DENTAL HOSPITAL INQUIRY

EXECUTIVE SUMMARY

July 2011

Background & Context

On Friday 4 February 2011, the Belfast Trust issued a press release announcing that 117 dental patients were being recalled for check-ups as a precautionary measure following a review of clinical performance in one Department of the Dental Hospital.

On Saturday, 5 February 2011 letters to those patients inviting them to a review clinic were delivered to them by courier. The letters explained that there were concerns about patients' initial consultations and advised patients to contact a helpline set up for appointment arrangements.

This recall followed a review by the Trust of concerns about the appropriateness and timing of patient referrals and treatment at the Dental Hospital. This period of review had lasted some 14 months.

On Monday 7 February 2011, Mr Michael McGimpsey, then Minister for the Department of Health, Social Services and Public Safety, made a statement to the Northern Ireland Assembly, apologising to patients and their families and sharing the public shock and concern, pointing to an apparent breakdown in communication in the health and social care service and announcing that he would establish an urgent independent inquiry into these matters.

The Terms of Reference of the Inquiry are outlined below:-

(a) Evaluate the general quality of care provided by the School of Dentistry and Belfast HSC Trust to all those patients recalled for

review as a consequence of the Belfast HSC Trust announcement up to the start of this Inquiry;

(b) Evaluate the systematic nature, extent, timeliness and effectiveness of communications between and within each of the Royal School of Dentistry, the Belfast HSC Trust, the HSC Board and Public Health Agency, and the Department as well as that with patients and the general public; and

(c) Make recommendations arising from the Inquiry findings on relevant improvements to quality and communications.

The Inquiry has been conducted under the terms of the Inquiries Act 2005. 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 Civil Servant was Assessor to the Inquiry Panel.

Inquiry Methodology

There were 2 main phases of the Inquiry's work – from 14 February 2011 when the Inquiry team was established until 31 March 2011, when the Inquiry presented a preliminary report to the Health Minister – and from 1 April 2011 until 28 June 2011 when Health Minister, Mr Edwin Poots made a statement to the NI Assembly about the outcome of the Inquiry.

In the first phase the Inquiry Panel met on 5 occasions. It scrutinised a dossier of documents relevant to the patient recall which was supplied to

it by the Department of Health, Social Services and Public Safety. The Inquiry commissioned further evidence and documentation from the Department, the Belfast HSC Trust, the Public Health Agency, the HSC Board and Queens University Belfast. The Inquiry also wrote to the recalled patients inviting their input.

The Inquiry held a meeting with representatives of the HSC bodies and patients, to explain the Inquiry's methodology and plan and to deal with any questions about the Inquiry.

In the second phase the Inquiry met on 4 occasions. This included meetings with patients, a visit to the Dental Hospital and further separate meetings with representatives of the Trust, the Department and the Board. Further input was obtained from patients by letter, email and telephone conversations.

Written submissions were received from the Belfast Trust, the Department, the Board, the Public Health Agency and Queens University Belfast.

A Report was submitted to the Minister for Health, Social Services and Public Safety on 3 June 2011.

The Dental Hospital

The Dental Hospital provides specialist dental services for the people of Northern Ireland. These include oral and maxillofacial surgery, oral medicine, oral pathology, orthodontics and paediatric dentistry. The Hospital's other 2 core services are the training of dental undergraduates and the training of dental specialists. Many of the dental staff work for both Queen's University Belfast and the Belfast HSC Trust. Their

working week comprises clinical, administrative, teaching and other academic work. A number of specialties, including oral medicine, have only one consultant.

Following a re-organisation in 2008 of the School of Medicine, Dentistry and Biomedical Sciences, the School of Dentistry became the Centre for Dental Education. Its Director is also Clinical Director of the Dental Hospital, within the Belfast HSC Trust.

Findings – Quality of Care

The Inquiry found that there was some cause for concern in relation to the quality of care being provided to patients by one Department of the School of Dentistry prior to the formal complaint by a consultant plastic surgeon, in November 2009.

This course for concern included the fact that on 24 April 2008 a patient had complained to the Trust about the late diagnosis of a cancerous lesion in her mouth while under the care of the School of Dentistry. When that complaint was investigated and rejected by the Trust, on 4 September 2008, the patient complained to the Northern Ireland Ombudsman on 21 April 2009. Thereafter the Ombudsman was in communication with the Trust so it was aware of concerns raised by the Ombudsman concerning that patient's treatment.

