NHS England

Guide for Commissioning Oral Surgery and Oral Medicine

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**03083**
Document Purpose	Guidance
Document Name	Guide for Commissioning Oral Surgery and Oral Medicine Specialties
Author	Resource Author – NHS England, Chief Dental Officer team
Publication Date	29 September 2015
Target Audience	NHS England Dental Commissioners
Additional Circulation List	Dental Public Health Team, Local Dental Network, Local Dental Committees, Clinical Directors CDS, Health Education England Dental Leads, Dental Schools Deans, Local Authority Directors of Public Health, British Dental Association Leads, National Dental Associations and Organisations, NHS England Regional Directors
Description	This document is to be used by commissioners to offer a consistent and coherent approach. They describe the direction required to commission dental specialist services. They will improve dental care and outcomes for patients, ensure they receive the highest quality dental care in the most appropriate setting, by professionals with the required skills, whilst ensuring value for money.
Cross Reference	This is part of a suite of documents including; Guide for Commissioning Specialist Dentistry Services Introduction, Guide for Commissioning Orthodontics, Guide for Commissioning Special Care Dentistry, Equality & Health Inequalities supplement
Superseded Docs (if applicable)	
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Dionne Hilton Area 6 B Skipton House, 80 London Road London SE1 6LH 07919 573 382

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Contents

1 Foreword

NHS England produced the *Five Year Forward View* to set out a shared view of the challenges ahead and the choices about health and care services in the future; it applies to all services including dentistry.

This consensus on the need for change and the shared ambition for the future is the context in which these Commissioning Guides for Dental specialties have been produced. Clinicians, commissioners and patients have contributed to this work to describe how dental care pathways should develop to deliver consistency and excellence in commissioning NHS dental services across the spectrum of providers to benefit patients.

In order to deliver this vision and implement the pathway's `a coalition of the willing', NHS England partners, HEE and PHE, specialist societies and others who have contributed to their development will need to respond in the implementation phase by unlocking structural and cultural barriers to support transformational change in dental service delivery.

It's a future that will dissolve the artificial divide between primary dental care and hospital specialists; one that will free specialist expertise from outdated service delivery and training models so all providers can work together to focus on patients and their needs.

These guides set out a framework and implementation and the pace of change will vary across England. This will be an iterative process; therefore, it will be necessary to review and update these guides regularly. However, implementation will require energy, brave decisions and momentum, together with a willingness to share, good practice, innovation and learning, as it emerges, to accelerate the speed and impact of change to improve patient care.

2 Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and,

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

3 Executive Summary

It is now widely recognised that the NHS needs transformational change to services, in order to deliver better outcomes for patients and to ensure that we commission effectively.

Progress has been made in improving oral health and access to services in general. However, inequality in oral health experience and inequity in access to primary and specialist care exists. These guides focus on the commissioning and delivery of specialist care pathways; however, the gateway to specialist care relies on access to efficient and effective primary dental care services. Whilst there has been some improvement in general access over the past few years, commissioners need to ensure that they continue to meet their duties to commission primary care services appropriate to the needs of their populations. This mean making effective use of available resources by challenging primary care providers to deliver care to those who need it most and by adopting appropriate recall intervals for those who can be seen less frequently, freeing capacity for access by new patients. Achieving improvements in access to primary care will widen access to specialist care for those who need it.

NHS England has developed these guides for commissioning dental specialties to be used by commissioners to offer a consistent and coherent approach. They describe the direction required to commission dental specialist services. This will reflect the need and complexity of patient care and competency of the clinician required to deliver the clinical intervention rather than the setting within which the care is delivered. Care will be delivered via a pathway approach which will provide clarity and consistency for patients, the profession and commissioners. There will be nationally agreed minimum specifications for each service, including how quality and outcomes are to be measured, which can be enhanced locally.

They will ensure there is national consistency in the NHS commissioning offer for dental specialist services and how they are delivered. The pathway will also provide consistency across England in agreeing at a national level as much of the detail around commissioning, such as referral criteria, core data set required on referral, quality of environment and equipment, contractual frameworks etc. as well as consistent measures of quality and outcomes. The frameworks describe the concept of clinical engagement and leadership through Managed Clinical Networks (MCNs) which will work closely with commissioners, Dental Local Professional Networks (LPNs) and describe and monitor the patient journey from primary to specialist care.

The first phase of this work during 14/15 has included developing frameworks for the following specialties: Orthodontics, Special Care Dentistry, Oral Surgery/Oral Medicine and Restorative dentistry. Further work on restorative mono specialties, Paediatric Dentistry and Supporting Specialties (Dental and Maxillofacial Radiology, Oral Microbiology and Oral and Maxillofacial Pathology) will follow.

NHS England is committed to working and engaging with patients, carers and the public in a wide range of ways. Throughout this process we have ensured that people's views are heard through having patient representatives on every group and by convening a patient review group who have helped us develop the content. This is outlined in detail in the patient engagement and stakeholder engagement appendices.

Moreover, it must be understood that ultimately it is the patient who should make the decision about what treatment, if any, to undergo. The practitioner's role is to advise on treatments and options, and benefits and risks. This discussion between patient and practitioner should form the beginning of every patient journey and every specialist care pathway. That includes patient consent to the information sharing needed for their journey along a pathway.

The process of developing these patient involvement frameworks has also included engagement with every stakeholder group that has an interest in dentistry, as outlined in the acknowledgments, stakeholder engagement appendix and governance model in the appendices.

This is the beginning of a process. Locally, commissioners need to undertake work to understand the specialist services that are currently being provided, by who and where. The quality and quantity of those services, together with the impact and cost, also need to be identified before any change or procurement takes place. Many commissioners and clinician have already made progress on aspects of this approach locally. However, they need to measure themselves against enablers within each of the guides to understand what needs to happen next and agree local priorities. Commissioners will need support to identify current dental resources so decisions can be made to ensure flexibility. For example, establishing MCNs may require investment or flexibility in contracting, such as the use of Commissioning for Quality and Innovation Payments (CQUIN). The work of developing the commissioning guides has identified a number of examples of innovative solutions and exploiting flexibility in current contracting forms. Locally, commissioners will need to consider investment and contractual flexibility to support the implementation of new care pathways. The implementation of care pathways could deliver efficiency gains in some areas; however, there may be a need to consider the use of these savings as investment to pump prime change in other areas of dentistry. The next phase of this work could support the validation and sharing of solutions to harness and communicate examples of good practice and innovation. Some of the identified enablers will be more difficult to implement at a local level; however, nationally, NHS England could support identified enablers to become a reality. An example would be expanding the use of the NHS number within dentistry.

There will be a particular emphasis on helping commissioners understand the financial impact of implementing the commissioning guides, by providing an estimate for the associated upfront costs along with any expected financial savings to the NHS. The initial work will involve needs assessment, understanding current provision, enabling consistent data collection and coding. Implementation support will also include the development of a commissioning pack to encourage effective and consistent commissioning to benefit patients. Work on an additional set of guides will also take place during this phase, focusing on Paediatrics, the Supporting Specialties (Dental and Maxillofacial Radiology, Oral Microbiology, Oral and Maxillofacial Pathology) and further detail on Restorative mono-specialties (Endodontics, Periodontics, Prosthodontics).

The implementation phase will include supporting commissioners to identify what could and should be undertaken nationally or regionally and what should be supported by the Commissioning Support Unit locally. However, the first steps for commissioners on publication of these first four strategic specialist commissioning guides will be to review current local progress against the frameworks and pathways,

to assess local priorities, and agree what enablers need to be put in place, such as establishing clinical networks and referral processes.

Commissioners need to be aware that the effective implementation of needs-led dental specialist care pathways relies on maintaining and ensuring access to effective primary dental care services, particularly for those groups in the population who do not access care routinely or have additional needs. Publishing these guides is the first step in what is intended to be an iterative process. Commissioners who need to procure services in this transition can use the guides to complete needs assessment, set minimum standards and service direction and ensure that proposed outcomes and quality measures are included in service specifications. The guides, including the overarching introductory framework, can be made available to potential bidders. Tendering providers will need to include a statement in their submissions on how they will work with commissioners to comply with the requirements of the guides.

Commissioning the new pathways is intended to ensure improved access, quality of care and patient outcomes.

4 Introduction

This document is intended as a guide for the appropriate commissioning of specialist Oral Surgery and Oral Medicine services. It provides a description of the services, including the current national picture in terms of where services are based and details of workforce and training. A summarised illustrative patient journey is provided to enable commissioners to understand Oral Surgery and Oral Medicine clinical pathways. Sources of available information that enable local needs assessment and understanding of local current services provision are described. Service transformation is considered, including the implications of service redesign on the workforce. A minimum standard specification for the procurement of specialist Oral Surgery and Oral Medicine services is presented. Outcome measures that assess clinical outcomes, patient safety and patient-reported outcomes (experience) are described to enable quality of services to be assessed and reviewed.

5 Description of the specialties

5.1 Oral Surgery & Oral Medicine

The specialty of Oral Surgery deals with the diagnosis and management of pathology of the mouth and jaws that requires surgical intervention. Oral Surgery involves the treatment of children, adolescents and adults, and the management of dentally anxious and medically complex patients. Oral Surgery care is provided by Oral Surgeons and by Oral & Maxillofacial Surgeons as the clinical competencies of these two specialties overlap. The UK General Medical Council recognises 'Oral & Maxillofacial Surgery' as a medical specialty.

Oral Medicine involves diagnosis and non-surgical oral health care management of patients with chronic, recurrent and medically related disorders of the mouth and associated structures

5.2 Related specialties

Oral & Maxillofacial Surgery (OMFS) is concerned with the diagnosis and treatment of diseases affecting the mouth, jaws, face and neck. This medical specialty is unique in requiring an undergraduate qualification in both medicine and dentistry and is often seen as a bridge between the two, as OMFS specialists treat conditions that require expertise from both backgrounds. Consultants in OMFS are trained in all areas of practice within the specialty (including the management of Oral Surgery and oral medicine conditions) and many develop sub-specialist interests in more than one field.

Dental & Maxillofacial Radiology, Oral & Maxillofacial Pathology and Oral Microbiology are involved in Oral Surgery and Oral Medicine patient pathways.

5.3 Description of the current national picture

Primary care-based General Dental Practitioners (GDPs) are expected to undertake routine Oral Surgery care, such as dental extractions, as part of their general dental services contracts. More complex Oral Surgery care is provided by specialists in Oral Surgery and by Oral Surgery and Oral & Maxillofacial Surgery consultants (including academics) who may work in primary care or secondary care settings[1]. Secondary care-based Oral Surgery consultants would not normally be found in stand-alone units; rather, they would be integrated with OMFS units with the opportunity for skill-mix and multi-disciplinary team working. Postgraduate dental trainees working under consultants may also provide Oral Surgery care.

Oral Medicine clinicians are employed either by the NHS or by Universities, the latter typically being employed with an honorary status. Access to academic units offering Oral Surgery and Oral Medicine services is not readily available in all areas of the country. Typically, Oral & Maxillofacial Surgery units in General Hospitals may provide these services.

Given the overlap between Oral Surgery, Oral & Maxillofacial Surgery and Oral Medicine, the workforce within local areas may comprise a variety of performers from

[1] Kendall N. Improving access to Oral Surgery services in primary care. Primary Dental Care 2009; 16(4): 137-142.

different specialties. Depending on the decisions and information provided by the referring clinician, patients with similar Oral Surgery/ Oral Medicine conditions may be seen by a specialist in Oral Surgery, Oral & Maxillofacial Surgery or Oral Medicine. It is important that commissioners can identify which specialists are providing which services locally.

A significant proportion of referrals made to Oral Surgery specialists include dentoalveolar surgery[2] and this less complex work has caused increasing pressure on hospital consultant service waiting lists since the dental contract reforms in 2006. The recent Medical Education England Dental Programme Board Review of Oral Surgery Services and Training recommended that much of the minor Oral Surgery care could be delivered by specialists; some specialists have established primary care-based Oral Surgery services which are commissioned locally (See Appendices 7 & 8). Forceps extraction and some minor Oral Surgery is undertaken in primary care by GDPs. Some dentists, who are not on the GDC specialist list for Oral Surgery, have enhanced skills and experience in Oral Surgery (and have previously been called, 'Dentists with a Special Interest', DwSI). These individuals may perform some Level 2 procedures within an MCN.

Information regarding activity is presented in Section 8 of this document. It is important to note that data are not consistently collected across all areas of England. However, general trends in activity may be identified when comparing different data sources.

5.4 Description of training and the current workforce

The General Dental Council (GDC) describes the learning outcomes that dental professionals need to demonstrate by the end of their training to facilitate registration and approves the specialist training curricula for each of the thirteen dental specialties.

5.4.1 The Oral Surgery and Oral & Maxillofacial specialties

Since the 1980s, Oral Surgery, as practised both in the acute sector and Dental Teaching Hospitals, transformed into 'Oral & Maxillofacial Surgery' (OMFS) with a requirement for both undergraduate medical and dental training and appropriate specialist training. Clinical practice broadened to encompass diseases affecting the face and neck as well as the mouth and jaws. A training programme that excluded undergraduate medical training and the surgical management of oral malignancy was preserved for some academic surgeons. This Academic Oral and Maxillofacial Surgery programme has now been superseded by Integrated Academic Training Programmes. Oral & Maxillofacial Surgery became a recognised medical specialty in 1994.

Oral Surgery was re-introduced in the UK as a dental specialty regulated by the General Dental Council in 2009. It is an EU recognised dental specialty with EU provision for the mutual recognition of specialist training when considering applications from EU nationals for admission to the GDC specialist Oral Surgery list.[34]

[2] Coulthard P, Kazakou I, Koron R, Worthington HV. Referral patterns and the referral system for oral surgery care. Part 1: General dental practitioner referral patterns. British Dental Journal 2000;188:142-145.

[3] European Union Directive 78/686/EEC, 1978.

Given that Oral Surgery is a relatively new specialty, some clinicians on the GDC Specialist List may not have completed the classical training pathway. Additionally, at the present time, a quality assured training pathway and assessment does not exist for Level 2 clinicians for example SAS grades. This is a transition period so, in the future, with appropriate needs assessment, there may be a requirement for training. This will require the identification of appropriate funding and development of a training programme to benchmark skills and competence nationally. There will need to be a robust process in place to assess the competencies of dentists providing this care. There may also be a need to redress the balance with respect to nationally available dental specialty training posts.

5.4.2 Oral Surgery

The Oral Surgery specialist training curriculum has been developed from the Joint Committee for Specialist Training in Dentistry Specialist Advisory Committee (SAC) for Oral Surgery Guidelines for the UK. Oral Surgery is one of two dental specialties recognised by the EU and is a dental specialty regulated by the GDC and the training curriculum is defined.[5] Oral & Maxillofacial Surgery is a medical specialty regulated by the General Medical Council with a defined training curriculum.[6]

The three year specialist Oral Surgery training programme describes the knowledge, skills and attitudes required to be a specialist and for holding a certificate of completion of speciality training (CCST).[7, 8] The learning outcomes include areas such as: management of oral infections; removal of teeth/impacted teeth and management of related complications; peri-radicular surgery; biopsy techniques and treatment of intra-oral benign and cystic lesions of hard and soft tissues; management of benign salivary gland disease by intra-oral techniques and familiarity with the diagnosis and treatment of other salivary gland diseases; insertion of dental implants including bone augmentation and soft tissue management; management of dentoalveolar trauma; management of orofacial pain including temporomandibular joint disorders; and diagnosis of oral cancer and dentofacial deformity. Appropriate pain and anxiety control including the use of conscious sedation techniques is another key requirement. Appendix 3 lists Specialty Training Learning Outcomes for Oral Surgery.

On successful completion of the training programme, and having passed the Intercollegiate Membership Oral Surgery examination, an application can be made for the award of a Certificate of Completion of Specialist Training (CCST) and entry to the GDC's List of Specialists in Oral Surgery.

Substantive and Honorary UK Consultants in Oral Surgery have usually completed the Intercollegiate Specialty Fellowship Examination (ISFE) and they possess clinical competencies that differentiate them from a Specialist, which include: the management of jaw and facial fractures; congenital and acquired jaw anomalies;

[4] European Union Directive 2001/19/EC. Official Journal of the European Communities. L206, 31.07.2001
[5] General Dental Council (2010). Oral Surgery Curriculum. Available at http://www.gdc-uk.org/Dentalprofessionals/Specialistlist/Documents/Oral%20Surgery%20Curriculum%20February%202014.pdf. Accessed February 2015
[6] http://www.gmc-uk.org/Oral_and_Maxillofacial_Surgery_Syllabus_01.pdf_30538196.pdf
[7] The Royal College of Surgeons (2009). The Specialty of Oral Surgery. The Board of the Faculty of Dental Surgery. The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London, WC2A 3PE
[8] Specialist Training Committee. Oral Surgery. 2010 Specialty Advisory Committee in Oral Surgery The Faculty of Dental Surgery. The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London, WC2A 3PE.

advanced oral implantology and bone augmentation; diagnosis and treatment of anomalies and diseases of the TMJ; and, diagnosis and treatment of salivary gland diseases. These individuals also have training in management of healthcare delivery[9], competencies in research and/or critical appraisal competency and are therefore appropriately qualified to lead a MCN. Staff grade and associate specialists (SAS grade clinicians) may undertake this complex clinical work within a multidisciplinary team; however, these grades are now closed to new entrants.

In the future, consideration could be given for existing SAS grades to have the opportunity to undertake further career development and training (e.g. management of health care delivery and competencies in research and/or critical appraisal) leading to appointment to consultant grade[10].

As described in Section 5.3, Oral Surgery is also undertaken by Oral & Maxillofacial consultants who have the necessary clinical competencies to deliver the Oral Surgery procedures described in this section. They also deliver surgical care for head and neck cancers, major trauma and craniofacial deformity. The General Medical Council and Specialist Advisory Committee (SAC) for Oral & Maxillofacial Surgery oversee training for this medical specialty.

This guide relates to all Oral Surgery service provision regardless of the setting in which it is undertaken.

5.4.3 Oral Medicine

Specialty training programmes in Oral Medicine are 5-years' duration. Trainees are required to pass the Intercollegiate Specialty Fellowship Examination (ISFE) in Oral Medicine to be admitted to the Oral Medicine Specialist List. At the end of the training consultants are able to diagnose and manage the full range of Oral Medicine conditions (see Appendix 4).

The emphasis on non-surgical management is a principal difference with the surgical specialties of Oral Surgery and Oral and Maxillofacial Surgery. The scope of the specialty includes diagnosis and management of mucosal disease, salivary gland disease and orofacial pain that does not relate directly to common dental pathologies such as caries or periodontal disease. Some presentations reflect local disease whereas others are orofacial manifestations of more widespread pathology affecting different parts of the body.

Oral and Maxillofacial Surgeons may also provide Oral Medicine services.

5.4.4 Oral Surgery and Oral Medicine Specialist Workforce

Table 5.1 presents the workforce delivering Oral Surgery and Oral Medicine services (including the OMFS workforce) in the UK. Table 5.2 depicts the breakdown of the England-only medical workforce 2011-12 and includes details of planned changes. Similar Oral Surgery and Oral Medicine information (i.e. for England only) is currently not available. There is a requirement for HEE to develop this information and identify related workforce trends.

[9] Career Development Framework for Consultant Appointments in Oral Surgery. 2010 Specialty Advisory Committee in Oral Surgery, The Faculty of Dental Surgery. The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London, WC2A 3PE.

[10] Medical Education England Dental Programmes Board.(2010) Review of Oral Surgery Services and Training. Available at http://www.baos.org.uk/resources/MEEOSreview.pdf Accessed February 2015.

Table 5.1 Specialist Dental and Medical Workforce (UK) delivering Oral Surgery and Oral Medicine Services

Specialist Dental Workforce, UK			
	Trainees[11]	**Registered on Specialist List**[12]	**Consultants**
Oral Surgery	40	755*	70
Oral Medicine	17	69	38
Specialist Medical Workforce, UK[13]			
	Trainees	**SAS grade****	**Consultants**
OMFS	137	347	322

* This figure includes OMFS consultants, trainees, and mediated entry,
** SAS grade figure includes staff grade, clinical assistant, associate specialist, trust grade and hospital practitioner numbers.

Table 5.2 Specialist Medical Workforce (England only) delivering Oral Surgery and Oral Medicine Services

Specialist Medical Workforce, England only (planned changes to workforce)[14]			
	Trainees	**SAS grade*****	**Consultants**
OMFS	122 (+4)	296 (-6)	270 (+20)

***SAS grade figure includes staff grade, clinical assistant, associate specialist, trust grade and hospital practitioner numbers.

5.5 Description of the complexity levels

The Department of Health Advanced Care Pathway Working Group defined procedures and modifying patient factors that describe the complexity of a case. The levels of complexity do not describe contracts, or practitioners or settings. Levels 1, 2 and 3 care descriptors reflect the competence required of a clinician to deliver care of that level of complexity.

Level 1 care complexity outlines the skill set and competencies a dentist covers on completion of undergraduate and dental foundation training. Therefore commissioners would expect that level of competence as a minimum standard for performers on the NHS performer list. Most practitioners develop interests, skills and competence with experience. The majority of GDPs operate above this level in a

[11] GDC Annual Report (2013). Available at: http://www.gdc-uk.org/newsandpublications/factsandfigures/Pages/default.aspx Accessed February 2015
[12] General Dental Council Facts and Figures (October 2014) Available at: http://www.gdc-uk.org/Newsandpublications/factsandfigures/Documents/Facts%20and%20figures%20from%20the%20GDC%20register%20October%202014.pdf Accessed February 2015
[13] Medical Education England Dental Programmes Board.(2010) Review of Oral Surgery Services and Training. Available at http://www.baos.org.uk/resources/MEEOSreview.pdf Accessed February 2015.
[14] BAOMS UK Workforce Survey (2011-12)

number of the specialist areas.

