

# OCDO

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OFFICE OF CHIEF  
DENTAL OFFICER  
ENGLAND

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## Jason Wong

Deputy Chief Dental Officer England

MBE, BDS, DPDS, FCGDent

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**Declaration of interests:**

*GDP and partner at the Maltings Dental Practice, Grantham, Lincolnshire*

*Director at Perspective Dental Education Ltd*

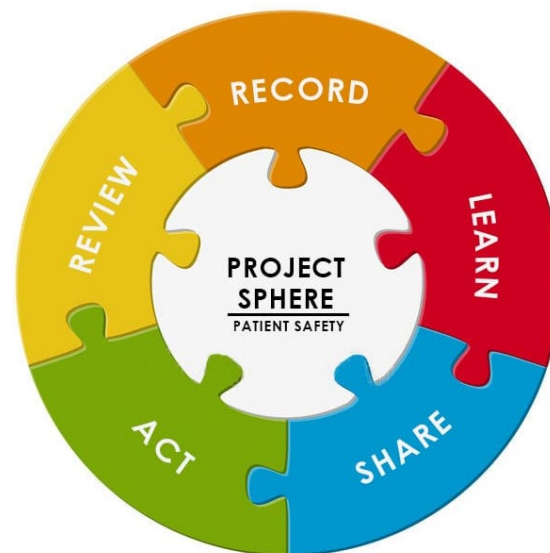
*Clinical Ambassador for the Mouth Cancer Foundation*

# Creating a positive patient safety culture

*The journey of a thousand miles begins with a single step.*  
Lao Tzu



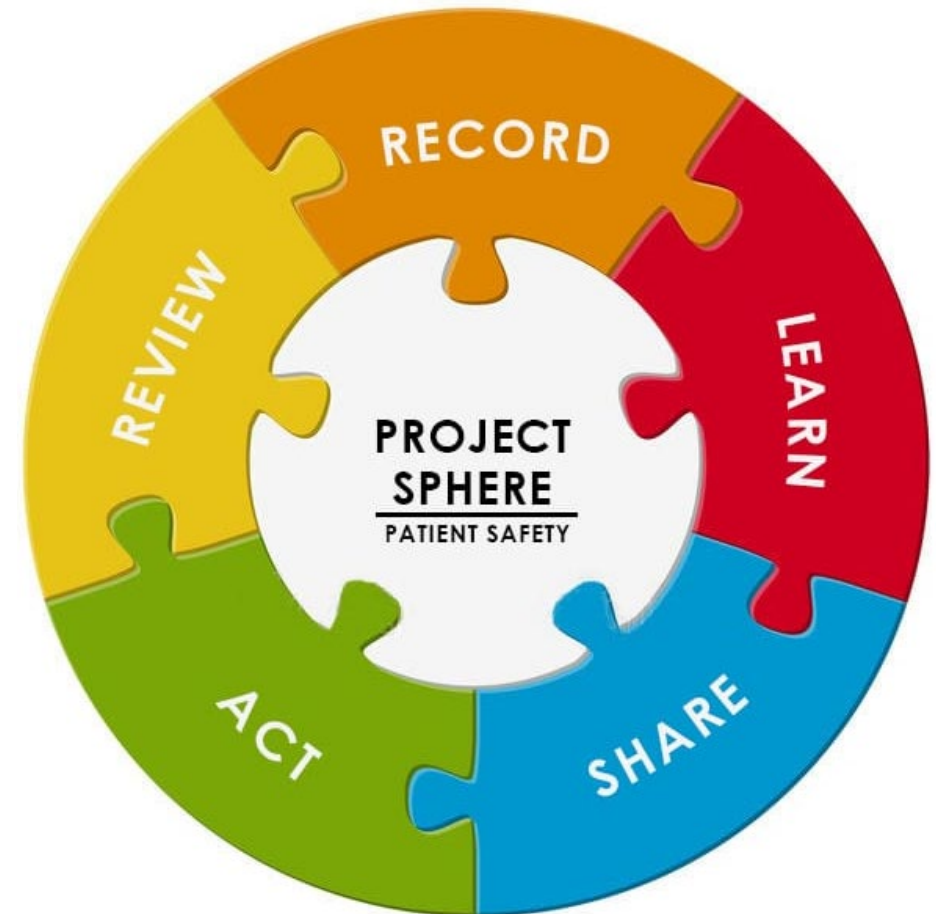
THE JOURNEY HAS TO START SOMEWHERE,  
AND WE HOPE THAT THIS WILL BE THE  
START OF MANY POSITIVE CHANGES IN  
DENTISTRY



# Creating a positive patient safety culture

- Is there a problem?
- How do we identify the problem?
- How do we solve the problem?

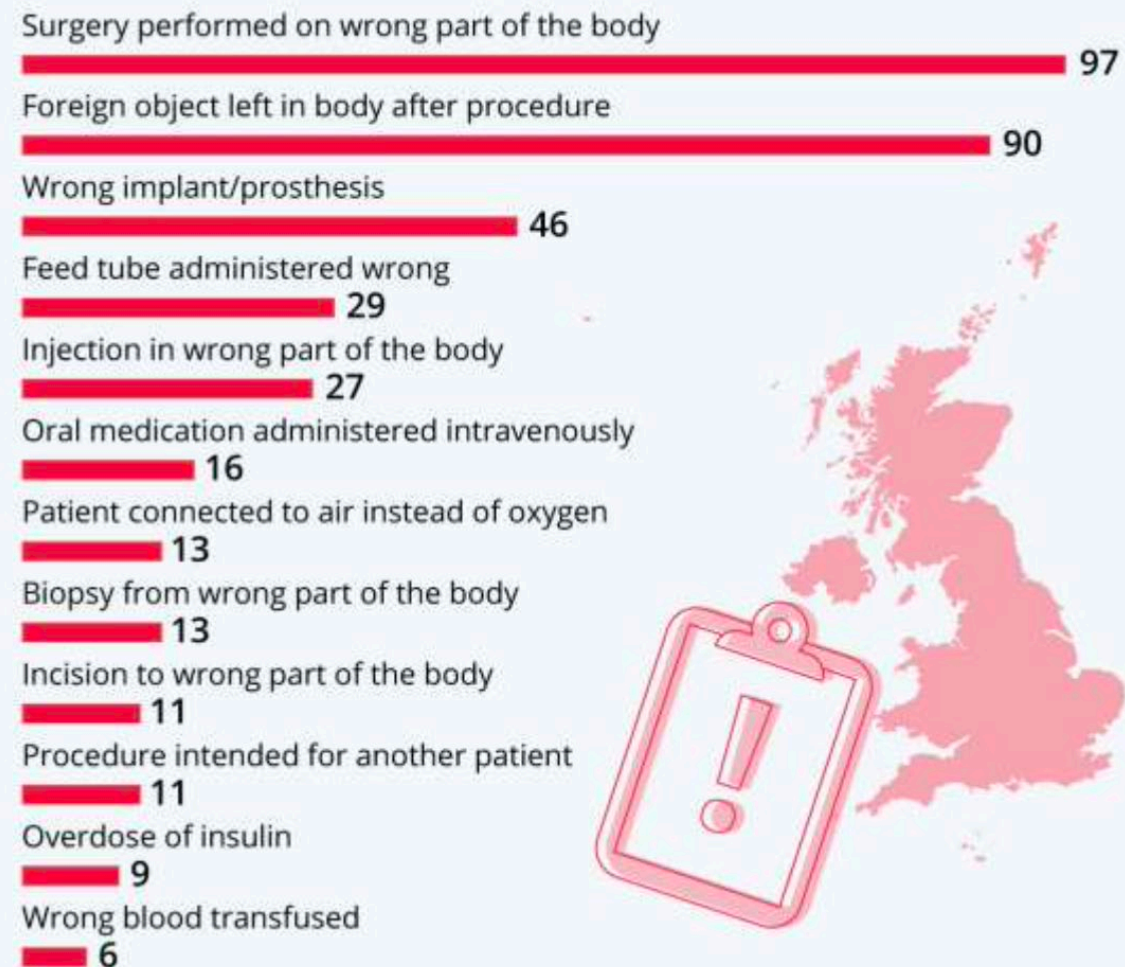
To initiate steps to move away from the current blame and fear culture to a just and learning culture



# Never events

## The NHS's Most Serious (and Avoidable) Errors of 2021

Number of serious medical errors that occurred in England despite being wholly preventable (Apr 2021-Feb 2022)



Source: NHS



# Never Events list 2018

January 2018

## Never Events list 2018

First published January 2018 (last updated February 2021)

### Surgical

#### 1. Wrong site surgery

An invasive procedure<sup>1</sup> performed on the wrong patient or at the wrong site (eg wrong knee, eye, limb). The incident is detected at any time after the start of the procedure.

##### Includes:

Interventions that are considered to be surgical but may be done outside a surgical environment – for example, wrong site block (including blocks for pain relief), biopsy, interventional radiology procedure, cardiology procedure, drain insertion and line insertion (eg peripherally inserted central catheter (PICC)/ Hickman lines).

