Medicine service, and additional academic posts as interim measures.**	Completed April 2013 Draft referral pathways -April 2012 Finalised referral package to be issued in September 2013 Ongoing 7 academic posts appointed IPT submitted to HSC Board for full time service OM consultant	Effective use of HSC resources. Primary care providers will have clear guidance on referral pathways. Safe and sustainable service	**Lead:** HSCB **Support:** QUB/BHSCT & Other NI Trusts **Lead**:- BHSCT/QUB **Support**:- HSCB and other HSC trusts	19,20, 22, 23 and further links to 30
	21. a)Training of General Dental	NIMDTA Courses	Patients are referred to an	**Lead:** HSCB	19, 23

* This refers to the Consultant-Led Hospital Dental Services Review Group

	Practitioners(GDPs) on prioritisation of referrals and referral pathways **b) Training for GDPs on the management of simple oral medicine conditions.**	planned for early 2014 CDO letter to NIMDTA in September 2012	appropriate clinician and seen in a timely manner.	**Support:** NIMDTA/ GDPs, **Lead:** NIMDTA/ GDPs **Support**:- HSC organisations	
	22. Appoint new academic staff, as appropriate.	Ongoing. Staffing strategy in place with associated targets; some progress made.	Ensures the correct staff/student ratios for training/education and patient treatment, and that appropriate academic leadership is in place.	**Lead:** QUB **Support:** BHSCT in liaison with HSC Board	23, and further links to 24
	23. a) Ensure appropriate processes and sufficient funding are in place to meet the future service and academic needs of specialist consultant dental services. **b) Promote networking arrangements for higher training, particularly for cross-cover/vulnerable specialties e.g. oral medicine should be established**	Funding and processes in place for 12 specialist training registrars. Implementation: immediate	Ensures that academic and clinical leadership in key disciplines is in place. Ensures staff have a balance between teaching and HSC dental services.	**Lead:** DHSSPS (HRD)/NIMDTA **Lead** QUB, BHSCT, NIMDTA	24
	24. Assess the induction process for non –clinical staff in the Dental Hospital and promote the importance of staff's role in patient safety.	Completed	Improved administrative care and communication between managers and staff, ultimately leading to improved patient care.	**Lead:** BHSCT **Suppor**t: Staff in dental hospital	25

Section	Action(s)	Timeframe for Delivery	Benefit to patients/staff	Responsibility for Delivery	Link to Recommendations
Adverse Impacts on Patients	**25. Establish a biopsy clinic and review the arrangements.**	Completed	Sufficient time allocated for biopsies to be undertaken.	**Lead**: BHSCT	26

Section	Action(s)	Timeframe for Delivery	Benefit to patients/staff	Responsibility for Delivery	Link to Recommendations
Communications	**26. Clarify the process for the involvement of service users in the planning, development and monitoring of the services provided in the Dental Hospital Hospital/School of Dentistry.**	Ongoing	Contributes to governance arrangements and patient safety and good outcomes.	**Lead:** BHSCT working in collaboration with QUB **Support**: patients, staff of dental Hospital and students	27, 29, 37
	27. Review the operation of the Early Alert System - HSC (SQSD) 10/2010.	Reminder circular to be issued to ensure understanding August 2013	Ensure the effectiveness of the current early alert system and that each organisation understands its role and responsibilities.	**Lead:** DHSSPS (SQSD) **Support:** HSC and other organisations	31, 32,33,35
	28. Linked to 27 above, clarify and review guidance on early alert system, SAIs, escalation policy, and recognise the importance of openness and need for transparency and an apology to individuals, when the service has been suboptimal.	Reminder circular to be issued to ensure understanding August 2013	Enhanced management of concerns/risk. Supports openness and transparency for patients and promotes public confidence	**Lead:** DHSSPS (SQSD) **Support:** HSC	30, 31, 32, 35, 36

