

WELSH HEALTH CIRCULAR



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Enclosure(s): Guidance and annex documents on above issue

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Summary

The purpose of this Circular is to provide detail of Welsh Government policy to deliver a more integrated and effective oral surgery service in order to improve access to specialist dental services across Wales.

Action

Health boards to work in collaboration to deliver a programme of effective oral surgery service delivery across Wales. All primary dental care practitioners will play an integral role with specialist staff working in both primary and secondary care settings on the delivery, strengthening existing good practice and introducing new procedures where appropriate.

1. Background

Together for Health – A National Oral Health Plan for Wales (NOHP) highlights the need to meet the four dental related actions included in the Welsh Government's Programme for Government. The NOHP requires health boards to develop local action plans, to meet identified oral health needs, and, identify three clear themes: prevention of oral disease; service delivery; and quality and safety.

In July 2015 Welsh Government produced the second Annual Report which identified a requirement for continued work with health boards to ensure all their actions are progressed, monitored and delivered. Common themes and key priorities of health board plans included issues associated with an increasing and ageing population, and a lack of access to more specialised services, in particular access to Oral Surgery. With the launch of the national plan for primary care in Wales, 2014-15 is the start of an ongoing focus into enhanced delivery of services in a primary care setting.

2. Key Issues

- A significant proportion of current referrals made to Oral Surgery/Oral & Maxillofacial Surgery (OMFS) specialists include dento-alveolar surgery and this less complex work has caused increasing pressure on hospital consultant service waiting lists since the dental contract reforms in 2006.
- Recent reports in England and Wales recommended that much of the minor oral surgery care could be delivered by specialists working in primary care.
- Some health boards have already established local primary care based oral surgery services using dentists with enhanced skills and experience in oral surgery.
- The All Wales Oral Surgery working group adapted work carried out by the Department of Health on defining procedures and modifying patient factors that describe the complexity of a case.

- Local Oral Surgery and Oral Medicine service delivery is often based on historical models. Health boards and clinicians working together with patients can begin to implement new models of service as they emerge. It is important the service (including the workforce) is evaluated to ensure it is appropriate for the needs of the population.
- The attached guidance contains a model pathway approach to Oral Surgery.
- This pathway ensures that primary care dental teams and medical colleagues understand how to navigate a patient via a referral management system. This system can comprise of 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

3. Needs Assessment

Oral health needs assessments for Oral Surgery and Oral Medicine, are currently poorly described. There are guidelines that define some elements of Oral Surgery need, e.g. NICE guidelines relating to the removal of third molars. However, for the majority of Oral Surgery procedures and Oral Medicine conditions, no specific needs assessments or guidelines exist. Therefore, health boards working with consultants in dental public health need to rely on proxy measure and service activity data. Sources of information that can assist in assessing the dental needs of the local population are available through PHW observatory data and Welsh Oral Health Information Unit (WOHIU) and data from Adult and Child Dental Health surveys <http://www.cardiff.ac.uk/dentistry/research/themes/applied-clinical-research-and-public-health/epidemiology-and-applied-clinical-research/wohiu>

Health boards should ascertain the composition of the workforce delivering Oral Surgery and Oral Medicine services locally i.e. the numbers of General Dental Practitioners, 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. In respect of patients treated, health boards obtain detailed FP17W data 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. In addition Hospital Episodes Statistics (HES) data can provide an overview of the care provided in secondary care and the potential for patients with less complex oral surgery needs to be treated in primary care.

4. Funding

No additional central funding allocation is available. It is expected that health boards can use current allocations for both primary and secondary dental care efficiently and effectively to achieve service change.

5. Programme development

Health boards should use this guide to review progress in implementing redesigned pathways to benefit patients. The first task will be to establish locally based Managed Clinical Networks¹ (MCNs) and then complete a needs assessment. This will involve working with PHW Consultants in Dental Public Health, clinicians and other stakeholders including patient groups. The introduction of a referral management system to engage clinicians should underpin this. This guidance contains direction and detail to support implementation of best practice.

It is acknowledged health boards are at different stages in developing specialist dental services and progress in introducing these services will therefore differ across Wales. It would be particularly challenging to expect all health boards to implement the programme immediately; however it is reasonable to expect an action plan to be delivered by April 2016.

6. Monitoring and Evaluation

Welsh Government Healthcare Policy team will monitor delivery through:

- discussion at annual review meetings with health boards;
- formal assessment of Local Oral Health Plan (LOHP) delivery;
- annual reports from relevant MCNs; and
- developing a Strategic Advisory Forum in Oral Surgery/Oral Medicine - the aims and objectives of which will be based on the current Strategic Fora in Orthodontics and SCD.

Evidence of the local consultation process will be required together with details of the action taken to engage local stakeholders and to deliver the required developments in service provision. A series of performance measures have been developed in order to monitor progress effectively (Annex 4 of the enclosed guidance).

