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Llywodraeth Cymru
Welsh Government

To: Chief Executives, Local Health Boards, NHS Trusts
Medical Directors, Local Health Board, NHS Trusts
Executive Directors of Nursing, Local Health Boards and NHS Trusts
Clinical Dental Leads, Local Health Boards
Assistant Directors of Quality and Safety, Local Health Boards, NHS Trusts

22 July 2021

Dear Colleagues

Never Events – Wrong tooth extraction

As you are aware Never Events are defined as patient safety incidents which are wholly preventable due to the national guidance or safety recommendations in place and implemented by all healthcare providers. The Welsh Health Circular, WHC/2018/12 sets out the current list of incidents which are classed as never events in Wales and the subsequent assurance review process to be followed. This list closely mirrors the incidents classified as never events in England.

Despite this list, however and the barriers in place to prevent these types of incidents we are still seeing incidents of this nature occurring, resulting in patient harm. This suggests that for a number of sub-types of never events the strength of the barriers is variable and potentially not as strong as originally thought and a review is required.

On this basis Welsh Government is engaged in work, led by NHS England/ Improvement, to systemically review barriers / safety recommendations for each type of never event to identify if they are truly strong and systemic, beginning with those that occur most frequently. The review is being conducted through a series of focus groups in collaboration with experts from the relevant medical Royal Colleges and other organisations with an interest in never events.

The first to be considered was wrong tooth extraction which forms part of the broader wrong site surgery never event category. Working with partners who included the Royal College of Surgeons: Faculty of Dental Surgery, the British Dental Association, the Faculty of General Dental Practice, the Association of Dental Hospitals, the Association of Peri operative Practice, the College of Operating Department Practitioners and the Healthcare Safety Investigation Branch, it was concluded the available barriers to prevent the removal of wrong teeth were considered not strong enough to prevent this type of incident from occurring in all cases.

Advice was also sought from the All Wales Clinical Dental Leads Group who were of the same view that the barriers in place were not strong enough to prevent these types of patient safety incidents, in all cases. The decision has therefore been taken to remove wrong tooth extraction

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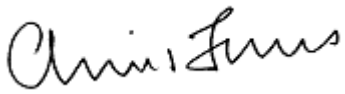
as a sub category of wrong site surgery on the never events list, with immediate effect. However, NHS organisations must continue to report and proportionately investigate these incidents locally / nationally depending on the level of patient harm, in line with the new Patient Safety Incident Policy issued in May 2021.

The Never Events list will be updated in due course and will be available on the NHS Wales Delivery Unit website Patient Safety Wales - Delivery Unit (nhs.wales) as a point of reference. I will provide updates as the review work progresses and further changes are made to never event categorisation. In the meantime if you have any queries please contact Jan Firby jan.firby@gov.wales who will be happy to help.

Yours sincerely



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