##### Excludes:

- removal of wrong teeth<sup>2</sup>
- local anaesthetic blocks for dental procedures (exclusion added May 2019)
- interventions where the wrong site is selected because the patient has unknown/unexpected anatomical abnormalities; these should be documented in the patient's notes
- wrong level spinal surgery\*
- wrong site surgery due to incorrect laboratory reports/results or incorrect referral letters
- contraceptive hormone implant in the wrong arm.

## Reporting processes for wrong tooth extraction: an update from Jason Wong and Matthew Fogarty

Wrong tooth extraction is a patient safety incident. That's why the NHS has strong processes in place such as patient safety incident reporting, to ensure that when it happens there is proper accountability and regard for patient welfare.

As you know, Never Events are serious incidents that are wholly *preventable* because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

The NHS has reviewed its list of "Never Events". Wrong tooth removal was originally included on the Never Events list as part of a broad category of wrong site surgery Never Events. As part of the current review of sub types of Never Events, it was concluded that despite wrong tooth extraction being an unacceptable incident, the available barriers to prevent the removal of wrong teeth are not strong enough to prevent this type of incident from occurring in all cases.

For example, the review found patients often had different numbers and locations of teeth, for example as a result of previous dental work or due to their individual dental anatomy. This was compounded by a lack of standardisation in types of tooth notation and difficulties with site marking.

Removal of the wrong tooth will not be classed as a Never Event from 1 April 2021.

However, even though there may be understandable reasons when it may occur, this does not mean that wrong tooth extraction is "just one of those things". It is still a patient safety incident.

### **Wrong tooth extraction incidents must be reported as a patient safety incident and managed according to local risk management policies.**

Along with the Office of the Chief Dental Officer, many stakeholders took part in the review which worked closely with partners including the Faculty of Dental Surgery, the British Dental Association, the Faculty of General Dental Practice, the Association of Dental Hospitals, the Association of Perioperative Practice, the College of Operating Department Practitioners and the Healthcare Safety Investigation Branch.

Based on the broad clinical input into this decision and the robust safety processes and reporting mechanisms in place, we are confident this is a safe and considered way to move forward.

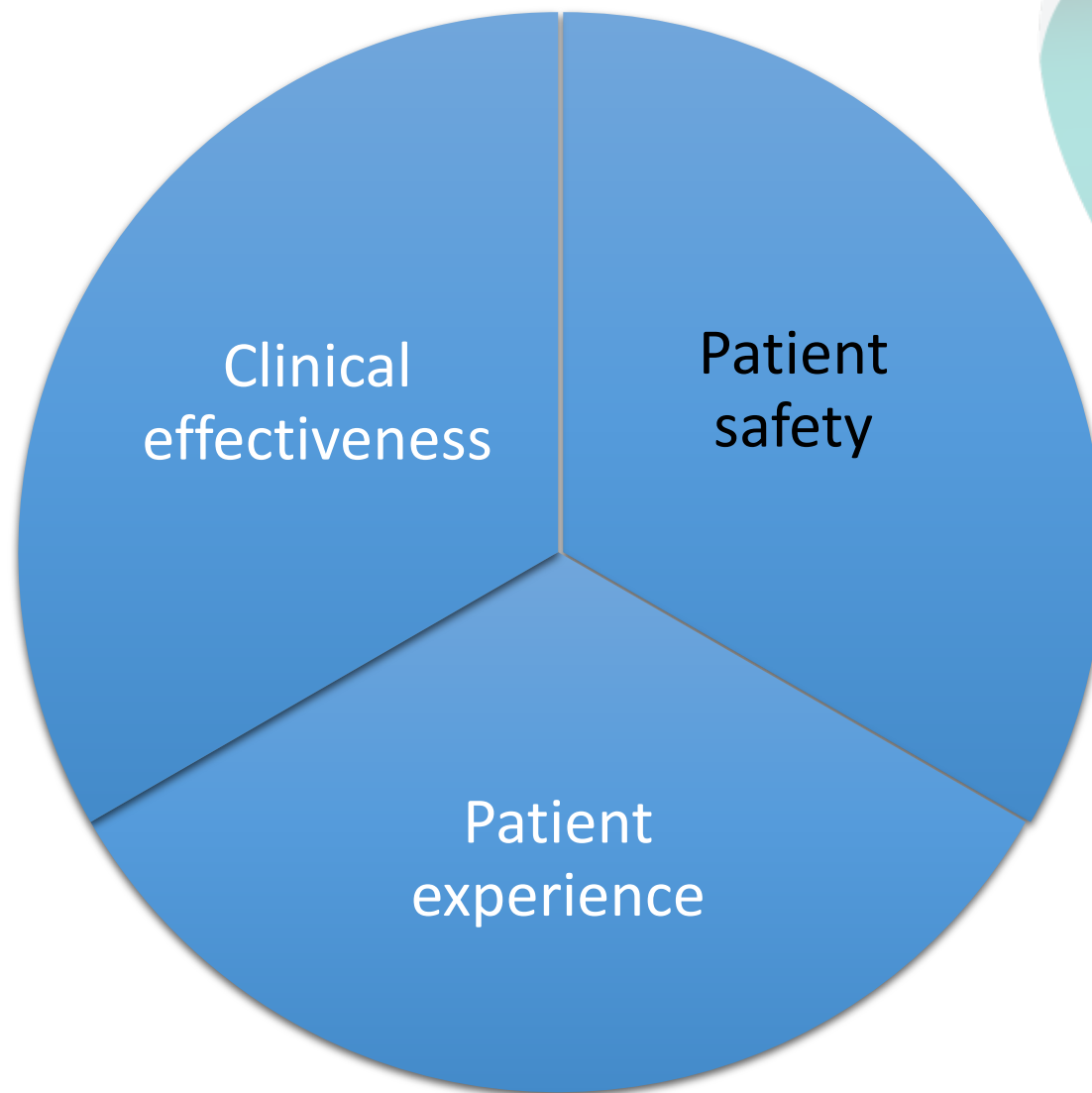
This clarification presents an opportunity for a renewed focus on the importance of existing measures to prevent wrong tooth extraction. These include the use of Local Safety Standards for Invasive Procedures (LocSSIPs). There are some excellent resources from the [Royal College of Surgeons England](#), including guidance on mechanisms to prevent Never Events and examples of good practice including dental extraction toolkits and checklists to be used in primary care settings.

We look forward to progressing this work with you all in the future.

**Dr. Jason Wong**  
Deputy Chief Dental Officer England

**Dr. Matthew Fogarty**  
Deputy Director of Patient Safety (Policy and Strategy), NHS England

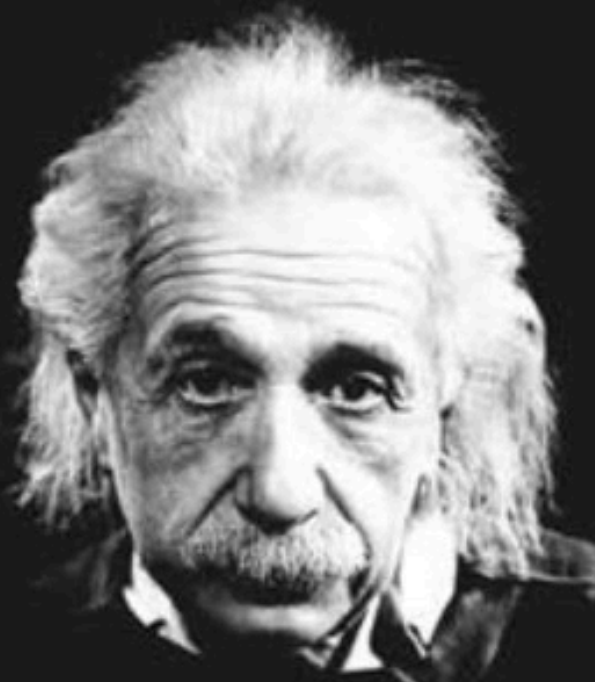
# What makes quality care?