This guide outlines the strategic framework for delivery of an Oral Surgery and Oral Medicine (specialist) patient care pathway. Many practitioners in primary care who are not on the specialist list deliver care at Level 2. Commissioners expect the same standards of quality and outcome regardless of the provider or setting. Every practitioner delivering care on referral will be expected to have a formal link with a consultant-led MCN and to complete a defined number of cases per annum as a minimum requirement to maintain competence.

Clinicians should be competent to provide a specific Oral Surgery procedure and manage any complications that may arise before proceeding. Any procedure should be planned as part of a comprehensive treatment plan and consideration should be given to a multi-disciplinary approach where appropriate.

The MCN will operate to assure quality of care and patient safety. This is a period of transition so it is likely that local circumstances will change as more data become available with respect to local needs.

The level of complexity may change depending upon one or more of the following factors:

- Medical History;
- Social;
- Patient anxiety;
- Other patient-associated modifiers.

Level 1 – Procedures/conditions to be performed or managed by a clinician commensurate with a level of competence as defined by the Curriculum for Dental Foundation Training or equivalent. This is the minimum that a commissioner would expect to be delivered in a primary care NHS Mandatory contract. Many dentists with experience have competencies above this. For more detail around levels of care, please refer to the overarching guide for commissioning specialist services.

Level 2 – • Level 2 care is defined as procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register. This care may require additional equipment or environment standards but can usually be provided in primary care. Level 2 complexity may be delivered as part of the continuing care of a patient or may require onward referral. Providers of Level 2 care on referral will need a formal link to a specialist to quality-assure the outcome of pathway delivery.

Level 3a – Procedures/conditions to be performed or managed by a clinician recognised as a specialist at the GDC defined criteria and on a specialist list; **OR** by a consultant.

Level 3b – Procedures/conditions to be performed or managed by a clinician recognised as a consultant in the relevant specialty, who has received additional training which enables them to deliver more complex care, lead MDTs, MCNs and deliver specialist training. The consultant team may include trainees and SAS grades. Oral Surgery is to be delivered by Consultants in Oral & Maxillofacial Surgery who have the necessary competencies. Where OMS consultants are not registered with the GDC, they will not be eligible for performers' list. Some OMFS consultants

will be included in both the GMC and GDC specialist list; others will only be included in GMC specialist register.

Level 1 and 2 procedures are usually performed in primary care settings. However, some Level 1, 2 and 3 procedures may be performed in a secondary care setting if modifying patient factors or local circumstances require this e.g. requirement for skill mix and/or multidisciplinary team and/or general anaesthetic. Draft frameworks of complexity levels with respect to Oral Surgery and Oral Medicine procedures are presented in Tables 5.3 and 5.4 respectively. Competencies of clinicians for each of the three levels of care are described in Appendix 5.

Table 5.3 Draft Framework of Oral Surgery Complexity Levels and Procedures

N.B. This table will be updated when the revised Curriculum for Foundation Training is published. A Department of Health Advanced Care Pathway Group developed and agreed initial levels of complexity for Oral Surgery procedures. These have been reviewed and enhanced as part of the development of this document. Commissioners should look to the MCN for clinical advice and guidance with respect to appropriate delivery of procedures by clinicians. Appropriate remedial action plans need to be in place to enable practitioners to develop skills so they are able to deliver appropriate levels of care.

LEVEL 1 procedures/conditions

Extraction of erupted tooth/teeth including erupted uncomplicated third molars

- Effective management, including assessment for referral unerupted, impacted, ectopic and supernumerary teeth
- Extraction as appropriate of buried roots (whether fractured during extraction or retained root fragments),
- Understanding and assistance in the investigation, diagnosis and effective management of oral mucosal disease
- Early referral of patients (using 2-week pathway) with possible pre-malignant or malignant lesions
- Management of dental trauma including re-implantation of avulsed tooth/teeth
- Management of haemorrhage following tooth/teeth extraction
- Diagnosis and treatment of localised odontogenic infections and post-operative surgical complications with appropriate therapeutic agents
- Diagnosis and referral patients with major odontogenic infections with the appropriate degree of urgency.
- Recognition of disorders in patients with craniofacial pain including initial management of temporomandibular disorders and identification of those patients who require specialised management

LEVEL 2 procedures/conditions

- Surgical removal of uncomplicated third molars involving bone removal
- Surgical removal of buried roots and fractured or residual root fragments
- Management and surgical removal of uncomplicated ectopic teeth (including supernumerary teeth)
- Management and surgical exposure of teeth to include bonding of orthodontic bracket or chain
- Surgical endodontics
- Minor soft tissue surgery to remove apparent non-suspicious lesions with appropriate histopathological assessment and diagnosis.

LEVEL 3 procedure/conditions

- Procedures involving soft/hard tissues where there is an increased risk of complications (such as nerve damage, displacement of fragments into the maxillary antrum and fracture of the mandible)
- Management and/or treatment of salivary gland disease
- Surgical removal of tooth/teeth/root(s) that may involve access into the maxillary antrum
- Management of temporomandibular disorders and craniofacial pain that have not responded to initial therapy
- Treatment of cysts
- Management of suspicious/non-suspicious oral lesions
- The placement of dental implants requiring complicated additional procedures such as bone grafting, sinus lifts etc.
- Treatment of complex dentoalveolar injuries
- Management of spreading infections and incision of abscesses (or abscess) requiring an extra-oral approach to drain

Depending on the complexity of the procedure, consultant-led care may be required to manage any of the above and, in addition, is required for the procedures listed below. These procedures will be delivered within a team (which may include specialist trainees, specialists and SAS grades) who have appropriate ability and facilities to provide high quality care for patients:

- management of jaw and facial fractures
- management of congenital and acquired jaw anomalies
- advanced oral implantology and bone augmentation
- diagnosis and treatment of anomalies and diseases of the TMJ
- diagnosis and treatment of salivary gland diseases.

Table 5.4 Draft Framework of Oral Medicine Complexity Levels and Procedures

LEVEL 1 procedures/conditions

Recognition of conditions within the scope of Oral Medicine clinical practice, which include the predominantly non-surgical recognition and provision of immediate care of:

- Oral mucosal changes presenting as red, white, red/white, ulcerated, vesicular/bullous, pigmented lesions or soft tissue swelling, which may be asymptomatic or an incidental finding;
- Changes in saliva and salivary gland presenting as oral dryness, excess saliva or salivary gland swelling;
- Orofacial pain/dysaesthesia/paraesthesia/numbness not due to typical dental disease (caries and periodontal disease), altered oral sensations and other neurological abnormalities.

Recognition of situations where the presenting complaint indicates referral, appropriate timing of this and choice of service:

- Priority: Suspicion of cancer (2-week pathway) or other conditions which may be life threatening if undiagnosed, such as vesiculobullous disease, HIV or trigeminal neuralgia, allergic or immunologic conditions and other underlying complex systemic disease;
- Co-morbid illness that may influence management of the presenting complaint.

Initiation of care (e.g. identify & address concerns, information, oral hygiene, 1st line topical treatments) with appropriate follow-up and/or referral.

LEVEL 2 procedures/conditions

Level 2 care should be provided for patients with complaints who fall within the scope of practice and require:

- Re-evaluation of diagnosis and the care pathway;
- Standardised assessment with respect to the need for Level 3 input with referral as appropriate;
- Initiation and evaluation of management not requiring Level 3 input;
- Management as directed by Level 3.

LEVEL 3 procedure/conditions

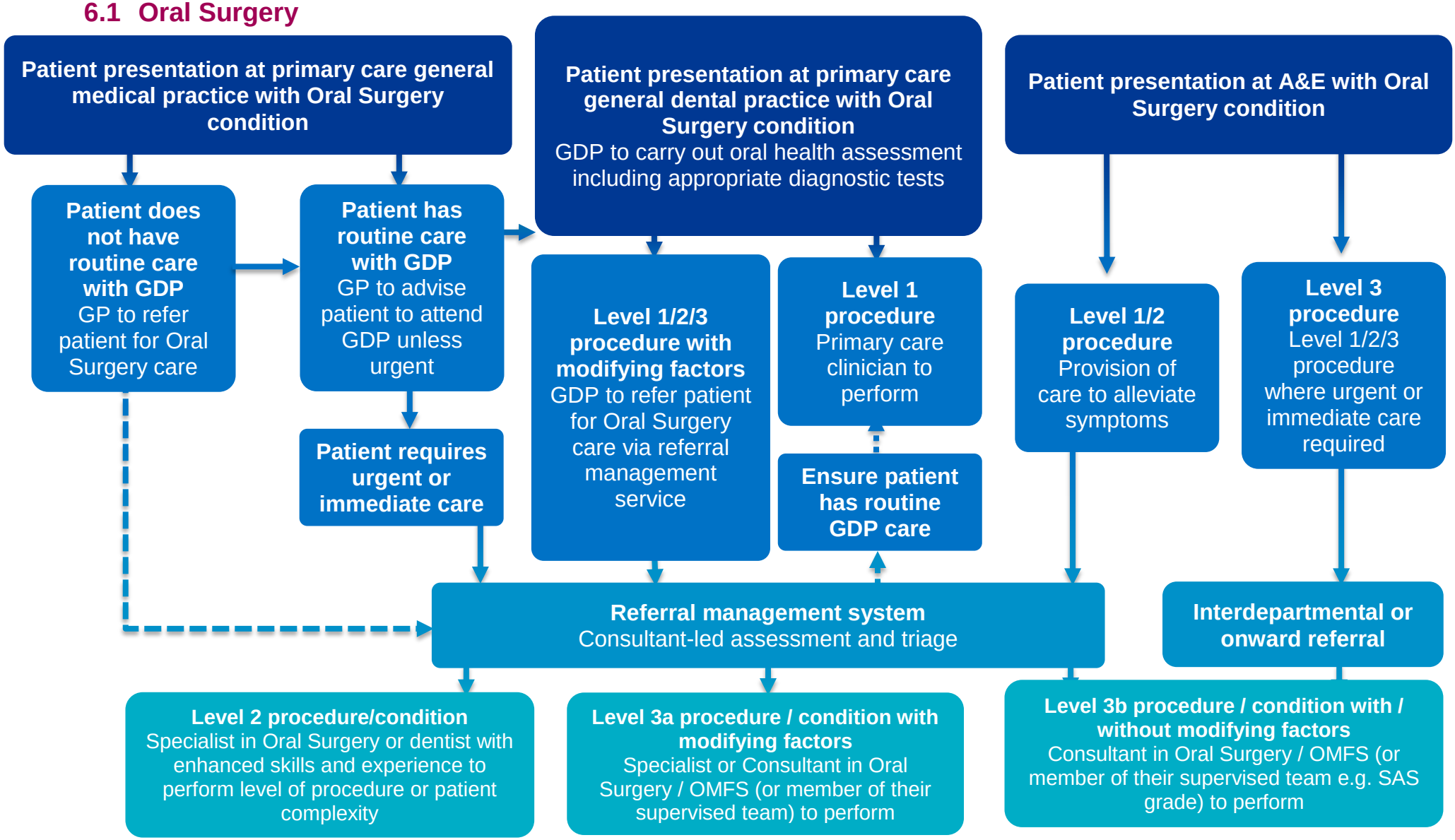
Level 3 care should be provided for patients with complaints that fall within the scope of practice where:

- The diagnosis is unclear.
- Interventions have not achieved a satisfactory outcome.
- The presenting complaint may represent an orofacial manifestation of a systemic or multi-site illness, or mental health issue.
- Management is complicated by significant co-morbid illness (physical or mental health) or the management of this.
- Management requires potent topical or systemic interventions (such as immune-modulating drugs and drugs used for pain-control or altered sensations).
- Multi-disciplinary or multi-professional management is indicated.

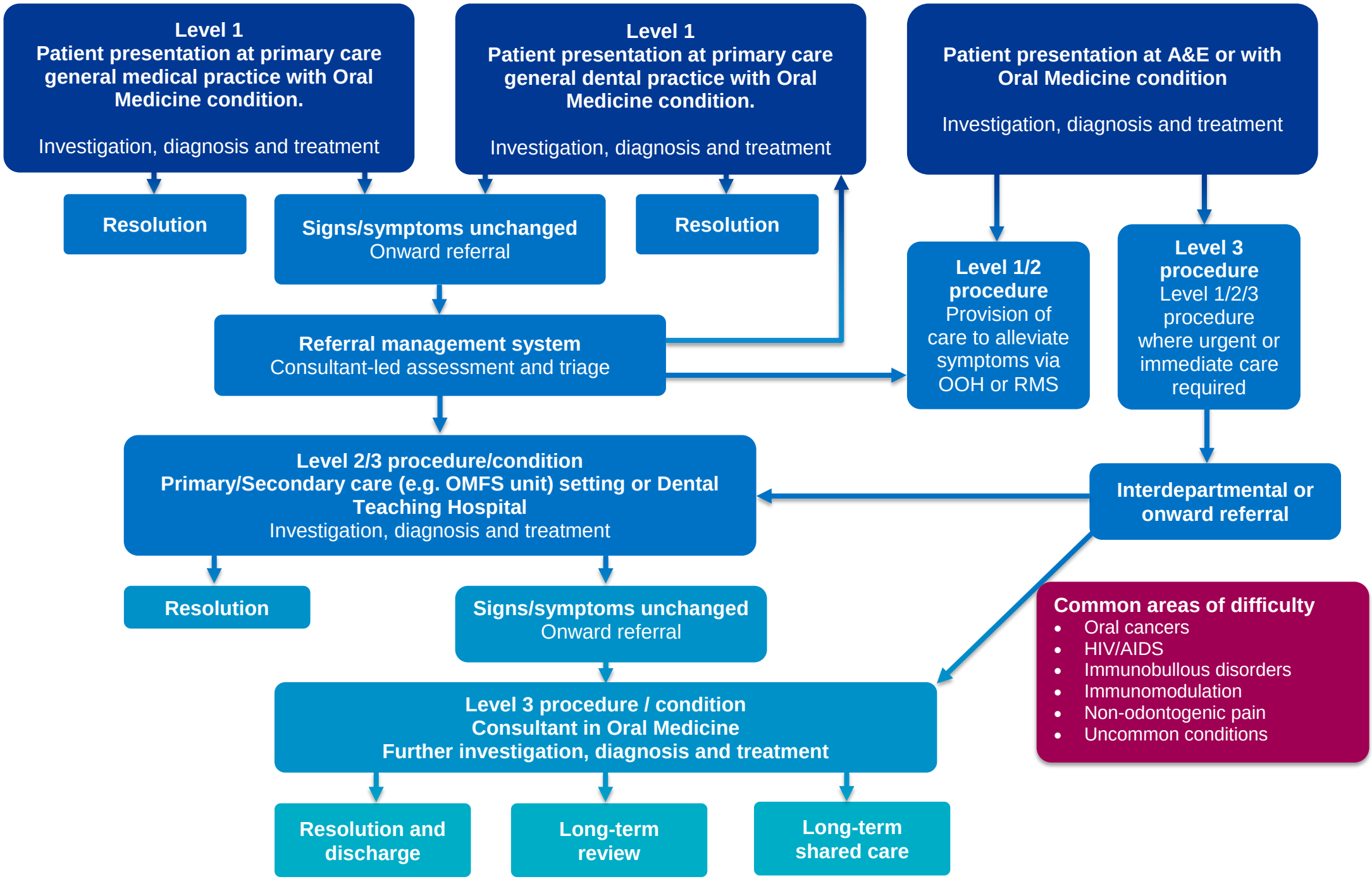
6 Summarised Illustrative Patient Journeys

NB. If an oral cancer is suspected or there is a suspicious head and neck (includes salivary gland) mass etc., the patient should be referred as per (2 week) Cancer Referral Pathway wait criteria to a head and neck oncology service.

6.1 Oral Surgery



6.2 Oral Medicine



7 Commissioning Oral Surgery & Oral Medicine services

An MCN will be established to oversee the implementation and the functioning of the specialist pathway, including quality improvement, mentorship, education, audit and leadership. The Chair will be accountable to commissioners and will be linked to the Dental LPN. It will be consultant-led where possible and all Level 2 and 3 Oral Surgery/Oral Medicine providers will play an active role and will have a formal link to the MCN.

This Oral Surgery and Oral Medicine commissioning guide has been developed to provide a framework to support commissioners working with clinicians and patient to transform services at a local level, meeting local needs and achieving best value and sustainability for the resources available.

This document includes a care pathway for Oral Surgery and Oral Medicine services describing consistent national elements for Oral Surgery and Oral Medicine delivery, regardless of setting. This is to ensure a focus on patient outcomes and greater consistency in delivery of Oral Surgery and Oral Medicine services, both in the sequencing, effectiveness and quality of clinical care and the 'journey' that patients experience.

Local delivery of Oral Surgery and Oral Medicine services is generally based on the model that was 'inherited' from PCTs. However, with commissioners and clinicians working with MCNs and Dental LPNs, work can begin to influence national frameworks as they emerge, promoting innovation, best practice, and sharing expertise to get the best 'local fit' at a pace and skill that reflects local circumstances.

Oral Surgery and OMFS are linked and often delivered from the same unit, so there is a need to understand what elements and resources are attributable to each in order to robustly plan and commission Oral Surgery services and ensure there is an appropriately trained and competent workforce.

Many of the consultants in OMFS perform procedures that fall within the Oral Surgery remit and junior staff and trainees perform Oral Surgery procedures as part of long-established training schemes. A significant proportion of procedures currently carried out in many secondary care services can and should be delivered by specialists and dentists in a primary care setting. Oral Surgery is of particular note, where there is scope for a strategic approach to redesign. A significant proportion of referrals in some OMFS units (up to 80%)[15] are for Oral Surgery and approximately 20% specifically require the services of an Oral and Maxillofacial Surgeon. This does not equate to the same proportion of a budget or resource as OMFS activity is more complex, more time-consuming and generally higher cost. Whilst this means accessibility for specific OMFS services remains good, the need for Oral Surgery is much greater in terms of quantity of cases.

Where Level 2 care can be delivered in a non-hospital setting (unless it is required for training purposes) a consultant-led MCN can work to ensure consistent quality of care and equitable cost of delivery.

[15] Medical Education England Dental Programme Board (2010) Review of Oral Surgery Services and Training. Available at: http://www.baos.org.uk/resources/MEEOSreview.pdf Accessed February 2015.

Transformation of services needs to reflect local circumstances with respect to availability of skill mix and local population's need for Oral Surgery.

8 Understanding need and current service provision

Oral health needs assessments for complex interventions, including Oral Surgery and Oral Medicine, are currently poorly described. Need, as opposed to demand, is based on the proportion of the population who, at any time, present with Oral Surgery or Oral Medicine requirements. There are guidelines that define some elements of Oral Surgery need, e.g. NICE guidelines relating to the removal of third molars.[16][17] However, for the majority of Oral Surgery procedures and Oral Medicine conditions, no specific needs assessments or guidelines exist. Therefore, commissioners and consultants in dental public need to rely on proxy measure and service activity data.

8.1 Local population profile

Information regarding Oral Health needs assessment for all specialist dental services can be found in the NHS England publication, *Guide for Commissioning Specialist Dentistry Services.* Commissioners are advised to be familiar with the sources of information available that can assist them in assessing the dental needs of the local population e.g. population number, residency, age, population growth, ethnicity, deprivation, lifestyle and prevalence of oral diseases and conditions.

8.2 Needs assessment data specific to the commissioning of Oral Surgery and Oral Medicine specialist services

8.2.1 Co-morbid conditions

Commissioners need to ascertain the proportions of the local population who have physical disabilities, mental health conditions or chronic health conditions that may be modifying factors for the provision of Oral Surgery and Oral Medicine care e.g. obesity, cardiovascular disease, diabetes, COPD, asthma, epilepsy, infectious diseases (HIV, Hep B/C etc.), drug dependencies, those taking anticoagulant and bisphosphonate therapies.

Local health profiles can be accessed from the Public Health England website.[18]

8.2.2 Sources of Oral Surgery and Oral Medicine referrals

In addition to considering the quantity of service activity required to meet the needs of a population it is important for commissioners to consider the placement of services and appropriate models of service delivery, ensuring optimal patient experience. With this in mind, it is essential to consider the location of sources of referral.

[16] National Institute of Clinical Excellence (2000) Guidance on the Extraction of Wisdom Teeth. Available at: http://www.nice.org.uk/guidance/ta1/resources/guidance-guidance-on-the-extraction-of-wisdom-teeth-pdf Accessed February 2015

[17] McArdle W, Renton T. The effects of NICE guidance on the management of third molar teeth. British Dental Journal 2012;213: 228-229.

[18] Public Health England website http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

The majority of elective specialist referrals are made by GDPs. Local (FP17) data regarding these can be requested from the NHS Business Services Authority.

Given that general medical practitioners (GMP) may be an additional source of referrals for specialist dental care, it would also be reasonable to map GMP practices. Information regarding general and personal medical services in England is available from the Health and Social Care Information Centre.[19]

8.2.3 Urgent and Emergency Oral Surgery Referrals

With respect to urgent or emergency referrals, it is essential to ascertain Oral Surgery-related attendances at local Accident and Emergency Departments. In England during the period 2012-2013, there were 47,947 recorded attendances of patients with OMFS conditions at Accident and Emergency Departments of which 13,873 (28.9%) had a dental investigation.[20] Locally, commissioners will need to interrogate these data for their local area.

8.2.4 Indices of Need

The PUFA index describes the presence of open pulp, ulceration, fistula, and abscesses in the mouth and was used in the most recent Adult Dental Health Survey.[21] Presence of any of the PUFA index features indicates a likely requirement for Oral Surgery or Oral Medicine assessment and treatment.

Seven per cent of dentate adults were found to have one or more PUFA lesions, most commonly an open pulp (4%). Ulceration related to decayed teeth was observed in 1% of dentate adults. Fistula or abscess in permanent dentition was present in 2%.

A positive PUFA score (i.e. any symptoms) was associated with socio-economic classification. A positive score was also more common among those who reported only seeing a dentist when they were symptomatic; it was also related to the length of time since last seeing a dentist. PUFA was related to both current and long-term pain.