¹MCNs should be based on the geographical areas covered by MCNs supporting other speciality areas (Special Care Dentistry and Orthodontics) in Wales. MCN objectives will include overseeing the implementation and the functioning of the specialist pathway, accrediting dentists with enhanced skills, quality improvement, mentorship, education, audit and leadership. The chair should be accountable to each constituent health board. It will be consultant-led where possible and all Level 2 and 3 Oral Surgery/Oral Medicine providers along with health board managerial colleagues will play an active role and will have a formal link to the MCN.

Guidance on the future development of oral surgery and oral medicine services in Wales

1. Introduction

This document is intended as a guide for the development of specialist Oral Surgery and Oral Medicine services in Wales. It provides an outline description of the services, including a summarised illustrative patient journey to enable the development of standardised Oral Surgery and Oral Medicine clinical pathways. 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. Measures that assess clinical outcomes, patient safety and patient-reported outcomes (experience) are described which enable quality and effectiveness of services to be assessed and reviewed. This guidance builds on a report entitled '*Future implementation of oral surgery services in Wales*' which was presented to the Welsh Dental Committee by the Oral Surgery working group to inform the advice given to the Minister for Health and Social Services. In addition it has drawn heavily on similar Commissioning guidance recently published by NHS England.

This guidance is about supporting health boards and primary care clusters to work together with clinicians to ensure that resources invested by the NHS in Oral Surgery are used in the most effective way to provide the best possible quality and quantity to meet patient's needs

This Oral Surgery and Oral Medicine guidance has been published to: transform services at a local level; to meet local needs and circumstances; and achieve best value and sustainability for the resources available.

2. Speciality and service descriptions

2.1 *Oral Surgery and 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 people of all ages,
- the management of dentally anxious and medically complex patients.
- provision of care by both Oral Surgeons and 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. Maxillofacial surgery is usually taken to mean more complex procedures including treatment of major trauma, head and neck malignancies and congenital facial deformity. The UK General Dental Council includes a specialist register for Oral Surgery / Oral Medicine.

In general the term "oral surgeon" applies to a clinician who is qualified in dentistry while "oral and maxillo facial surgeon" is more usually applied to a clinician who is qualified in both dentistry and medicine.

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.

2.2 *Historical and current service provision*

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 (OMFS) consultants (including academics) who may work in primary care or secondary care settings. 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 dentists in training working under consultants may also provide oral surgery care.

Access to academic units offering Oral Surgery and Oral Medicine services is only available in the University Hospital of Wales, Cardiff. Typically, OMFS units in District General Hospitals also provide some of these services.

A significant proportion of referrals made to Oral Surgery/OMFS specialists include dento-alveolar surgery and this less complex work has caused increasing pressure on hospital consultant service waiting lists since the dental contract reforms in 2006. Recent reports in England and Wales recommended that much of the minor oral surgery care could be delivered by specialists working in primary care. Some health boards have already established local primary care based oral surgery services. Some dentists, (who are not necessarily on the GDC specialist list for Oral Surgery) have enhanced skills and experience in oral surgery. They are referred to as

Dentists with Enhanced Skills (previously called, 'Dentists with a Special Interest' (DwSI)).

The development of high quality patient centred care using prudent healthcare principles means that it is not appropriate to provide treatment in secondary care services which can safely and effectively be provided in primary care settings. Evidence from Audits of referrals in Wales and across the UK indicate that a significant percentage of patients treated in Oral and Maxillofacial departments could have received care outside the hospital department often more locally and probably in a more cost effective manner by an appropriately trained clinician.

In planning Oral Surgery services, health boards should be mindful that reconfiguration could jeopardise the sustainability of Oral and Maxillofacial departments where this service is still required, or that at least the configuration of these services should also be considered if more effective primary care based services are developed.

2.3 Training issues

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.

A detailed description of training issues for each speciality is contained in Annex 1.

3. Clinical Services

3.1 Complexity levels and procedures

The All Wales Oral Surgery working group adapted work carried out by the Department of Health Advanced Care Pathway Working Group on defined procedures and modifying patient factors that describe the complexity of a case. The provision of Oral Surgery is on the basis of the competency of the practitioner providing the service rather than the setting of its provision, although there is obviously a relationship between the two. As noted previously the most cost effective care is often provided outside hospital settings by practitioners with the correct level of competence for the treatment required. However this model may not be appropriate under all circumstances and it is necessary to establish levels of training and experience that meet patient treatment needs. It is suggested that three levels should be recognised where demand is appropriate to this model.

Level 1 – Procedure/conditions to be performed or managed by a dentist commensurate with a level of competence as defined by the Curriculum for Dental Foundation Training or its equivalent.

Level 2 – Procedures/conditions to be performed or managed by a dentist with evidence of additional competencies above those commensurate with level of competence as defined by the Curriculum for Dental Foundation Training or its

equivalent but below the level of a professional recognised as a specialist at the GDC defined criteria (a Dentist with Enhanced Skills - DES).