# Do we have the evidence to measure quality?

**"Not everything that  
counts can be counted,  
and not everything that  
can be counted counts."**

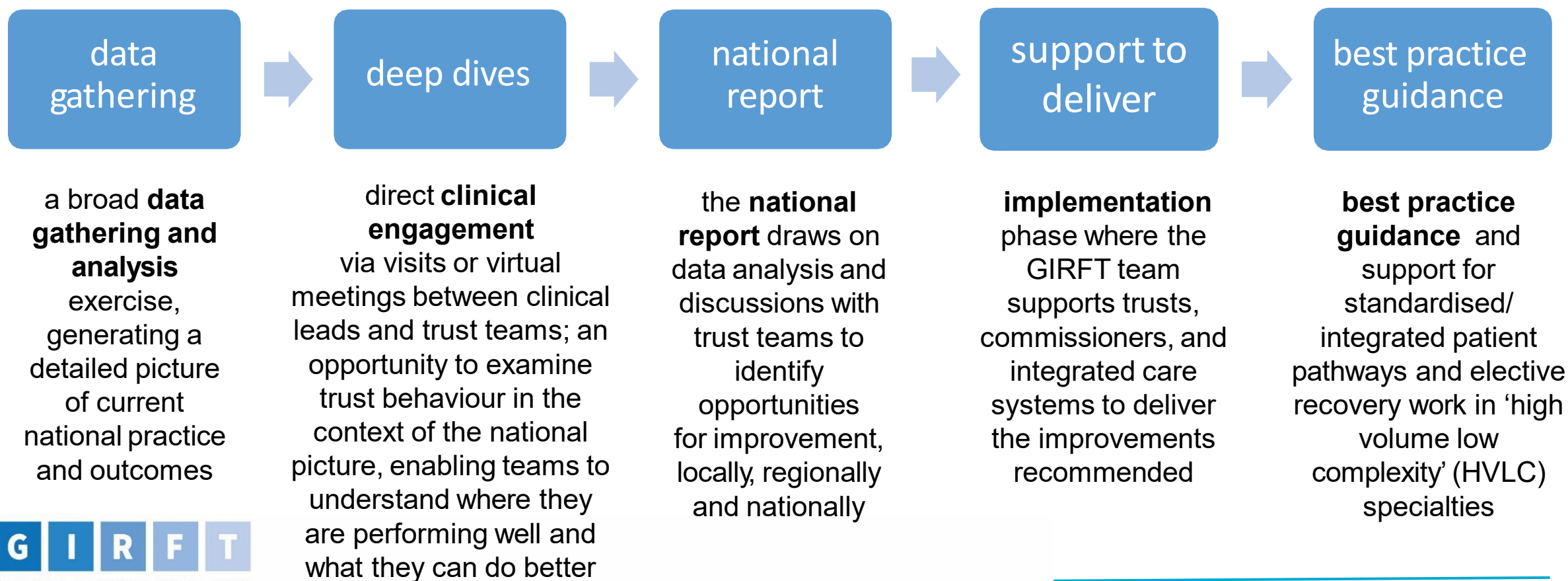
-Albert Einstein





# Introducing GIRFT

By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes to help improve care and patient outcomes, as well as delivering efficiencies



# Primary Dental Care Proof of concept pre-pilot



GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust, NHS England and NHS Improvement

# Barriers to and incentives for safety event reporting in emergency departments

- Jeffrey R Brubacher , Garth S Hunte, Lynsey Hamilton, Annemarie Taylor 2011
  - Semi-structured interviews were carried out with front-line nursing staff and nurse managers in EDs across British Columbia to explore their perception of barriers to and incentives for PSE reporting.
  - One hundred and six interviews were conducted with staff from 94 of the 98 EDs in British Columbia.
  - Only 4-50% of PSEs are reported.
-

# Barriers to recording

Barrier	Solutions
<b>Time constraints</b>	<p>Streamline PSE reporting process</p> <p>Simplify</p> <p>Provide alternative reporting pathways</p> <p>Provide staff with time for reporting</p>
<b>Sense of Futility</b>	<p>Ensure prompt investigation and feedback</p>
<b>Fear of reprisals</b>	<p>Have reports investigated by a 'safety manager' not involved with staff hiring or discipline</p> <p>Allow option of anonymous reporting</p>
<b>Lack of education</b>	<p>Provide education on the value of PSE reporting and on what events should be reported (i.e., including near-miss and no-harm event)</p>
<b>Viewing PSE reports as indicators of failure</b>	<p>Ensure reports are valued and units with more reports are viewed positively rather than as unsafe</p> <p>Ensure that front-line staff and managers at all levels know that reporting is 'safe' and that reports are for learning and not used to assess a department's safety performance</p> <p>Have statistical reports focus on learning and change rather than number of PSEs</p>
<b>Inaccessibility of reporting forms</b>	<p>Provide alternative reporting methods</p> <p>Ensure reporting forms are readily accessible for all staff</p>



# Incentives to recording

Incentives for Reporting	Examples
Feedback and visible change	Newsletters E-mails Communication books Posters Verbal feedback during safety huddles or rounds Point-of-care warnings
Valuing reporting	Encourage reporting as a learning opportunity Praise units that successfully increase reporting rates Provide education to front-line staff on reporting as a component of patient safety Provide education to upper-level management (Leaders, executive, hospital boards) on increased reporting volume as a positive indicator of safety culture Provide resources for reporting, report investigation and feedback Employ executive walk-arounds
Alternative reporting pathways	Telephone safety reporting ‘hotlines’ Anonymous drop boxes Whiteboards Informal verbal community Safety huddles Executive walk-arounds

# Patient safety in dentistry – the bigger picture

Priya Chohan,<sup>\*1</sup> Tara Renton,<sup>2</sup> Jason Wong<sup>3</sup> and Edmund Bailey<sup>4</sup>

## Key point

Presents a body of research within the dental profession relating to attitudes and awareness towards patient safety.

Highlights there is a lack of awareness relating to patient safety within dentistry.

Emphasises the importance of education and collaboration to promote a positive patient safety culture.

## Abstract

**Background** Patient safety incidents (PSIs) have recently become a topic of discussion within dentistry. NHS England data has highlighted that wrong tooth extraction is the most common surgical Never Event (NE); however, this data reflects mainly a secondary care picture. Consideration needs to be given to reporting of PSIs occurring in primary care.

**Aims** To establish the current attitudes of both primary and secondary care dentists within this field and to use this to promote a positive, supportive culture.

**Methods** A national electronic survey was sent to dentists for data capture related to this topic, from April to September 2019 inclusively.

**Results** There were 104 responses to the survey. Responses included that 39% of responders were general dental practitioners (GDPs), 90% were aware of NEs, 48% were not aware of how to report PSIs and 74% of dentists felt that fear of the General Dental Council/Care Quality Commission repercussions was a barrier to them reporting PSIs. Additionally, 86% of dentists felt that a trainee/GDP support network would be useful to share learning regarding PSIs.

**Conclusion** The survey results highlighted that there is a lack of knowledge concerning PSI reporting, combined with a culture of fear of the repercussions of reporting. The survey data will aim to be used to implement a supportive network for dentists, develop a positive ethos surrounding PSIs and optimise patient care.



# Patient Safety Research - Outcomes

- 66% of dentists felt comfortable reporting never events
- 86% of dentists thought that a trainee/GDP support network would be useful to share learning from incidents
- 88% thought it was important to report incidents to learn from and prevent them happening
- Most responders who were unfamiliar with PSI related terms (Never Events/Serious Incidents/Near Misses) were primary care based



# Positive Learning Points...

**Table 2 Rate how important you feel these reasons are for reporting PSIs**

Reasons	Degree of importance				
	Very important	Fairly important	Important	Slightly important	Not important
To learn from and prevent PSIs	87.5% (n = 91)*	5.8% (n = 6)	6.7% (n = 7)	–	–
To improve patient care	86.5% (n = 90)*	5.8% (n = 6)	7.7% (n = 8)	–	–
To support the development of a 'just culture'	43.3% (n = 45)	28.8% (n = 30)	17.3% (n = 18)	5.8% (n = 6)	4.8% (n = 5)
To identify systems and process errors	64.4% (n = 67)*	23.1% (n = 24)	11.5% (n = 12)	1% (n = 1)	–
To improve team cohesion	45.2% (n = 47)	20.2% (n = 21)	22.1% (n = 23)	9.6% (n = 10)	2.9% (n = 3)
To provide teams with an opportunity to identify problems with current practice	63.5% (n = 66)*	21.2% (n = 22)	14.4% (n = 15)	1% (n = 1)	–
To monitor and potentially alter budgets for hospital trusts/primary care services	22.1% (n = 23)	21.2% (n = 22)	26.9% (n = 28)	17.3% (n = 18)	12.5% (n = 13)
To allow patients to choose the safest care facilities	26% (n = 27)	26% (n = 27)	30.8% (n = 32)	12.5% (n = 13)	4.8% (n = 5)
To uphold duty of candour	55.8% (n = 58)	21.2% (n = 22)	17.3% (n = 18)	5.8% (n = 6)	–

**Key:**

\* = Key findings



## Patient safety and CQC



- CQC is primarily bound by the legislation that underpins our role.
- A “well led” service understands risks and takes steps to minimise them. There is a culture of openness and learning.
- CQC understand reluctance to report incidents
- CQC understand the importance of human factors when incidents happen.
- We enquire about whether staff members are comfortable raising concerns and feel that they will be listened to.
- We expect to see appropriate learning from incidents and near misses and will ask about this when we inspect services.
- Reporting an incident will not automatically result in an inspection.

## Reporting to CQC

### 1 Abuse or allegations of abuse

Providers must tell the CQC of any allegations of abuse in their service. This requirement is tied to the need for providers to ensure they are safeguarding their service users. This is primarily aimed at whether abuse emanates from the service. Individual concerns about service users do not necessarily need to be reported to CQC.

### 2 Serious injuries

The CQC defines a serious injury to a service user as one that: permanently impairs their sensory, motor or cognitive functions; or causes prolonged pain; or changes the structure of their body; or shortens their life expectancy. We expect this to be proportionate in dental services.