8.2.5 Adult Dental Health Survey Findings

The Adult Dental Health Survey 2009 reported that 8% of dentate adults were found to have one or more untreated teeth with unrestorable decay i.e. require Oral Surgery treatment. Those with unrestorable decay had an average of 2.2 teeth in this condition.

[19] Health and Social Care Information Centre http://www.hscic.gov.uk/catalogue/PUB13849/nhs-staf-2003-2013-gene-prac-rep.pdf
[20] Health and Social Care Information Centre http://www.hscic.gov.uk/catalogue/PUB13464
[21] Health and Social Care Information Centre. Executive Summary: Adult Dental Health Survey 2009 http://www.hscic.gov.uk/catalogue/PUB01086/adul-dent-heal-surv-summ-them-exec-2009-rep2.pdf

8.2.6 Local Oral Surgery and Oral Medicine Workforce

Commissioners need to ascertain the composition of the workforce delivering Oral Surgery and Oral Medicine services locally i.e. the numbers of GDPs, dentists with enhanced skills and experience, Oral Surgery specialists, Oral Surgery consultants, OMFS Surgery Consultants, Oral Medicine consultants, SAS grades and Oral Surgery/Oral Medicine/OMFS trainees.

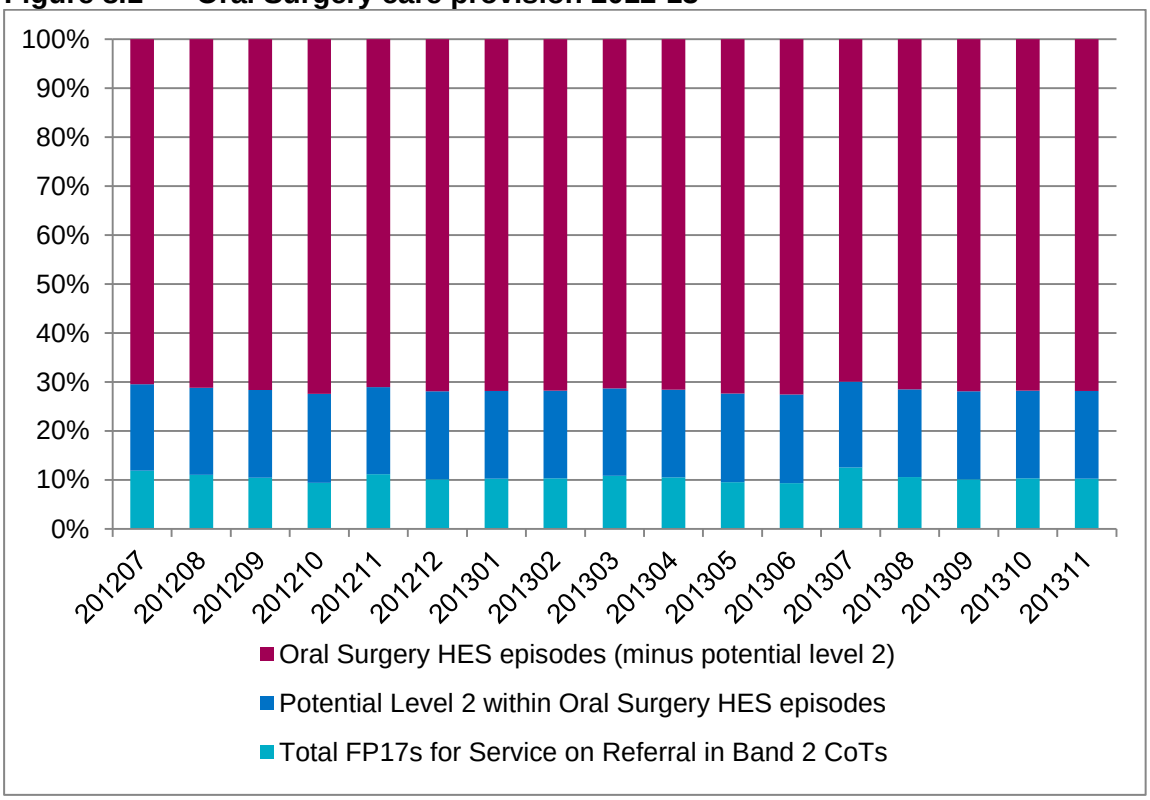
8.2.7 Current Oral Surgery Care Provision

Commissioners can request detailed FP17 data from the NHS BSA to get an idea of the numbers of Band 2 and Band 3 courses of treatment that include dental extractions and those that are for treatment on referral and, of those, the number that included provision of sedation.

Hospital Episodes Statistics (HES) data can provide an overview of the care provided in secondary care and the potential for deflection of patients with less complex Oral Surgery needs to primary care-based general dental practitioners, dentists with enhanced skills and competence and Oral Surgery specialists.

As an example, Figure 8.1 utilises FP17 data from the NHS BSA and also secondary care HES data that combine code 140 (Oral Surgery) and code 144 (Maxillo-Facial Surgery) episodes of care.

Figure 8.1 Oral Surgery care provision 2012-13[22]



There are a number of caveats associated with the data presented: it is intended to provide an indication of activity, rather than precise figures. These data assume that the period July 2012 to November 2013 is representative of Oral Surgery activity. In fact, this period covers NHS transition and so may not be a true picture of long-term activity; rather, it presents an indication of seasonal trends.

[22] Data from Information Service NHSBSA September 2014 and NHS England Informatics

Band 2 treatments on referral are assumed to be predominantly for Oral Surgery; however, it is acknowledged that a proportion of Band 2 treatments on referral may be for other dental specialties e.g. restorative.

It is also assumed that approximately 30% of secondary care Oral Surgery procedure codes represent Level 2 procedures, which have the potential to be delivered in a primary care setting, if that aligns with local circumstances. However, of these cases, 30% may be for patients with modifying factors that require Level 3 care and a secondary care setting. This presents a potential deflection of 20% of cases to primary care which correlates with referral management outcomes in regions that have implemented central referral and triage systems. Local needs assessment and understanding case complexity and current services is required as a first step in any pathway implementation. A focus on procedural complexity alone from secondary care data returns will be insufficient for service redesign. Related financial assumptions become more complex, as it is very difficult (if not impossible) to reflect the cost of the Primary Care Activity. Similarly when considering Secondary Care costs, the tariff of what 'deflected' episodes might cost is extremely difficult.

8.2.8 Current Oral Medicine Service Provision

Oral Medicine provision is fragmented and largely dependent on proximity to a Dental Teaching Hospital with a consultant-led Oral Medicine team. If patients do not have easy access to such a service, they may be referred to a local non-specialist service e.g. Oral Surgery or OMFS department. Patients initially managed by other dental and medical specialties may be referred to specialist Oral Medicine services.

In the current overall population, Oral Medicine need at all levels could be assessed, but underestimated, by analysing the total number of Oral Medicine related cases seen in:

- Consultant-led OMFS services (around 17%-39% of all outpatient clinical activity);
- Consultant-led Oral Surgery services;
- Consultant-led Oral Medicine services (data available from NHS Trusts).

Individual Oral Medicine need at case complexity Levels 1, 2 and 3 would require a more detailed analysis of clinical activity.

8.3 Tools which enable more precise Oral Surgery and Oral Medicine needs assessment

In order to capture the need within a defined population, deployment of a referral management system that utilises consultant-led triage is recommended. This approach enables all referrals for Oral Surgery and Oral Medicine to be captured and categorised into Levels 1, 2 or 3 (relating to the provider delivering the care). Initially, there is no requirement to divert patients to alternative services or settings; the system simply generates the health needs assessment. Consideration should be given to ensure that sedation need is captured at this stage. An assessment tool has been developed to support clinician decision-making with respect to the provision of conscious sedation and to enable commissioners to identify the proportion of patients

who need sedation in order to receive dental care.[23] A published study suggests that around 7% of the general population may need sedation for dental care but the proportion who require sedation services specifically for Oral Surgery care is not known.[24, 25, 26, 27]

If referral management is not currently in place, it is recommended that a newly-introduced system should operate for a minimum 3-6 months to enable a rich data set of needs to be generated. Determining the numbers of Level 1, 2 and 3 cases can enable an informed commissioning decision to be made with respect to provision of care in the appropriate setting given local circumstances, procurement of additional services (if required), contract management, support and training. The data can inform discussions with secondary care establishments regarding activity and contracts to prevent destabilisation of existing provider units.

A referral management system can also be used to manage secondary care waiting time pressures by appropriately redirecting Level 2 care to established specialist primary care providers. Should additional services prove necessary, the referral management system can respond to a new directory of services by diverting cases where appropriate.

Referral management systems have been used successfully in a number of former PCTs. Examples of referral management systems and data are presented in Section 8.5.

8.4 Service analysis

8.4.1 Provision of Oral Surgery care by primary care dental practitioners

NHS Dental Statistics data (Table 8.1) indicates that almost one-fifth of Band 2 and Band 3 courses of treatment (CoT) 2013/14 included dental extractions (around 8% of the total 39.8 million CoT delivered in 2013/14). Data indicate little change compared with the period 2012/3.

[23] Coulthard P, Bridgman C, Gough L, Longman L, Pretty IA, Jenner T. Estimating the need for dental sedation. 1.The Indicator of Sedation Need (IOSN) - a novel assessment tool. British Dental Journal 2011;9:211(5):E10.

[24] Pretty IA, Goodwin M, Coulthard P, Bridgman C, Gough L, Sharif MO. Estimating the need for dental sedation. 2. Using IOSN as a health needs assessment tool. British Dental Journal 2011;211(5):E11.

[25] Goodwin M, Coulthard P, Pretty IA, Bridgeman C, Gough L, Sharif MO. Estimating the need for dental sedation. 4. Using IOSN as a referral tool. British Dental Journal 2012;212(5):E9.

[26] Goodwin M, Pretty M. Estimating the need for dental sedation. 3. Analysis of factors contributing to non-attendance for dental treatment in the general population across 12 English primary care trusts. British Dental Journal 2011;211(12):599-603.

[27] Goodwin M, Pretty M. Estimating the need for dental sedation. 3. Analysis of factors contributing to non-attendance for dental treatment in the general population across 12 English primary care trusts. British Dental Journal 2011;211(12):599-603.

Table 8.1 Proportion (%) of adult courses of treatment that included extractions[28]

Band 1		Band 2		Band 3		Urgent		TOTAL (All CoT)	
2012/13	2013/14	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14
0.0	0.0	18.6	18.7	17.0	17.1	5.2	4.9	7.9	7.8

8.4.2 Secondary Care Oral Surgery and Oral Medicine activity

Scrutiny of Service Level Agreement Monitoring (SLAM) and Contract and Information Shared Services Unit (CISSU) data reveal variation between Acute Trusts in the recording and coding of the presenting needs and classification of patients and in the procedures delivered. This prevents commissioners from clearly understanding local needs and activity undertaken.

As part of the development of a single operating model, it is essential that there is robust intelligence data that can be benchmarked and reliably inform commissioning decisions. There is an opportunity within the existing coding and tariff framework to develop a consistent approach to coding and the delivery of a consistent commissioning data set.

Whilst currently available data may be flawed if patients are not classified consistently between Acute Trusts, it is not possible to identify emerging trends which act as a starting point on which commissioners can base decisions. Local needs assessments should include discussions with secondary care providers regarding the accuracy of coding. In the future, more consistent data collection can further inform needs assessments.

In order to inform this, and other dental specialty commissioning guides, a comparative analysis of dental activity by treatment function code was requested from NHS England Analytics Team. This information can improve consistency in coding of dental activity and any variation of clinical setting in which dental activity is delivered.

Region level summaries of secondary user service (SUS) data were extracted. Inpatient and outpatient activity data occurring between April 2012 and November 2013 were extracted for the treatment function listed in Table 8.2

Table 8.2 Treatment function codes for dental and associated specialties

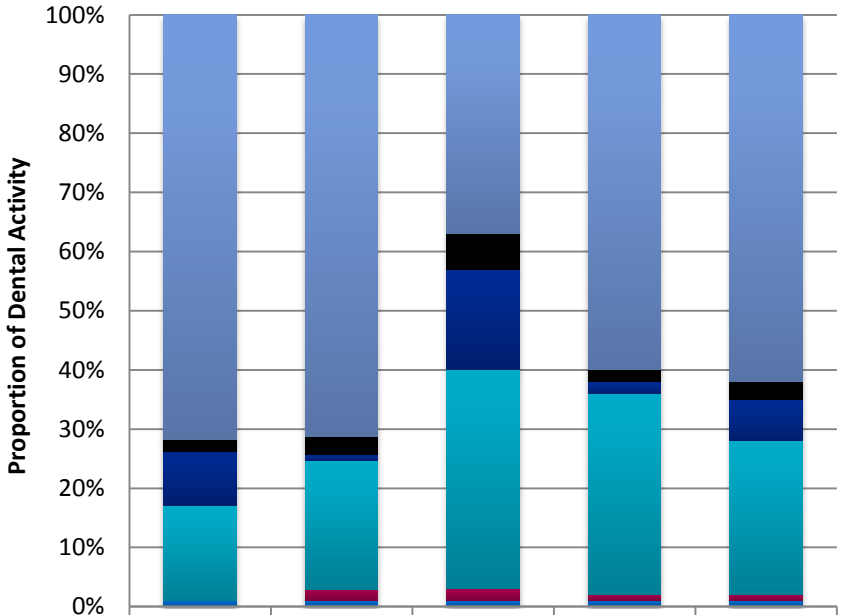
Code	*Treatment Function*
140	ORAL SURGERY
141	RESTORATIVE DENTISTRY
142	PAEDIATRIC DENTISTRY
143	ORTHODONTICS
144	MAXILLO-FACIAL SURGERY
217	PAEDIATRIC MAXILLO-FACIAL SURGERY
450	DENTAL MEDICINE SPECIALTIES

There is variation in the proportion of inpatient activity by dental treatment function code by region (See Figure 8.2). The highest proportion of activity is coded as Oral

[28] NHS Dental Statistics for England 2013-14 Report. Available at: http://www.hscic.gov.uk/catalogue/PUB14738/nhs-dent-stat-eng-13-14-rep.pdf. Accessed February 2015

Surgery (140). The proportion of activity coded as Oral Surgery ranges between 60 and 72% outside London. For London, the proportion coded as Oral Surgery is lower at 37% and the region has a greater proportion of treatment coded as maxillofacial surgery (37%) compared to other Regional Teams. The apparent lack of Oral Medicine activity may reflect the predominantly outpatient bases of this specialty and its delivery by Oral Surgery and OMFS units, where no local Oral Medicine consultant-led services exist.

Figure 8.2 Proportion of dental inpatient activity by treatment code[29]



	North	Midlands & East	London	South	ENGLAND
ORAL SURGERY	71	72	37	60	62
RESTORATIVE DENTISTRY	2	3	6	2	3
PAEDIATRIC DENTISTRY	9	1	17	2	7
ORTHODONTICS	0	0	0	0	0
MAX-FAC SURGERY	16	22	37	34	26
PAEDIATRIC MAX-FAC SURGERY	0	2	2	1	1
DENTAL MEDICINE SPECIALTIES	1	1	1	1	1

8.4.3 Patient classification

The patient classification is a fundamental stage in the process to enable commissioners to interpret data from SUS and HES. At present, the manner in which data are coded for patients (and the resulting tariff) differs between outpatients and day case/inpatients. It is therefore essential patients are classified correctly. Table 8.3 presents the definitions proposed from the APC data dictionary national codes:

[29] Unpublished Data from NHS England Regional analysis of secondary care dental activity.

Table 8.3 Patient Classification

Admission type	Definition	Patient Classification
Ordinary admission	A patient not admitted electively and any patient admitted electively with the expectation that they will remain in hospital for at least one night, including a patient admitted with this intention who leaves hospital without staying overnight. A patient admitted electively with the intent of not staying overnight, but who does not return home as scheduled, should be counted as an ordinary admission	**INPATIENT**
Daycase admission	A patient admitted electively during the course of the day with the intention of receiving care who requires the use of a hospital bed but not overnight and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission	**DAY CASE**
Regular day admission	A patient admitted electively during the day as part of a series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classed as an ordinary admission. The series of regular day admissions ends when the patient no longer requires frequent admissions	**OUTPATIENT**

8.4.4 Further service analysis detail using the North as an example

The following data relate to Oral Surgery procedures performed in Greater Manchester and uses HES data, which may be different to local SUS data. Some anomalies are apparent, e.g. lack of outpatient data for DDT region. Total Oral Surgery inpatient episodes, episodes by admission type and common procedure codes are presented in Figure 8.3, Figure 8.4, Table 8.4 and Figure 8.5 respectively.

Where financial values are calculated, this is based on the HRG tariff for the episode. Other costs may be incurred, so these figures should be read with caution until validated by finance teams. The ‘common procedures’ are based on work in Greater Manchester. It is an estimation of the procedure codes which could be mapped to Level 1 (i.e. suitable for primary care setting). It is not comprehensive and should be read as indicative only.

Figure 8.3 Oral Surgery Inpatient Episodes (per 1,000 weighted population)

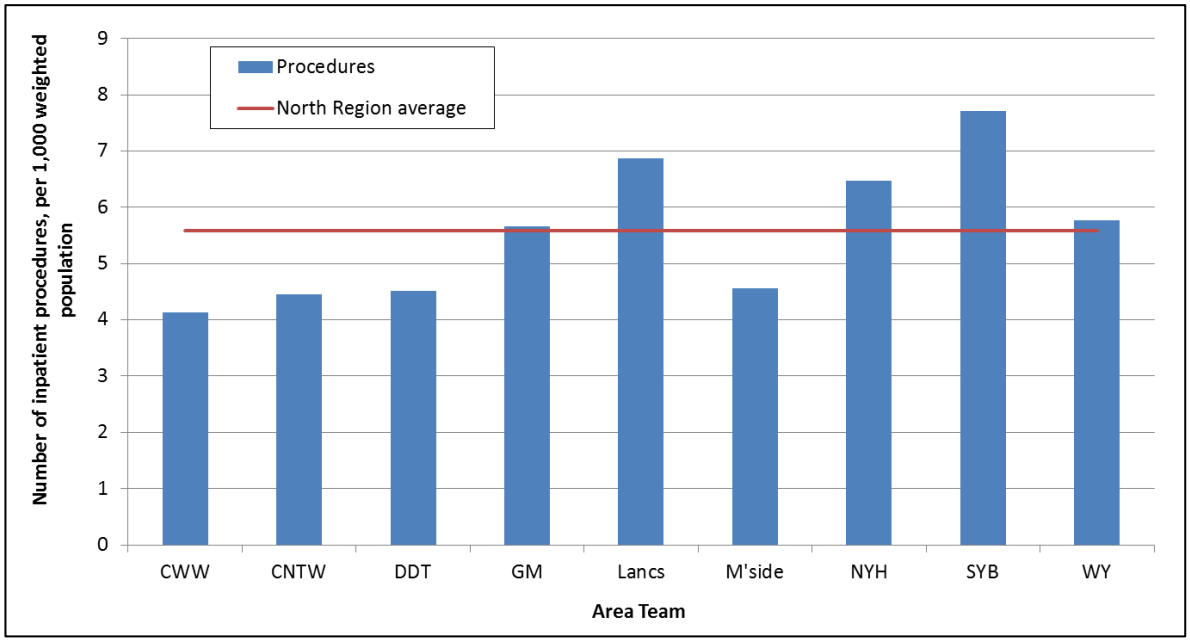


Figure 8.4 Oral Surgery Inpatient episodes by admission type (per 1,000 weighted population)

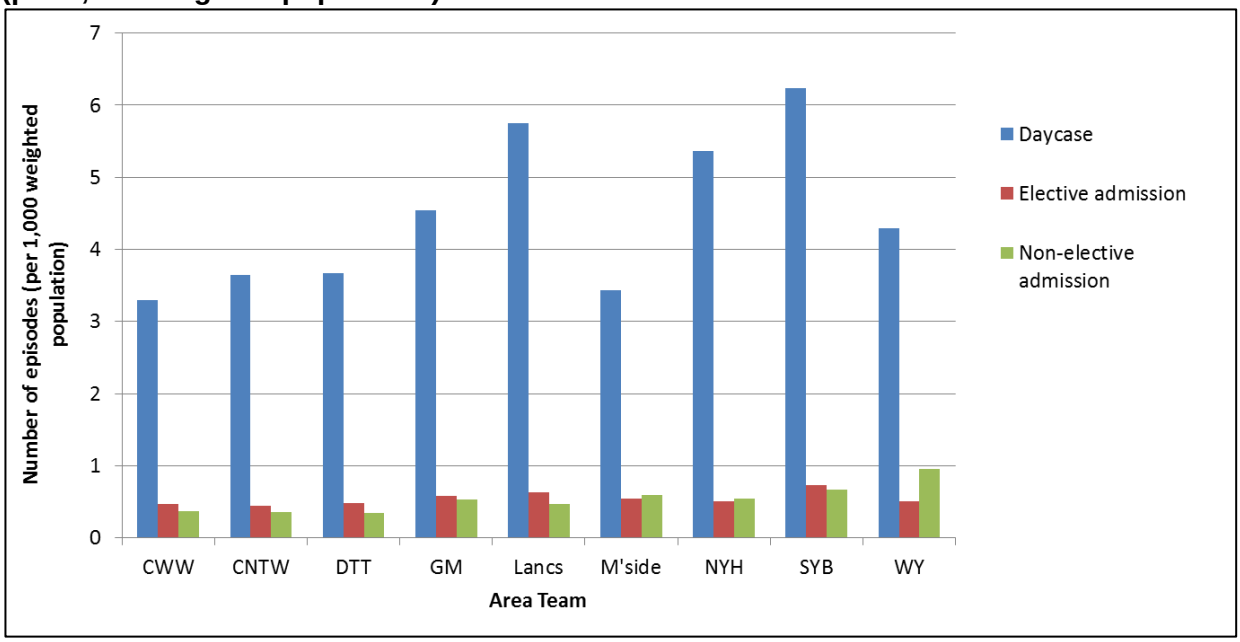


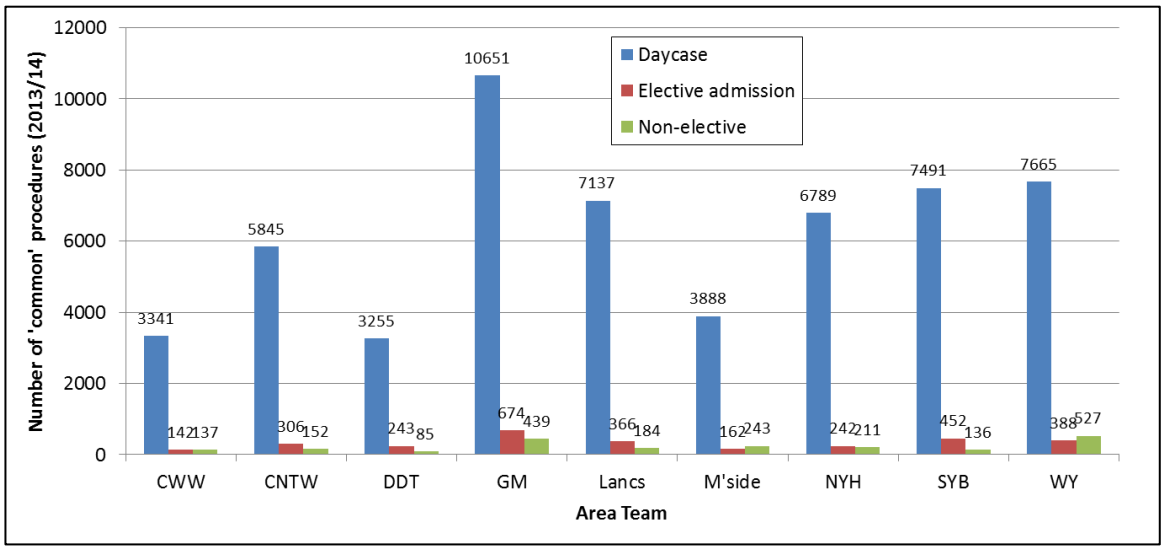
Table 8.4 The 'common' procedures performed in outpatient settings in the North Region during 2013/14 - Codes 140 and 144 OMFS/OS