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.

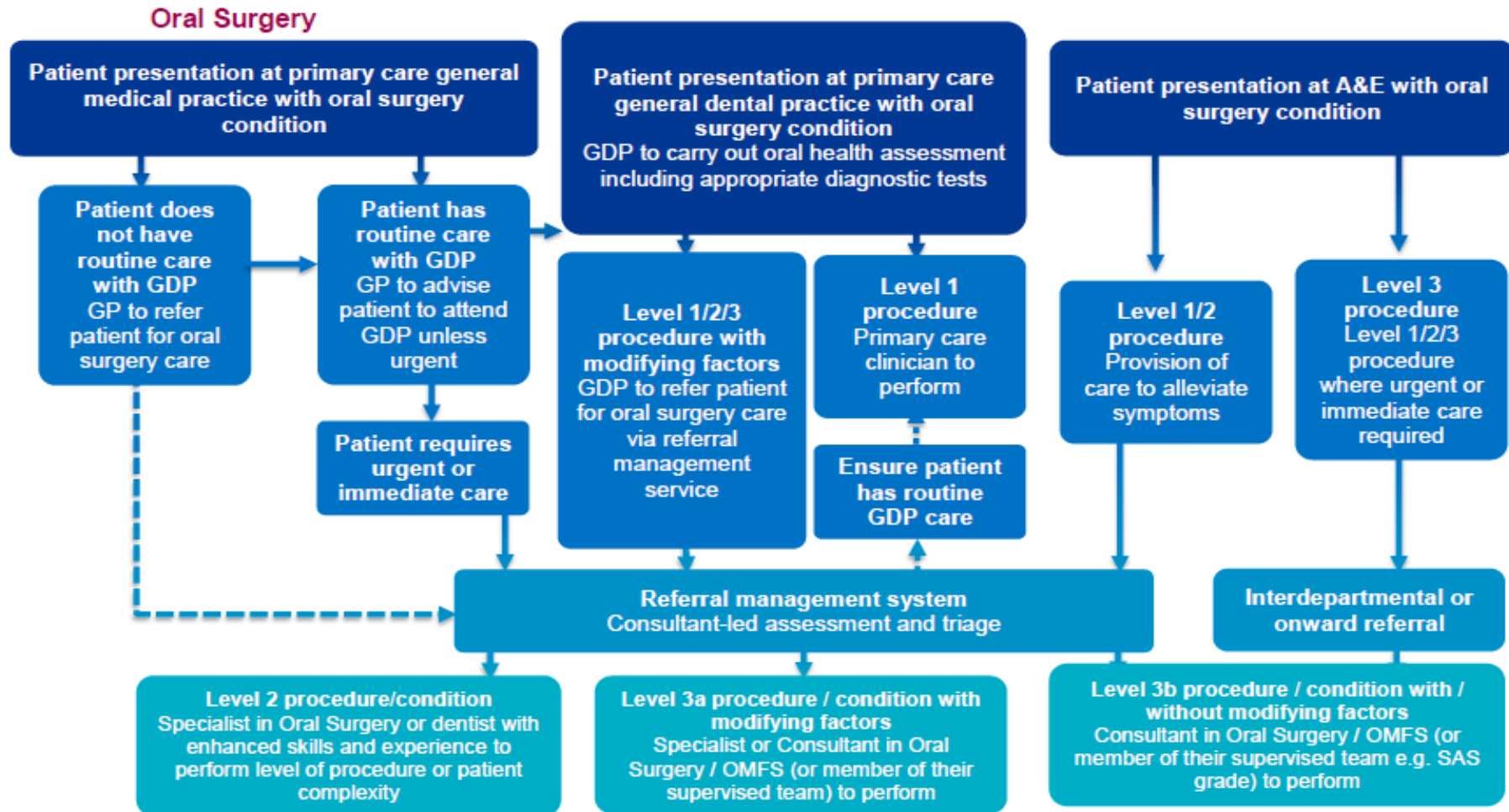
Level 3b – Procedures/conditions to be performed or managed by a clinician recognised as a consultant in the relevant specialty, who has received additional training which enables them to deliver more complex care, lead MDTs, MCNs and deliver specialist training. The consultant team may include trainees and SAS grades. 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 would usually be performed in primary care setting. 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.