29. Linked to 27 and 28 above, review guidance on the investigation of incidents, taking account of the need for enhanced communication within and between organisations when concerns and risks emerge.	Reminder circular to be issued to ensure understanding August 2013 Regional learning system will further reinforce guidance on investigation of incidents December 2013	Clarity on conducting incident reviews, escalation policy and differentiation of incident types.	**Lead:** DHSSPS (SQSD) **Support:** HSC	28-33, 35
30. Incorporate the need for information-sharing into the reviews, as identified in 28 and 29, above; and into local HSC processes to highlight the need for good communication where concerns arise. **(This action is relevant to MHPS and other disciplinary procedures as undertaken in HSC organisations - see also action 6 above)**	Regional learning system will outline arrangements for better communication and information sharing December 2013	To assist organisational decision making into when to share information in relation to concerns and with whom.	**Lead:** DHSSPS (HRD/CMO Group) **Support:** HSC organisations /responsible officers involved	32, 35 and links to 4-8
31. Review operation of PPI policy to ensure that local procedures meet statutory duty of involvement.	Completed Revised Policy Circular issued in Sept 2012	Maximise service user involvement.	**Lead:** DHSSPS (SQSD) **Support:** HSC	Links to 37
32. Include Dental Services, as appropriate, within	2012 and ongoing,	Promote prompt and	**Lead:** DHSSPS	34

the BHSCT Accountability Review Meeting, and seek assurance on robustness of systems and disclosure of information.	if required	appropriate Trust action on issues within HSC Dental Service.	**Support:** BHSCT	
33. Look at user experience within the teaching environment - feedback into both the PPI and CDE process.	From 2012/13 user experience included within revised dental curriculum Patient satisfaction feedback survey in place to staff and students	Maximise user involvement.	**Lead:** QUB **Support:** BHSCT	37
34. Take cognisance of the need for Openness and Transparency, and an apology, if appropriate, and seek advice from HSCB/PHA or other organisation, if necessary.	Ongoing	Improved communication, openness and transparency.	**Lead:** BHSCT **Support**:- HSCB/PHA	32, 36,
35. Review locally whether any further correspondence is required to be sent to patients arising from the practice of Dr X.	Ongoing	Improved communication, openness and transparency.	**Lead:** BHSCT **Support:** HSCB	38, 39
36. a) Issue a letter to all dental staff reminding them of relevant guidance: the *Minimum Standards for Dental Care and Treatment* (March 2011), which applies to primary dental care and used by RQIA to inspect general dental practice. **. b) Promote the GDC standards on record keeping and their application to all dental professionals to include the need for regular**	Letter issued by CDO in August 2012	Robust patient records are essential to safe and effective patient care	**Lead:** DHSSPS (CDO)	41

	audit				
	37. Ensure effective cascade of alert letters (regarding concerns about performance of a practitioner) to all organisations providing dental services – to include HSC organisations, general dental practitioners and private practitioners and hospitals/ clinics.	Completed – March 2012	Potential benefit to patient and public safety by allowing organisations to take appropriate, timely action if required.	**Lead:** DHSSPS (HRD/CMO group) **Support:** CDO/HRD responsible officer / RQIA	30, 31, 32, 35

Section	Action(s)	Timeframe for Delivery	Benefit to patients/staff	Responsibility for Delivery	Link to Recommendations
Other Recommendations	**38. Include the mission of the Dental Hospital (as recommended in the Saunders Report[1]) as part of the Review of Consultant-Led Hospital Dental Services.**	Review Report issued for consultation in July 2012 These matters will be incorporated into the final Review Report September 2013	Clarity and enhancement of the commissioning and provision of consultant led hospital dental services in the Dental Hospital.	**Lead:** Project Board of Review Group[*] (Chair CDO)	42
	39. Complete an audit of the relevant biopsy pathology results.	Completed; all 12 patients followed up	Promote comprehensive patient care.	**Lead:** BHSCT	43
	40. Appropriate patients as set out in recommendation 44 should be offered a review appointment.	Completed in September 2012	Ensure comprehensive patient care.	**Lead:** BHSCT **Support:** HSCB	44
	41. Compile report on the recall process and submit to HSC Board	Completed April 2013	Completion of recall process and any lessons learnt	Lead:- BHSCT Support: HSC Board	44
	42. Develop a collaborative implementation process that provides Minister with the assurance that full implementation of the Action Plan is achieved.	Implementation process identified in Action Plan Completed	Ensure appropriate recommendations are fully implemented.	**Lead:** DHSSPS	45

