NHS England

# Referral Pathway

# Minor Oral Surgery

# South Yorkshire and Bassetlaw

THE NHS CONSTITUTION
the NHS belongs to us all

# NHS England

# South Yorkshire and Bassetlaw Area Team

# Referral Pathway – Minor Oral Surgery

Version 2 Review Date 31st March 2016

Contents

**Summary**

This document builds on the guidance issued by the NHS Commissioning Board in February 2013.[1]

Using the care pathway approach the document describes a pathway for the provision of (minor) oral surgery procedures. It is based on 3 tiers of provision namely the General Dental Practitioner; the Specialist Oral Surgery Practitioner in Primary Care and the Consultant led Trust based service.

The pathway is intended to provide greater choice for both patient and referrer in terms of location and provider whilst at the same time enabling commissioners to commission services in a cost effective and appropriate way.

The importance and role of training, education and quality assurance in maintaining and developing oral surgery pathways is recognised in the document.

## 1 Introduction

1.1 This document describes the pathway which should be followed for any patient requiring an oral surgery procedure. It is primarily (but not exclusively) intended to provide guidance to General Dental Practitioners (GDPs) and other clinicians who are considering making a referral to a specialist oral surgery service.

1.2 It describes the procedures undertaken by and conditions treated by each of the service Provider groups on the pathway namely;

- General Dental Practitioners
- Specialist Oral Surgery Practitioners based in a community setting
- Consultant led secondary care services (OMFS)

1.3 The guidance is not intended to be prescriptive and clinicians are expected to use their professional judgement in the best interest of their patients. However, referring clinicians are requested to follow the pathway unless there are compelling reasons for not doing so.

1.4 Whichever pathway is considered appropriate, the referral requirements of each of the chosen service Provider must be observed. Specifically these will include;

- Contemporaneous radiographs
- Completion of service specific referral proforma (or locally agreed generic proforma if available) describing clear and specific treatment request
- Patient medical history
- Confirmation that the treatment to be provided on referral along with any associated NHS patient charges has been explained to the patient

1.5 Commissioners recognise that some Providers (specifically OMFS departments in acute Trusts) have a training function and as such require a mixed caseload to provide a diverse training experience for trainees. There may be concern that the pathway will restrict the range of procedures undertaken in Trusts and that they will be predominantly complex in nature. However, patient choice of service Provider and location is expected to maintain a reasonable degree of case mix for Trusts. In addition, commissioners will wish to monitor referral patterns and work with Providers to ensure that Trust training obligations can be met.

## 2 Scope

2.1 This pathway is applicable to;

i) all patients who are resident in South Yorkshire and Bassetlaw and / or

ii) any patient who is under the care of a dental service Provider who holds a GDS Contract or PDS Agreement with NHS England South Yorkshire and Bassetlaw Area Team

2.2 Tier 2 Providers may receive a referral for a patient who does not meet the criteria described in 2.1 above. In such cases (and where it is the intention of the Provider to offer treatment under their PDS Agreement with NHS England) the same considerations as to most appropriate service provider and location shall apply.

## 3 Aim

3.1 The aim of this patient referral pathway guidance for oral surgery procedures is to ensure, as far as possible, that the patient receives the right treatment in the right place and from the most appropriately qualified Provider.

3.2 However the guidance should not be considered to be prescriptive to the extent that it over rides the clinical judgement of the referring clinician or other healthcare professionals involved in the pathway. Ultimately the objective is to achieve the best outcome for the patient.