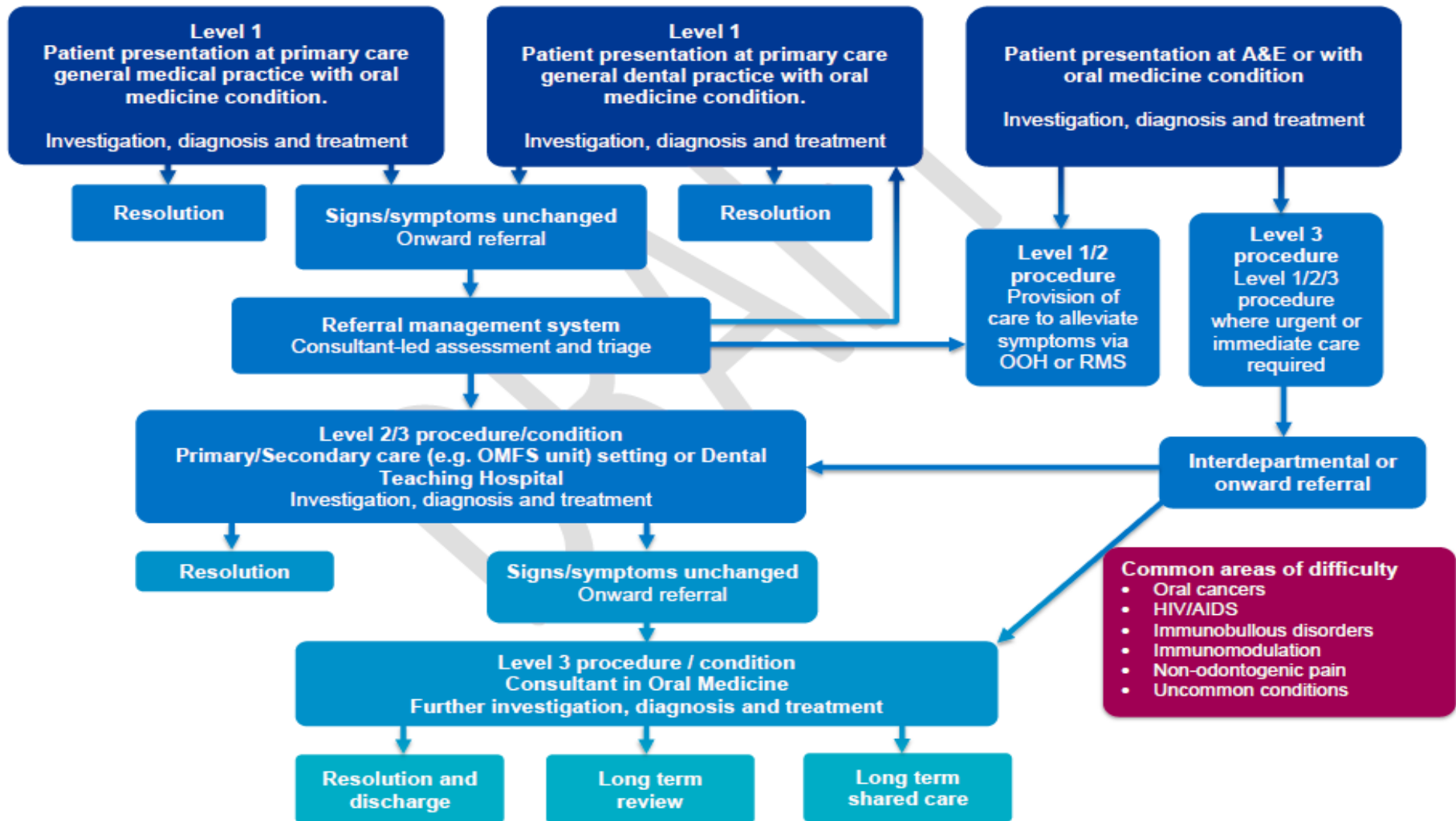
Annex 2 contains a detailed description of each level of competency and procedure along with any associated modifying factor.

Summarised Illustrative Patient Journeys

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



Oral Medicine



Reproduced from NHS England Commissioning Guide

4. Service Re-design and future development of Oral Surgery and Oral Medicine in Wales

4.1 Current models and challenges

Local Oral Surgery and Oral Medicine service delivery is often based on historical models. Health boards and clinicians working together with patients can begin to implement new models of service as they emerge. This will promote innovation; allow testing and validating of best practice, and sharing of expertise to get the best 'local fit'. It will help to overcome local vested interests and ensure services are delivered in the best interests of patients and the population. Once a pathway approach to Oral Surgery care is established it is important that the service (including the workforce) is 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.

4.2 Oral Surgery service redesign

Together for Health: A National Oral Health Plan for Wales 2013-2018 was published in March 2013 and highlighted the need for health boards to develop additional access to community based dental specialist services. It aligns to the purpose of this Oral Surgery and Oral Medicine guidance. Oral Surgery and Oral Medicine services need to be integrated and delivered around the needs of patients rather than organisations or training programmes. This is particularly relevant for Oral Surgery where emerging care pathways can support and strengthen primary and 'out of hospital care'. 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 health boards and primary care clusters to work together with clinicians to ensure that resources invested by the NHS in Oral Surgery are used in the most effective way to provide the best possible quality and quantity of care for patients to meet need. Consultants and specialists in Oral Surgery and Oral Medicine can assist in leading change and provide a more effective use of resources by broadening their influence with primary care clinicians. Consultants and specialists should consider whether some of their specialist time and knowledge would be better spent supporting primary care, and thereby benefit many more patients than they can treat working in an acute setting.