[1] *A Report on the Dental School at Queen's University, Belfast and Belfast HSC Trust*, 2010
[*] This refers to the Consultant-Led Hospital Dental Services Review Group

Annexe A

Recommendations of the Dental Hospital Inquiry (July 2011)

Please note that the recommendations have been numbered here for ease of reference.

Quality of Care

1. The current design of the Oral Medicine clinic should be revised to ensure that there is appropriate patient confidentiality.

2. All non-routine l dental radiology (e.g. sialography) should be undertaken by and reported by consultant radiologists.

3. Patient outcome measures should be implemented and regularly audited.

4. A protocol is required in relation to the assignment of each complaint/concern to the SAI, MHPS or other process. This protocol would include documenting the considerations and deliberations which informed the rationale and the reasons for choosing which process to follow, together with details of the parties to the decision. It would be prudent to avail of the opinion of the Board, in particular, when making the decision, as sometimes happens at present. The decision when taken should not be considered as definitive. It should be subject to regular review (frequency to be determined) as investigations, such as look back exercises are progressed and be subject to escalation or de-escalation, as appropriate.

5. A template is required to record interactions, consultations, advices, deliberations, decisions, rationale and progress in relation to SAI and MHPS investigations.

6. The raising of an SAI/MHPS should result in the generation of a living document/dossier of all related material which would facilitate the ongoing investigation, reports and responses to queries.

7. Risk assessments need to be conducted at intervals during the investigation process and as information emerges. Patient safety should always be the criterion for escalation irrespective of other considerations.

8. Commissioned reports, expert opinion, advices from regulatory bodies and NCAS should be used to inform and, if appropriate, alter the course of the investigations/look backs. The institution, in its own right, has an obligation to uphold and foster patient safety and quality assurance on behalf of its patient cohort and to exercise a level of urgency in so doing.

9. It is necessary to ensure that those charged with conducting investigations, look-back exercises, etc. are willing and able to devote the time necessary to bring the exercise to a conclusion within a reasonable timeframe. Regular review and evaluation should ensure that if expectations in this regard are proving difficult to meet, the matter is documented and brought to the attention of all bodies for resolution.

10. Human Resource concerns in respect of any employee need to be recorded and collated. This would include complaints, issues raised by the employee, differences in perception, expectations, compliance and non-compliance, all of which should be documented and followed to conclusion through the use of a stepped protocol, which if it exists needs to be implemented and adhered to in all cases.

Supervision/Appraisal

11. Mechanisms for joint appraisal and job planning by Queen's University Belfast and the Trust must be reviewed urgently to ensure such activities are undertaken in a timely manner and recorded centrally.

12. It is advisable that there be relevant external expertise as a component of any investigation[3] process both as a control and as evidence of transparency.

Administrative Considerations

13. The timing of appointments in Oral Medicine should be reviewed with consideration of (1) the nature of the likely disease of patients; (2) clinical urgency of the symptom/sign; and (3) the number and seniority of attending clinical staff. There should be consultation with the British Society for Oral Medicine on appropriate appointment templates.

14. Protocols for the allocation of appointments within Oral Medicine (i.e. clinic templates) should be agreed and implemented to maximise clinical use and communication between all members of the Oral Medicine clinical team. The protocols should be reviewed annually.

15. Administrative and records support of the Oral Medicine Clinic and Dental Hospital must be urgently reviewed. Protocols for the appropriate and timely processing of referral letters and the filing of clinical correspondence should be implemented and regularly audited.

16. Protocols for letters concerning patients of Oral Medicine and Oral Surgery should be agreed. It is advisable that patients receive copies of any correspondence.