### 3 Events that prevent or threaten to prevent the registered person from carrying on an activity safely and to an appropriate standard

When handling a flood, fire or financial crisis in a service it is unlikely to be at the forefront of managers' minds that the CQC must be told, but that is the duty. Importantly, the CQC can play a role in helping to find alternative services or accommodation for the service users.

### 4 Deaths of service users.

Unusual in dental practice, but it is important to notify us if a death might be related to the provision of regulated activity.

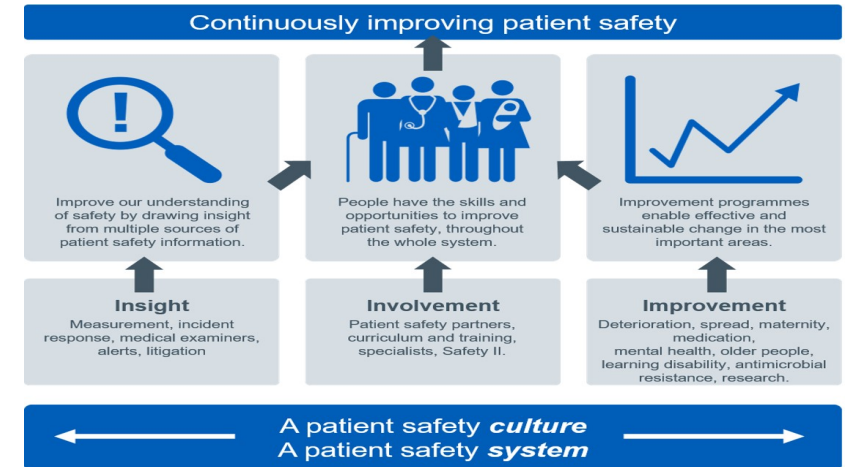
# Creating a positive culture

- Defensive Dentistry
- Lack of clarity as to best and acceptable practice
- Culture of fear and blame
- Cognitive dissonance
- Professional conduct
- Profound impact on whole system



# NHS patient safety strategy, Safety culture foundations

- Insight
- Learn from patient safety events (LFPSE) service formerly known as PSIMS – enables the recording and learning from incidents and from examples of excellence - launched Jul-21
- Patient Safety Incident Response Framework (PSIRF) – Establishing the interventions that support the right cultural conditions at all levels. Expectations set for informing, involving and supporting patients. Staff to be involved and treated with equity and fairness. Pilots underway, to be launched in 2022
- Involvement
- Patient Safety Specialists – 700+ dedicated experts within organisations who champion safety culture and support Speaking Up. Supported by Medication Safety Officers, Medical Device Safety Officers and Maternity Safety Champions.
- Patient safety syllabus – 5 training levels, each with a safety culture module - launched Oct-21
- Framework for involving patients in patient safety – patient safety partners working within organisations to improve patient safety – launched Jun-21



Safety culture is one of the foundations embedded throughout the NHS patient safety strategy



[NHS patient safety strategy](#)



# LFPSE recording pathway



Record patient safety events

**BETA** This is a new service – [email us your feedback](#) to help us to improve it.

## Learn from patient safety events

Using this service, health and social care staff can:

- Record information about things could have or did affect the safety of patients, or things that have gone well, in order to support learning and safety improvement
- Access, review and update event records they have permission to edit, and undertake governance activities to support local patient safety response and improvement
- View and download data about what patient safety events have been recorded within their own organisation to the new Learn From Patient Safety Events service

Information is available about the project to design and implement [this new service](#).

### e-Form users

If you were redirected to this page from the NRLS GP-eform, we have a dedicated webpage providing specific [information for primary care organisations](#) about the introduction of the Learn from patient safety events service.

### Before you start

This is a new service, and it is being rolled out across England, Wales and Northern Ireland. Some organisations will be recording patient safety events to this new Learn from Patient Safety Events service, and others will still be reporting incidents to the National Reporting and Learning System (NRLS).

Speak to your local safety team about which system you should currently be using.

Read more about how we [learn from recorded patient safety data](#).

### Sign in

You will need to create an NHS England Applications account and sign in if you want to:

- save draft patient safety event records
- review patient safety event records you have previously submitted
- update patient safety event records you have previously submitted
- access data about what your organisation has recorded

**Sign in to start** ➤

Or [set up an account](#) if you've never used this service before

### Record a patient safety event anonymously

You can record a patient safety event without creating an account and signing in. You will not be able to save drafts, review or update previous records, or retrieve this record.