The Inquiry did not find a proper or adequate system for recording or collation of concerns in respect of the quality of care or clinical performance at the Dental Hospital.

In November 2009 concerns were expressed about delayed referrals by the Oral Medicine Department of patients ultimately found to have oral

cancer. By 1 December 2009, details of concerns about the quality of care provided to 6 patients with oral cancer were available and the Trust decided to commence a formal investigation and to manage the concerns. The investigation was led by the Associate Medical Director of the Belfast HSC Trust. It was also agreed that 2 recently retired consultants would be asked to review not only those 6 index cases but also to carry out a look-back exercise involving a review of the charts of all patients seen by the Oral Medicine Department in 2009. It was further decided to introduce supervision arrangements with the objective of ensuring that there was proper protection for patients, in view of the concerns expressed and pending the outcome of the look-back chart review.

The Inquiry considered that there were grounds for making a Serious Adverse Incident Report (SAI) which would have enabled greater and more effective communication between the relevant HSC bodies, resulting in the deployment of collective expertise and resources to help resolve the problem. The Trust obtained advice from the National Clinical Advisory Service (NCAS). The DHSSPS was informed in early December 2009 of the concerns raised in respect of the 6 index cases and the steps taken by the Trust. Similar information was provided to the appropriate regulatory bodies, namely the General Medical Council (GMC) and the General District Council (GDC) on 18 December 2009.

In view of the matters outlined above the Trust ought to have had concerns for the potential for significant damage to the health of not only the 6 index patients but the possibility of the potential for damage to the health of other patients.

On 25 February 2010 the Trust received the report of the case investigator. The Inquiry considered that an SAI Report ought to have

been made at this stage. This made recommendations for more direct action to address concerns for patient safety.

The look-back chart review started in December 2009. There ought to have been a system for interim reports or regular formal reviews of the progress and findings of the exercise to date. Instead there appears to have been informal contact. There was information from the exercise that there were major and intermediate concerns in relation to the quality of care of patients, going well beyond the 6 index patients. These concerns were acted upon during the look-back to the extent that available records permitted such action.

Indications of significant administrative problems likely to impact adversely on the quality of patient care were becoming available; it was noted, for example, at a Doctors' Case Review Meeting on 18 March 2010 that there were concerns about records in the Oral Medicine Department.

Serious Adverse Incident (SAI) Report

It is considered that this additional information ought to have removed any doubt the Trust may have had as to whether to report this matter as an SAI as it clearly met the criteria for the reporting of same.

There is no documentary evidence of the consideration of the reporting of the incident as an SAI from December 2009 until December 2010 nor any apparent consideration of deployment of the Early Alert System. During this period, namely on 8 September 2010, the Trust was also advised by NCAS **not** to defer decisions on how to proceed pending receipt of the look-back report but to act on the Investigation Report. The Trust did not act on this advice.

The Trust did not respond to the explicit guidance in the 28 May 2010 Early Alert Circular by immediately updating the Department and thereby the Minister on this case wherein the situation had already deteriorated. The Trust clearly did not comply with the principle of "no surprises" and failed in its duty to report.

On 4 November 2010 the draft look-back report was received by the Trust and the final report on 1 December 2010. The Trust decided that a call-back of certain patients should be undertaken as a precaution in view of the findings of this report. On receipt of the look-back report the Trust contacted the DHSSPS, the HSCB and the PHA in late November/early December 2010.

Administrative Concerns

It is clear that there was a significant problem with the keeping of patient records in the Oral Medicine Department of the Dental Hospital. It has been suggested that this was a long-standing problem and that for some years it was not unusual for a significant percentage of patients' records to be unavailable when patients attended the Oral Medicine clinics. Incident Report records confirm that there was a recurring problem. It has been suggested to the Inquiry that complaints were made but did not achieve any substantial improvement. There is no evidence of a concerted effort to solve this problem until 2011.

When the look-back case review was being undertaken between December 2009 and November 2010 serious difficulties were encountered due to the lack of availability of patients' records when they were required. In some cases records were incomplete and in other cases wholly absent. This delayed completion of the look-back exercise.

Unfiled records were discovered on occasions. The reviewers had to reassess several hundred of the charts after additional records from patients' charts were found. The final look-back chart review report stated that in the course of reviewing 3062 patients' charts, there were:

- 1156 unfiled items
- 93 charts missing
- 161 hospital concerns (which included many administrative errors)
- difficulties with the appointment system so that patients who required follow-up could be 'lost'.