17. The methods of tracking clinical files within the Dental Hospital must be reviewed to (1) reduce the risk of loss of records; (2) ensure all reports are filed correctly; and (3) that patient records are available 48 hours before commencement of a clinic. The process of tracking should be regularly audited.

18. Clinical Governance within the School of Dentistry must be urgently reviewed. It is advisable that a local governance committee be established.

HR/Training/Workload Planning

19. Criteria for the referral of patients to Oral Medicine of the Dental Hospital should be established. The clinical demands of local primary health care providers and Oral Surgery specialists with regard to Oral Medicine provision in Northern Ireland should be determined and any training needs of primary care providers as regards Oral Medicine identified.

[3] Please note that the Panel here means investigation of an adverse incident.

20. Care pathways for patients within Oral Medicine of the Dental Hospital should be established and regularly monitored. In view of the limited numbers of specialists in Oral Medicine in Northern Ireland consideration should be given to the establishment of distance diagnosis and clinical monitoring mechanisms.

21. Levels of nursing support within the Oral Medicine service should be reviewed with consideration of the numbers of attending qualified clinicians. The organisation of nursing support must reflect the need for appropriate chaperones.

22. In the interests of patients' safety, special consideration and oversight should be afforded in situations where specialist clinical expertise is supplied by one clinician. This would also address issues such as access to additional support, for example in terms of sick leave, special leave and annual leave cover.

23. The University and Trust should establish a long-term strategy for the delivery of clinical care and education in Oral Medicine. There is an immediate requirement to secure the financial resources to appoint a second consultant-level specialist in this specialty.

24. A higher training programme in Oral Medicine centred upon Northern Ireland should be established. Strong alliances with Oral Medicine units in Ireland and the UK should be sought. Consultation with the Intercollegiate Specialist Advisory Committee on Additional Dental Specialties and leading specialists in the field of Oral Medicine is strongly advised.

25. Training and induction of support staff, particularly administrative staff, needs to ensure that staff fully understand the pivotal role they play in patient safety. This needs to be reinforced for existing staff. Periodic formal, documented meetings should be used facilitate administrative staff in raising concerns about the barriers to discharging their duties for example in relation to keeping files up-to-date and having case notes available for all patients at all consultations.

Adverse Impacts on Patients

26. The policy of undertaking biopsies on busy Oral Medicine outpatient clinics should cease. There should be consideration of the creation of additional clinics to allow sufficient time for biopsies to be undertaken and/or additional appointments be made available within Oral Surgery for the provision of such care.

Communications

27. A Patient and Public Involvement (PPI) group should be established within the Dental Hospital to ensure consultation with patients/public on clinical activity, education and research allied to oral health.

28. A taxonomy needs to be developed in relation to investigations to ensure that all parties understand what is meant by the levels of intervention and what each actually entails, e.g. *look-back*, *case review, mentorship* and in particular *supervision*. These descriptors need to be clearly explained, both in content and degree. They need to be communicated to all bodies, including regulatory bodies who will then be able to make an informed decision on their adequacy.

29. The process should include recording the experience as articulated by the patient and family together with demonstrating how that has informed/influenced the exercise.

30. It is important to defend and operate out of a robust process. Such processes should be established to ensure patient safety and positive outcomes from their treatment.

31. A mechanism needs to be put in place to ensure that the formal processes are followed in relation to the communication arrangements that exist.

32. From the outset, communications with the Department, the Board, PHA and other bodies should err on the side of generosity so as to maximise all the resources available and to enhance transparency, credibility and public confidence. Copies of reports should be provided to the bodies and it is preferable that all bodies would have the same degree of information.

33. The various bodies should be proactive in seeking updates and information as the investigation progresses.

34. The twice-yearly Accountability Review Meetings between the Trust and the Department should be greater utilised to communicate ongoing issues of concern, particularly when the process of dealing with such concerns may have changed since the last meeting.

35. In order to demonstrate espoused patient safety, quality assurance, patient engagement and empowerment - patients, the public, healthcare bodies, units and personnel need to be advised at the earliest opportunity of emerging concerns during investigations/look-backs, etc. Deviation from a high level of transparency needs to be supported by documented deliberations, consultations and reasons for decisions.