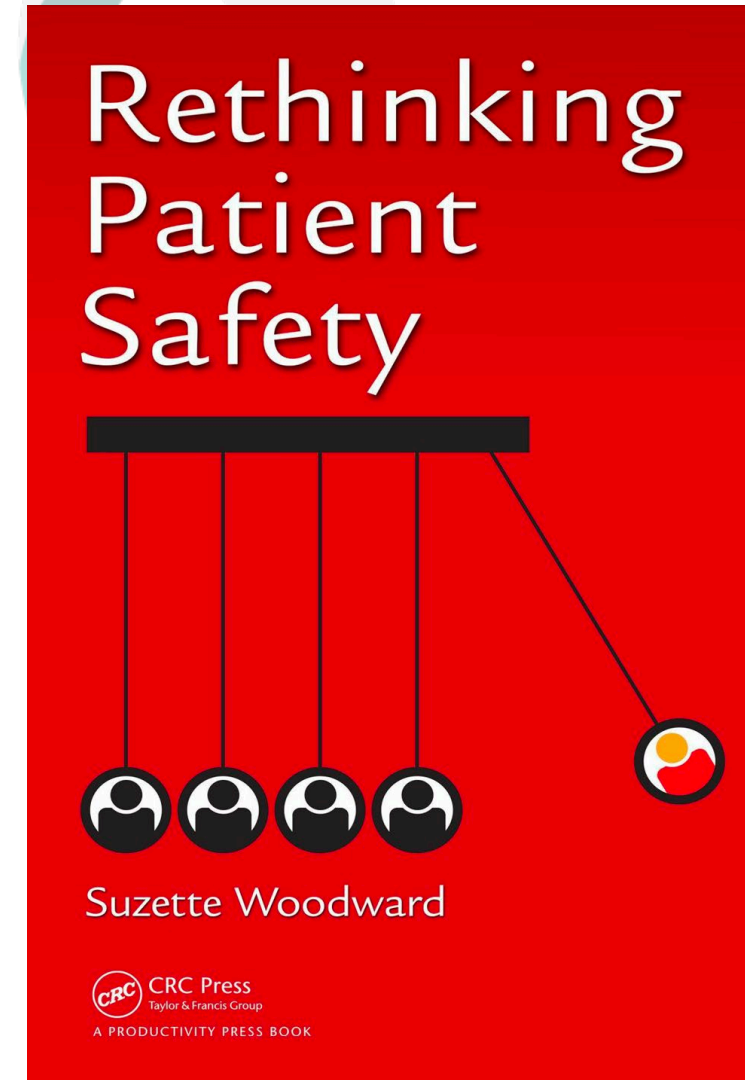
**Record anonymously** ➤

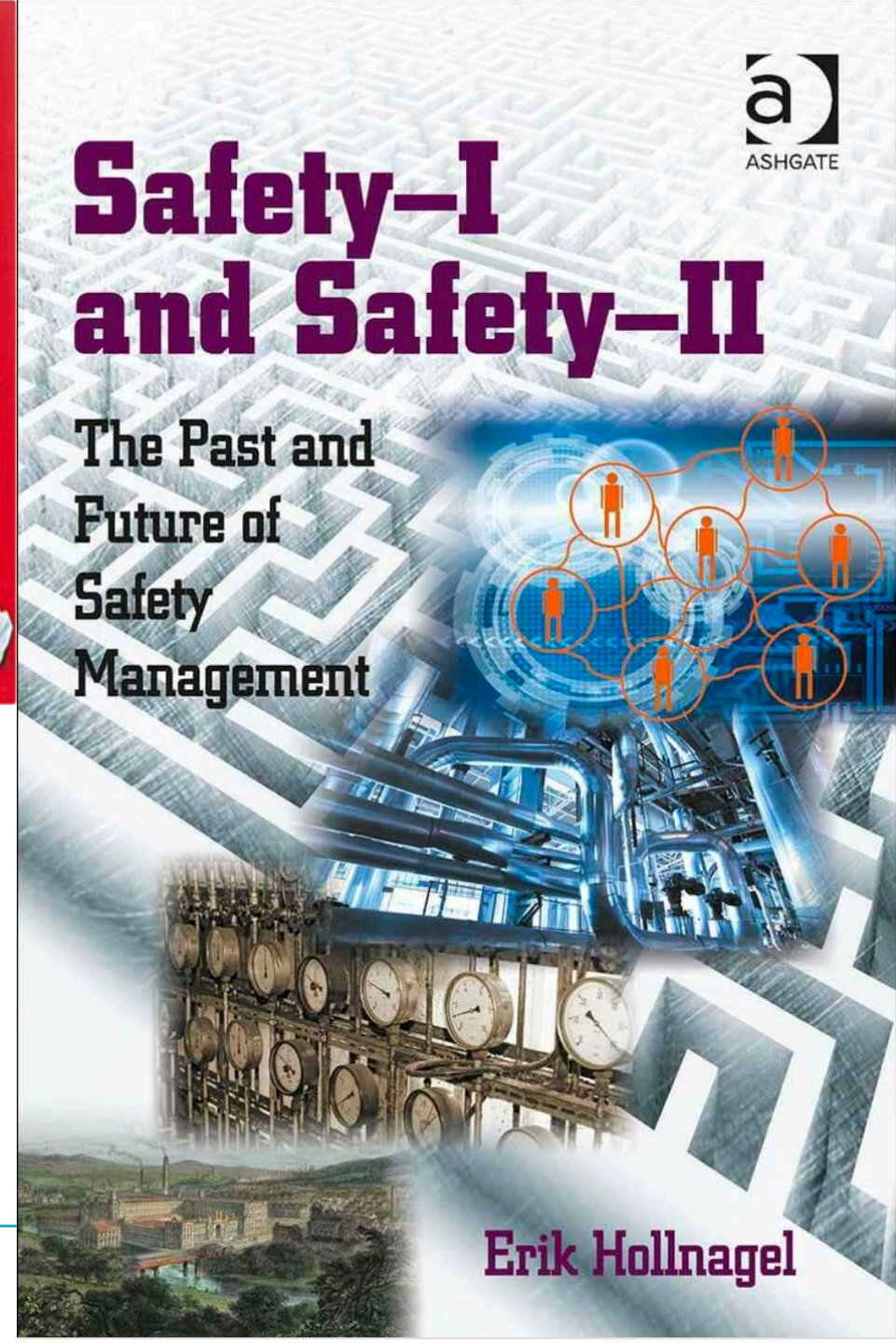
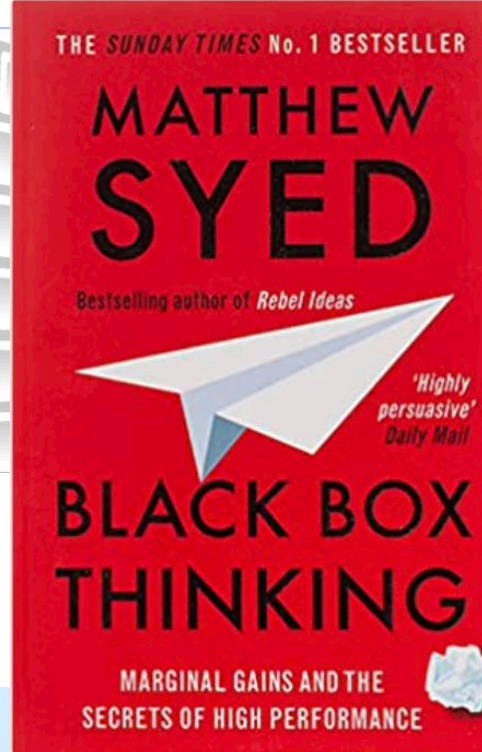
Link: <https://record.learn-from-patient-safety-events.nhs.uk/>

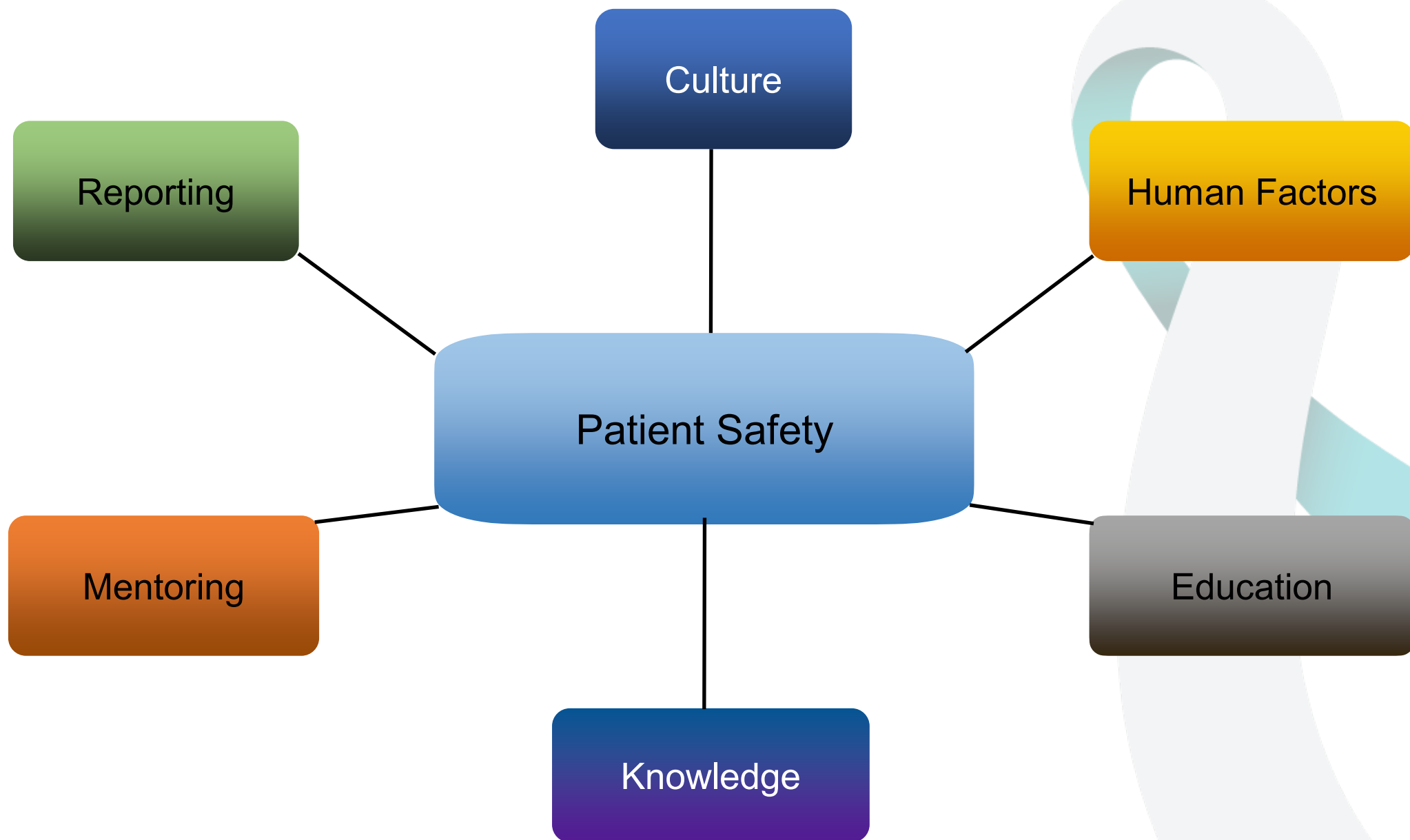


# Creating a patient safety positive culture

- Feeling safe is one of the most important needs for our patients. – **AND OUR TEAMS**
- The act of keeping patients safe is about being constantly vigilant; noticing what happens every moment of every day, noticing when it goes right, noticing when it could go wrong and noticing when it does go wrong. With that knowledge, we then constantly adapt our behaviour and practice; constantly refine our performance or our way of working so that it gets safer and safer and safer.
- Woodward, Suzette. Rethinking Patient Safety