The Trust has stated that there were 85 rather than 93 missing charts as 8 patients' names/numbers had been duplicated. Between 15 September 2010 and 31 January 2011, 25 of these missing charts were found. After a more determined search between 31 January 2011 and 2 February 2011 a further 35 charts were found. One of these 35 patients was part of the call-back exercise. 25 charts remained missing and only one of these was subsequently found. All 25 of these patients were included in the call-back exercise.

Patient Safety

These statistics indicate an extremely serious deficiency in record management with the potential to have a significant adverse impact on the quality of patient care. The fact that 35 of the 60 missing files were found in a 2 day period between 31 January 2011 and 2 February 2011 suggests that this deficiency could have been at least alleviated at a much earlier stage if the appropriate resources or efforts had been directed to that task. A pilot study of the charts of 60 patients at the outset of the look-back chart review exercise in early 2010 indicated

administrative problems but these problems do not appear to have been addressed with sufficient urgency until the 31 January–2 February 2011 search which uncovered 35 of the missing charts in 2 days. Even then 25 remained missing which is unexplained and unacceptable.

While the Trust may have considered that patient safety was being protected during the look-back chart review because attempts were made to deal with 'major' and 'intermediate' concern cases as they were uncovered, this could not provide any protection for those patients whose files were missing or grossly incomplete. Neither would it fully protect patients from the risk of inaccurate assessments as the supervision was confined to reviewing subjective note-taking and record keeping. It is noted that the inclusion of the 25 people whose files were missing in the call-back exercise resulted in 10 of these 25 patients being added to the long-term review list at the Dental Hospital. None of the 25 have been diagnosed with oral cancer but that does not equate to confirmation that there has been no adverse impact upon their health due to the absence of records.

It is noted that a wider review of administrative and clinical services within the Dental Hospital was commenced in March 2011 because of the identification of major deficiencies.

Staffing Levels

The Saunders Report on the School of Dentistry in December 2010 found that there was a 50% reduction in the number of Consultant level staff from 20 to 10 in the period from 2003 to 2010. It was clear that there was a need for appointment of a second Oral Medicine Consultant but a request in 2007/2008 for same was apparently rejected primarily on funding grounds as not falling within the priority categories

established at that time. Given the volume and geographical spread of the patients with disease requiring specialist Oral Medicine input it is considered that there is a potential risk of patient care being compromised when relying upon one practitioner to provide the service in such circumstances. Although a Consultant has been recruited as locum on behalf of the Trust there appears to be no formalized plan to ensure that in future there will be 2 Oral Medicine Consultants in the Dental Hospital or even to obtain a specialist registrar in addition to a single oral medicine consultant.

The Oral Medicine Clinic in the Dental Hospital had a high volume of patients and the number increased significantly from in or about 2008 onwards. The Investigation Report in February 2010 recommended that there needed to be a reduction in the number of patients attending the Oral Medicine Clinic and that the referral criteria for access to the Clinic ought to be considered in order to achieve same. Different views have been expressed as to the responsibility for the excessive workload but it clearly existed

There also appears to have been a lack of an adequate secretarial and administrative support system. It has been suggested that a lack of nursing staff to meet the needs of overbooked clinics may also have contributed. The deficiencies in the administration have already been referred to above and how the problems arose is less important than how they were addressed. Administrative staffing issues should be addressed as a result of the Review of administration and clerical services which started in March 2011. The Inquiry understands that a group has been established to take forward these issues.

Patient Call-back

The look-back chart review report identified 18 cases where there was "major concern" for patient safety but subsequently this category was enlarged to 22 cases. It is unknown at this stage what effect, if any, delay in diagnosis or referral has had on the outcome for these patients or the other patients with malignant disease associated with the mouth. It is recognised by all the health organisations that delays in the detection of malignancy are likely to adversely affect patient outcomes.

There were 105 cases identified by the look-back chart review report as being "intermediate concerns" which was defined as "cases where there is a potential for a significant effect on patient care but not necessarily in the short term". However when it was decided to conduct the "call-back" exercise it was considered that it was necessary to include only 21 of those 105 cases given the criteria applied.

Any action considered necessary on the other intermediate cases was taken by the reviewers in the course of the look-back chart review. None of the 117 patients included in the call-back was found to have oral cancer. To date, biopsies have been carried out on 38 of these patients; 47 have been put on the review list and 6 will require further appointment. 57 patients have been discharged. Clearly none of these 117 patients have developed oral cancer by reason of delay in diagnosis or referral, if any, but it is not known whether there has been any other adverse impact on their health, whether physical or psychological.