## 4 Service Provider Groups and Typical Procedures

| Tier 1 | Tier 2 | Tier 3 |
|---|---|---|
| **Procedures / cases typically expected to be managed by a GDP** | **Procedures / cases typically expected to be managed by a specialist practitioner** | **Procedures / cases typically expected to be managed by a Consultant led acute trust based service** |
| Simple exodontia of all fully erupted adult and deciduous teeth including uncomplicated 3rd molars | Failed extraction where root division is not possible / appropriate / difficult | Suspected neoplastic lesions (14 day protocol) |
| Exodontia of teeth that have previous RCT including molars | Where there would be the need for flap raising with / without bone removal ***** | Soft tissue lesions requiring histopathology examination |
| Multiple extractions on the same patient | Submerged / other common impactions | |
| Elevation of unburied retained roots / fractured teeth (including molars) | Surgical endodontics (only if re-orthograde is not an option) – excluding lower premolars and molars | Where there is a significant risk of tuberosity fracture with and ankylosed tooth |
| Division of roots in order to enable successful extraction by means of elevation | Impacted 3rd molars with uncomplicated associated pathology e.g. recurrent pericoronitis | For investigation of abnormal lesion (bone or soft tissue) |
| Simple soft tissue relieving incisions to allow access for uncomplicated extractions by elevation followed by surgical closure with suture | Where there is an obvious need for surgical intervention prior to attempting an extraction (e.g. unfavourable roots on a previous RCT'd tooth)* | For extractions where there is a history of radiotherapy affecting the jaws or surrounding and associated risk of osteoradionecrosis |
| Where there would be the need for flap raising with / without bone removal***** | | |
| Extractions where the patient is able to tolerate treatment under LA alone | Where bone re-contouring (pre-prosthetic surgery) is likely to be necessary following multiple dental extractions, prior to surgical closure | Patients currently on or previously having had IV bisphosphonate therapy (for oral bisphosphonates follow local guidelines). |
| Removal of uncomplicated****** lower 3rd molars<br>• Not radiographically involving the ID canal<br>• No associated pathology (e.g. cystic type lesions) | Extractions where there is a risk of AOC or minor fracture to the tuberosity | Impacted teeth (including 3rd molars) that are unerupted or present with complicated morphology / complicated local anatomy (e.g. ID canal) / associated pathology |
| Removal of uncomplicated****** upper 3rd molars<br>• Not impacted<br>• Partially or fully erupted with favourable root morphology<br>• No associated pathology (e.g. cystic type lesions)<br><br>*****for example good access, favourable root form, no history of difficult extraction*** | Excision biopsy of non-malignant lesions<br>E.g. polyps, papillomata, mucous extravasation cysts<br><br>***(subject to availability of timely collection / delivery of tissue samples for histology)*** | Medically compromised patients;<br>• Risk of abnormal haemorrhage due to medication such as warfarin, clopidogrel + aspirin combination / new generation non- warfarin anticoagulant treatments, combination anti-platelet treatments and difficult / surgical extractions on simple anti-platelet treatments ***(but refer to Appendix 1)***<br>• Patients with significant immunosuppressive where there may be a need for communication between specialists, special pre-treatment investigations / tests or prophylactic care<br>• Where it is considered unsafe for the patient to be treated in general practice (e.g. unstable angina, recent MI)<br>• Other significant medical comorbidites |
| | | Ectopic teeth that need removal / surgery to aid orthodontic care |
| | | Large cysts and other pathology of the jaws |
| | | Oral medicine complaints / concerns that are not resolved by initial management by the GDP |
| | | TMJ dysfunction that has not resolved by local measures or GDP feels that the complaint may require special investigation / diagnosis |
| | | Where it is inevitable that a GA will be required for treatment |

****subject to GDP assessment and clinical judgement***

## 5 Other Considerations

### *5.1 Bisphosphonates*

5.1.1 General Dental Practitioners should be aware of patients taking bisphosphonates and the associated risks of bisphosphonate-related osteonecrosis of the jaws (BRONJ). The level of risk varies and depends on the mode of bisphosphonate treatment (e.g. intravenous or oral), concomitant medication (e.g. steroids) or health conditions (e.g. malignancies) and the procedure required.

5.1.2 For patients where there is uncertainty about the level of risk of BRONJ, GDPs may wish to liaise with their local OMFS Consultant.

### *5.2 Patients on warfarin and other anti-coagulant therapy*

5.2.1 Patients on warfarin and other anti-coagulant therapy should be managed in accordance with the guidance described in Appendix 1.

### *5.3 Sedation Services*

5.3.1 A limited number of patients may be unable to tolerate an oral surgery procedure normally undertaken under local anaesthesia (LA) only. In such cases the patient should be offered referral to a Provider who can carry out the procedure with conscious IV sedation and LA. Alternatively if the treatment to be provided falls within Tier 1, the GDP may wish to consider whether the procedure could be undertaken if supported by an oral anxiolytic.