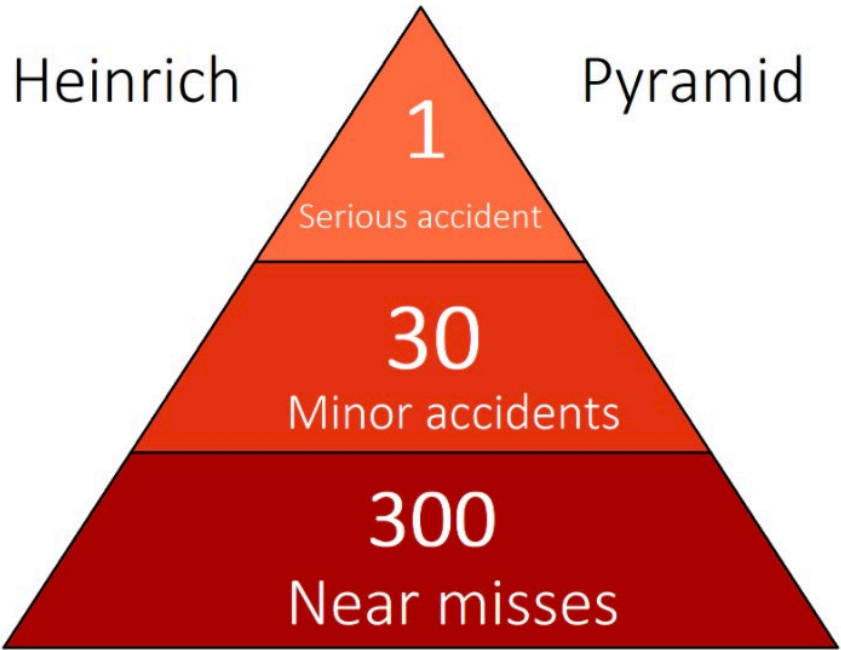




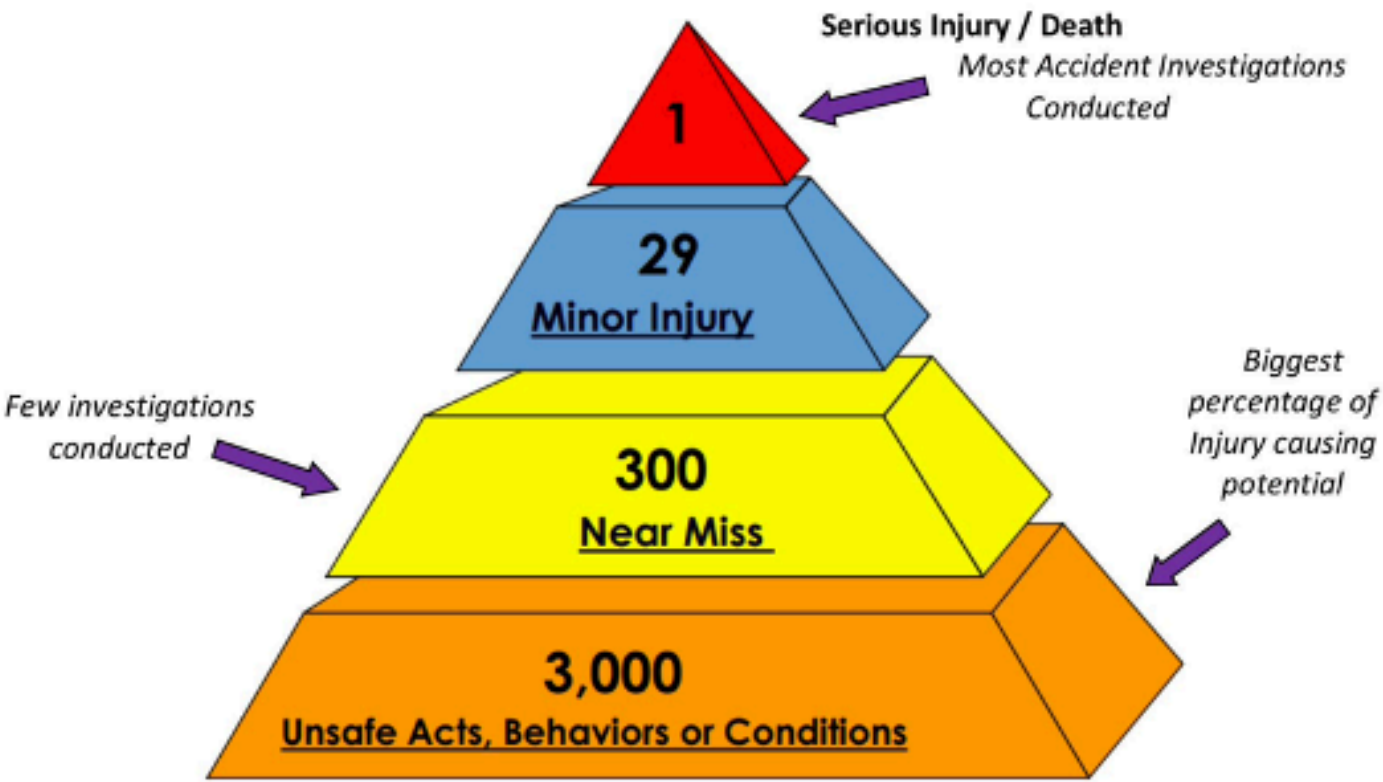


Heinrich

Pyramid



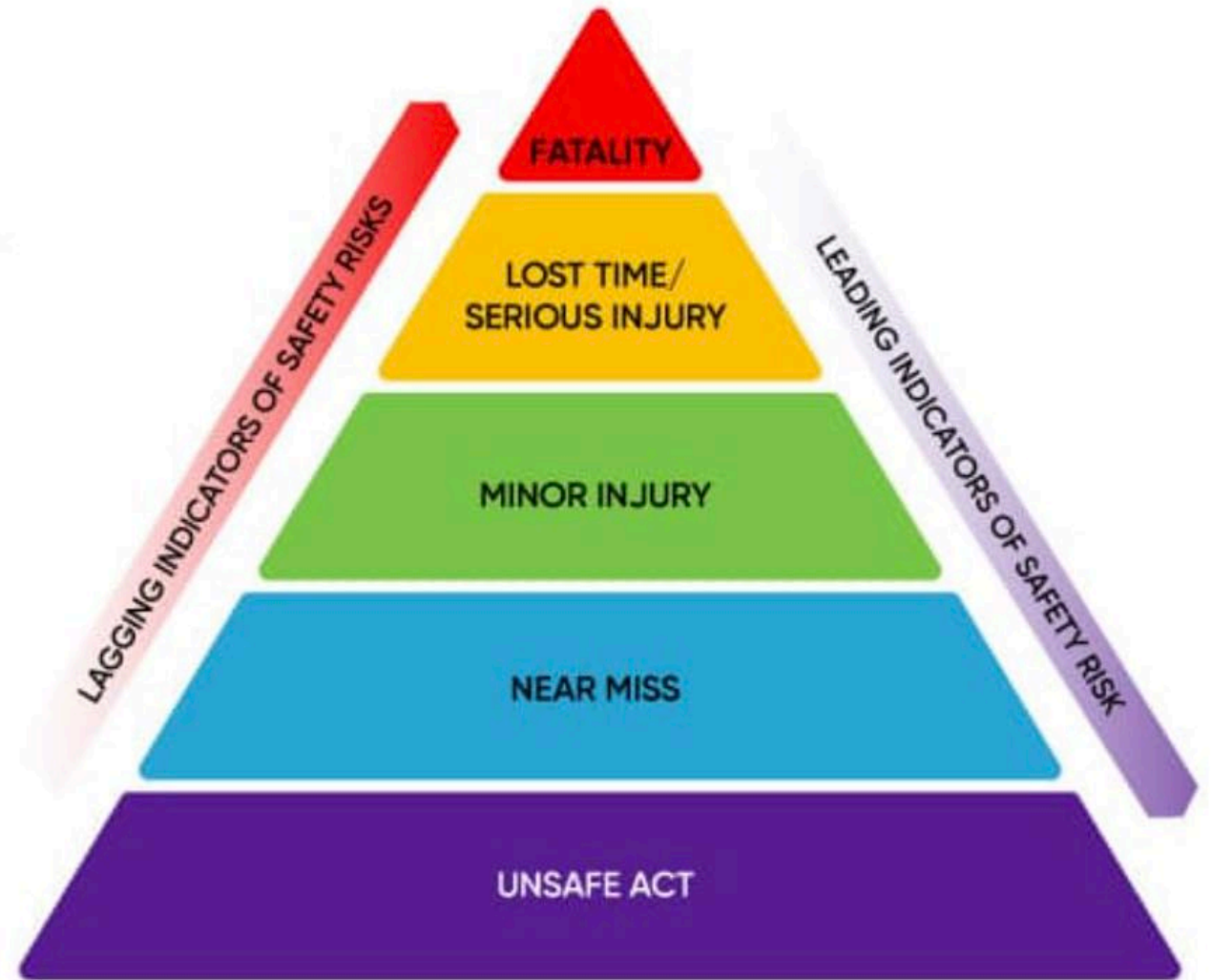
Incident Ratio Model –  
Heinrich’s Triangle