Failures in Communication

It is unclear to what extent all concerns or complaints were collated and communicated in an effective manner within the Trust. There is a lack of evidence of all concerns/complaints being considered or summarised when a formal complaint was made in November 2009.

There was a failure to ensure that the administration problems previously discussed were communicated effectively to those in a position to address them until on or about 31 January 2011, approximately a year after the existence of significant administrative problems ought to have been known.

Although the need for a second Oral Medicine Consultant was recognised and funding for same was unsuccessfully sought in 2007/2008, there is a lack of evidence of any significant communication on this issue or upon consideration of alternative means of resolving the oral medicine workload problem thereafter, notwithstanding a significant increase in the volume of patients attending the clinic.

The Trust did not make a formal report of the matter to DHSSPS as an SAI in December 2009 when a senior consultant made his formal complaint, nor in February 2010, when the Investigation Report and the information on the early stages of the look-back chart review exercise were available. However it did inform DHSSPS on 4 December 2009 of the concerns raised by Consultants in relation to the care of 6 patients with oral cancer. This included information that the investigation was underway, and that a look-back chart review had been requested.

The Trust ought to have kept DHSSPS fully informed of the existence of ongoing significant concerns, including major concerns for the safety of patients.

The Trust is not solely responsible for this lack of communication because DHSSPS had sufficient information from December 2009 to have required a proper explanation as to why an SAI report had not been made and to have insisted upon the provision of ongoing information to enable it to ensure that the safety of patients was being adequately protected. The primary responsibility for the failure to provide a proper formal report, rather than initially keeping DHSSPS "in the loop", rests with the Trust but DHSSPS ought to have been more proactive given the information available to it.

When it was determined that a look-back chart review exercise should be carried out, the Trust decided not to tell the patients whose charts were to be reviewed of the conduct of the exercise.

The majority of patients who were in the category of intermediate concerns and all in the category of minor concerns in the look-back chart review report have not been informed of any potential for harm to them by reason of the care provided by the Department of Oral Medicine. Patients whose records were missing or incomplete have not been informed of any potential for harm to them unless within the group of 25 whose records remained missing on 2 February 2011, who became part of the call-back group. This is unacceptable in view of the likely public and press interest in the publication of the present public inquiry.

It is unclear precisely what information has been given to those patients who were within the call-back group since the initial letter requesting them to attend. It is considered that each such patient should be

informed in writing by the Trust of the outcome of his/her call-back attendance and the potential for harm which existed/exists. The 7 non-cancer patients in the group of 22 “major concerns” should each receive a letter of the concerns which were/are held re them and the potential for harm which existed/exists. It is perhaps relevant that patients are not routinely provided with copies of any correspondence concerning their care by the Oral Medicine service of the Dental Hospital.

Conclusions

(a) 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, which may have impacted adversely on the health of some of them to a significant degree and certainly had the potential to do so. Indeed the Inquiry also found serious deficiencies in the quality of care provided by that Department to the 6 index patients and to those patients identified as being of major concern during the course of the look-back exercise.

(b) 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 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.

Recommendations

Dental Hospital

Quality of Care

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

- All non-routine intra-oral dental radiology (eg silaography) should be undertaken by and reported by consultant radiologists.

- Patient outcome measures should be implemented and regularly audited.

- 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.

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

- 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.

- 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.

- 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.

- 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.

- 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, 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

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

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

Administrative Considerations

- 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.

- 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 annually reviewed.

- 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.

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

- 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.

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

<u>HR/training/workload planning</u>

- 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.

- 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.

- 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.

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

- 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.

- 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.

- Training and induction of support staff, particularly administrative staff, needs to ensure that they 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 eg 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

- 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

- 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.

- 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.

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

- 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.

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

- 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.

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

- 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.

- 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.

- 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.

- 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 so. Patient SP, for example, made such an offer.

- Each of the 7 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.

- 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.

- When a Trust receives a complaint concerning clinical performance, 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.

- 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

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

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

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

- 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.

GOSSARY OF TERMS

HSC	**Health & Social Care**
SAI	**Serious Adverse Incident**
MHPS	**Managing High Professional Standards**
GMC	**General Medical Council**
GDC	**General Dental Council**
NCAS	**National Clinical Assessment Service**
DHSSPS	**Department of Health, Social Services and Public Safety**
PHA	**Public Health Agency**
HSC Board	**Health & Social Care Board**
Belfast HSC Trust	**Belfast Health & Social Care Trust**
QUB	**Queens University Belfast**