36. Communications to patients need to be timely, clear as to effect, causation, prognosis and future action. Details of this communication need to be documented. Patient input comment needs to be documented.

37. Where patients have offered and are willing to contribute to healthcare improvement as a result of that experience, they should be facilitated and encouraged to do so38. Each of the seven non-cancer patients in the group of 22 “major concerns” should receive a letter setting out the concerns which existed/exist regarding each of them and the potential for harm which existed/exists as appropriate.

39. Each of the patients in the call-back exercise should receive a letter stating the outcome of his/her call-back attendance and the potential for harm which existed/exists as appropriate.

40. When a Trust receives a complaint concerning clinical performance of a consultant level staff, an opinion from an appropriately qualified consultant independent of that Trust should be obtained on the merits of the complaint unless there are exceptional reasons for not so doing.

41. Dental staff should be reminded of the GDC guidance “Standards for Dental Professionals” which states that dental practitioners must make and keep accurate and complete patient records, including a medical history, at the time they meet patients.

Other Recommendations

42. The mission of the Dental Hospital should be reviewed with cognisance of the 2010 external review.

43. Patients diagnosed as having histopathologically confirmed oral epithelial dysplasia and not presently under clinical review should be offered review by the Oral Medicine service.

44. Patients who were managed in the Oral Medicine Department of the Dental Hospital in 2010 and not included in the supervision should be offered review by the Oral Medicine service.

45. The Minister for Health, Social Services and Public Safety is advised to establish an appropriate mechanism to ensure that those recommendations which he considers to have merit are fully implemented.

Annexe B

Terms of Reference of the Short-Life Working Group

The purpose of the Short-life Working Group is to agree an Action Plan (to be drafted by DHSSPS) by the end of August 2011 that:

- Has at its core a commitment to promote high-quality care and patient safety, reduction in harm, and enhancement of public confidence in the services provided by the Dental Hospital/School of Dentistry;
- Takes account of the 45 recommendations as specified in the Report;
- Links, where appropriate, specific actions and recommendations to existing policy, best practice and service review processes, identifying lead responsibility for implementation consistent with extant policy and operational responsibilities, recognising existing accountability arrangements;
- Assesses any major resource implications arising from the Action Plan and its associated recommendations;
- Considers the process of engagement with those patients who were affected by the Inquiry findings; and
- Develops a collaborative implementation process that provides Minister with the assurance that full implementation will be achieved within a specified timeframe.

The Working Group is to submit this Action Plan for Ministerial approval, prior to communication with the Health Committee and its formal publication.

Membership of Short-Life Working Group

Dr. Paddy Woods, DCMO, DHSSPS
Mr. Donncha O'Carolan (Co-Chair), CDO, DHSSPS
Dr. Maura Briscoe, SCD (Co-Chair), DHSSPS
Dr. Jim Livingstone, SQS, DHSSPS until 12 October 2012
Ms. Diane Taylor, HRD, DHSSPS
Mr. Michael Donaldson, HSC Board
Mr. Iain Deboys, HSC Board
Dr. Janet Little, PHA
Dr. Tony Stevens, Belfast HSC Trust
Mr. Brian Barry, Belfast HSC Trust
Mr. James O'Kane/ Professor Patrick Johnston, Queen's University, Belfast
Ms. Stella Cunningham, Patient-Client Council

External advisor: Dr. Margaret Kellett, Leeds Dental Institute
Secretariat: Michelle Connor and Jim McComish DHSSPS.