5.3.2 Referrals to such sedation services should be made with reference to the criteria described in Appendix 3 and in accordance with the Modified Dental Anxiety Scale (MDAS), Appendix 4.

## 6 Education and Training

6.1 The pathway makes assumptions about the skills and experience of GDPs in so far as it describes procedures that they would generally be expected to undertake. All Performers (and Providers) associated with Tier 1 are expected to be able to carry out the treatments described within that tier – which in turn reflects the standard expected of a UK dental graduate on completion of DF1.[(2)]

6.2 However it is recognised that for a variety of reasons there is likely to be a spectrum of ability in performing minor oral surgery.

6.3 It is intended to develop opportunities for practitioners to enhance, update and refresh their oral surgery skills which in turn should enable the pathway to be operated in an effective manner.

6.4 These opportunities will be based on;

- An expectation that primary care specialist oral surgery Providers are able to offer an (as yet to be agreed) level of support to GDPs seeking (or advised) to enhance or update their skills
- active support and promotion of the post graduate oral surgery training offered by Charles Clifford Dental Hospital

## 7 Quality Assurance

7.1 As stated in (3) above the primary aim is to establish an effective, high quality service which delivers the required outcomes for patients.

7.2 Commissioners will determine whether this aim is being achieved by capturing the views of service users, referrers and service providers and using this information to further enhance the quality and effectiveness of the pathway.

**Appendix 1**

**Managing patients who are taking warfarin and who are undergoing dental treatment**

NHS
National Patient Safety Agency
National Reporting and Learning Service

# Managing patients who are taking warfarin and undergoing dental treatment

## General guidelines

- **If patients on warfarin who require dental surgery have an International Normalised Ratio (INR) of below 4.0, they can usually receive their dental treatment in primary care without needing to stop their warfarin or adjust their dose.**
- **The risk of thromboembolism after temporary withdrawal of warfarin therapy outweighs the risk of oral bleeding following dental surgery.**
- **Patients on warfarin may bleed more than normal, but bleeding is usually controlled with local measures.**

## Advice to be given to patients

Advice for patients is available in the patient leaflet, *Oral Anticoagulant Therapy: Important information for dental patients.*

## Drug interactions

**Amoxicillin**
There have been anecdotal reports that amoxicillin interacts with warfarin causing increased prothrombin time and/or bleeding, but documented cases are relatively rare. Patients requiring a course of amoxicillin should be advised to be vigilant for any signs of increased bleeding.

**Clindamycin**
Clindamycin is restricted to specialist use and should not be used routinely for dental infections due to its serious side effects. There is a single case report of an interaction between warfarin and clindamycin.

**Erythromycin and other macrolide antibiotics (for example, azithromycin)**
*Macrolide antibiotics interact with warfarin unpredictably and only in certain individuals. Patients should be advised to be vigilant for any signs of increased bleeding.*

If increased bleeding occurs then the patient should be advised to contact the GP or anticoagulant clinic to arrange additional INR testing and dose review.