The focus is therefore to develop an oral surgery pathway to support a single, consistent, integrated model of service delivery. This 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, and health boards (supported by Public Health Wales) are encouraged to:

- review local patient need and current service provision,
- Assess progress using the illustrated patient journey within this guide as a benchmark to set pace and direction locally.
- An assessment of how much progress the redesign of a local service has made should be the first step and a priority for health boards.

4.3 Oral Medicine service redesign

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. A consultant-led Managed Clinical Network (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. In this model the health boards could utilise the existing clinical resource supported by greater team-working and 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 or OMFS).

4.4 Development of Managed Clinical Networks

Local MCNs need to be established. The networks will be based on the geographical areas covered by MCNs supporting other speciality areas (Special Care Dentistry and Orthodontics) in Wales. MCN objectives will include overseeing the implementation and the functioning of the specialist pathway, accrediting dentists with enhanced skills, quality improvement, mentorship, education, audit and leadership. The chair should be accountable to each constituent health board. It will be clinician-led where possible and all Level 2 and 3 Oral Surgery/Oral Medicine providers along with health board managerial colleagues will be invited to play an active role and will have a formal link to the MCN.

In addition Welsh Government will develop a Strategic Advisory Forum in Oral Surgery/Oral Medicine - the aims and objectives will be based on the current Strategic fora in Orthodontics and SCD.

Health boards and clinicians must work together with MCNs and in doing so can begin to influence service planning and design to promote innovation, implement best practice, and share expertise to get the best ‘local fit’ at a pace that reflects local circumstances.

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.

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

Oral Surgery services will be delivered using guidance developed from a consultant-led MCN. Health boards and MCNs would ensure the correct level of competence and that 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. Additional training may be required 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. Health Boards will need to identify these individuals and liaise with local consultant units/Wales deanery to facilitate the development of competency.

The Oral Surgery pathway would ensure that primary care dental teams and medical colleagues 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 in primary care (with sedation if need is identified). There would be MCN assessment/assurance of clinicians' competency to deliver care effectively. Services would be provided using detailed service specifications, and underpinned by the same standards as secondary care oral surgery units.

Level 3 services would be delivered, depending upon local availability, by consultant-led oral surgery teams within twenty six weeks of patient referral. This would enable OMFS units to deliver more complex care. Where there are no local consultant Oral Surgery teams, OMFS units will provide Level 3 care. 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 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. These data could be used for benchmarking and annual review of services. Careful consideration of local needs would be required when making new appointments following the retirement of OMFS and Oral Surgery consultants. Local Oral Surgery need would also need to be considered with respect to other Oral Surgery and OMFS staffing levels.

5. Procuring new Oral Surgery and Oral Medicine Services

5.1 *Understanding need and current service provision*

5.1.1 *Dental Need*

Oral health needs assessments for complex interventions, including Oral Surgery and Oral Medicine, are currently poorly described. There are guidelines that define some elements of Oral Surgery need, e.g. NICE guidelines relating to the removal of third molars. However, for the majority of Oral Surgery procedures and Oral Medicine conditions no specific needs assessments or guidelines exist. Therefore, health boards working with consultants in dental public health need to rely on proxy measure and service activity data. Health boards 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- much of this is available through PHW observatory data and Welsh Oral Health Information Unit (WOHIU) and data from Adult and Child Dental Health surveys

<http://www.cardiff.ac.uk/dentistry/research/themes/applied-clinical-research-and-public-health/epidemiology-and-applied-clinical-research/wohiu>

5.1.2 *Workforce issues*

Health boards through MCNs should 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.

5.1.3 *Service provision data*

Health boards can use their access to e-reporting which can be used to obtain detailed FP17W data 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. In addition Hospital Episodes Statistics (HES) data can provide an overview of the care provided in secondary care and the potential for patients with less complex oral surgery needs to be treated in primary care.

5.1.4 *Impact on existing services*

In planning Oral Surgery services, health boards should be mindful that reconfiguration could jeopardise the sustainability of Oral and Maxillofacial departments where this service is still required, or that at least the configuration of these services should also be considered if services that could produce more effective and cost effective oral surgery services for the population of Wales were developed.

5.2 Minimum standard specification

The same quality standards of care are expected in primary and secondary care Oral Surgery and Oral Medicine services. NHS procurement advice recognises the weighting of quality against cost. Where service redesign releases funds any savings should be invested into enhancing provision of high quality Oral Surgery and Oral Medicine services elsewhere in the health board.

Annex 3 contains details of the minimum service specification required.

5.3 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/Health boards

Specialty-specific measures 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.

Annex 4 contains detailed guidance on quality and outcome measures

6. Issues relating to the development of contracts

6.1 Regulation

- The NHS (Personal Dental Services Agreements)(Wales) Regulations 2006 (as amended)
- The NHS (General Dental Services Contracts)(Wales) Regulations 2006 (as amended)
- NHS Standard Contract
- 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 can be used where the full range of mandatory services are not being provided. The NHS Standard Contract is mandated by NHS Wales for use by commissioners for all contracts for healthcare services other than primary care.