Procedure	No. performed (13/14)
Unspecified simple extraction of tooth	3952
Extraction of multiple teeth NEC	2970
Biopsy of lesion of mouth NEC	2573
Surgical removal of wisdom tooth NEC	2399
Surgical removal of tooth NEC	2356
Surgical removal of impacted wisdom tooth	1446
Surgical removal of retained root of tooth	1389
Other specified simple extraction of tooth	966
Removal of suture from skin of head or neck	914
Apicectomy of tooth	452
Excision of lesion of mouth NEC	452
Excision of lesion of skin of head or neck NEC	411
Biopsy of lesion of salivary gland	383
Packing of tooth socket	371
Surgical removal of impacted tooth NEC	298
Removal of suture from mouth NEC	214
Other specified other operations on tooth	189
Surgical exposure of tooth	133
Other specified other operations on maxillary antrum	124
Sialography	116
Unspecified surgical removal of tooth	98
Upper dental clearance	81
Drainage of abscess of alveolus of tooth	69
Lower dental clearance	65

Procedure	No. performed (13/14)
Other specified surgical removal of tooth	62
Enucleation of dental cyst of jaw	60
Excision of gingiva	34
Full dental clearance	30
Drainage of lesion of skin of head or neck	28
Oral alveoplasty	24
Fitting of orthodontic bracket	21
Open extraction of calculus from submandibular duct	20
Closure of fistula between maxillary antrum and mouth	17
Surgical arrest of postoperative bleeding from tooth socket	16
Marsupialisation of dental lesion of jaw	12
Other specified excision of dental lesion of jaw	9
Gingivoplasty	4
Unspecified excision of dental lesion of jaw	4

Figure 8.5 Common procedure codes: inpatients

In the North Region during 2013/14, 61,195 of these 'common procedures' were performed in inpatient settings (for Oral and Maxillofacial Surgery). Care should be taken when interpreting these results: it has been assumed that each patient episode consisted of only one procedure, which may not be accurate and could lead to an overestimation of activity volume and cost.



8.5 Oral Surgery and Oral Medicine referrals

Capture of referral data can enable commissioners to build up a picture of local need. As mentioned in Section 8.3 of this document, use of a referrals management system can provide a rich data set for local health needs assessment and can also relieve pressure on secondary care services by redirecting Level 2 cases to primary care specialist providers, where local circumstances permit.

8.5.1 Example of active referral management

The following data, from a North West of England region, illustrate use of referrals management to relieve waiting time pressure by directing Level 2 cases to known primary care specialist providers rather than secondary care. The referrals management system from which these data have been provided employs central capture of referral data (electronically and paper) and consultant-led triage (average 1.4 days from referral to triage decision and provider allocation). Dentists use separate referral forms for patients requiring routine and urgent specialist Oral Surgery, Oral Medicine and Oral and Maxillofacial services (Appendix 6). Suspected cancer or suspicious lesions are referred separately to ensure that these are prioritised and meet the criteria of the 2 week cancer pathway.

On average, 17,000 specialist dental service referrals per quarter are received. Of these, 37.7% are for Oral Surgery, 6.9% for OMFS and 5.1% for Oral Medicine services (Figure 8.6). Referral forms are rejected if: specialist treatment is requested using the incorrect form; insufficient clinically relevant information is provided; referring clinicians fail to provide radiographs without giving a reason; or if referrals are for non-commissioned activity (e.g. implants) or for inappropriate treatment plans e.g. molar apicectomy.

Given the locally available specialist services, these data reflect the assumption by the triaging clinician that Level 1 complexity is suitable for delivery by a primary care GDP and Level 2 is appropriate for delivery by a clinician with enhanced skill and experience who may or may not be on a specialist register (locally, there are no Oral Medicine primary care specialists). Level 3 is defined as consultant-led care requiring a secondary care environment (but which may be delivered by trainees and SAS grades given that there are high ratios of these clinicians to consultants in Oral Surgery/OMFS units).

Figure 8.6 Breakdown of all dental specialty referrals (based on the main reason for referral)

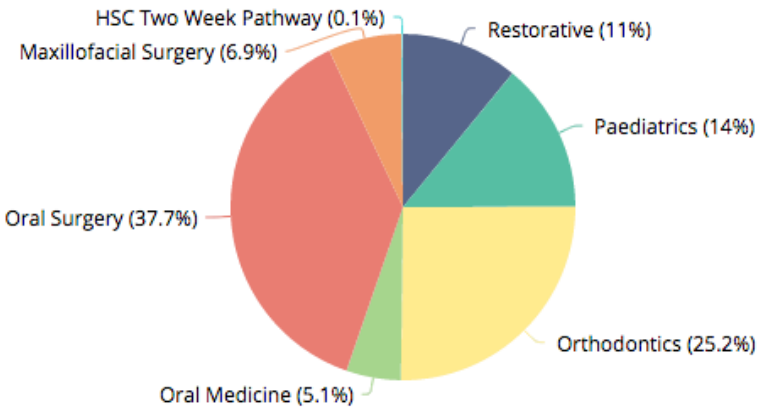


Table 8.5 illustrates Oral Surgery referrals received over a 12-month period and their assessed complexity. Tables 8.6 and 8.7 present similar data for Oral Medicine and OMFS respectively.

Table 8.5 Oral Surgery Referrals

	Level 1 Complexity	Level 2 Complexity	Level 3 Complexity	Rejected	TOTAL
Feb-14	0	824	1242	115	**2181**
Mar-14	0	922	1338	142	**2402**
Apr-14	1	945	1199	115	**2260**
May-14	161	969	977	128	**2235**
Jun-14	91	1274	800	136	**2301**
Jul-14	87	1339	822	172	**2420**
Aug-14	70	1129	645	84	**1928**
Sep-14	100	1430	778	126	**2434**
Oct-14	100	1514	935	126	**2675**
Nov-14	70	1356	824	131	**2381**
Dec-14	67	1245	688	62	**2062**
Jan-15	112	1461	729	58	**2360**
Total	**859**	**14408**	**10977**	**1395**	**27639**

Table 8.6 Oral Medicine Referrals

	Level 1 Complexity	Level 2 Complexity	Level 3 Complexity	Rejected	TOTAL
Feb-14	0	1	288	3	**292**
Mar-14	0	2	322	1	**325**
Apr-14	0	2	323	2	**327**
May-14	0	0	329	2	**331**
Jun-14	0	1	340	0	**341**
Jul-14	0	1	354	1	**356**
Aug-14	0	3	321	6	**330**
Sep-14	0	2	395	1	**398**
Oct-14	0	0	401	1	**402**
Nov-14	0	1	355	0	**356**
Dec-14	0	0	368	3	**371**
Jan-15	0	0	366	3	**369**
Total	**0**	**13**	**4162**	**23**	**4198**

Table 8.7 OMFS Referrals

	Level 1 Complexity	Level 2 Complexity	Level 3 Complexity	Rejected	TOTAL
Feb-14	0	31	399	10	**440**
Mar-14	0	29	416	8	**453**
Apr-14	0	26	416	9	**451**
May-14	1	31	402	11	**445**
Jun-14	7	48	383	14	**452**
Jul-14	4	42	365	13	**424**
Aug-14	4	31	310	7	**352**
Sep-14	1	46	353	8	**408**
Oct-14	3	62	407	13	**485**
Nov-14	5	51	348	6	**410**
Dec-14	0	35	304	1	**340**
Jan-15	5	49	301	10	**365**
Feb-15	0	11	60	0	**71**
Total	**30**	**492**	**4464**	**110**	**5096**

Few referrals are received for Level 1 Oral Surgery and Oral Medicine procedures; this indicates that general dental practitioners are delivering the majority of this care in primary care. Level 2 cases account for 52% of the Oral Surgery referrals; without

referral management, it is likely that a significant proportion of these would have been directed to secondary care with associated detrimental effect on waiting times.

8.5.2 Example of 'blind' referral management

The following data illustrate the use of 'blind' referral management in another area of the North West of England i.e. referrals captured centrally and cases directed to primary or secondary care specialist services in accordance with the wishes of the referring clinician. Post hoc triage to ascertain case complexity can then be used to analyse complexity case mix of providers and inform local workforce requirements. Geography of referrals can also be analysed to ascertain whether patients could have been offered appropriate care closer to home. Table 8.8 illustrates data for Oral Surgery, Oral Medicine and OMFS referrals combined. Table 8.9 presents data for Oral Surgery referrals only and illustrates that almost two-thirds (605/973) of the cases assessed as Level 3 (not requiring sedation) by GDPs and referred to secondary care providers were triaged as Level 2 complexity (highlighted). These could have been delivered by primary care specialist Oral Surgery providers.

Tables 8.10 and 8.11 present analyses of the complexity case mix of secondary care providers within the same area. It is evident that in some hospital unit, a large proportion of Oral Surgery activity (Table 8.11) is Level 1 and Level 2. Such data can inform discussions with secondary care providers regarding contracts and activity provided to ascertain the impact on hospital units if Level 2 complexity cases were redirected. In order for units to remain sustainable, it may be appropriate to consider merger of strategic units to ensure sufficient Level 3 complexity cases are maintained.

Table 8.8 Blind referral management assessment of complexity (Oral Surgery/Oral Medicine/OMFS)

		COMPLEXITY BASED ON GDP REFERRAL PROVIDER CHOICE			
		LEVEL 2	LEVEL 2 SEDATION	LEVEL 3	LEVEL 3 SEDATION
HOC POST TRIAGE Assessed Case Complexity	TOTAL L1	313	144	138	66
	TOTAL L2	2923	784	**1977**	705
	TOTAL L3	206	72	2564	391
Total		**3442**	**1000**	**4679**	**1162**

Table 8.9 Blind referral management assessment of complexity (Oral Surgery only)

		COMPLEXITY BASED ON GDP REFERRAL PROVIDER CHOICE			
		LEVEL 2	LEVEL 2 SEDATION	LEVEL 3	LEVEL 3 SEDATION
HOC POST TRIAGE Assessed Case Complexity	TOTAL L1	298	135	51	119
	TOTAL L2	2848	774	**605**	1590
	TOTAL L3	162	65	317	553
Total		3308	974	973	2262

Table 8.10 Complexity case mix of secondary care providers (Oral Surgery/Oral Medicine/OMFS)

HOSPITAL PROVIDER	TOTAL REFERRALS	LEVEL 1	LEVEL 1 SEDATION	LEVEL 2	LEVEL 2 SEDATION	LEVEL 3	LEVEL 3 SEDATION	REJECTED
1	1999	52	21	626	227	490	93	*490*
2	1347	35	7	437	123	378	52	*315*
3	1653	24	18	383	158	544	60	*466*
4	1240	8	7	198	134	381	135	*377*
5	657	9	6	196	33	212	26	*175*
6	459	1	3	38	7	278	4	*128*
7	96	3	2	35	8	26	3	*19*
8	236	3	0	26	5	129	0	*73*
9	69	0	1	13	2	25	10	*18*
10	26	0	0	8	3	8	0	*7*
Total	**7782**	**135**	**65**	**1960**	**700**	**2471**	**383**	***2068***

Table 8.11 Complexity case mix of secondary care providers (Oral Surgery only)

HOSPITAL PROVIDER	TOTAL REFERRALS	LEVEL 1	LEVEL 1 SEDATION	LEVEL 2	LEVEL 2 SEDATION	LEVEL 3	LEVEL 3 SEDATION	REJECTED
1	1277	48	16	489	177	140	65	342
2	897	34	7	387	113	93	52	211
3	894	17	12	284	139	124	45	273
4	381	7	6	171	29	47	17	104
5	775	7	4	161	122	90	119	272
6	68	2	2	31	7	6	3	17
7	85	1	2	21	5	19	3	34
8	61	1	0	20	5	14	0	21
9	41	0	1	8	2	6	9	15
10	15	0	0	6	2	2	0	5
Total	**4494**	**117**	**50**	**1578**	**601**	**541**	**313**	**1294**

9 Transforming Oral Surgery & Oral Medicine services

9.1 Current models and challenges

Analysis of NHS dental activity data suggest that incentives incorporated into the 2006 NHS primary care dental contract led to an increase in Oral Surgery referrals to acute services. Effectively, in some areas, proportions of the Oral Surgery service are being paid for twice: through NHS-banded courses of treatment and secondary care contracts.

In a number of areas, providers (including dentists with enhanced skills and experience) have been identified to provide Oral Surgery services (including Level 2 procedures) in primary care settings. However, it is possible that the same providers may also undertake Level 1 procedures referred to them. National standards for services undertaken by dentists with additional experience and/or skills are not currently available.

Oral Surgery services provided in secondary and acute care settings are intended to provide more complex Oral Surgery care (Level 2 and Level 3) or treatment for patients with modifying factors such as a complex medical history. However, referral data suggest less complex (Level 1) care may also be provided.

Provision of Oral Medicine services is dependent on ease of access to a consultant-led service (irrespective of the level of complexity). As a result, patients who may have benefitted from an early assessment in Level 3 setting are often referred to a local non-specialist service. Similarly, patients who could be managed in the primary care setting may be referred to a secondary care setting due to an under-developed or under-resourced skill set.

Teaching Hospitals (and District General Hospitals) require access to an appropriate number of patients at all levels of complexity (to support teaching and training). The same is true, in terms of workforce development, of District General Hospitals and other secondary care settings, which will also require sufficient numbers of patients of suitable complexity to develop appropriately skilled clinicians. Any transformation of services will require a related transformation of training so that education is mapped to local need.

Local, current Oral Surgery and Oral Medicine service delivery is often based on the models that were ‘inherited’ from PCTs. However, commissioners and clinicians working together with patients can begin to implement national frameworks as they emerge. This promotes innovation, tests and validates best practice and shares expertise to get the best ‘local fit’; thus overcoming local ‘turf wars’ and organisational interests to benefit patients and the population.

9.2 Workforce implications

9.2.1 Oral Surgery Workforce implications

Once a pathway approach to Oral Surgery care is established it is important that the workforce is continually evaluated to ensure it is appropriate for the needs of the population.

Introduction of a referral management service with consultant-led triage will provide more accurate data with respect to population need. The skill mix required to deliver the levels of care required and the implications for each group are presented in Table 9.1.

Table 9.1 Oral Surgery workforce implications with respect to transformation of services

Group	Service transformation implications
Dental Undergraduates	HEE to ensure appropriate number of undergraduate university places with respect to population need. Appropriate number of routine Level 1 Oral Surgery cases required for training.
Dental Postgraduates	Appropriate number of routine Level 1, and more complex Level 2/3 Oral Surgery referrals required for training.
Dental Care Professionals	Extended roles of DCPs to include suture removal and appropriate training for the delivery of post-operative 'home check' telephone calls (collection of patient-reported outcome measures) Appropriate number of nurses trained in conscious sedation for Level 2 and Level 3 service providers who can offer conscious sedation as an alternative to general anaesthetic.
Primary care General Dental Practitioners	Appropriate commissioning including performance management for local delivery of Level 1 care. Appropriate support and training available for providers who currently lack the necessary skills to deliver Level 1 care competently.
Dentists with additional experience and/or competencies	Appropriate assurance of competence. Appropriate commissioning and performance management for local delivery of Level 2 Oral Surgery procedures. Note: presently there is no training pathway or quality assured qualification. Competence can be assured and this will be a role for the MCN.
Oral Surgery Specialists	Appropriate numbers of specialists are required to meet population need for Oral Surgery procedures.
Oral Surgery Consultants	A proportion of Oral Surgery consultant time will be required to manage and supervise the MCN. Appropriate numbers of consultants are required to meet population need for Oral Surgery procedures and reduce pressure on OMFS departments so the latter can concentrate on delivery of more complex care.

9.2.2 Oral & Maxillofacial Surgery Workforce implications

It is important to ensure that there are sufficient OMFS consultants to undertake the current OMFS caseload that cannot be managed by a consultant in Oral Surgery. The local workforce needs to reflect complexity of cases. With a consistent pathway approach, including more accurate coding of secondary care procedures, it will be possible for commissioners to identify the proportions of OMFS and Oral Surgery procedures delivered by local secondary care providers including Acute Trusts.

Given that OMFS training is a lengthy and expensive process for both HEE and trainees (who have to undertake a second, self-funded undergraduate degree), HEE will need to consider the number of OMFS training posts available relative to the population need for this complex care.

9.2.3 Oral Medicine Workforce implications

The short-term implications for the Oral Medicine workforce primarily relate to the need to identify appropriate individuals to undertake the local role both as the local lead and as network/ team members. In the medium to long-term consideration will need to be given to further developing the Oral Medicine workforce to facilitate the delivery of specialist lead high-quality care irrespective of the proximity to a Dental Teaching Hospital (Table 9.2).

Delivery of an Oral Medicine MCN would require reorganisation of job plans for nearly all, if not all, members of the network. One example will be the need for Direct Clinical Care (DCC) programmed activity time to be allocated to triage and case-based discussions across the network team.

Table 9.2 Workforce implications with respect to transformation of service

Group	Service transformation implications
Dental undergraduates	HEE to ensure appropriate number of undergraduate university places with respect to population need. Appropriate number of routine Level 1 Oral Medicine cases required for training.
Dental postgraduates	Appropriate number of routine Level 1, and more complex Level 2/3 Oral Surgery referrals required for training.
Dental care professionals	Extended roles of DCPs to include suture removal and appropriate training for the delivery of post-operative 'home check' telephone calls (collection of patient-reported outcome measures)
Primary care General Dental Practitioners	Appropriate commissioning including performance management for local delivery of Level 1 care. Appropriate support and training available for providers who currently lack the necessary skills to deliver Level 1 care competently.
Dentists with additional experience and/or competencies	Appropriate assurance of competence. Appropriate commissioning and performance management for local delivery of Level 2 Oral Medicine service.
Oral Medicine specialists	Appropriate numbers of specialists are required to meet population need for Oral Medicine services.
Oral Medicine consultants	A proportion of Oral Medicine consultant time will be required to manage and supervise the MCN.

9.3 Service redesign

9.3.1 Oral Surgery service redesign

The NHS England *Five Year Forward View* was published in October 2014 and confirmed, 'Increasingly we need to manage systems – Networks of Care – not just organisations'.[30] It aligns to the purpose of this Oral Surgery and Oral Medicine commissioning guide. Oral Surgery and Oral Medicine services need to be integrated and delivered around the needs of patients rather than organisations or training programmes. Commissioners will need to work with MCNs to determine how care is provided between primary care and hospitals.

The *Five Year Forward View* is particularly relevant for Oral Surgery care and this emerging care pathway framework will meet one of the most important changes it heralds – to expand and strengthen primary and 'out of hospital care'. It also aims to focus on creating and protecting health not just treating ill health and providing isolated episodes of care. Current inefficiencies in the system are identified in the document. However, this commissioning guide is not concerned with reducing costs; rather, the release of resource from one part of a system and using it more effectively in another. It is intended to support a change; clinicians need to understand that there is a clinical cost to working in an out-dated way. One abandoned or failed treatment is potentially another patient's delay or lack of treatment that could have improved oral health. This guide is about supporting commissioners and clinicians to work together to ensure that resources invested by the NHS in Oral Surgery care are used in the most effective way to provide the best possible quality and quantity of care for patients to meet need.

As responsible clinical stewards, consultants and specialists in Oral Surgery and Oral Medicine can assist in leading change and provide a more effective use of constrained resources by broadening their influence with primary care clinicians. Consultants and specialists should consider if some of their specialist time and knowledge would be better spent supporting primary care to benefit many more patients than they can treat working in an acute setting.

The focus is on commissioning the entire dental pathway as a single, consistent, integrated model of service delivery. This reflects the fact that, as a general principle, the NHS should be offering the same high standard in terms of quality, value and outcome of care regardless of where in the country it is delivered.