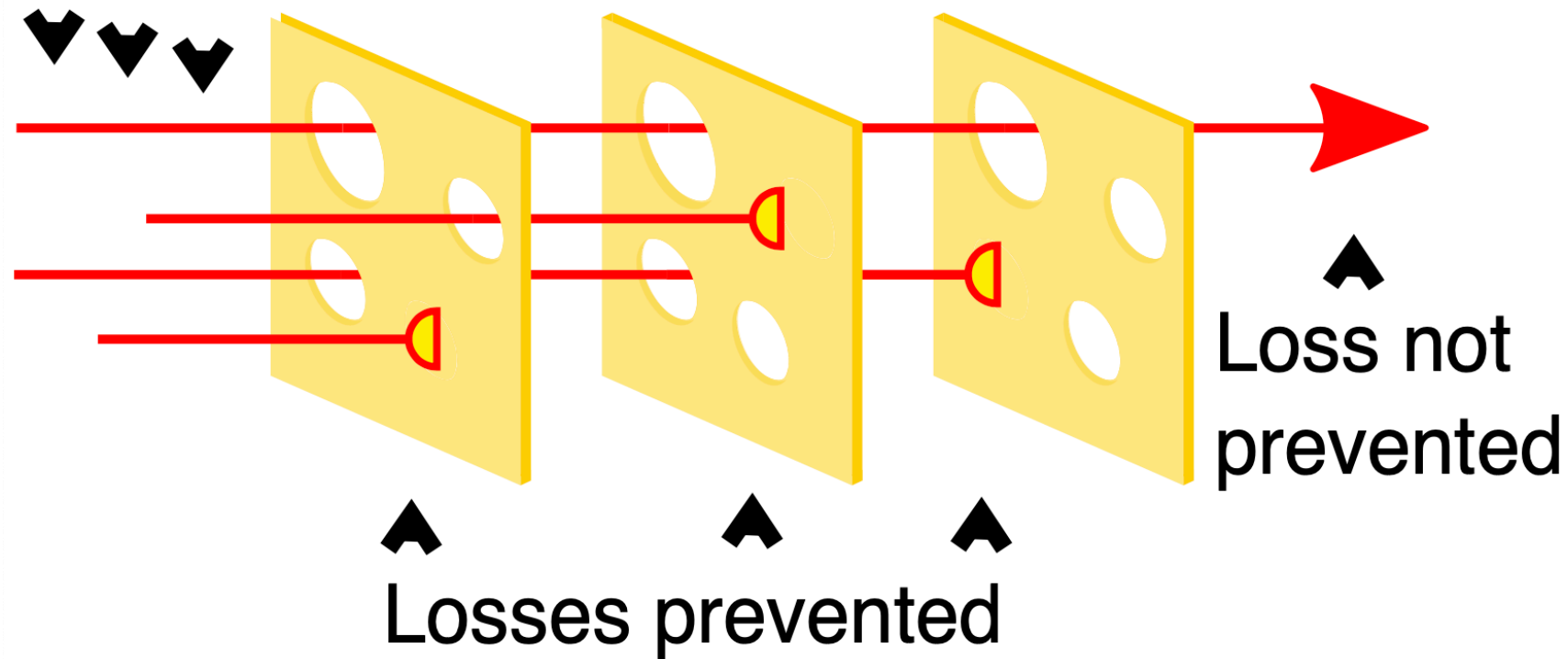
# Components of Safety Triangle

## Heinrich's Triangle Theory



Heinrich's Triangle Theory

Hazards



# Aims



- To initiate steps to move away from the current blame culture, to a positive, fair, and learning culture within dental settings
  - To review the current recording mechanism to create an appropriately supported infrastructure for recording Patient Safety Events in Dentistry
  - To develop templates for practitioners to use to enhance learning from Patient Safety Events
  - To look at Practitioner support and how to encourage recording
  - To set up a regional pilot study of post-incident support and get feedback. Reduce fear of recording patient safety events
  - Categorising patient safety events to promote the correct procedures
  - Sharing patient safety events
  - To promote duty of candour
-

# Our stakeholders





# Our Logo



# Project Sphere: 2021-2023 overview

Hosted 6 meetings with our main stakeholder group since Dec 2021

Raising awareness of LFPSE in Dentistry

Written 2 bulletins awaiting to be published raising awareness of the LFPSE reporting pathway & project sphere

Currently attending:

- Primary care patient safety discovery group (PCPSDG)
- Monthly PS Strategy Implementation
- Safety Culture Implementation group (SCIG)

Discussions with CG Dent to support the project

Presented our project in the OCDO theatre at the British Dental Industry Association Conference 26th March 2022, London Excel

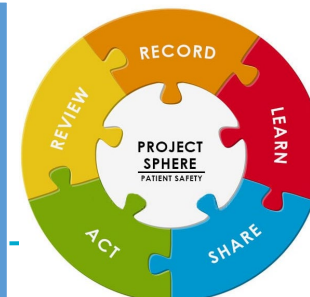
Huddle sheets can be utilised by the whole dental team

We are looking at categorising Patient Safety Events

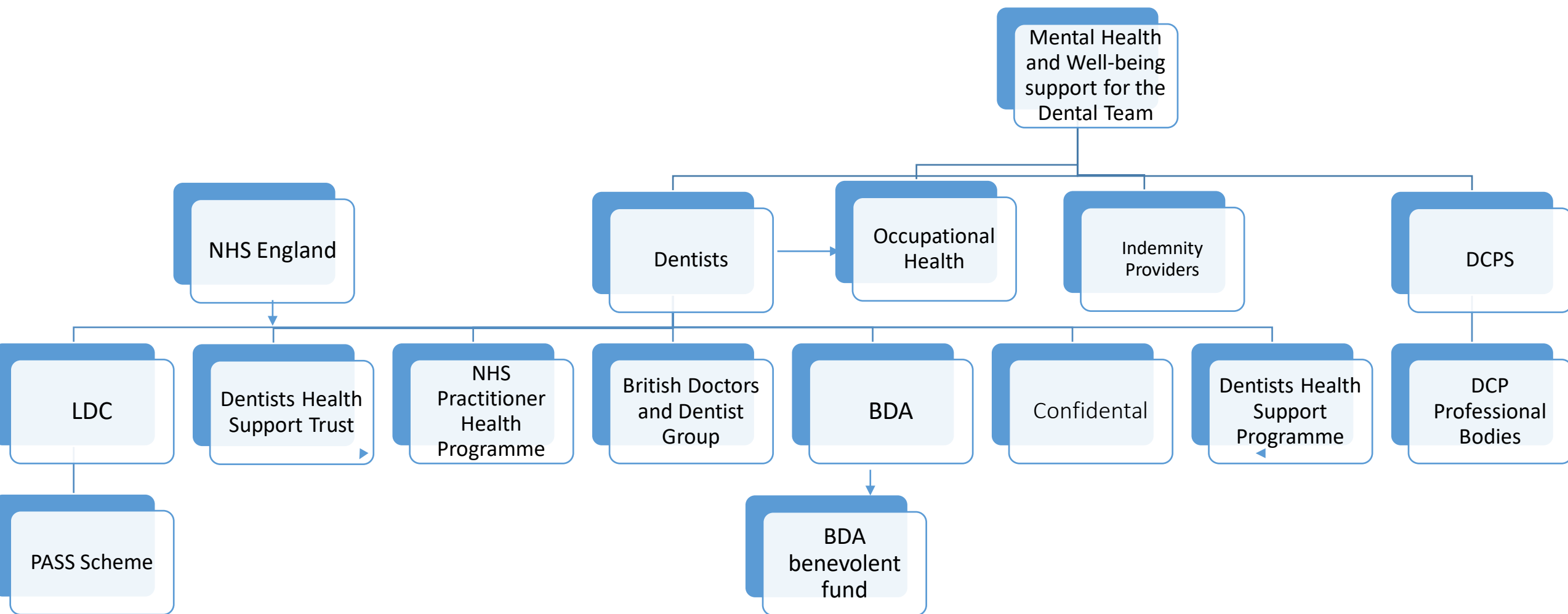
Discussions to create a support group for the whole dental team

Presented Project Sphere on 4<sup>th</sup> October 2022 at the Dentistry show London

Indemnity consensus statement



# Current support available to the dental team



# Huddle sheets



## Daily patient safety huddle

- Enables any issues to be raised at the start/end of the day or session.
- It is a guide and does not need to be completed on paper.
- Can be completed verbally between the practice team or the operator and the dental nurse.
- It can also be written on a board in a mutual staff area.
- Copies of the document do not need to be kept from the huddle.

Daily patient safety huddle	Date:
Who is present for the huddle?	
Are staffing levels sufficient today? Is everyone here that needs to be? What is your role today?	
Environment: Any equipment issues?	
Patient related issues: Risks to patient safety today?	
Team Well-being: Any issues or additional stresses to share?	
Any other updates or concerns? Are any reasonable adjustments required?	



## Post patient safety event huddle

- Patient safety huddles should be carried out following a safety incident, near-miss, or major event.
- Allow staff to express themselves in a safe, supportive, and learning environment.
- Maintain a non-judgmental and open discussion.

Patient Safety Event Review	Date:
Who was involved/affected? What was your role? Is everyone here that needs to be?	
Discuss the patient safety event, what happened or could have happened? What was intended to happen? Provide a brief summary of the event.	
Has the event had an impact on patient care for the day? Are there any immediate actions or changes required?	
How has the event been recorded and where?	
Has the patient expressed any immediate feedback following the event? Are staff aware of the patient perspective?	



## Reflection huddle

- Reflection huddles should be carried out a significant amount of time after a safety incident, near-miss, or major event. Their purpose is to provide a reflective insight in to preventing the event in the future, as well as discussing the lessons learnt.
- Allow staff to express themselves in a safe and supportive environment, to help facilitate learning.
- Maintain a non-judgmental and open discussion.
- Focus the discussion on existing processes/systems rather than individuals.

Reflection huddle sheet		Date:
In hindsight, what happened during the event or near miss? What could have happened?		
Reflect on the event and discuss the lessons learnt.		
What went well?		
Factors	What are the environmental factors?	
	What are the Human factors? Clarify the human factors using the supporting document.	
	What are the systemic factors?	



# Daily patient safety huddle



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Environment: Any equipment issues?	
Patient related issues: Risks to patient safety today?	
Team Well-being: Any issues or additional stresses to share?	
Any other updates or concerns? Are any reasonable adjustments required?	