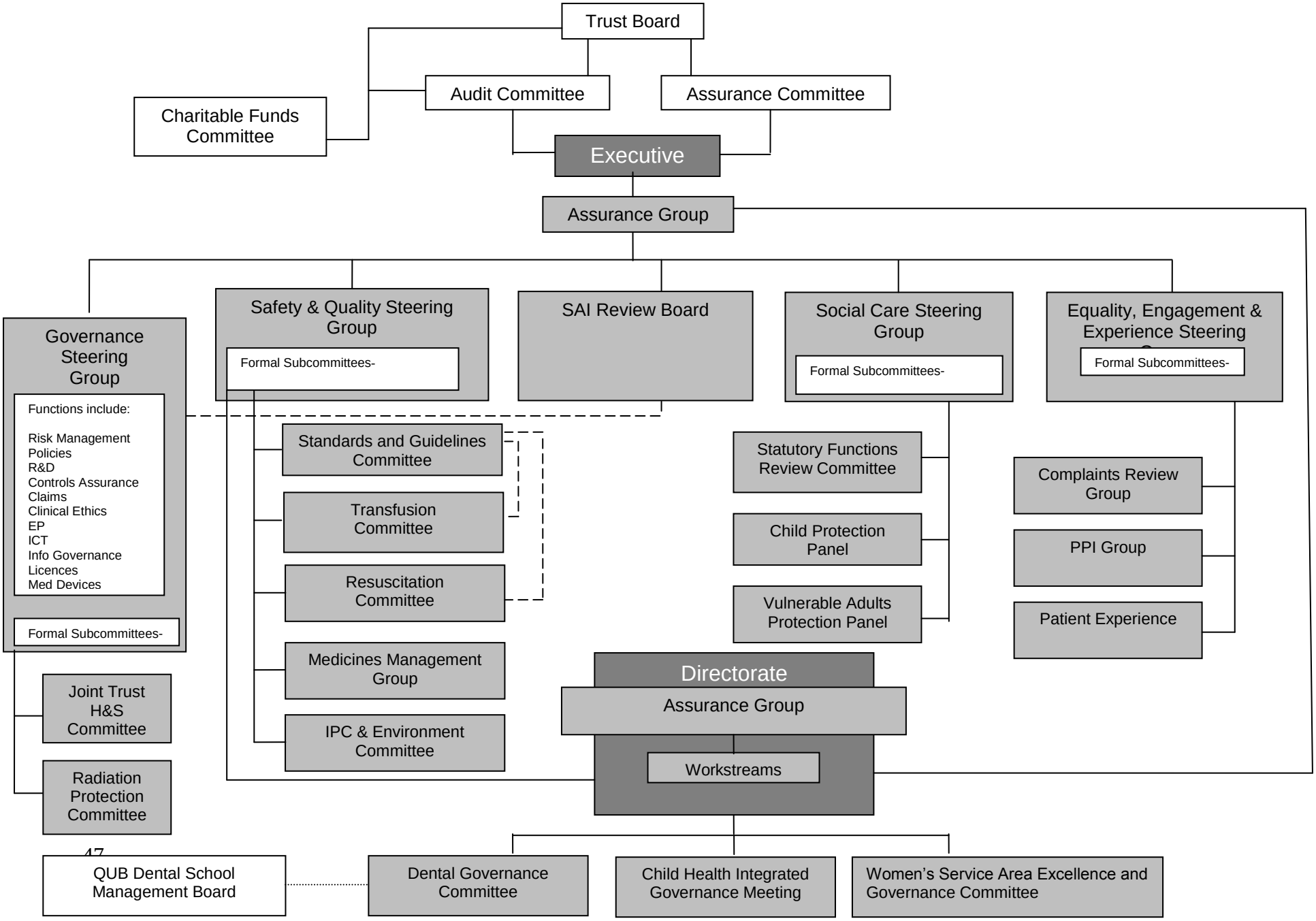
Annexe C

Dental Services Governance Committee meeting

Terms of Reference

COMMITTEE	**Dental Governance Committee Incorporating :** 1. Consultant-led specialist dental services delivered in the BHSCT. 2. Dental Services delivered in the Relief of Dental Pain Clinic at Belfast City Hospital. 3. BHSCT Community Dental Services delivered in Trust Community Clinics 4. Teaching Programmes delivered in the School of Dentistry and in outreach centres a. Dental undergraduate teaching programme b. Dental Hygiene teaching programme c. Dental Technology teaching programme
PURPOSE	• To provide assurance to Specialist Hospitals, Women and Child Health Assurance Committee, that effective governance systems are establish, monitored and maintained within the Service Area. • To ensure that there is a robust integrated mechanism to support the Belfast Trust governance framework in the School of Dentistry and the BHSCT Community Dental Clinics within both the Clinical Services and the teaching programmes.
MEMBERSHIP	**Chair: Donald Burden** **Secretary: Elaine Lamont** **Membership:** Clinical Director/Head of School – Donald Burden Co Director – Karin Jackson Service manager – Ciaran Bradley Assistant Service Manager – Julie Mulligan Governance and Quality Manager – Anne McAuley Performance/Administration Manager – Sharon Ward/Owen Farrelly Relevant areas • Nursing – Ali McGivern • Dental nursing – Samantha McHugh • Clinical Service Technical Laboratory – Tony Fegan • Dental Technician teaching programme- Pat McElwee • Dental Hygiene teaching programme – Lorna McGrath • Dental Radiography– Carolyn Boyd • University and Clinical Leads in Dentistry– David Hussey, Chris

	Irwin, Chris Johnston, Karen Humphreys, John Marley, Anne Stevens (Staff who have been nominated to sit on the committee as a representative of their group should ensure that the views of their group are brought to the meeting and that feedback is given to their group following the meeting)
DUTIES	• To review complaints, incidents, claims, audits and user feedback, in order to identify trends within the sub-directorate. • To ensure that learning from these events is acknowledged and shared. • To ensure that the Service Group Management Plan encapsulates any issues raised above. • To ensure that all staff within the Service Area receive information on governance relevant to their role/area. • To ensure that operational arrangements are in place for improving and monitoring the quality of care within the Service Area. • To ensure