This commissioning guide recognises that 'one size does not fit all' and is intended to stimulate debate and action locally. However, transformational and transactional change is required in the delivery of Oral Surgery and Oral Medicine specialist services. Commissioners are encouraged to review need and local current services, using the enablers set out in the patient journey within this guide as a benchmark, to set pace and direction locally. An assessment of how much progress has been made locally should be the first step and a priority for Commissioners.

An example of service transformation is included in Appendix 8.

[30] NHS England (2014) Five Year Forward View. Available at: http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf Accessed February 2015.

9.3.1.1 How an 'ideal' Oral Surgery Service model might look

The *Guide for Commissioning Specialist Dentistry Services* describes the duties and responsibilities of commissioners and their obligation to commission services that deliver the highest quality care for patients.

Oral Surgery services would be delivered through a consultant-led MCN. Commissioners and MCNs operating within transformed services would ensure that the correct level of competence, quality and outcome were being achieved for patients regardless of setting.

Primary care clinicians would competently deliver Level 1 case complexity. Supervised undergraduate clinicians would deliver an agreed proportion of Level 1 cases as part of their training.

Consultant-led support would be provided for those clinicians lacking core clinical skills (either self-referred or identified through the referral management system) to enable them to deliver Level 1 care competently.

The Oral Surgery pathway would ensure that primary care dental teams and medical colleagues would understand how to navigate a patient to a referral management system. This system would comprise robust, consultant-led triage, take into account local skill mix and efficiently direct those patients with more complex Oral Surgery needs to the most appropriate provider and location.

Urgent/suspicious lesions would be appropriately referred for assessment and treatment in accordance with the 2-week cancer pathway.

Oral Surgery specialists would be responsible for the timely delivery of the majority of Level 2 Oral Surgery services (with sedation if need is identified) in primary care. There would be consultant-led assessment/assurance of a clinician's competence to deliver care effectively. Care would be delivered, as per detailed service specifications, to the same standard as secondary care Oral Surgery units. If Oral Surgery or OMFS consultants delivered Level 2 services, remuneration would be the same as primary care providers.

Level 3 services would be delivered, depending upon local availability, by consultant-led Oral Surgery teams within eighteen weeks of patient referral. This would enable OMFS units to deliver more complex care. Where there were no local consultant Oral Surgery teams, OMFS units would provide Level 3 care. Remuneration for services provided would be made on the basis of Oral Surgery (and not OMFS) coding/tariffs.

Undergraduate/postgraduate trainees in acute or dental hospital consultant-led settings would deliver a locally agreed proportion of Level 2 and Level 3 Oral Surgery services.

Appropriate use of Oral Surgery codes in secondary care and collection of similar coding information from Level 2 primary care providers would provide more accurate data regarding local provision of Oral Surgery services.

Appropriate use of Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) and quality indicators would provide data with respect to the quality of service provision, clinical effectiveness and patient

experience delivered by providers. These data could be used for benchmarking and annual review of services.

Careful consideration to local needs would be given when making new appointments following the retirement of OMFS and Oral Surgery consultants. Local Oral Surgery need would also be considered with respect to other Oral Surgery and OMFS staffing levels.

9.3.2 Oral Medicine service redesign

A consultant-led MCN based on a ‘Hub and Spoke’ model could provide significant benefits in terms of continuity, ease of transfer between settings, education, research and training and an enhanced patient journey with improved outcomes. Oral Medicine specialists and dentists with enhanced skills and experience could provide support, based in, or shared between, district general hospitals, other secondary care settings and primary care (dependent on local support service availability). Teams working with other specialties could facilitate greater use of the collective skill mix across the spectrum of clinical cases and enable the delivery of a more efficient service.

At the present time, Oral Medicine does not have specialist primary care practitioners and so a transitional phase would be required whilst the workforce was developed. In this model, the MCN could utilise the existing clinical resource, supported by greater team-working, as described above. This would be assisted by the appointment of an Oral Medicine consultant lead clinician and local lead clinicians within each secondary care setting (may be from another dental specialty). This could provide an identifiable focus for timely, efficient transfer of patients and information between primary and other secondary care providers.

10 Illustrative journey of a patient (elective Oral Surgery care)

Level 1 complexity	Procedures/conditions to be performed or managed by a clinician commensurate with a level of competence as defined by the Curriculum for Dental Foundation Training or its equivalent. This is the minimum that a commissioner would expect to be delivered in a primary care contract.
Level 2 complexity	Procedures/conditions to be performed or managed by a clinician with enhanced skills, and experience who may or may not be on a specialist list. This care may require additional equipment or environment standards, but can usually be provided in a primary care setting.
Level 3a complexity	Procedures/conditions to be performed or managed by a clinician recognised as a specialist in the GDC-defined criteria and is on a specialist list; **OR** by a consultant.
Level 3b complexity	Procedures/conditions to be performed or managed by a clinician recognised as a consultant in the relevant specialty, who has received additional training which enables them to deliver more complex care, lead MDTs, MCNs and deliver specialist training. The consultant team may include trainees and SAS grades. Oral Surgery to also be delivered by Consultants in Oral & Maxillofacial Surgery who have the necessary competencies.

PRIMARY CARE DENTIST

Oral Surgery procedures should only be undertaken in those situations where they will clearly contribute to the oral health of the patient.

In all situations the clinical advantages and long-term benefits of Oral Surgery procedures to the patient should justify such treatment and outweigh any detrimental effects.

The clinician should ensure that the cooperation, motivation, aspirations and general health of the patient are consistent with the provision of Oral Surgery.

Prior to the provision of Oral Surgery, a comprehensive oral health assessment should be undertaken; the information collected and the risks identified should be reviewed before Oral Surgery procedures are undertaken.

The information gathered and reviewed in the oral health assessment should be used to reach a consensus as to whether it is in the patient's best interests to provide an Oral Surgery procedure or to make a referral to another clinician.

Level 1 complexity are Oral Surgery procedures or conditions to be performed or managed by a dentist commensurate with the level of competence as defined by the Curriculum for Dental Foundation Training, or its equivalent. The level of complexity may, however, change from Level 1 to Level 2 or Level 3 depending on one or more modifying factors, for example:

Medical History/ Social factors; Level of anxiety; Other complications.

DENTIST REFERRAL	STANDARDS	METRICS	ENABLERS
Dentist makes referral and ensures that the consistent required data set is complete. Dentist ensures all relevant medical history detail is provided. Dentist ensures that all work-up & readable radiographs are available as per agreed Oral Surgery referral guidelines. Dentist ensures that information regarding the referral and triage processes is appropriately explained to patient Referrals from other health professionals, except	Level 2 and 3 procedures communicated to referrers and OS providers. Agreed OS referral guidance, including required data set, communicated to referrers and Oral Surgery providers. Consistent and accurate data set with respect to referrer details. Appropriate radiographs to support diagnosis; ideally these should be digital images sent electronically. Documentation of incidences when patient compliance prevented diagnostic radiographs. Consistent and accurate data set with respect to patient demographics and contact details.	Number (%) of referrals received that have complete referrer details. Number (%) of referrals received that have complete patient demographic and contact details. Number (%) of referrals that have specific relevant medical history. Number (%) of patients aware of the Oral Surgery procedure they require and why. Number (%) of patients confirming receipt of information with respect to: procedure; choice appropriate to needs and level of complexity; and Oral Surgery	Referral management system. Electronic proforma. Oral Surgery Providers' patient preparation information and maps available to download by referrer. Availability of national patient information template in a variety of accessible formats.

suspected head and neck cancers must have primary dental care assessment.	Specific relevant medical history communicated to Oral Surgery provider. Patient appropriately informed and aware of the Oral Surgery procedure that is required and the reasons why it is required. Patient anxiety assessed. IOSN completed if sedation is considered necessary. ASA (American Society of Anesthesiologists) physical classification of the patient is assessed: I, II, III or IV I - A normal healthy patient II - A patient with mild systemic disease III - A patient with severe systemic disease IV - A patient with severe systemic disease that is a constant threat to life Dentist referring within 2 working days of the decision to refer being made.	provider details. Number (%) of patients assessed with respect to level of dental anxiety. Number (%) of patients requiring sedation who have a completed IOSN.	

TRIAGE DECISION-MAKING WITH RESPECT TO COMPLEXITY AND SETTING	STANDARDS	METRICS	ENABLERS
Every patient identified by a unique reference number (URN) to enable tracking of referral e.g. NHS number, dental registration number or other URN. Consultant-led decision-making Within 2 working days of receipt of referral. When triage decision unclear (Level 2 or Level 3, escalate) patient may be required to attend an assessment clinic to determine appropriate care provision.	Specialist triage decision made within 2 working days of receipt of referral. Relevant medical history details included with triage decision. Any other information e.g. wheelchair user Accuracy of diagnostics assessed and reported upon. All referrals received have appropriate readable radiographs and work up. Primary care dentists who refer Level 1 procedures contacted to ascertain their reasons for referral and any requirements for remedial training	Number (%) of referrals where specialist triage decision is made within 2 working days from receipt of referral. Number (%) of referrals that are deemed at triage to have appropriate Oral Surgery procedural level and setting request. Number (%) of incidents of unplanned difficulties reported. Number (%) of referrals received that have readable radiographs and work up as set out in referral/ procedure guidelines OR that reported patient compliance issues that prevented accurate diagnostic radiographs from being taken. Number (%) of referrals received that require patient assessment and onward referral to specialist Level 2 or 3 service in a secondary care setting due to surgical difficulty not recognised by referrer, complex medical condition or other.	Electronic access to referrals available within 48 hours. Referral and triage decision can be tracked electronically by both referrer and patient. Specialist triage decision-making Incorporated into specialist (consultant) job plan. Referrers have access to high quality digital DPT radiography facilities and can use these appropriately to assist in timely diagnosis, referral and treatment. Access to, and funding for, Head and Neck EQA compliant diagnostic service in a CPA/ISO1519 accredited laboratory

ASSESSMENT: DECISION MADE TO TREAT	STANDARDS	METRICS	ENABLERS
Referral and triage decision can be tracked electronically by referring dentist and by patient. Patient receives information in an appropriate format regarding Oral Surgery procedure and provider setting.	Patient informed of triage decision within one week of triage decision or earlier as part of the referral management system Referring dentist and patient informed when referrals have been assessed and require onward referral to Level 2 or 3 service in a secondary care setting due to surgical difficulty not recognised by referrer, complex medical condition or other. Appointment offered to patient within 4 weeks of triage decision or assessment.	Number (%) of referrals received that are assessed and need to be onward referred to specialist Level 2 or 3 service in a secondary care setting due to surgical difficulty not recognised by referrer, complex medical condition or other. Number (%) of triaged referrals that are appointed within 4 weeks for assessment and linked Oral Surgery treatment appointment made. Number (%) of appointments that are cancelled/postponed by patients.	Direct booking procedures. Availability of national patient information template in a variety of accessible formats. Oral Surgery providers appropriate to area/need and level of complexity. Outcome and performance indicators available to them. Responsive specialist-led Level 2 and 3 services established in primary care setting and commissioned in teaching units (DH acute hosted). Responsive specialist-led Level 3 services available in secondary care setting.

PATIENT ATTENDS FOR ORAL SURGERY ASSESSMENT IN PRIMARY OR SECONDARY DENTAL CARE SETTING	STANDARDS	METRICS	ENABLERS
Patient has received appropriate information regarding the Oral Surgery assessment appointment Patient has choice of appointment time. Patient has all necessary maps and information about setting. When required, a responsible adult accompanies the patient to assist their understanding so they are able to give valid informed consent. Patient has information with respect to appropriate self-care after Oral Surgery procedure has been completed.	All criteria specified i.e. competence and qualification of operator and DCP. Record of CPD and evidence informed and based on professional consensus on treatment practices. Specialist formal appraisal and peer review; twice annual supervision visits and review format agreed. DPT radiography available on site and access to Cone Beam CT imaging available. Drugs and equipment available as recommended by RC UK. Unimpeded ambulance access to building and surgery (DDA compliant). Consent process aligned to	Number (%) of patients who have received appropriate information from referring practitioner re: proposed Oral Surgery procedure and choice of providers. Number (%) of cancellations by provider. Number (%) of DNAs/ cancellations by patient. Number (%) of records completed using key diagnostic words and procedure codes to agreed toolkit.	Availability of a national patient information template in a variety of accessible formats. Choice of provider. Performance metrics published. Consultant supervision of Level 2 primary care provider (including appraisal) as part of consultant job plan. SLA in place with acute provider and funding mechanism agreed to reflect actual costs. Equipment and environment reviewed annually against published 'gold standards' as part of SLA. Consistent diagnostic, procedure and tariff toolkit available and used by all providers.

	current secondary care process. Chair-side IT available. All records completed using key diagnostic words and procedure codes to agreed toolkit. Tariff consistent with agreed NHS CB pricing		Availability of workforce with the relevant training to deliver Oral Surgery care. Research to inform evidence-based practice in Oral Surgery.

DELIVERY OF ORAL SURGERY PROCEDURE **IN PRIMARY OR SECONDARY DENTAL CARE SETTING**	**STANDARDS**	**METRICS**	**ENABLERS**
Patient has received sufficient information about procedure to enable them to provide informed consent. If secondary care setting is required, patient is aware why this is necessary Where sedation is required, a responsible adult accompanies the patient.	All criteria specified i.e. competence and qualification of operator and DCP. Record of CPD and evidence informed and based on professional consensus on treatment practices. Specialist formal appraisal and peer review and twice annual supervision visits and review format agreed. Environment and equipment available e.g. for Oral Surgery, meets specified	Number (%) of cancellations by provider. Number (%) of DNAs/ cancellations by patient. Number (%) of cases where triage decision was different to care provided Number (%) of unplanned difficulty.	Availability of national patient information and consent templates in a variety of accessible formats. Equipment and environment reviewed annually against published 'gold standards' as part of SLA. Consistent diagnostic,

Patient has information with respect to appropriate self-care after Oral Surgery procedure has been completed. Named consultant takes responsibility of biopsied tissue that is sent to pathology services for reporting. Arrangements made for timely reporting of biopsy results to patient.	standards i.e. sterile water supply, single use water line and surgical hand piece available. DPT radiography available on site and access to Cone Beam CT imaging available. Suitable magnification for endodontic Oral Surgery. Service setting needs to meet decontamination best practice HTM 01-05. Drugs and equipment available as recommended by RC UK. Sedation equipment and environment meets SAAD checklist. Local Head and Neck EQA compliant pathology services and safe transfer system in place – gold standard. Unimpeded ambulance access to building and surgery (DDA compliant) Consent process aligned to current secondary care process Chair-side IT available.	Number (%) of adverse incidents e.g. extraction of wrong tooth; nerve injury; Re-admission/admission. Theatre and day case admission environment and process. Number (%) of records completed using key diagnostic words and procedure codes to agreed toolkit Number (%) of cases reported by Head and Neck EQA pathologist and in accredited laboratories	procedure and tariff toolkit available and used by all providers Investigate current workforce and ensure availability of workforce with the relevant training to deliver Oral Surgery care. Responsive Level 2 and Level 3 Oral Surgery service in secondary care setting. Fast track to care when wrong triage decision has been made. Primary care Oral Surgery providers' access to Datix reporting system.

	Responsiveness to an admitted patient's personal needs. Control of pain, nausea or vomiting. All records completed using key diagnostic words and procedure codes to agreed toolkit. Tariff consistent with agreed NHS CB pricing		

DISCHARGE AND FOLLOW-UP	STANDARDS	METRICS	ENABLERS
Patient is provided with all necessary discharge information in an appropriate format, including: Information on advised self-care and who to contact following procedure should there be a problem; What to expect during the recovery period; and Information about post-operative 'home check'.	Patient-friendly information available in a number of formats including information on what to expect post-surgery and who to contact and what to do if problems occur after discharge. Patient comfortable on discharge and prescribed pain relief where appropriate. Patient contacted for 24 hour 'home check' (using skill mix) e.g. telephone call, online	Number (%) of treatments completed where discharge information sent to referrer. Number of cases when the patient had to return or seek advice due to unexpected adverse event following care i.e. infection; post-op bleeding; pain, numbness/nerve injury etc. PROMs collected through 'home check' and other	Availability of common national template for postoperative instructions in web- and paper-based formats. Provider has all details of referring dentist correct from initial referral data. Discharge information sent to referring clinician and/or GMP Responsive administrative support.

	email survey or text messaging (maximum 2 contact attempts) to ask patient if they are experiencing any of the following: Persistent Bleeding; Nerve injury; Unmanaged pain. If yes to any of the above or a Level 3 procedure has been carried out, patient contacted again (2nd 'home check') within 1 week of Oral Surgery procedure. If patient has not returned to normal function, review arranged. Adverse events and complications recorded and reported using Datix e.g. Patient collapse; Wrong site surgery; Damage to adjacent tissues; Jaw fracture; Displacement of tooth/root fragment; Chemical, thermal or mechanical damage e.g. to lip.	surveys. Routinely reported PROMs are described in section 13.3 of this Commissioning Guide Number (%) of patients who do not respond to 1st and 2nd 'home check' contact telephone calls.	Datix reporting system available and used by primary care Oral Surgery providers as aligned to current secondary care system through consultant SLA. 24-hour Responsive Level 3 Oral Surgery service in secondary care setting. Ensure preferred patient contact details are accurate and available to Oral Surgery provider.

11 Illustrative journey of a patient (Oral Medicine)

Level 1 complexity	Procedures/conditions to be performed or managed by a clinician commensurate with a level of competence, as defined by the Curriculum for Dental Foundation Training, or its equivalent. This is the minimum that a commissioner would expect to be delivered in a primary care contract.
Level 2 complexity	Procedures/conditions to be performed or managed by a clinician with enhanced skills and experience who may or may not be on a specialist list. This care may require additional equipment or environment standards, but can usually be provided in a primary care setting.
Level 3a complexity	Procedures/conditions to be performed or managed by a clinician recognised as a specialist in Oral Medicine in the GDC-defined criteria and is on a specialist list; **OR** by a consultant.
Level 3b complexity	Procedures/conditions to be performed or managed by a clinician recognised as a consultant in Oral Medicine, who has received additional training which enables them to deliver more complex care, lead MDTs, MCNs and deliver specialist training. Consultants in Oral & Maxillofacial Surgery have the necessary competencies to deliver some Oral Medicine procedures. Some OMFS consultants will be included in both the GMC and GDC specialist list; others will only be included in GMC specialist register.

PRIMARY CARE DENTIST

Management of Oral Medicine conditions should only be undertaken in those situations where they will clearly contribute to the oral health of the patient.

In all situations, the clinical advantages and long-term benefits of Oral Medicine management to the patient should justify such treatment and outweigh any detrimental effects.

The clinician should ensure that the cooperation, motivation, aspirations and general health of the patient are consistent with the provision of Oral Medicine.

Prior to the provision of management of Oral Medicine conditions, a comprehensive oral health assessment should be undertaken; the information collected and the risks identified should be reviewed before management of Oral Medicine conditions are undertaken.

The information gathered and reviewed in the oral health assessment should be used to reach a consensus as to whether it is in the patient's best interests to provide management of an Oral Medicine condition or to make a referral to another clinician.

Level 1 complexity are Oral Medicine procedures or conditions to be performed or managed by a dentist commensurate with the level of competence as defined by the Curriculum for Dental Foundation Training, or its equivalent. The level of complexity may, however, change from Level 1 to Level 2 or Level 3 depending on one or more modifying factors, for example:

Medical History/ Social factors; Level of anxiety; Other complications.

DENTIST REFERRAL	STANDARDS	METRICS	ENABLERS
Dentist makes referral and ensures that the consistent required data set is complete. Dentist ensures all relevant medical history detail is provided. Dentist ensures that all work up & readable radiographs are available as per agreed Oral Medicine referral guidelines. Dentist ensures that information regarding the referral and triage processes is explained to patient, including levels of complexity, the urgency of further care and the different providers who can deliver management at these levels.	Level 2 and 3 procedures communicated to referrers and Oral Medicine providers. Agreed Oral Medicine referral guidance, including required data set, communicated to referrers and Oral Medicine providers. Consistent and accurate data set with respect to referrer details. Appropriate clinical images and radiographs to support diagnosis; ideally these should be in digital format. Consistent and accurate data set with respect to patient demographics and contact details.	Number (%) of referrals received that have complete referrer details. Number (%) of referrals received that have complete patient demographic and contact details. Number (%) of referrals that have specific relevant medical history. Number (%) of patients aware of the Oral Medicine problem and why it requires a referral. Number (%) of patients confirming receipt of information with respect to: choice appropriate to needs and level of complexity; and Oral Medicine provider details.	Referral management system. Electronic proforma. Oral Medicine Providers' patient preparation information and maps available to download by referrer. Availability of standard Consent forms and patient information.

Referrals from other health professionals, with the exception of suspected head and neck cancers, should ideally have primary dental care assessment, where dentally relevant.	Specific relevant medical history communicated to Oral Medicine provider. Patient informed and aware of the Oral Medicine problem and the reasons why referral is required. Patient receives information on procedure, choice appropriate to needs & level of complexity and provider details. Anxiety of patient assessed. IOSN completed if sedation is considered necessary. Dentist referring within 2 working days of the decision to refer being made.		

TRIAGE DECISION-MAKING WITH RESPECT TO COMPLEXITY AND SETTING	STANDARDS	METRICS	ENABLERS
Every patient identified by a unique reference number (URN) to enable tracking of referral e.g. NHS number,	Specialist triage decision made within 2 working days of receipt of referral.	% of referrals where specialist triage decision is made within 2 working days from receipt of referral.	Electronic access to referrals available within 48 hours. Referral and triage decision

dental registration number or other URN. Specialist (consultant) decision-making Within 2 working days of receipt of referral. When triage decision unclear (Level 2 or Level 3, escalate) patient may be required to attend an assessment clinic to determine appropriate care provision.	Relevant medical history details included with triage decision. Any other information e.g. wheelchair user Accuracy of diagnostics assessed and reported upon. All referrals received have appropriate readable radiographs and work up.	% of referrals that are deemed at triage to have appropriate Oral Medicine management level and setting request. % of referrals received that have readable radiographs and work up as set out in referral/ procedure guidelines. % of referrals received that require patient assessment and onward referral to specialist Level 2 or 3 service in a secondary care setting.	can be tracked electronically by both referrer and patient. Specialist triage decision making Incorporated into specialist (consultant) job plan. Referrers have access to DPT radiography facilities.