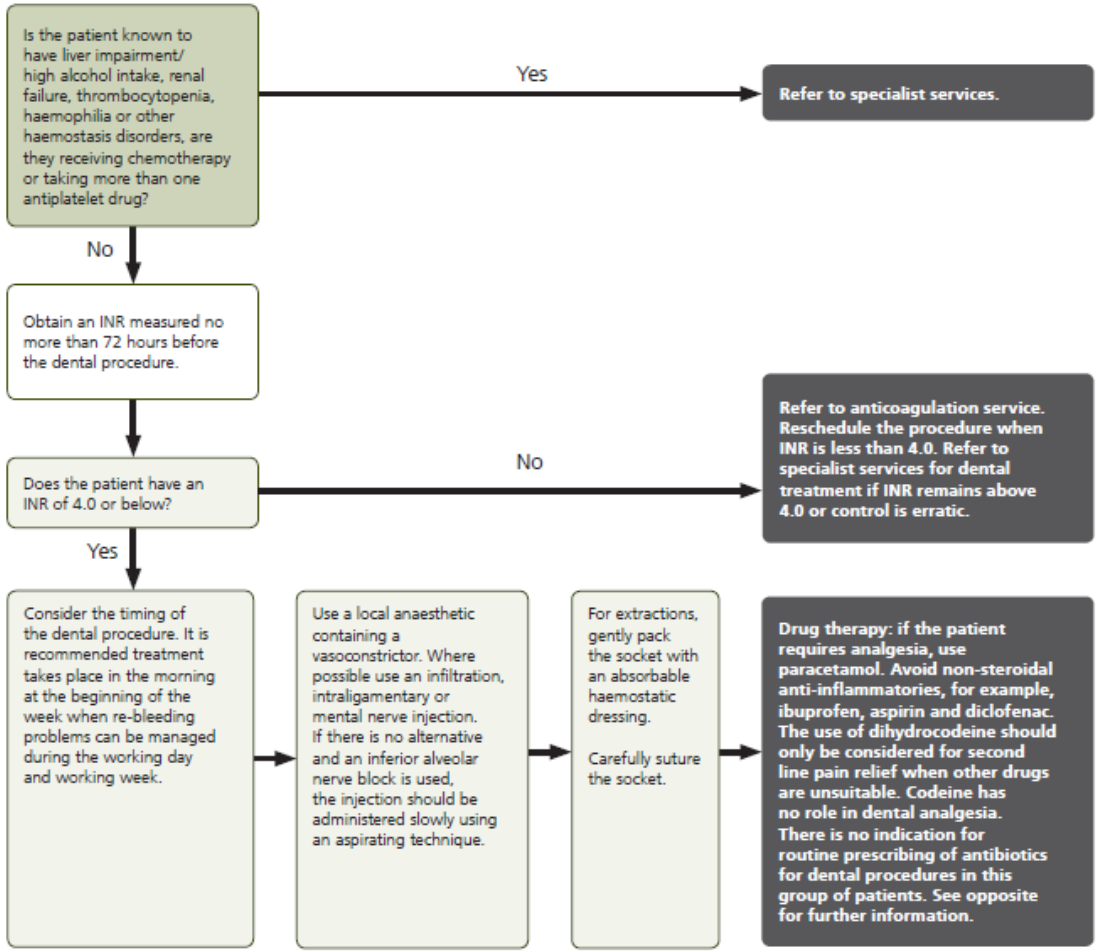
**Metronidazole**
Metronidazole interacts with warfarin and should be avoided if possible. If it cannot be avoided, the warfarin dose may need to be reduced by a third to a half, and re-adjusted again when the antibiotic is discontinued. Contact the GP or anticoagulant clinic to arrange additional INR testing and dose review.

**Non-steroidal anti-inflammatory drugs**
Drugs including ibuprofen, aspirin and diclofenac should not be used as analgesics in patients taking warfarin.

## Dental surgery covered by this advice includes:

Treatment where the INR ***does not*** need to be checked:
- Prosthodontics
- Conservation
- Endodontics

Treatment where the INR ***does*** need to be checked (follow flow diagram):
- Extractions
- Minor oral surgery
- Periodontal surgery
- Biopsies



**Appendix 2**

**Oral Surgery Providers – South Yorkshire and Bassetlaw**

**See separate information sheet for list of current Providers**

**Appendix 3**

**Conscious IV Sedation Criteria**

| Acceptance Criteria | | |
|---|---|---|
| ***You must answer "yes" to ONE of the following criteria for acceptance of the referral*** | **Yes** | **No** |
| The patient is anxious or phobic and is unlikely to co-operate with the intended dental procedure using behavioural management techniques and local anaesthetic alone | | |
| The patient does not normally require sedation for routine care but is likely to require it to enable this procedure to be carried out without undue distress | | |
| ***You must answer "True" to ALL of the following criteria for acceptance of the referral*** | **True** | **False** |
| The patient is 16yrs of age or older | | |
| The patient is ASA Grade I or II (*American Society of Anaesthesiologists Classification of Anaesthetic Risk – refer to Sedation Referral Protocol for description)* | | |
| The patient has not previously tolerated the intended treatment under LA only | | |
| The patient has not stated that he / she does not want conscious sedation | | |
| The intended treatment is available on the NHS | | |
| Relevant Radiographs enclosed | | |