that the Service Area Risk Register reflects all significant risks, in order that these risks can be effectively managed. • To ensure Service Group representation at relevant Trust committees by nominating members and establishing reporting mechanisms. • To ensure there is effective communication and support between the Belfast Trust, and the Clinical and Teaching Services within the School of Dentistry and within the BHSCT Community Dental Clinics. • To provide the interface for reporting/discussing any material governance issues between BHSCT and QUB. In addition, the Director of the Centre for Dental Education/Clinical Director is required to report any incidents or issues to the QUB School Management Board as part of his written report to that meeting.
AUTHORITY	The Dental Governance Committee is authorised to review and act on any governance issues as listed in the duties.
MEETINGS	**Quorum** 50% of membership **Frequency of Meetings** Quarterly and prior to Service Group Assurance meeting. **Papers** Agenda, previous minutes, completed report template, risk register, any other current papers. These will be sent to members electronically, prior to the meeting.
REPORTING	Accountable to Specialist Hospitals, Women and Child Health Assurance Committee.
CONFLICT/ DECLARATION OF INTEREST	The Chair will seek and record any declaration or conflict of interest from members prior to meetings.
REVIEW	Annually


Trust Board
Audit Committee
Assurance Committee
Charitable Funds Committee
Executive
Assurance Group
Governance Steering Group
Functions include:
Risk Management
Policies
R&D
Controls Assurance
Claims
Clinical Ethics
EP
ICT
Info Governance
Licences
Med Devices
Formal Subcommittees-
Safety & Quality Steering Group
Formal Subcommittees-
SAI Review Board
Social Care Steering Group
Formal Subcommittees-
Equality, Engagement & Experience Steering
Formal Subcommittees-
Standards and Guidelines Committee
Transfusion Committee
Resuscitation Committee
Medicines Management Group
IPC & Environment Committee
Statutory Functions Review Committee
Child Protection Panel
Vulnerable Adults Protection Panel
Complaints Review Group
PPI Group
Patient Experience
Joint Trust H&S Committee
Radiation Protection Committee
Directorate
Assurance Group
Workstreams
QUB Dental School Management Board
Dental Governance Committee
Child Health Integrated Governance Meeting
Women's Service Area Excellence and Governance Committee

Annexe D

Bibliography

Belfast HSC Trust, *Clinical Governance and Administrative Reviews - Terms of Reference*, 2011.