ASSESSMENT: DECISION MADE TO TREAT	STANDARDS	METRICS	ENABLERS
Referral and triage decision can be tracked electronically by referring dentist and by patient. Patient can download or have access to information regarding Oral Medicine problems and provider setting.	Patient informed of decision within one week of triage decision or earlier. Referring dentist and patient informed when referrals have been assessed and require onward referral to Level 2 or 3 services in a secondary care setting due to Oral Medicine complexity not recognised by referrer.	% of referrals that are directed for 'one appointment' assessment and care where appropriate % of referrals received that are assessed and need to be onward referred to specialist Level 2 or 3 service in a secondary care setting due to Oral Medicine complexity not recognised by referrer.	Direct booking procedures. Patient choice of Oral Medicine providers appropriate to need and level of complexity. Outcome and performance indicators available to them. Responsive specialist-led Level 2 and 3 services established.

	Appointment offered to patient within 4 weeks of triage decision or assessment.	% of triaged referrals that are appointed within 4 weeks for assessment.	Responsive specialist-led Level 3 services available in secondary care setting.

PATIENT ATTENDS FOR ORAL MEDICINE ASSESSMENT **IN PRIMARY OR SECONDARY DENTAL CARE SETTING**	**STANDARDS**	**METRICS**	**ENABLERS**
Patient has received all information regarding the Oral Medicine problem and information regarding the Oral Medicine provider including performance and waiting times. Patient has choice of appointment time. Patient has all necessary maps and information about setting. When required, a responsible adult accompanies the patient to assist their understanding so they are able to give valid informed consent. Patient has information with respect to appropriate self-care	All criteria specified i.e. competence and qualification of operator and DCP. Record of CPD and evidence informed and based on professional consensus on treatment practices. Specialist formal appraisal and peer review and twice annual supervision visits and review format agreed. Appropriate diagnostic radiography onsite and clinical photography available. Access to diagnostic and pathology services.	% of Informed patients. % of cancellations by provider. % of DNAs/cancellations by patient. % of records completed using key diagnostic words and procedure codes to agreed toolkit.	Choice of provider. Performance metrics published. Consultant supervision of Level 2 provider as part of consultant job plan. SLA in place with acute provider and funding mechanism agreed to reflect actual costs. Equipment and environment reviewed annually against published ‘gold standards’ as part of SLA. Consistent diagnostic, procedure and tariff toolkit available and used by all providers.

after any investigative procedure has been completed.	Drugs and equipment available as recommended by RC UK. Unimpeded ambulance access to building and surgery (DDA compliant). Consent process aligned to current secondary care process. Chair-side IT available. All records completed using key diagnostic words and procedure codes to agreed toolkit. Tariff consistent with agreed NHS CB pricing		Availability of workforce with the relevant training to deliver Oral Medicine care. Research to inform evidence-based practice in Oral Medicine.

DELIVERY OF ORAL MEDICINE MANAGEMENT **IN PRIMARY OR SECONDARY DENTAL CARE SETTING**	**STANDARDS**	**METRICS**	**ENABLERS**
Patient has received all information regarding the Oral Medicine management plan and information regarding the Oral Medicine provider	All criteria specified i.e. competence and qualification of operator and DCP. Record of CPD and evidence	% of referrals that receive 'one appointment' assessment and management. % of cancellations by provider.	Equipment and environment reviewed annually against published 'gold standards' as part of SLA.

including performance and waiting times. If secondary care setting is required, the patient is aware why this is necessary Where sedation is required, a responsible adult accompanies the patient. Patient has information with respect to appropriate self-care after Oral Medicine investigations have been completed. Named consultant takes responsibility of biopsied tissue that is sent to pathology services for reporting. Arrangements made for timely reporting of biopsy results to patient.	informed and based on professional consensus on treatment practices. Specialist formal appraisal and peer review and twice annual supervision visits and review format agreed. Environment and equipment available for Oral Medicine investigations meet specified standards. DPT radiography available on site and access to Cone Beam CT imaging and clinical photography available. Suitable facilities and equipment to perform Oral Medicine investigations. Service setting needs to meet decontamination best practice HTM 0105. Drugs and equipment available as recommended by RC UK. Local pathology services, haematology services,	% of DNAs/cancellations by patient. % of cases where triage decision was different to care provided % of adverse incidents % of records completed using key diagnostic words and procedure codes to agreed toolkit	Consistent diagnostic, procedure and tariff toolkit available and used by all providers Availability of workforce with the relevant training to deliver Oral Medicine care. Responsive Level 2 and Level 3 Oral Medicine service in secondary care setting. Fast-track to care when wrong triage decision has been made. Primary care Oral Medicine providers' access to Datix reporting system.

	biochemistry services, immunology services, bacteriology services, virology services and safe transfer system in place – gold standard. Unimpeded ambulance access to building and surgery (DDA compliant) Consent process aligned to current secondary care process Chair-side IT available. Responsiveness to an admitted patient's personal needs. Control of pain, nausea or vomiting. All records completed using key diagnostic words and procedure codes to agreed toolkit. Tariff consistent with agreed NHS CB pricing		

DISCHARGE AND FOLLOW-UP	STANDARDS	METRICS	ENABLERS
Patient has all necessary discharge information, including: Information on advised self-care and need for on-going monitoring of Oral Medicine condition by primary dental care or medical care services.	Patient-friendly information available in a number of formats Patient comfortable on discharge and prescribed pain relief where appropriate. Adverse events and complications recorded and reported using Datix e.g. Patient collapse, Medication error	% of treatments completed where discharge information sent to referrer. Number of cases when the patient had to return or seek advice due to unexpected adverse event following care.	Provider has all details of referring dentist correct from initial referral data. Discharge information sent to referrer and GMP Responsive administrative support. Datix reporting system available and used by primary care Oral Medicine providers as aligned to current secondary care system through consultant SLA. .

12 Procuring Oral Surgery & Oral Medicine services

12.1 Minimum standard specification

The same standards of care are expected in primary and secondary care Oral Surgery and Oral Medicine services and, therefore, remuneration of providers should be the same.

NHS procurement advice recognises the weighting of quality against cost. There is expected to be some efficiency in the system; however, any savings should be invested into enablers for provision of high quality Oral Surgery and Oral Medicine services.

12.1.1 National/local context and evidence base

12.1.1.1 General legislation and guidance

- NHS Constitution for England, updated 2015[31]
- Five Year Forward View, 2014[32]
- Securing Excellence in commissioning NHS dental services, 2013[33]
- Equity and excellence: Liberating the NHS, 2010[34]
- Implementing care closer to home, modified 2009[35]
- High Quality Care for All – NHS Next Stage Review Final Report, 2008[36]
- NHS England Specialty Training, Health Education England [37] (formerly, Modernising Medical Careers)
- NHS Personal Dental Services Agreement[38]
- Health Technical Memorandum 01-05: Decontamination in primary care dental practices, 2013[39]
- Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER), 2012[40]
- HIV-infected health care workers: Guidance on management and patient notification, 2005[41]
- Equality Act, 2010[42]
- Human Rights Act 1998[43]
- Dental Practitioners' Formulary[44]
- GDC Scope of Practice guidance[45]

[31] Available at: https://www.gov.uk/government/publications/the-nhs-constitution-for-england. Accessed February 2015.
[32] Available at: http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf. Accessed February 2015.
[33] Available at: http://www.england.nhs.uk/wp-content/uploads/2013/02/commissioning-dental.pdf. Accessed February 2015.
[34] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf. Accessed February 2015.
[35] Available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419 Accessed February 2015.
[36] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf Accessed February 2015.
[37] Available at: http://specialtytraining.hee.nhs.uk. Accessed February 2015
[38] Standard clauses for a Personal Dental Services Agreement available at: https://www.gov.uk/government/publications/standard-general-dental-services-contract-and-personal-dental-services-agreement. Accessed February 2015.
[39] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170689/HTM_01-05_2013.pdf. Accessed February 2015.
[40] Available at: https://www.gov.uk/government/publications/the-ionising-radiation-medical-exposure-regulations-2000. Accessed February 2015.
[41] Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116415. Accessed February 2015.
[42] Available at: http://www.legislation.gov.uk/ukpga/2010/15/contents. Accessed February 2015.
[43] Available at: http://www.legislation.gov.uk/ukpga/1998/42/contents. Accessed February 2015.
[44] Available at: http://www.evidence.nhs.uk/formulary/bnf/current/dental-practitioners-formulary. Accessed February 2015.

- GDC Fitness to Practice advice[46]
- GDC Standards for the Dental Team guidance[47]
- Caldicott review: information governance in the health and care system, 2013[48]

12.1.1.2 Legislation and guidance pertinent to Oral Surgery and Oral Medicine

- NICE Technology Appraisals Guidance No.1 - Guidance on the Extraction of Wisdom Teeth, 2000[49]
- Conscious sedation in the provision of dental care: report of an Expert Group on Sedation for Dentistry, Standing Dental Advisory Committee, 2003[50]

12.1.2 Scope

- Aims/objectives
- Scope/Care pathway
- Population covered
- Acceptance/exclusion criteria
- Procedures to be delivered e.g. dentoalveolar surgery including 3rd molar surgery, single root apicectomies, multiple extractions, removal of buried roots and impacted teeth, temperomandibular joint dysfunction, surgical exposure of unerupted teeth, management of supernumerary teeth [51].
- Interdependencies with other services

12.1.3 Applicable Service Standards

- National Standards
- Local Standards

12.1.4 Key Service Outcomes

E.g.

- To provide optimum patient care
- To reduce referrals into secondary care for dentoalveolar surgery.
- To provide a positive patient experience through increased access to the service and increase patient perceived quality of life following effective treatment
- To provide cost effective practice

12.1.5 Performers

- Allocation criteria
- Competence
- Qualifications

---

[45] Available at: https://www.gdc-uk.org/Newsandpublications/Publications/Publications/Scope%20of%20Practice%20September%202013.pdf. Accessed February 2015.
[46] Available at: https://www.gdc-uk.org/Dentalprofessionals/Fitnesstopractise/Pages/default.aspx. Accessed February 2015.
[47] Available at: https://www.gdc-uk.org/Newsandpublications/Publications/Publications/Standards%20for%20the%20Dental%20Team.pdf. Accessed February 2015.
[48] Available at: https://www.gov.uk/government/publications/the-information-governance-review. Accessed February 2015.
[49] Available at: http://www.nice.org.uk/guidance/ta1/resources/guidance-guidance-on-the-extraction-of-wisdom-teeth-pdf. Accessed February 2015.
[50] Available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069257. Accessed February 2015.
[51] http://www.gdc-uk.org/Dentalprofessionals/Specialistlist/Documents/Oral%20Surgery%20Curriculum%20February%202014.pdf

- References
- Interview
- Portfolio
- Skills test
- MCN/LDN
- Communication skills

12.1.6 Service description

- Access/location
- Hours of operation
- Referrals management
- Radiographs required
- Waiting times
- Data protection
- Payments
- Care delivery
- Post-operative care
- Discharge

12.1.7 Quality Requirements

12.1.7.1 Generic specialist provider requirements

- Compliance with Health and Safety at Work etc. Act, 1974[52]
- Compliance with Employers' Liability (Compulsory Insurance) Act, 1969[53]
- Compliance with Electrical safety at work regulations[54]
- Compliance with safety requirements for autoclaves[55]
- Compliance with IRMER[56]
- Compliance with Control of Substances Hazardous to Health (COSHH)[57]
- Compliance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)[58]
- Compliance with Water Supply (Water Fittings) Regulations, 1999[59]
- Disability access requirements
- CQC registration[60]
- Risk management policy
- Business continuity plan
- Whistle-blowing policy
- Confidentiality
- Complaints
- Booking system
- Staffing

[52] Information available at: http://www.hse.gov.uk/legislation/hswa.htm. Accessed February 2915
[53] Information available at: http://www.hse.gov.uk/pubns/hse40.pdf. Accessed February 2015.
[54] Information available at: http://www.hse.gov.uk/electricity/. Accessed February 2015.
[55] Information available at: http://www.hse.gov.uk/pubns/guidance/pm73.pdf. Accessed February 2015.
[56] Available at: https://www.gov.uk/government/publications/the-ionising-radiation-medical-exposure-regulations-2000. Accessed February 2015.
[57] Information available at: http://www.hse.gov.uk/coshh/. Accessed February 2015.
[58] Information available at: http://www.hse.gov.uk/riddor/. Accessed February 2015.
[59] Available at: http://www.legislation.gov.uk/uksi/1999/1148/contents/made. Accessed February 2015.
[60] Information available at: http://www.cqc.org.uk. Accessed February 2015.

- Staff indemnity insurance
- Staff appraisal
- Staff personal development plans

12.1.7.2 Facilities and equipment

- Dental chair and operating light
- Single patient use water lines for Level 2 service provision[61][62]
- Surgical hand pieces and appropriate numbers of Oral Surgery instruments/equipment
- High volume aspiration
- Recovery area
- Emergency drugs including portable oxygen
- Airway adjuncts
- Appropriate monitoring equipment
- Arrangements for sharps disposal
- Defibrillator

12.1.7.3 Care Pathway

- Preoperative instructions
- Medical History forms
- Consent forms
- Post-operative instructions

12.1.7.4 Patient experience

- Care with dignity
- Patient feedback mechanism in place
- Collection of PREMs data (Section 13.2 of this document)

12.1.7.5 Professional standards

- Audit
- Record keeping

12.1.8 Education and Training

- Undergraduate
- Postgraduate
- Specialty trainees
- Remedial training

As Oral Surgery is a relatively new dental specialty, the number of training posts is small, despite population need. There is a requirement for training to be incorporated into the delivery of this Oral Surgery pathway. HEE should utilise needs assessment and commissioning outcomes to develop the workforce.

[61] Pankhurst CL, Coulter W, Philpott-Howard JJ, Harrison T, Warburton F, Platt S, Surman S, Challacombe S. Prevalence of legionella waterline contamination and Legionella pneumophila antibodies in general dental practitioners in London and rural Northern Ireland. British Dental Journal 2003; 195: 591–594.

[62] Pankhurst CL, Coulter W, Philpott-Howard JN, Surman-Lee S, Warburton F, Challacombe S. Evaluation of the potential risk of occupational asthma in dentists exposed to contaminated dental unit waterlines. PRIMARY DENTAL CARE. 2005 Apr;12(2):53 - 59.

12.1.9 Performance Indicators

- PREMs/PROMs as described in this document (Sections 13.2 and 13.3 of this document)
- Productivity
- Timescales
- Waiting list
- Failed attendances (FTA/DNA)
- Written care plans
- Treatment provided
- Proportion (%) of patients re-operated on or admitted to hospital post procedure
- Serious Untoward Incidents (SUI) reported
- Planned and unplanned follow up appointments
- Plaudits and complaints
- Results of user and service audits and improvements
- Patient safety[63][64][65]

12.1.10 Minimum dataset

- As described in Section 14.3 of this document

12.1.11 Service Implementation and Timescales

To be agreed between Commissioners and providers or included within service specification.

[63] Ashley MP, Pemberton MN, Saksena A, Shaw A, Dickson S. Improving patient safety in a UK dental hospital: long-term use of clinical audit. British Dental Journal. 2014 Oct;217(7):369-73
[64] Saksena A, Pemberton MN, Shaw A, Dickson S, Ashley MP. Preventing wrong tooth extraction: experience in development and implementation of an outpatient safety checklist. British Dental Journal. 2014 Oct;217(7):357-62
[65] Cevasco M, Ashley SW. Quality Measurement and Improvement in General Surgery. Permanente Journal 2011; 15(4): 48–53

Quality and outcome measures

Quality and outcome measures used in Oral Surgery and Oral Medicine will be used by a variety of groups including:

- Patients
- Patients' carers/families
- Professionals
- Commissioners

Specialty-specific measures used need to be patient-centred, clear and meaningful with regard to these different audiences using the data; for example, it should be possible for non-clinical audiences to understand clinical outcome measures.

12.2 Quality and Outcome Key Assessment Areas

12.2.1 Access

Access measures will need to be linked to, and considered against, local oral health needs assessments as well as service capacity, but should consider the following:

Referral to services

How service users access Oral Surgery services. This may be via a variety of means, including self-referral, GDP- or GMP- referral and referral management centres will need to be taken account of when developing appropriate measures and data sources.

Appropriate measures could also be developed to look at the gap between local oral health needs assessment and those actually accessing services.

Accessibility

The types of measures that might be considered include:

- location of services;
- ease of access for different patient groups including parking, ramps and rails, accessible toilets and all other requirements of the Equality Act 2010;
- Access to suitable transport or recommendations of transport services if not arranged by the dental service;
- Waiting times and access to urgent care.

A change of treatment location may be justified for clinical reasons; appropriate communication of this is necessary to prevent patients feeling disadvantaged.

Continuity of care and transitional arrangements

12.2.2 Communication

Some patients requiring Oral Surgery and Oral Medicine services will have special communication needs. Signage and accessible information such as 'Easy read' that take into account the additional needs of these patients must be appropriate to the individual needs of each patient. Large print or easy read appointment cards should be available, if required. Waiting area includes appropriate seating and communication aids as well as adequate space for people who use wheelchairs or mobility scooters.

12.2.3 Value for Money

Any assessment of value for money needs to take account of the balance between economics, efficiency and effectiveness.

12.2.4 Clinical Care

Clinical outcomes could be measured in terms of a blend of qualitative and quantitative measures, considering whether the right processes and protocols are in place and whether those processes and protocols are being used appropriately and effectively. Reports from CQC inspections and clinical audits may be utilised supported by triangulation with central data collection, where appropriate.

12.3 Oral Surgery and Oral Medicine Patient reported Experience Measures (PREMs)

Generic Patient Reported Experience Measures (PREMs) are included in the *Guide for Commissioning Specialist Dentistry Services.* Table 13.1 presents PREMs for Oral Surgery and Oral Medicine patients.

Table 13.1 Oral Surgery and Oral Medicine PREMs

Question	Patient response to be recorded
Did the clinical team (clinician) involve you in your treatment decision in terms that you understand?	*Agree/disagree/not sure*
Did you receive information about the risks/ benefits in terms that you can understand before the operation?	*Agree/disagree/not sure*
Was your pain managed well during the procedure?	*Agree/disagree/not sure*
Was your anxiety managed well during the procedure?	*Agree/disagree/not sure*
Did you receive information, in a format that you could understand, about care after the operation and a contact number to call for help?	*Agree/disagree/not sure*
Were you given the opportunity to ask questions?	*Agree/disagree/not sure*
Did a member of staff tell you about medication side-effects to watch out for when you went home?	*Agree/disagree/not sure*

12.4 Patient Reported Outcome measures (PROMs)

The use of appropriate PROMs is essential for measuring the four key areas (access, communication, value for money and clinical care). The measures should be patient-focused and consider potential inequalities throughout the patient journey. PROMs can be collected following treatment through 'home check' telephone calls and other surveys. However, providers should consider users' different communication needs and alternative ways in which they can provide feedback.

PROMs should include core data that are collected consistently at a national level; and may additionally include data collected at local levels. Triangulation with other sources of information should be possible in order to validate data. There should be evidence to demonstrate that PROMs data are representative of the patient groups treated and not just those who can easily provide feedback. Generic PROMs regarding the effectiveness of care (using simple questions around function and oral health) are included in the *Guide for Commissioning Specialist Dentistry Services*.

Oral Surgery and Oral Medicine services should report how they have evaluated, responded to, and acted upon PROMs feedback. Then they should demonstrate how services are being developed to improve patient experience as a result of these data.

12.4.1 Routinely-reported Oral Surgery PROMs

Routinely-reported (core) data should include specialty-specific (not procedure-specific) PROMs. These are detailed in Table 13.2 below.

Table 13.2 Core PROMS for Oral Surgery

Question	Response	Details
Did you need to seek advice or assistance hours/ days after the procedure?	*Yes/No/Unsure*	*List for data recorder (not shared with the patient unless clarification or prompts needed) Interested in:* *Uncontrolled bleeding (%)* *Inadequate pain relief that needed further medication (e.g. dry socket? Typically 5% of cases)* *Infection that needed further treatment (%)* *Damage to other teeth/fillings (%)* *Nerve injury altered sensation (Typically 1% of cases) fifth or trigeminal* *TMD*
Have you had to have additional surgery subsequent to this treatment?	*Yes/No/Unsure*	*If yes, what is the problem?* *Fractures jaw* *Unintentional root retention* *Bone infection* *Nerve injury (1%) fifth or trigeminal*
Time taken to achieve restoration of normal activities or appearance	*Yes/No/Unsure*	Days Weeks Months

Codes used for the Oral Surgery complications listed in Table 13.2 are based on the most contemporary revision of the WHO International Statistical Classification of Diseases and Related Health Problems, currently ICD-10[66][67] and NHS Classifications OPCS-4[68].

12.4.2 Relevant CQUIN outcomes for admitted OS patients.

- Number (%) of emergency readmissions within 30 days of discharge from hospital.
- Number (%) requiring revision of procedure.
- Number of days spent in hospital.
- Associated medical complications e.g. DVT, PE.
- Number (%) with hospital acquired infections e.g. MRSA.