**Appendix 4**

**Modified Dental Anxiety Scale (MDAS)**

**CAN YOU TELL US HOW ANXIOUS YOU GET, IF AT ALL, WITH YOUR DENTAL VISIT?**

**PLEASE INDICATE BY INSERTING 'X' IN THE APPROPRIATE BOX**

**1. If you went to your Dentist for TREATMENT TOMORROW, how would you feel?**

| | | | | |
|---|---|---|---|---|
| *Not Anxious* ☐ | *Slightly Anxious* ☐ | *Fairly Anxious* ☐ | *Very Anxious* ☐ | *Extremely Anxious* ☐ |

**2. If you were sitting in the WAITING ROOM (waiting for treatment), how would you feel?**

| | | | | |
|---|---|---|---|---|
| *Not Anxious* ☐ | *Slightly Anxious* ☐ | *Fairly Anxious* ☐ | *Very Anxious* ☐ | *Extremely Anxious* ☐ |

**3. If you were about to have a TOOTH DRILLED, how would you feel?**

| | | | | |
|---|---|---|---|---|
| *Not Anxious* ☐ | *Slightly Anxious* ☐ | *Fairly Anxious* ☐ | *Very Anxious* ☐ | *Extremely Anxious* ☐ |

**4. If you were about to have your TEETH SCALED AND POLISHED, how would you feel?**

| | | | | |
|---|---|---|---|---|
| *Not Anxious* ☐ | *Slightly Anxious* ☐ | *Fairly Anxious* ☐ | *Very Anxious* ☐ | *Extremely Anxious* ☐ |

**5. If you were about to have a LOCAL ANAESTHETIC INJECTION in your gum, above an upper back tooth, how would you feel?**

| | | | | |
|---|---|---|---|---|
| *Not Anxious* ☐ | *Slightly Anxious* ☐ | *Fairly Anxious* ☐ | *Very Anxious* ☐ | *Extremely Anxious* ☐ |

---

**Instructions for scoring (remove this section below before copying for use with patients)**

*The Modified Dental Anxiety Scale*. Each item scored as follows:

| | | |
|---|---|---|
| Not anxious | = | 1 |
| Slightly anxious | = | 2 |
| Fairly anxious | = | 3 |
| Very anxious | = | 4 |
| Extremely anxious | = | 5 |

Total score is a sum of all five items, range 5 to 25:  Cut off is 19 or above which indicates a highly dentally anxious patient, possibly dentally phobic.

HUMPHRIS GM, MORRISON T and LINDSAY SJE (1995) 'The Modified Dental Anxiety Scale: Validation and United Kingdom Norms' Community Dental Health, 12, 143-150

**Appendix 5**

**Tier 2 IMOS Procedure – Referral Proforma**

# Intermediate (Tier 2) Minor Oral Surgery Referral Form

***For use only when referring to Tier 2 Providers in Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield***

| **Patient Name and Address** | **Referring Practice Stamp** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| **Telephone -** | **Date of Birth -** |

| | | | |
|---|---|---|---|
| **Name of referrer** | | | |
| **Signature of referrer** | | **Date** | |

| **Brief history (including relevant medical history) and procedure requested** | |
|---|---|
| | |
| **Reason for referral and checklist (tick as appropriate)** | |
| Removal of buried / fractured roots or residual root fragments | |
| Removal of impacted / ectopic / supernumerary tooth | |
| Minor soft tissue surgery | |
| Apicectomy (not including lower pre-molars or molars) | |
| Is the referral Routine? ☐ Urgent? | |
| Confirm that an appropriate radiograph(s) enclosed? ***(Referral not accepted without x-ray)*** | |
| Is there a recent medical history enclosed? | |
| Is the patient considered to be a regular attender at the practice? (Y/N) | |
| **Any other relevant information to assist the receiving practice** | |

**References**

1 Securing excellence in commissioning NHS dental services
NHS Commissioning Board, February 2013

2 Interim Dental Foundation training curriculum and assessment framework guidance 2013-14
Committee of Post Graduate Dental Deans and Directors (COPEND), August 2013