6.2 Factors for consideration

- **Patient charge revenue (PCR):** PDS and GDS contracts permit collection of patient charges; NHS standard contract does not.
- **Differing activity measures and currencies:** PDS and GDS (Units of Dental Activity (UDA)); National contract (activity based upon outpatients, in patients and day case volumes).
- **Performers List:** GDS and PDS contracts require performers delivering services to be on the health board Performers List; no such requirement exists for clinicians based in secondary care Oral Surgery/OMFS and Oral Medicine units.
- **Performance metrics:** in order to seek 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 should 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 health boards have access comparable information and can comprehensively understand the services being delivered to the local population.
- **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:
 - o Maintenance of performer competency levels
 - o Training/support for referring clinicians who need to improve core skills.
 - o More formal undergraduate and postgraduate student training placement requirements.
- There are currently some 'non-hospital based' services (under Primary Care contracts / NHS Standard / other) with issues such as variable superannuation eligibility for performers.

Annex 5 contains details of training competencies- reproduced from DH document

6.3 Minimum standard data collection and reporting

Standard data collection and reporting should reflect the main objectives of the quality framework for dentistry and national commissioning that include consistent:

- Coding
- Clinical outcomes; (Annex 4)

- Quality Standards; and
- PREMs and PROMs (Annex 4)

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; and
- Patient safety data.

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

7. Planning for Action

This guidance provides a general framework on how to develop and monitor Oral Surgery and Oral Medicine services. Health boards can use this guide to review progress in implementing redesigned pathways to benefit patients. The first task will be to establish locally based Managed Clinical Networks and then complete a needs assessment. This will involve working with PHW Consultants in Dental Public Health, clinicians and other stakeholders including patient groups. The introduction of a referral management system to engage clinicians should underpin this. This guidance contains direction and detail to support implementation of best practice.



Annexes: Guidance on the future development of Oral Surgery and Oral Medicine services in Wales

Annex 1:

Training issues relating to Oral Surgery, Oral & Maxillofacial and Oral Medicine specialties

1. Since the 1980's 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.

2. Oral Surgery was re-introduced in the UK as a dental specialty regulated by the General Dental Council (GDC) 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 General Dental Council (GDC) specialist oral surgery list.

3. Given that Oral Surgery is relatively new specialty, some clinicians who had some additional training or can demonstrate equivalent experience may not have completed the classical training pathway and would not be eligible to enter the GDC Specialist List. At the present time, a quality assured training pathway and assessment does not exist for non specialist clinicians. This is a transition period. In order to accredit non specialist clinicians MCNs will need to use the best evidence available in order for them to develop robust processes to assess the competencies of dentists providing care. MCNs should use processes developed by RCS England to accredit DwSIs as a starting point. It is understood that more guidance on the issue of the application of standards for the accreditation process is being developed on an inter-collegiate basis and will be published in due course.

Oral Surgery Specialist Training

4. 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. Oral & Maxillofacial Surgery is a medical specialty regulated by the General Medical Council with a defined training curriculum. 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).

5. 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 CCST and entry to the GDCs 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 competences that differentiate them from a Specialist which include:

- the management of jaw and facial fractures, congenital and acquired jaw anomalies;
- advanced oral implantology and bone augmentation;
- diagnosis and treatment of anomalies and Temporomandibular Joint Disorders (TMJ);
- and diagnosis and treatment of salivary gland diseases.

6. These individuals also have training in management of healthcare delivery, 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.

7. 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 SAC for Oral & Maxillofacial Surgery oversee training for this medical specialty.

Oral Medicine

9. 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.

10. 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 oro-facial pain that does not relate directly to common dental pathologies such as caries or periodontal disease. Some presentations reflect local disease whereas others are oro-facial manifestations of more widespread pathology affecting different parts of the

body. Oral and Maxillofacial surgeons may also provide Oral Medicine services.

Annex 2:

Framework of complexity levels and procedures for Oral Surgery

Level 1 Procedures/Condition

- Extraction of erupted tooth/teeth including erupted uncomplicated third molars in line with NICE guidance;
- Effective management, including extraction where appropriate, of buried roots (whether fractured during extraction or retained root fragments);
- Effective management of unerupted, impacted, ectopic and supernumerary teeth;
- Understand and assist in the investigation, diagnosis and effective management of oral mucosal disease, including the early referral of patients 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;
- Diagnose and treat localised odontogenic infections and post-operative surgical complications with the appropriate therapeutic agents, and diagnose and refer patients with major odontogenic infections with the appropriate degree of urgency; and
- Recognise disorders in patients with craniofacial pain including the initial management of temporomandibular disorders and identify those patients that require specialised management, and to refer such conditions appropriately.