12.4.3 Oral Medicine PROMS

PROMs are currently primarily used in Oral Medicine for research purposes. Whilst a significant number have been reported, the best validated and most commonly used are:

- Oral Health Impact Profile (OHIP) 14 and 49[69]
- Medical Outcome Survey Short Form 12, 20 and 36

[66] WHO International Statistical Classification of Diseases and Related Health Problems. ICD-10. Available at: http://apps.who.int/classifications/icd10/browse/2015/en Accessed February 2015.
[67] Health and Social Care Information Centre Technology Reference data Update Distribution site. NHS Classifications ICD-10 Available at: https://isd.hscic.gov.uk/trud3/user/guest/group/0/home. Accessed February 2015.
[68] Health and Social Care Information Centre Technology Reference data Update Distribution site. NHS Classifications OPCS-4. Available at: https://isd.hscic.gov.uk/trud3/user/guest/group/0/home. Accessed February 2015.
[69] Slade GD. Derivation and validation of a short-form oral health impact profile. Community Dental Oral Epidemiology. 1997 Aug;25(4):284-90.

Table 13.3 details the data that can be collected as part of the 'home check' contact 24 hours after treatment provision.

Table 13.3 Core PROM for Oral Medicine

Question	Response	Details
If you had pain and discomfort, have the options for management been explained and are they effective?	*Yes/No/Unsure*	*If No, request information re: postoperative information provided and nature of pain/discomfort.*

12.5 Clinical Outcome Measures

Clinical Outcomes

Reference to CQC inspection reports and CQC outcomes could be used as evidence that appropriate processes and protocols are in place.

Publication of key outcome measures for dentistry and Oral Surgery in accordance with MyNHS (February 2015).[70]

12.5.1 Oral Medicine clinical outcome measures

As with PROMs, clinical outcome measures in Oral Medicine are currently most commonly used to support research and include those relating to:

- Oro-facial disease: Oral disease activity scores (Lichen planus, mucous membrane pemphigoid, pemphigus vulgaris, oro-facial granulomatosis, recurrent aphthous stomatitis and Sjogrens syndrome); and

- Pain: Hospital Anxiety and Depression (HAD),[71] Brief Pain Inventory (BPI),[72] McGill Pain Questionnaire.[73]

12.6 Value and Impact

12.6.1 Value for Money

Assessing value for money needs to take account of local oral health needs assessments and service capacity.

Consider

- Access to Oral Surgery services and barriers to care.
- Efficiency and effective measures
    - access, waiting times, provision of urgent care / freedom from pain

[70] MyNHS (February 2015). greater transparency for better health and care MyNHS planning 2015-2017 Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403093/mynhsroadmap.pdf Accessed February 2015

[71] Ingvar Bjelland, Alv A Dahl, Tone Tangen Haug, Dag Neckelmann. The validity of the Hospital Anxiety and Depression Scale An updated literature review. Journal of Psychosomatic Research 2002 52 (2): 69–77.

[72] Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Annals of the Academy of Medicine, Singapore 1994: 23(2):129-138.

[73] Melzack R. The McGill Pain Questionnaire: Major properties and scoring methods. PAIN (1975) 1 (3): 277–299.

- some data could be collected using PROMs.
- Safety
- Quality of life questionnaires

12.7 Quality Assurance

12.7.1 Oral Surgery quality assurance

All patients deserve optimal health care that delivers maximum benefit and minimal harm. Oral Surgeons have traditionally measured their surgical activity and have not included measures for quality of care.

Quality indicators should assist in the analysis and optimisation of patients' care. They should reflect whether or not the treatment provided was indicated, appropriate, of benefit and acceptable to the patient and carer; and whether or not it was provided in a suitable accessible environment.

Evidence indicates that patients' perspectives may not accurately reflect the quality of surgical care. Specific care quality indicators are therefore required to capture outcomes of care. There are significant benefits to routine, quality-coded and qualitative data capture or process-of-care measures including:

- Process-based feedback.
  - This may more speedily incorporate improved outcomes into surgical practice, as opposed to analysis of morbidity and mortality rates;
- Incorporation of patient safety measures into the captured data.
  - This will help simplify data-collection efforts and enhance pay-for-performance initiatives;
- Process-of-care analysis.
  - This will help identify best practice, an important component of surgery improvement efforts currently missing from outcomes measures;
- Standardised measurement across health settings.
  - This improves communication and information transfer.

Health team culture is particularly important. Whilst the WHO Surgical Safety Checklist has been demonstrated to improve the quality of surgical care, its impact depends on how effectively it is implemented. This has been recently evidenced in relation to wrong site surgery in Oral Surgery. A minimal data set using routine NHS coded data capture and patient feedback is required to ensure that Oral Surgery care and patient safety continues to improve

Direct measurement of surgical skills may play a growing role in future quality measurement and improvement efforts by, for example, minimising nerve injury in relation to dental surgery. Traditionally, surgical and communication skills have been assessed through direct observation by mentors and peers, but there is mounting pressure for more formal measurement. Precisely how to measure these skills has not been clearly established; the reasons for this include lack of objective assessment methodology, lack of proper infrastructure for implementation, and high costs associated with individual performance analysis. It is important that quality measurement and improvement in general surgery is here to stay.

12.7.2 Oral Medicine quality assurance

It is to be expected that clinicians engage with the British Society for Oral Medicine quality assurance process which considers the subject in relation to four areas:

- Personal and public lives;
- Professional lives as clinicians;
- Professional lives as researchers;
- Professional lives as teachers.

12.7.2.1 Personal and public lives

Guidance in this area is provided by The Committee on Standards in Public Life (the so-called Nolan Committee, 1995) which set out seven principles (selflessness, integrity, objectivity, accountability, openness, honesty and leadership) which are also inculcated into the GDC's document 'Standards for the Dental Team'.[74]

12.7.2.2 Professional lives as clinicians

It is to be expected that clinicians work within their expertise and competencies and adhere to the available guidelines for various clinical conditions and their management.

It is also essential that professionals endorse and work within a no-blame culture where important lessons from errors or 'near misses' are shared openly and without fear of recrimination.

12.7.2.3 Professional lives as researchers

Expectations in this area are outlined in the GMC 'Good Medical Practice – Good Practice in Research: Honesty and Integrity' as well as by the Higher Education Funding Council for England (HEFCE)[75] guidance in relation to open-access to peer-reviewed publications.

12.7.2.4 Professional lives as teachers

This aspect is well addressed by Higher Education Academy (HEA)[76] which has published benchmark descriptors to allow individual academics and their institutions to be recognized as pursuing excellence in their field of teaching and learning.

[74] General Dental Council (2013) Standards for the Dental Team. Available at: http://www.gdc-uk.org/Dentalprofessionals/Standards/Pages/standards.aspx Accessed February 2015
[75] HEFCE. http://www.hefce.ac.uk/
[76] HEA; https://www.heacademy.ac.uk

13 Contracting

13.1 Regulation

NHS Personal Dental Services Agreement 2013[77]
NHS General Dental Services Contract 2013
NHS Standard Contract[78]

NHS PDS Agreements and GDS Contracts enable contracting for advanced mandatory primary care services that could include Oral Surgery. PDS contracts can specify the length of contract and be used where the full range of mandatory services are not being provided. The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care.

13.1.1 Factors for consideration

- **Patient charge revenue (PCR):** PDS and GDS contracts permit collection of PCR; NHS standard contract does not
- **Differing activity measures and currencies:** PDS and GDS (Units of Dental Activity, UDA); National contract (activity based upon outpatients, inpatients and day case volumes – national tariff)
- **Performers List:** GDS and PDS contracts require performers delivering services to be on the national performers' list; no similar requirement exists for clinicians based in secondary care Oral Surgery/OMFS and Oral Medicine units
- **Performance metrics:** in order to establish a level playing field for services on referral (regardless of provider) there should be consistent expectations with respect to quality and outcomes.
- **Remuneration for service providers:** This should be consistent and reflect consistency in the competencies of clinicians delivering the services and consistent standards with respect to the service facilities/environment.
- ***Currently there is significant variation across secondary care provision, and almost no way of benchmarking between primary and secondary care provision, even where this is comparable.***
- **Coding:** Use of consistent coding is necessary so that commissioners have access comparable information and can comprehensively understand the services being delivered to the local population.
- **Tariff considerations:** particularly in light of 'local tariffs' and variable overhead costs.
- **Local variation:** Models of service delivery may need to vary to reflect different geography and local skill mix. Commissioners may wish to consider a contract to deliver services at multiple sites,
- **Training requirements:** It may be appropriate to incorporate training requirements within some contracts to enable:
    - Maintenance of performer competency levels
    - Training/support for referring clinicians who need to improve core skills.
    - More formal undergraduate and postgraduate student training placement requirements.

[77] Available at: https://www.gov.uk/government/publications/standard-general-dental-services-contract-and-personal-dental-services-agreement. Accessed February 2015.
[78] Information available at: http://www.england.nhs.uk/nhs-standard-contract/. Accessed February 2015.

- There are currently some 'non-hospital based' services (under Primary Care contracts / NHS Standard / other) with issues such as variable superannuation eligibility for performers.

13.2 Enablers for delivery

13.2.1 Referral Management

Referral management offers the following benefits:

- Use of a unique patient reference (e.g. NHS number, or another unique reference number) to track referral;
- Improved quality of referrals with respect to clinical data and rationales for care;
- Permits patient choice;
- Enables provision of care in the most appropriate setting;
- Facilitates collection of local needs assessment data;
- Can react to waiting list pressures by redirecting patient flow;
- Informs commissioners with respect to referral patterns;
- Supports a consistent approach for Oral Surgery coding;
- Enables improved transparency with respect to costs of service provision.

13.3 Minimum standard data collection and reporting

Standard data collection and reporting should reflect the main objectives of the quality framework for dentistry[79] and national commissioning intentions[80] i.e. the implementation of patient pathways that include consistent:

- Coding (Appendix 9 of this document);
- Clinical outcomes;
- Quality Standards;
- PROMs and PREMs (Section 13 of this document)

Minimum standards should be established with respect to:

- Facilities to be provided;
- Decontamination arrangements;
- Clinical standards;
- Clinician competency to undertake particular levels of complexity;
- Clear activity measures;
- Participation in national audit programmes;
- Waiting times;
- Patient safety data.

13.3.1 Data collection

- A standard dataset should be collected across the whole pathway
- This should include consistent coding /recording of:
    - activity / number of referrals received;
    - waiting times;

[79] Dental Quality and Outcomes Framework 2011. Available at: https://www.gov.uk/government/publications/dental-quality-and-outcomes-framework. Accessed February 2015.
[80] NHS Commissioning Board. Securing Excellence in Commissioning NHS Dental Services February 2013. Available at: http://www.england.nhs.uk/wp-content/uploads/2013/02/commissioning-dental.pdf. Accessed February 2015.

- patient feedback;
- number of completed cases;
- number of cases subject to onward referral/could not be treated by provider;
- failed/cancelled appointments.

13.3.2 Coding

There should be an equitable approach to coding across all settings and good oral health outcomes. Coding should be applicable to the following stages of the pathway:

- Diagnostic;
- Treatment;
- Adjunctive;
- Outcome;
- Comorbidity.

13.3.3 Codes currently used in secondary care

Descriptions of the diagnostic, treatment, adjunctive, clinical outcome and co-morbidity codes currently used within Acute Trusts are presented in Appendix 9 of this document, along with sources of current coding reference documents. Current coding deficiencies are also highlighted.

13.3.4 Clinical Quality Outcomes

Table 14.1 outlines specific quality outcomes that are recommended for Oral Surgery.

Table 14.1 Clinical Quality Outcomes for Oral Surgery

QUALITY OUTCOME	Details	Reference in this Commissioning Guide document
Clinical codes	In order to measure quality and effectiveness, these should include: Diagnosis Treatment Outcomes	Appendix 9: coding used by secondary care Oral Surgery department
Clinical effectiveness	**Diagnosis OPCS-4 codes** **Treatment ICD codes** **Outcomes ICD codes** **Reported patient safety events** *Could include:* *Consent* *Patient info* *Pain management* *Anxiety management* *Patient information* *Morbidity* *PROMS* *Patient safety (QOF, CQUIN, CQC, MHRA)* *Compliance with guidelines:* *Patient information* *Antibiotic prescribing* *NICE indications for M3Ms* *Endodontic surgery* *Dry socket* *Basic suggestion - Have you required further corrective surgery?* *Retreatment surgery or medication or admission* *Mortality* *Professional standards e.g. GDC, RCS*	
Quality standards	Quality and Outcomes Framework (QOF)[81]	
Patient experience	Specialty-specific (NOT procedure-specific) PREMs & PROMs	Sections 13.1, 13.2 and 13.3
Safety	**Medication and Healthcare products regulatory agency (MHRA)** reported adverse drug reactions using the Yellow Card Scheme (any drug related serious event see below)[82] Medical history checked. Appropriate drug prescription[83] **NPSA/ NRLS[84] [85]** Wrong site surgery Wrong implant Retained foreign object Overdose of midazolam STEIS (http://www.nrls.npsa.nhs.uk/report-a-	

[81] Health and Social Care Information Centre. Quality and Outcomes Framework. Available at: http://www.hscic.gov.uk/qof Accessed February 2015
[82] MHRA Vigilance, safety alerts and guidance . Available at:. http://www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/ Accessed February 2015
[83] SCDEP Drug Prescribing For Dentistry Second Edition, published August 2011 Latest Update - September 2014. Available at: http://www.sdcep.org.uk/?o=2334 Accessed February 2015
[84] NHS Commissioning Board Special Health Authority Patient Safety (National Patient Safety Agency) Available at: http://www.nrls.npsa.nhs.uk/ Accessed February 2015
[85] National Patient Safety Agency National Reporting and Learning System Available at: https://report.nrls.nhs.uk/nrlsreporting/ Accessed February 2015

	patient-safety-incident/serious-incident-reporting-and-learning-framework-sirl/) **Commissioning for Quality and Innovation (CQUIN)**[86] NHS Trusts report quarterly on: The proportion of patients with harm from a fall in care The proportion of patients with a VTE risk assessment % The proportion of patient with appropriate VTE prophylaxis % The proportion of patients being treated clinically for a new VTE% Overall The proportion of patients with 'harm free' care% **Care Quality commission (CQC)**[87] Collates data on reported serious events and governance and PROMs & PREMs. Serious events must be reported to the CQC within 21 days by provider or registered manager[88] if: Is fatal Is life-threatening- the patient is was in the view of the investigator, at immediate risk of death from the adverse event as it occurred Results in an UNPLANNED in-patient hospitalisation, or prolongs an existing hospitalisation Is significantly or permanently disabling Is a congenital anomaly or birth defect Iv antibiotics Serious harm to patients or death are events that require obligatory reporting to CQC and commissioning body	

13.3.5 Primary Care Oral Surgery Provider minimum data set

The following is an example minimum dataset currently used by a primary care specialist Oral Surgery provider.

13.3.5.1 Diagnosis and Procedure

- Unique patient reference number
- Performer name
- Provider practice
- Name of referring dentist
- Date referral received by practice
- Date of appointment given
- Length of time from referral to appointment
- Appointment attendance (attended/failed)
- Pre-operative assessment appointment details
- Details of procedure performed
- Procedure date
- Follow-up visit details
- Total number of visits to complete the treatment
- Details of discharge letter sent to referring practitioner
- Oral Surgery-related adverse events
- Oral Surgery complication details, if any

[86] CQUIN http://www.institute.nhs.uk/commissioning/pct_portal/cquin.html
[87] Care Quality Commission. Dentistry. Available at: http://www.cqc.org.uk/content/dentists Accessed February 2015
[88] Care Quality Commission. Notifications. Available at: http://www.cqc.org.uk/content/notifications Accessed February 2015

- Treatment provided for Oral Surgery complication
- Final outcome of treatment
- Biopsy result
- Appropriateness of referral for the service
- Payment validity details

13.3.5.2 Outcomes of appointment

- Attended
- Not suitable for primary care Oral Surgery service
- Operative Procedure Not Required
- Patient Cancelled
- Patient Did Not Attend
- Unable to contact patient despite repeated attempts

13.3.5.3 Clinical Outcome

- Bleeding
- Dry Socket
- Generalised Pain
- Infection
- None
- Oro-antral Communication
- Possible nerve injury
- Swelling

13.3.5.4 Treatment provided for complication

- Debridement of Bone
- Intraoral Incision and Drainage Of Abscess.
- Packing of tooth socket
- Prescription of Oral Antibiotics
- Surgical Arrest of Bleeding from Tooth Socket
- Suture of gingiva

13.3.5.5 Outcomes of treatment

- Discharged- No Treatment provided
- Discharged- Treatment Completed
- For Follow up
- Referral to Secondary Care: Further management of current treatment
- Referral to Secondary Care: As a new consultation
- To see referring GDP for further discussion/management

14 Next steps

This commissioning guide contains evidence on how to commission and monitor the specialty. Commissioners can use this guide to review progress against the enablers that would assist them to implement redesigned pathways to benefit patients. The first task will be to complete a needs assessment, working with PHE Consultants in Dental Public Health, clinicians and other stakeholders, including patient groups. The introduction of a referral management system and establishing a MCN network to engage clinicians should underpin this. This guide contains direction and detail to facilitate regions to make progress to implement best practice pathways.

Appendix 1 – Membership of the Oral Surgery and Oral Medicine Working Group

Paul Coulthard	Chair of the Oral Surgery and Oral Medicine Working Group, and Head of the School of Dentistry, The University of Manchester
Tim Baker	Association of Dental Hospitals
Colette Balmer	Secondary Care Oral Surgeon
Pippa Blacklock	SAS Grade Oral Surgeon
Julie Bradshaw	NHS England, Contracts Manager & Strategic Dental Lead, Essex
Colette Bridgman	Consultant in Dental Public Health
Pete Brotherton	SAS Grade Oral Surgeon
Melanie Catleugh	Public Health England
Geoff Chiu	Fellow in training OMFS
Andy Cole	NHS Business Services Authority
Dave Cottam	British Dental Association
Gary Cousin	Faculty of Dental Surgery, Royal College of Surgeons of England
Michael Davidson	British Association of Oral and Maxillofacial Surgeons
Tariq Drabu	Dental Local Professional Network
Michael Escudier	British Society for Oral Medicine
Helen Falcon	Health Education England
Emma Fernandez	Royal College of Surgeons
Ruth Gasser	NHS Business Services Authority
Mark Greenwood	Association of Dental Hospitals
Rob Haley	NHS England, Commissioning Guides Support
Andrew Harris	NHS England, Commissioner
Elaine Hawthorne	Dental Local Professional Network
Richard Hayward	Faculty of General Dental Practice
Ann Heaton	Patient / Public representative
Rebecca Hierons	Primary Care Oral Surgeon
Dionne Hilton	NHS England, Dental Pathways Programme Manager
Ilanko Ilankovan	British Association of Oral and Maxillofacial Surgeons
Clare Jones	NHS England, Commissioning Guides Support
Serbjit Kaur	NHS England, Deputy Chief Dental Officer
Jasveen Matharu	Dental Core Trainee
Neil Oastler	Primary Care Oral Surgeon
Kim Piper	British Society for Oral and Maxillofacial Pathology
Tara Renton	British Association of Oral Surgeons
Nouha Seoudi	Oral Microbiology
Ian Sharp	Associate Postgraduate Dental Dean
Andrew Smith	Oral Microbiology
Ben Squires	NHS England, Head of Primary Care Operations, Lancashire & Greater Manchester
Madeleine Wang	Patient / Public representative
Cem Yatak	NHS England, Programme Support

This does not mean endorsement of these guides by any individual or their organisation

Appendix 2 – Glossary of Terms

Commissioning	The Department of Health defines commissioning as the means to secure the best value health care for the local population and tax payers
CCGs	Clinical commissioning groups are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
CPD	Continuing Professional Development is an activity that contributes to an individual's professional development and is relevant to their practice or intended practice.
CQC	The Care Quality Commission is the independent regulator of health and social care in England. It is responsible for monitoring, inspecting and regulating services to make sure they meet fundamental standards of quality and safety and publishes findings, including performance ratings to help people choose care.
CQUIN	The Commissioning for Quality and Innovation payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
FP17	Providers submit forms detailing dental activity data. The data recorded on the FP17 show the patient charge collected, the number of units of activity performed and treatment banding information.
HEA	The Higher Education Academy (HEA) is the national body for enhancing learning and teaching in higher education (HE).
HEE	Health Education England is a Special Health Authority of the Department of Health. Its function is to provide national leadership and coordination for the education and training within the health and public health workforce within England.
HEFCE	The Higher Education Funding Council for England promotes and funds high quality, cost-effective teaching and research, meeting the diverse needs of students, the economy and society.
HES	Hospital episode statistics contains details of all admissions to NHS hospitals and all NHS outpatient appointments in England
HTM 01-05	Health Technical Memoranda are guidance documents providing comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare. HTM 01-05 is focuses on the quality of decontamination

	work in primary care dental services by covering the decontamination of reusable instruments within dental facilities.
ICD codes	International Statistical Classification of Diseases and Related Health Problems This a medical classification list used by the World Health Organization. It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.
MCN	Managed Clinical Networks. Linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and Health Board boundaries, to ensure equitable provision of high quality clinically effective service.
NHSBSA Dental Services	The NHS Business Services Authority Dental Services remunerates dentists and provides dental statistics and key information to national, regional and local NHS organisations.
OMFS	Oral and Maxillofacial Surgery. A surgical specialty that treats and manages conditions and diseases affecting the face and neck as well as the mouth and jaws
OPCS Codes	The Office of Population Censuses and Surveys (OPCS). This is a published procedural classification and coding of operations, procedures and interventions. This is a 4 character code system. The first character is always a letter and the other three are numbers. All codes beginning with ‘F’ are related to the mouth
PbR	Payment by results. The mechanism which secondary care providers use to finance their service.
PCR	Patient charge revenue is generated by the fees charged for dental treatment at Band 1, 2 and 3.
Performer	A qualified clinician who is contracted to perform the service
PREMs	Patient Reported Experience Measures is a rolling programme of experience gathering which reports regularly to demonstrate experience trends and can be used to inform service development and improvement. This is usually completed through questionnaires.
PROMs	Patient Reported Outcome Measures are a quality of life measure, by measuring the quality of life before and after a treatment or intervention, then again a fixed amount of time after. This gives insight into the impact of a treatment or intervention to a patient’s life
Provider	The contract holder to provide a service.