Department of Health, *Equity and excellence: Liberating the NHS*, 2010. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353.

Department of Health, *Trust, Assurance and Safety (White paper): The Regulation of Health Professionals*, 2007 – www.dh.gov.uk.

DHSSPS and Queen's University, Belfast, *A Report on the Dental School at Queen's University, Belfast and Belfast HSC Trust* (The Saunders Report), 2010.

DHSSPS, *Quality 2020 - A 10-Year Quality Strategy for Health and Social Care in Northern Ireland*, 2011. available on http://www.dhsspsni.gov.uk/quality_2020_-_a_10-year_quality_strategy_for_health_and_social_care_in_northern_ireland.pdf

DHSSPS, Quality Strategy: Implementation Plan, 2012. Available on: http://www.dhsspsni.gov.uk/quality_2020_implementation_plan.pdf

DHSSPS, Establishment of an Early Alert System, 2010. Available on: http://www.dhsspsni.gov.uk/hsc__sqsd__10-10.pdf

DHSSPS, *Code of Practice on Protecting the Confidentiality of Service User Information*, 2012. Available at http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf.

DHSSPS, *Your Right to Confidentiality*, 2012. Available at http://www.dhsspsni.gov.uk/codeofpracticeleafletapril2012

DHSSPS, *Confidence in Care*, 2009. Available at http://www.dhsspsni.gov.uk/index/hss/ahp-confidence_in_care.htm

DHSSPS, *Framework Document*, 2011. Available at http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf

DHSSPS, *Health and Social Care Regional Template and Guidance for Incident Investigation/Review Reports*, 2007. Available at http://www.dhsspsni.gov.uk/hsc_sqsd__34-07_guidance.pdf

DHSSPS, *Maintaining High Professional Standards in the Modern HPSS*, 2005. Available at http://www.dhsspsni.gov.uk/hrd_suspensions_framework.pdf

DHSSPS, *Minimum Standards for Dental Care and Treatment*, 2011. Available at http://www.dhsspsni.gov.uk/min_stds_dental_candt.pdf

DHSSPS, *Service Level Agreement between DHSSPS and NCAS*, 2004-11.

DHSSPS, *Improving Patient Safety: - Building Public Confidence,* 2006. www.dhsspsni.gov.uk

IR (ME) R (NI) 2000 legislation. Ionising Radiation (Medical Exposure) Regulations, Northern Ireland, 2000 [as amended S.R.2010 No.29] Available at http://www.legislation.gov.uk/nisr/2000/194/pdfs/nisr_20000194_en.pdf

Labour Relations Agency, *Advice on Conducting Employment Investigations*, 2010. Available at http://www.lra.org.uk/index/agency_publications-2/advice_and_guidance_on_employment_matters-3/advisory_guides2/advice_on_conducting_employment_investigations.htm

McCormick, Andrew, Permanent Secretary of DHSSPS, *Escalation of Risk Within and Between Health and Social Care Organisations* (letter to all HSC Chief Executives - ref. AMCC 3133), 08 November 2011.

National Patient Safety Agency, NHS, *Being Open*, 2009. Available at http://www.nrls.npsa.nhs.uk/beingopen/

NI Assembly, *Ministerial Statement: Belfast Health and Social Care Trust*, 28 June 2011. Available at http://www.niassembly.gov.uk/record/reports2011/110628.htm#a11

Regional Governance Network Northern Ireland Sub-Group, *Practical Guide to Conducting Patient Service Reviews or Look Back Exercises*, 2007. Available at http://www.dhsspsni.gov.uk/microsoft_word_-_hss__sqsd__18-07_patient_service_review_guidelines_-_final_feb07.pdf

Regional Review of Consultant –led Hospital Dental Services. A consultation document published by DHSSPS in July 2012. Available at http://www.dhsspsni.gov.uk/showconsultations?txtid=57681

RQIA, *RQIA Escalation Policy and Procedure*, 2009.