Level 2 Procedures/Conditions in addition to those in level 1

- Surgical removal of uncomplicated third molars involving bone removal in line with NICE guidance;
- 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 for incisor and canine teeth;
- Minor soft tissue surgery to remove apparent non-suspicious lesions; and
- Placement of an uncomplicated dental implant in accordance with NHS protocols.

Level 3 Procedures/Conditions

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. 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.

Modifying Factors

Clinicians should feel 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 level of complexity may however change depending on one or more of the following factors:

- Medical History
- Social factors
- Level of patient anxiety
- Other potential complications

Framework of Oral Medicine Complexity Levels and Procedures

Level 1 Procedures/conditions

Recognition of conditions within the scope of oral medicine clinical practice, which includes 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 changes presenting as oral dryness, excess saliva or salivary gland swelling.
- Oro-facial 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 vesiculo-bullous 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

- 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

- The diagnosis is unclear.
- Interventions have not achieved a satisfactory outcome.
- The presenting complaint may represent an oro-facial 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.

Annex 3: Minimum Service Specification

This section outlines suggested requirements for Minimum Service Specification and can be adapted for local use.

The Health and Care Standards (Welsh Government, 2015) provide a framework for services in Wales and they will underpin any service specification. The NHS Wales governance e-manual provides guidance to support the Health and Care Standards.

The requirements of Healthcare Inspectorate Wales dental practice inspection process will also inform the standards

The National Service User Experience framework must be taken into account when developing PROMS and PREMS systems to seek patient feedback

General legislation and guidance

- NHS Wales Act 2006
- Together for Health: A National Oral Health Plan for Wales 2013 -2018
- Securing Excellence in commissioning NHS dental services, DH 2013
- Future implementation of Oral Surgery Services in Wales 2013
- NHS England Specialty Training, Health Education England (formerly, Modernising Medical Careers)
- The NHS Personal Dental Services Agreements (Wales) Regulations 2006 (as amended)
- Welsh Health Technical Memorandum WHTM01-05: Decontamination in primary care dental practices and community dental services Revised 2014
- Ionising Radiation (Medical Exposure) Regulations 2000 IR(me)R, 2012
- HIV-infected health care workers: Guidance on management and patient notification, 2005
- Equality Act, 2010
- Human Rights Act 1998
- Dental Practitioners' Formulary
- GDC Scope of Practice guidance
- GDC Fitness to Practice advice
- GDC Standards for the Dental Team guidance
- Caldicott review: information governance in the health and care system, 2013
- Putting Things Right (PTR)

Legislation and guidance pertinent to Oral surgery and Oral Medicine

- NICE Technology Appraisals Guidance No.1 - Guidance on the Extraction of Wisdom Teeth, 200049
- Conscious sedation in the provision of dental care: report of an Expert Group on Sedation for Dentistry, Standing Dental Advisory Committee, 2003
- A review of 'Standards for Conscious sedation in the Provision of Dental Care' : Report of the Intercollegiate Advisory Committee for Sedation in Dentistry 2015

Scope

- Aims/objectives for each specified service
- Scope/Care pathway
- Population covered
- Acceptance/exclusion criteria
- Procedures to be delivered e.g. dento-alveolar surgery including 3rd molar surgery, single root apicectomies, multiple extractions, removal of buried roots and impacted teeth, temporo-mandibular joint dysfunction, surgical exposure of unerupted teeth, management of supernumerary teeth.
- Interdependencies with other services

Applicable Service Standards

- National Standards (see General legislation and guidance)
- Local Standards
- Healthcare Inspectorate Wales (HIW) dental practice inspection standards
- Quality Assurance System (QAS)

Key Service Outcomes

- To provide effective OS and OM care in the most appropriate setting
- To provide optimum patient care
- To reduce referrals into secondary care for OS and OM care which can safely be provided in primary care
- To provide a positive patient experience through improved access to the service and increase patient perceived quality of life following effective treatment
- To provide cost effective practice

Performers

- Allocation criteria
- Competence
- Qualifications/References
- Portfolio
- Skills test
- MCN/LDN
- Communication skills
- Appointed in line with good governance – this will include an interview

Service description

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

Quality Requirements

Generic specialist provider requirements

- Compliance with Health and Safety at Work etc. Act, 1974
- Compliance with Employers' Liability (Compulsory Insurance) Act, 1969
- Compliance with Electrical safety at work regulations
- Compliance with safety requirements for autoclaves
- Compliance with IR(me)R
- Compliance with Control of Substances Hazardous to Health (COSHH)
- Compliance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- Compliance with Water Supply (Water Fittings) Regulations, 1999
- Disability access requirements
- HIW registration
- Risk management policy
- Business continuity plan
- Whistle blowing policy
- Confidentiality
- Dealing with concerns, including complaints
- Booking system
- Staffing
- Staff indemnity insurance
- Staff appraisal
- Staff personal development plans