## End of the day huddle

End of the day huddle	Date:
Who is present for the huddle?	
What went well today?	
Patient related issues: Any concerns from the day?	
Team Well-being: Any issues or additional stresses to share?	
Anything to take forward for tomorrow? Were any reasonable adjustments fulfilled? Were any inequalities identified and require addressing?	

# Post patient safety event huddle sheet



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Has the event had an impact on patient care for the day? Are there any immediate actions or changes required?	
How has the event been recorded and where?	
Has the patient expressed any immediate feedback following the event? Are staff aware of the patient perspective?	

Has the patient had a follow up call? If no, then please expand. If yes, what was discussed?	
What emotional support does the team require?	
List changes in systems/processes to be implemented following the event to prevent this from happening again. Anything further to add?	
Arrange a review of changes implemented and if they have been effective? Include a time frame.	

# Reflection huddle sheet



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What went well?		
Factors	What are the environmental factors?	
	What are the Human factors? Clarify the human factors using the supporting document.	
	What are the systemic factors?	

What processes were followed to record the event?	
Has there been any further feedback from the staff or patient(s) involved?	
Any additional team training requirements identified?	
Are there any areas that need to be reviewed in the future? What are they and how often?	

# Supporting document (6 pages)

## Huddles supporting document

- Aids in the completion of the huddle sheets.
- Adapted from the Safety Engineering Initiative for Patient Safety (SEIPS), a core component of the Patient Safety Incident Response Framework (PSIRF).
- Enables teams to systematically evaluate each element comprising the work system and identify human factors which can be modified, to maximise performance and processes in the clinical environment.
- Serves as an adjunct to the huddle sheets, providing prompts to teams when undertaking their safety and reflection huddles.
- This document is a guide, with each event and team being unique, possessing their own considerations.

Factors	Considerations	Examples
People and teams	<p><b>How can we support and optimise the performance of individuals and teams?</b></p> <ul style="list-style-type: none"> <li>• Can we adjust training to meet individuals and team learning needs?</li> <li>• Was there effective communication between the dental team members and the patient?</li> <li>• Were individual roles and responsibilities clearly defined and understood?</li> <li>• Were there any role or goal conflicts identified?</li> <li>• Do people feel safe to raise questions or concerns with colleagues and management?</li> <li>• How are people treated when they do raise concerns or are involved in an adverse event?</li> </ul>	<ul style="list-style-type: none"> <li>• Positive guidance and mentorship for all team members is encouraged and staff feel supported and competent to perform their tasks and raise questions or concerns.</li> <li>• Training needs have met CPD requirements and staff have been supported with resources to complete this.</li> <li>• Staff recognising when they themselves/colleagues may need additional training and supporting them to achieve this.</li> <li>• Staff clearly understood their individual and team roles and responsibilities such as: <ul style="list-style-type: none"> <li>(i) ensuring the clinician always has the responsibility of disposing of their own sharps.</li> <li>(ii) nurses responsible for giving post-operative instructions, whilst implementing and providing patient leaflets for each type of procedure.</li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>• No goal conflicts were identified such as fatigue versus production pressures.</li> <li>• Clear, jargon-free effective communication with patients in a language and format that was understood, whilst maintaining a duty of candour.</li> <li>• Patients' opinions and concerns are listened to and acknowledged.</li> <li>• Effective team and management communication is encouraged.</li> <li>• Alternating colleagues/staff involved in particular teams/treatment sessions, as they may have additional qualifications and experience to help maintain performance and safety levels <u>i.e.</u> a nurse with additional qualifications in managing patients receiving IV sedation.</li> <li>• Inclusive engagement of all team members in daily team huddles is encouraged.</li> <li>• There is a focus on learning what happened to improve safety and not who is to blame during team debriefings following a near miss or adverse event.</li> <li>• Staff are supported and signposted to guidance if they are involved in an adverse event.</li> <li>• Ensuring patients requiring additional needs or adjustments are highlighted at time of booking appointments, and the staff involved with treatment are notified and can prepare in good time. This may include accommodating for hearing needs, ensuring a carer is present, or translation services.</li> </ul>
Tasks	How can we make tasks, and procedures easier for people to understand and perform, to minimise the cognitive and physical workload required?	<ul style="list-style-type: none"> <li>• Adequate time was allocated to complete the task safely.</li> <li>• Highly complex tasks were not scheduled back-to-back and buffer time slots were included in</li> </ul>



# Working with indemnity providers



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## Patient safety: indemnity consensus statement

# Indemnity Consensus Statement

10<sup>th</sup> May 2023



# Working with indemnity providers

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Summary

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Statement

## Summary

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In March 2022 a working group of indemnity providers was formed to discuss patient safety. This group was a branch of Project Sphere, which is led by Jason Wong (Deputy Chief Dental Officer for England), and run by Jyoti Sumel (Dental Therapist and NHSE - Midlands (WT&E) Clinical Leadership Fellow) with the support from a group of key stakeholders including the regulators. The aim of this group is to initiate steps to move away from the current blame culture into a positive and fair learning culture within dental settings.

With the ever-increasing use of social media and informal sources, the indemnity working group agreed there was a need for a consensus statement encouraging individuals to seek advice from the correct source. As a result, this consensus statement was created with the input and support of various indemnity providers.

## Acknowledgments

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Jason Wong – Office of the Chief Dental Officer

Bryan Harvey – Dental Defence Union

Gary Monaghan – Professional Dental Indemnity

Len De Cruz – British Dental Association Indemnity

Lesley Harrison – Dental Protection

Stephen Henderson – Medical & Dental Defence Union of Scotland

Tom Hester – Densura

Tom Chaston – All Med Pro

## Indemnity Consensus Statement

It is inevitable that, from time-to-time, errors will occur in clinical practice and patients may be avoidably harmed. Unfortunately, a blame culture has developed adding to the stress that dental professionals already feel. The best way to reduce the chances of errors being repeated is to encourage a culture where, instead of blaming the dental professional or team, a non-judgmental learning culture is developed. We support the move from a blame culture to a learning from events culture in clinical dental practice and we encourage the local and national regulators to take the same approach. Currently, some dental clinicians appear confused as to the best place to seek advice, whilst feeling that they are isolated and worried about the consequences of seeking advice. We are concerned that there appears to be too much reliance on social media forums as the first source of advice where dental professionals seek advice from well-intentioned colleagues, rather than contacting their own professional indemnity provider. The advice should come from an experienced adviser, who is knowledgeable of the dentolegal environment and competent to give appropriate advice. When an incident has occurred or advice is needed, it is recommended that the indemnity provider be contacted as soon as practicable. This is to ensure advice about the immediate management and the management of any subsequent claim or complaint can be obtained. With policies, a failure or delay in reporting incidents may impact upon the ability of the provider to assist, so we encourage dental professionals to check the terms of their policy. We, as individuals and representing the following organisations, confirm that there is no limit to the number of times you can call for advice, and the frequency of calls does not impact individual indemnity fees.

Spring 2023

# How can we relieve the pressure on dental professionals?

By John Makin

Comments



Patients deserve prompt and fair resolution in the event of a problem - but so too do dental professionals, argues John Makin, head of the DDU.

Fears about NHS 'dental deserts' appearing across the country are long-standing, but have gained traction since the pandemic. Now, the Health and Social Care Committee has

## Topics

Health and wellbeing

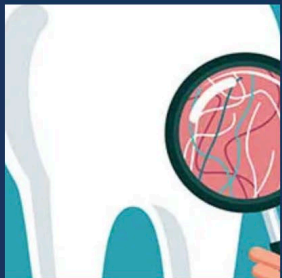
GDC



## What to do when things go wrong...

No-one looks forward to dealing with an adverse incident, but the simple fact is they do happen - so knowing how to handle them is a key facet of everyday practice.

## Nerve damage dilemmas

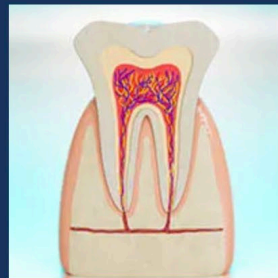


### CASE STUDY

#### Allegation of permanent nerve damage

A DDU member's case shows how important independent expert evidence can be to successfully defending a claim.

Being sued



### ADVISORY CALLS

#### Damage to lingual nerve

A dentist needed reassurance from the DDU on the correct course of action after an incident triggered the practice's statutory duty of candour.

Managing incidents

# Conclusion



STEPS TO CULTURE CHANGE WILL  
TAKE MANY YEARS TO ACHIEVE



THE JOURNEY HAS TO START  
SOMEWHERE, AND WE HOPE THAT  
THIS WILL BE THE START OF MANY  
POSITIVE CHANGES IN DENTISTRY



THE OCDO, REGULATORS, DENTAL  
PROFESSIONAL ORGANISATIONS AND MANY  
OTHER KEY STAKEHOLDERS ARE WORKING  
TOGETHER TO ACHIEVE OUR AIMS.