QOF	The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice. The QOF contains five main components (domains): Clinical; Public Health; Public Health - Additional Services; Patient Experience; Quality and Productivity. Each domain consists of a set of achievement measures, known as indicators, against which practices score points according to their level of achievement. The Dental Quality and Outcomes Framework (DQOF) forms part of the arrangements for piloting aspects of reforms to the NHS dental contract and will measure the performance and clinical outcomes of dentists' work.
SAS grade clinicians	The Specialty and Associate Specialist (SAS) grade includes associate specialists, specialty doctors, staff grades, clinical assistants, general medical practitioners, general dental practitioners and hospital practitioners. SAS clinicians provide experienced, specialist care, often within a multi-disciplinary team. They are responsible for the delivery of a significant proportion of Oral Surgery service.[89] SAS doctors/dentists are non-training roles where the doctor/dentist has at least four years of postgraduate experience, two of those being in a relevant specialty. Whilst staff grade and associate specialists are amongst the grades included as SAS doctors, these grades are now closed to new entrants. New recruits are named 'Specialty' doctors or dentists.
SLAM	Service Level Agreement Monitoring data, sometimes called Trading Data, are routinely sent from NHS Trusts to Commissioning organisations according to provisions of the information schedule in the standard contract. Almost all acute Trusts send trading data, but there is no standardised way of sharing the same information. Trading data are effectively a monthly invoice, aggregated and at patient level, sent according to the national timetable of reconciliation and post-reconciliation dates.
SUS	Secondary Uses Service data are patient-level information regarding service provision. This information can be used for healthcare planning, commissioning services, Payment by

[89] Brotherton P, Gerrard G, Bennett K, Coulthard P. The scope of practice of UK Oral Surgeons. Oral Surgery 2015;8(2):25

Results, improving public health and developing national policy.

Appendix 3 – Oral Surgery Specialty Training Learning Outcome[90]

Learning outcomes are categorised within the following key areas:

- Extraction of teeth & retained roots/pathology and management of associated complications including oro-antral fistula
- Management of odontogenic and all other oral infections
- Management of impacted teeth; management of complications
- Peri-radicular surgery
- Dentoalveolar surgery in relation to orthodontic treatment
- Intraoral and labial biopsy techniques
- Treatment of intra-oral benign and cystic lesions of hard and soft tissues
- Management of benign salivary gland disease by intra-oral techniques and familiarity with the diagnosis and treatment of other salivary gland diseases
- Insertion of osseointegrated dental implants including bone augmentation and soft tissue management
- Appropriate pain and anxiety control, including the administration of standard conscious sedation techniques
- Management of adults and children as in-patients, including the medically at risk patient
- Management of dentoalveolar trauma and familiarity with the management and treatment of fractures of the jaws and facial skeleton
- Management of oro-facial pain including temporomandibular joint disorders
- Clinical diagnosis of oral cancer and potentially malignant diseases, familiarity with their management and appropriate referral
- The diagnosis of dentofacial deformity and familiarity with its management and treatment
- Diagnosis of oral mucosal diseases and familiarity with their management and appropriate referral.

Appendix 4 – Outcomes[91]

Oral Medicine Specialty Training Learning

- History taking
- Clinical examination
- Investigations
- Patient management
- Prescribing and therapeutics
- Operative interventions e.g. definitive management of benign disease or tissue diagnosis (including oral malignancy)
- Knowledge of oral soft tissue health and correlation of health of lips/oral soft tissues to disease states
- Specialist assessment and management of oral soft tissue disease
- Investigation, diagnosis and management of hypersensitivity reactions
- Diagnosis of oral soft tissue infections
- Knowledge of salivary glands and saliva in health and correlation of health of salivary glands and saliva to disease states
- Knowledge of the nervous system in health and correlation of health of the nervous system to disease states
- Diagnosis and management of orofacial pain
- Diagnosis and management of neurological dysfunction
- Provision of advice with respect to specific oral implications of disease
- Development of management plan for chronic disease
- Identification of serious or incidental psychiatric morbidity in patients presenting with oral disease

Substantive and Honorary Consultants in Oral Surgery in the UK possess clinical competences that differentiate a Consultant from a Specialist and may include the following[90]:

- Management of jaw and facial fractures
- Management of congenital and acquired jaw anomalies
- Advanced oral implantology and bone augmentation
- Diagnosis and treatment of anomalies and diseases of the TMJ
- Diagnosis and treatment of salivary gland diseases
- These individuals also have training in management of healthcare delivery and competencies in research and/or critical appraisal.

[90] Career Development Framework for Consultant Appointments in Oral Surgery. 2010 Specialty Advisory Committee in Oral Surgery The Faculty of Dental Surgery. The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London, WC2A 3PE.

EU Directive XV/E/8385/3/95-EN by the Advisory Committee on the Training of Dental Practitioners (ACTDP).

Appendix 5 – Competency Framework for Oral Surgery practitioners

N.B. The professional qualifications and training requirements listed in this table apply to individuals who are currently undertaking training or who wish to undertake training in the future. Existing practitioners and providers may not necessarily have followed the recently established training pathways, and may not hold any or all of these qualifications, but have demonstrated clinical excellence in Oral Surgery for many years. These practitioners should not currently be excluded from consideration of provision within the commissioning process.

Assurance Criteria	Primary care dentist (non-specialist)	Dentist with enhanced skills and competence	Specialist in Oral Surgery	Consultant in Oral Surgery
Experience	Registered as a dentist with the GDC.	GDC-registered primary care dentist with enhanced skills and competence in Oral Surgery	Must be on GDC Oral Surgery Specialist List.	Must be on GDC Oral Surgery Specialist List.
Qualifications	No additional qualifications necessary.	Additional experience, enhanced skills and competence assured by MCN		
Training in Oral Surgery	No specific training in Oral Surgery.	No specific training in Oral Surgery. Evidence of experience, enhanced skills and competence		
Teaching and Education	Undergraduate teaching in Oral Surgery. May have attended relevant postgraduate Oral Surgery courses.	Evidence of attendance at relevant postgraduate Oral Surgery courses. Evidence of experience, enhanced skills and competence.	Supervision of higher training in Oral Surgery and provision of mentorship for dentists with enhanced skills and competence who provide primary care Oral Surgery services. Involvement in undergraduate &/or postgraduate training desirable.	Leading higher training in Oral Surgery and provision of mentorship for dentists with enhanced skills and competence who provide primary care Oral Surgery services. Involvement in undergraduate &/or postgraduate training desirable.
Referral Base	Providers must provide Level 1 care.	Providers will accept Level 2 care referrals as defined by the terms of the Oral Surgery care pathway. It is not expected that Level 1 care will be provided.	Providers will accept Level 2 referrals as defined by the terms of the Oral Surgery care pathway	Providers will accept Level 3 referrals as defined by the terms of the Oral Surgery care pathway

Assurance Criteria	Primary care dentist (non-specialist)	Dentist with enhanced skills and competence	Specialist in Oral Surgery	Consultant in Oral Surgery
Clinical Expertise	Clinical experience limited for patients with Oral Surgery needs. May undertake shared care with specialist or dentists with enhanced skills and competence. Ability to recognise when the help and advice of a specialist or dentist with enhanced skills and competence is required.	Ability to carry out a range of clinical activity for patients with moderate needs. Ability to recognise when help and advice of a specialist is required. Membership of Managed Clinical Network (MCN)	Acceptance of a wide range of clinical cases for patients with complex needs. Taking a lead role for developing a local infrastructure for the delivery of Oral Surgery. Participation in Managed Clinical Network.	Acceptance of a wide range of clinical cases for patients with complex needs. Taking a lead role for developing a local infrastructure for the delivery of Oral Surgery, including service development and workforce planning. Participation and supervisory role in Managed Clinical Network
Continuing professional development	May attend relevant Oral Surgery courses as part of CPD cycle (GDC requirement.	Participation in CPD of relevance to Oral Surgery. .	Co-ordination, provision and participation in CPD in Oral Surgery.	Taking a lead role, provision and participation in CPD in Oral Surgery.
Setting and Facilities	Primary care setting. Compliance with CQC, DDA and HTM 01-05. Appropriate Oral Surgery equipment to meet current quality and patient safety standards.	Primary care setting. Compliance with CQC, DDA and HTM 01-05 at best practice level. Appropriate Oral Surgery equipment to meet current quality and patient safety standards. Provision of care as per specific contract.	Clinical experience and training enables provision of care in a variety of clinical settings, including primary and secondary care. Appropriate Oral Surgery equipment to reflect complexity of procedures delivered, which meets current quality and patient safety standards.	Clinical experience and training enables provision of care in a variety of clinical settings including primary and secondary care. Appropriate Oral Surgery equipment to reflect complexity of procedures delivered which meet current quality and patient safety standards.
Dental team and multidisciplinary teams	Works with dental team and may not have any training in Oral Surgery	Dental team trained both formally and informally in Oral Surgery, appropriate to contracted activity, to include sedation, BLS/PLS etc.	Dental team trained both formally and informally in Oral Surgery appropriate to contracted activity to include sedation, ILS/PLS etc.	Dental team trained both formally and informally in Oral Surgery to include sedation, ILS/PLS etc. Part of MDT.

Appendix 6 – Specialist Dental Services Referral Form Example

ORAL MEDICINE FORM

Age of Patient in years:	Patient's Title & Name:	Sex ...	Date of Birth (DD/MM/YY) / /
Patient's Address:			
Patient's Town or City:	Preferred Contact No:		Patient's Postcode

Referrer's Name:	Practice Postcode:	Date of Decision to refer / /	Interpreter required? ☐ YES / ☐ NO Language?
Practice Name and Address:			Practice Phone Number:
GDC Number:	Care Type (Routine or Urgent) (NOTE - Use HSC205 for suspected cancer referrals) Select..		URN:
If Urgent Care please state why:			

RADIOGRAPHS MUST BE ATTACHED FOR HARD TISSUE REFERRALS

Patient's GP Name and Address including Postcode:

Patient's principle complaint and history of complaint:
(Please include any previous treatment for the condition referred or hospital visits).

****PLEASE NOTE THAT THIS FORM SHOULD NOT BE USED FOR SUSPECTED CANCER REFERRALS.**

Patient's past medical history, medication and relevant social history (NOTE: If extensive medical history and medication, please complete a separate medical history form):

Please describe here any additional information, and add additional sheets as necessary (quoting URN)

Please describe your examination findings. Describe why specialist care is required?

Appendix 7 – Example of Primary Care-Based Specialist Oral Surgery Services

The North East Primary Care Oral Surgery Services:
Queensway Dental Clinic, Teeside, County Durham & Darlington

Services: these were commissioned as PDS (Personal Dental Service) and AQP (Any Qualified Provider) contracts as two separate services: QDDOSS (Queensway Durham and Darlington Oral Surgery Service) in 2008 and QTOSS (Queensway Tees Oral Surgery Service) in 2009. Queensway remains the sole provider for Tees but has been joined by two other regional providers for the Durham & Darlington Service following the AQP procurement in 2012.

Remit: to provide intermediate Oral Surgery services for adults and adolescents as an alternative for GDPs to referring patients to secondary care. Procedures are performed under local anaesthetic with or without relative analgesia or intravenous sedation based on patient need. ASA I, II and stable ASA III patients are treated. Further information can be found on the following link:
http://www.queensway.co.uk/dental-treatments/oral-surgery/

Requirements: all surgeons providing treatment must be on the specialist list for Oral Surgery (subject to postgraduate training which is specialist-led – see below). DCPs (Dental Care Professionals) are sedation qualified to a national standard. All premises and facilities meet contemporary NHS standards and have passed CQC inspection.

Model: agreed referral protocols have been adopted. GDPs complete a standard referral form, which is logged on receipt by the reception staff. Initial triage is carried out and non-compliant forms are returned to the GDPs for clarification. At assessment by a Specialist Oral Surgeon (at a separate visit to the potential treatment) the patient is consented for treatment, referred back to the GDP or referred to secondary care as appropriate. Copies of all referral protocols and assessment documentation as well as service specification are available on:
http://www.queensway.co.uk/dental-professionals/dental-referrals/oral-surgery-referral-form-darlington-and-durham/
Protected appointment time for the assessment and treatment of urgent cases is available. Aftercare and follow-up arrangements are in place for every patient.

Table APP7.1 reflects a typical year for each service.

	QDDOSS Service Summary 2012-2013	QTOSS Service Summary 2012-2013
Referrals Received Male Female	3619 1639 1980	2676 1342 1334
Non-responders	491	648
Assessments Assessments booked Not Met Referral Criteria Referred to Secondary Care Failed to attend assessment	 3128 173 128 363	 2028 64 38 274
Treatments Local Anaesthesia IV Sedation Inhalation Sedation Failed to attend treatment Total Treatments	 689 711 890 174 2290	 459 605 513 75 1577

Complications: Complications are logged, audited, sent to the commissioners and discussed at quarterly peer review meetings.

Table APP7.2 Average complication rates of all treatments over a six-year period (2008-2013) for QDDOSS & QTOSS

	Bony Sequestrum	Dry Socket	Post-op Infection	Post Op Bleeding	Pain Post Extraction	Other (altered sensation)	Total
% Of Total Treatments	0.04%	2.00%	2.79%	0.02%	1.59%	2.39% (0.4%)	8.83%

Patient Satisfaction: All patients are invited to fill out a satisfaction survey immediately after their treatment appointment (this is surgeon-specific). The overall patient satisfaction scores for both services over the same six year period is shown below:

Table APP7.3 Patient Satisfaction Trends

Overall Patient Satisfaction	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
Excellent	96%	94%	93%	98%	96%
Very Good	4%	6%	7%	2%	4%

Complaints: both verbal and written complaints have been low, averaging 1 or 2 a year for both services. These have all been amicably resolved within the practice.

Training opportunities: The specialists delivering this service are keen to promote Oral Surgery training for referring colleagues. To this end, both services were contracted in 2014 by the Deanery to provide one session of Oral Surgery hands-on training to each of the regional FDs (Foundation Dentists), which was agreed by the commissioners. All patients were fully informed and appropriately consented. 75% of FDs responded to the feedback questionnaire, 100% felt that all learning outcomes were achieved, that the training would change the way they worked and all would recommend the session to others. Additionally, two of the specialists provide phantom head Oral Surgery courses to GDPs for the Deanery and one-to-one Oral Surgery sessions in the practice. There is separate Deanery funding for these sessions due to the resource implication, as time is needed for teaching. Other GDP colleagues are welcome to come and observe at any time.

Summary: QDDOSS and QTOSS are highly successful services. They are run to optimal clinical and surgical standards with low complication rates and excellent patient satisfaction. They also demonstrate it is possible to carry out high quality post-graduate Oral Surgery training in a primary care setting.

Appendix 8 – Example of Transformation of Services

The Birmingham Model

The Greater Birmingham area is a large conurbation at the heart of the West Midlands, with a population of 2 million people. The area is served by a MCN for Oral Surgery with appropriate engagement from the multiple providers across the area and a clear agenda in regard to transforming Oral Surgery provision.

The MCN includes primary, secondary and tertiary care representatives from Birmingham, Solihull and the Black Country – which is the geographical scope of the LPN. As such, the MCN includes a number of commissioners, GDPs, Oral Surgeons from Birmingham Dental Hospital, Salaried Services clinicians and managers, OMFS Surgeons and DPH Consultants.

Delivery of services across such a large and diverse patch is complicated. Patient access is variable and has been addressed over recent years via a number of developments in salaried services centres. These provide excellent facilities in which outreach services can be provided with appropriate specialists visiting on a sessional basis. Specialist sessions in Orthodontics, Paediatric Dentistry and Oral Surgery / OMFS are provided.

The OMFS service at University Hospital Birmingham provides a hub and spoke model with eleven consultants and all inpatient work centred at University Hospital Birmingham, but with regular outreach services being provided at DGH units in Solihull and City Hospital and paediatric services at Birmingham Children's Hospital. Joint clinics for tertiary work are carried out at Birmingham Dental Hospital, Birmingham Children's Hospital and University Hospital Birmingham with appropriate specialist representation in all these clinics. Through this model, the team is able to deliver both a local OMFS service, a large volume of Level 2 and 3 Oral Surgery and also address the needs of the regional and supraregional services which are hosted in the unit.

Birmingham Dental Hospital is a part of Birmingham Community Healthcare Trust and is currently going through transition and integration with the broader community dental service. The Oral Surgery department at Birmingham Dental Hospital delivers a large volume of all aspects of Oral Surgery and is responsible for the training of undergraduates and postgraduates. Treatment under sedation is a particular strength.

A number of practices in the area have specialist level practitioners delivering significant amounts of Level 2 Oral Surgery activity and providing services with sedation support. A highly developed sedation service runs as an integral part of the salaried services delivery across the area.
There are important considerations with regard to training in the Undergraduate and Postgraduate arena and the hospital units deliver Oral Surgery and OMFS in a

coordinated way. Through joined-up working and shared programmes, the units have delivered a 3 +2 Oral Surgery training pathway to Consultant level as well as hosting 40 Dental Core Trainees across the Birmingham, Solihull and the Black Country area. The OMFS units deliver training in OMFS for 9 trainees as part of the wider West Midlands rotation.

The next step in development of the network is implementation of a referral triage and allocation process to ensure most appropriate management of patients close to their home and by the correct practitioner. The principle of training following service has served patients, trainees and units well and is vital for maintaining and developing the skills of the workforce.

Appendix 9 – Coding used by Secondary Care Oral Surgery/OMFS departments

Descriptions of clinical codes used by secondary care Oral Surgery/OMFS units are presented in the following tables APP9.1 – APP9.4.

Electronic versions of the National Clinical Coding Standards ICD-10 4th Edition reference book and the National Clinical Coding Standards OPCS-4 reference book, for use from 1 April 2015, are available from the Health and Social Care Information Centre Technology Reference data Update Distribution site[93]. Commissioners are also advised to refer to the current chapter of HRG and associated coding.

Table APP9.1 Diagnostic codes
(These do not currently conform to NICE guidelines)

DIAGNOSIS
Periapical abscess
Dental caries
Pericoronitis (no code)
Periodontal disease
Radicular Cyst
Odontogenic cyst
Resorption M2M or M3M
In line of fracture
For orthognathic or ablative surgery
Retained root

Table APP9.2 Treatment codes

TREATMENT
Procedure not carried out because of patient's decision for other and unspecified reasons (*Use code for failed appointment)*
Intraoral examination
Unspecified examination of the mouth
Intraoral radiology film
Other diagnostic imaging of mouth
Creation of impression for dental prosthesis e.g. bite guard
Simple extraction of tooth
Surgical extraction of third molar(s)
Surgical extraction of other teeth
Surgical removal of wisdom tooth
Surgical removal of tooth
Surgical removal of retained root of tooth
Extraction of multiple teeth
Apicectomy of tooth
Surgical exposure of tooth
Insertion ortho appliance
Coronectomy
Biopsy of lesion on tongue
Full dental clearance
Extraction single tooth

Enucleation cyst
Excision lesion from jaw
Fraenectomy
Packing socket of tooth
Arrest haemorrhage
Debridement of socket
Biopsy gingivae
Biopsy tongue
Biopsy palate
Biopsy lip
Biopsy lesion of mouth
Operation maxillary antrum
Drainage of abscess of alveolus
Suture of mouth
Removal suture from mouth
Fitting of dental prosthesis bite guard
Minor mouth or throat procedure
Intermediate mouth or throat procedures
Oral Surgery
Oral & Maxillofacial Surgery
Local anaesthetic
Oral sedation
Inhalation sedation
IV sedation
Outpatient general anaesthetic
Inpatient anaesthetic
Steroids
Antibiotics
Other

Table APP9.3 Clinical outcome codes (ICDN code)

CLINICAL OUTCOME
Dry socket
Trigeminal nerve injury
Altered sensation/numbness/pain
Use for implant insertion damaging inferior alveolar nerve
Numbness of tongue or lip
Paraesthesia of tongue or lip
Pain in joint (TMJ)
Infection of bone /joint Osteomyelitis Cellulitis
Oro-antral fistula / chronic sinusitis
Fracture mandible Tuberosity fracture OAC
Fracture of tooth

Retained root
Dislocation of tooth: luxation, extrusion or avulsion
Unintentional cut during surgical e.g. tongue/cheek laceration
Bleeding from socket
Retreatment <21 (CQC) <30 days (CQUIN) Surgical reoperation Medical

Current coding deficiencies that require addressing:
No codes for acute or chronic pericoronitis;
No ability to differentiate if caries is in the tooth itself or adjacent teeth;
No codes for local spreading infection;
No code for high risk of development of caries /damage in adjacent tooth;
No codes for LA, Sedation, GA or additional operative medication;
No code for coronectomy.

Table APP10.4 Co-morbidity codes used in Oral Surgery departments in secondary care

CO-MORBIDITY
Smoker
Blindness
Ischaemic heart disease
Cardiac Arrhythmia
Prosthetic Heart Valve
Cardiac Failure
Congenital Cardiac Malformation. This code refers to the cardiac chambers and connections. If this is for ASD or PFO Q21.9 would be more appropriate. Please confirm.
Cerebrovascular disease
Hypertension
COPD / COAD
Asthma
Chronic renal disease If with increased BP/failure If with increased BP/no failure
Chronic liver disease
Transplanted (any) organ
Pre-transplant/chemo/bisphosphonate assessment
Epilepsy
Parkinson's disease
Movement disorder
MS
Dementia
Dental phobia
Mental health problems
Learning disabilities
Diabetes type 1

Diabetes type 2
HIV disease - symptomatic HIV disease – asymptomatic
Hepatitis B
Hepatitis C
Other infectious disease
Bleeding disorders, Coagulopathy
Long term anticoagulant therapy
Sickle cell disease
Bisphosphonate therapy
Cancer current disease.
History of malignant disease
Alcohol dependence
Cannabis Dependence
Cocaine Dependence
Heroin/methadone Dependence
Drug Dependence (combination)
Endocrine Disorder
Disease of digestive system
Autoimmune Disease
Congenital Malformation of skull/face bones
Arthritis, unspecified