Facilities and equipment

- Dental chair and operating light
- Single patient use water lines for Level 2 service provision⁶¹⁶²
- 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

Care Pathway

- Medical History
- Consent process to obtain valid consent
- Preoperative instructions
- Post-operative instructions

Patient experience

- Care with dignity
- Patient feedback mechanism in place
- Collection of PREMs data (Section 10.2 of this document)

Professional standards

- Audit (local and all Wales, including antimicrobial prescribing and WHTM 01-05)
- Use of recognised improvement methodologies as per 1000 Lives service improvement
- Compliance with GDC requirements for CPD
- Compliance with HIW inspection process
- Record keeping

Performance Indicators

- PREMs/PROMs as described in 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
- audits and concerns review (including complaints)
- Results of user and service audits and improvements
- Patient safety

Minimum dataset

- As described in Section of 4 of this document

Annex 4: Quality and Outcome Key Assessment Areas

Oral Surgery and Oral Medicine Patient reported Experience Measures (PREMs) (see NSUE recommendations. This questionnaire isn't in line with all Wales patient experience questionnaire)

PREMs for Oral Surgery and Oral Medicine patients.

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 can understand?	<i>Agree/disagree/not sure</i>
Did you receive information about the risks benefits in terms that you can understand before the operation?	<i>Agree/disagree/not sure</i>
Was your pain managed well during the procedure?	<i>Agree/disagree/not sure</i>
Was your anxiety managed well during the procedure?	<i>Agree/disagree/not sure</i>
Did you receive information, in a format that you could understand, about care after the operation and a contact number to call for help?	<i>Agree/disagree/not sure</i>
Were you given the opportunity to ask questions?	<i>Agree/disagree/not sure</i>
Did a member of staff tell you about medication side effects to watch out for when you went home?	<i>Agree/disagree/not sure</i>

Patient Reported Outcome Measures (PROMs)

Routinely-reported Oral Surgery PROMs

Routinely-reported (core) data should include specialty-specific (not procedure-specific) PROMs.

Table 10.2 Core PROMS for Oral Surgery Question	Response	Details
Did you need to seek advice or assistance hours/days after the procedure?	<i>Yes/No/Unsure</i>	<p><i>List for data recorder (not shared with the patient unless clarification or prompts needed)</i></p> <p><i>Interested in:</i></p> <ul style="list-style-type: none"> • Uncontrolled bleeding (%) • <i>Inadequate pain relief that needed further medication (e.g. dry socket? Typically 5% of cases)</i> • Infection that needed further treatment (%) • Damage to other teeth/fillings (%) • <i>Nerve injury altered sensation (Typically 1% of cases) fifth or trigeminal</i> • TMD
Have you had to have additional surgery subsequent to this treatment?	<i>Yes/No/Unsure</i>	<p><i>If yes, what is the problem?</i></p> <ul style="list-style-type: none"> • Fractures jaw • <i>Unintentional root retention</i> • Bone infection • <i>Nerve injury (1%) fifth or trigeminal</i>
<i>Time taken to achieve restoration of normal activities or appearance</i>	<i>Yes/No/Unsure</i>	<p>Days</p> <p>Weeks</p> <p>Months</p>

I 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 10: coding used by secondary care oral surgery department
Clinical effectiveness	<p>Diagnosis OPCS-4 codes Treatment ICD codes Outcomes ICD codes Reported patient safety events</p> <p><i>Could include</i> Consent Patient info Pain management Anxiety management Patient information Morbidity PROMS</p> <p><i>Patient safety (QOF, CQUIN, CQC, MHRA)</i> 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</p>	
Quality standards	Quality and Outcomes Framework (QOF) ⁵¹	
Patient experience	Specialty-specific (NOT procedure-specific) PREMS & PROMS	Sections 11.1, 11.2 and 11.3
Safety	<p>Medication and Healthcare products regulatory agency (MHRA) reported adverse drug reactions using the Yellow Card Scheme (any drug related serious event see below)⁵² Medical history checked. Appropriate drug prescription⁵³ NPSA/ NRLS^{54 55} Wrong site surgery Wrong implant Retained foreign object Overdose of midazolam STEIS (http://www.nrls.npsa.nhs.uk/report-a-</p>	

Primary Care Oral Surgery Provider minimum data set

The following is an example minimum dataset for use by a primary care specialist oral surgery provider.

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

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

Adverse Clinical Outcome

- Bleeding
- Dry Socket
- Generalised Pain
- Infection

- Oro-antral communication
- Possible nerve injury
- Swelling
- None

Treatment provided for complications or adverse outcomes:

- Debridement of Bone
- Intraoral Incision and Drainage Of abscess.
- Packing of tooth socket
- Prescription of Oral Antibiotics
- Prescription other medication, EG analgesia
- Surgical Arrest of Bleeding from Tooth Socket
- Suture of gingiva
- Other

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

Annex 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.

Tables reproduced from NHS England Oral Surgery 2015 Commissioning Guide