Oral Surgery Managed Clinical Network Committee
Southwest of England
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Dear Colleague

NHS England published the guidance for managed clinical networks for Oral Surgery in 2015. The Southwest managed clinical network committee was established in 2017. The following guidance has been agreed to assist General Dental Practitioners when deciding to refer patents. This guidance is applicable to the Southwest Region which comprises of Devon, Cornwall, Isles of Scilly, Somerset, North Somerset, Bristol and South Gloucestershire.

The guidance is agreed by all specialist oral surgery care providers in the region and used as the basis for triaging referrals for oral surgery.

Improving the Oral Surgery Care Pathway is a local and national priority for NHS England we would like your help to achieve this.

Currently throughout the South West area patients requiring oral surgery are referred to secondary care hospitals and a variety of primary care-based providers. There is a wide variety of methods of referral and referral forms that have a common agreed format with some local variation reflecting specific access for services relevant in your local area.

The following guidance will be regarded as a consistent set of guidelines for practitioners in the geographic South West region. Guidance can see downloaded from the link below.

*https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/*

We would especially ask you to take note of the sections on referrals for general anaesthesia, radiographs, and medical conditions.

If you have any comments or queries please contact the LDN chair via

https://www.england.nhs.uk/south/info-professional/dental/dcis/south-west-ldn/membership/

With kind regards

Oral Surgery Managed Clinical Network Committee
Southwest of England

**All practitioners must use the referral forms for all oral surgery referrals of patients over 16. The relevant forms for your area can be downloaded from your local provider or the LDN website. (Appendix 4)**

**Please use the forms to avoid rejection at triage.**

It is rare for a patient's medical history to complicate the extraction to such an extent that it needs to take place within the hospital setting. Specific examples are listed. (**Appendix 2**)

GDC guidelines indicate that "particular care must be taken when referring patients for treatment under general anaesthesia or sedation". **General anaesthesia carries an increased level of risk and should not be offered to patients as a routine alternative. Comprehensive details must be provided to support any request.**

**Failure to achieve adequate local anaesthesia is not normally seen as sufficient justification unless there are supporting circumstances**

If referring for sedation or general anaesthetic the patient must complete and sign the "GA or Sedation Referral form" ***Failure to complete all sections will result in the return of referral and subsequent delay in the patients' treatment.*** (**Appendix 1)**

**Email referrals**
The NHS secure email standard regulations require that emails sent to and from health and social care organisations must meet the secure email standard (DCB1596) so that everyone can be sure that sensitive and confidential information is kept secure.

Please see https://s3-eu-west-1.amazonaws.com/comms-mat/Training-Materials/Guidance/DentistryFAQ.pdf for further details on how to sign up for NHS mail

**Patient NHS numbers**
NHS numbers are mandatory on referrals.

**Fax referrals**
The use of fax for referrals is not supported by the NHS as it is not secure.

**All suspected oral cancer cases should be "fast tracked" direct by secure email or "Choose and book" and their receipt confirmed.**
**(Appendix 4)**

**For advice please consider contacting your local provider or hospital for advice by telephone.**

NHS England

# Contents

## Section 1: General Principles

1.1 As part of their GDS contract/PDS Agreement NHS providers and performers are expected to carry out extractions of teeth and retained roots. The patient should ONLY be referred if they present with special difficulties that lie outside the competence of a GDP. Where treatment required is within the scope of a GDP but the dentist concerned does not feel confident to deliver this treatment care should be provided by another clinician working under the same GDS contract/PDS Agreement.

1.2 It would not be expected that practitioners would refer teeth with a favourable root formation that are fully erupted and accessible to forceps extraction.

1.3 **Practitioners are reminded, that if diagnostic quality radiographs exist prior to referral, that the Ionising Radiation (Medical Exposure) Regulations 2017 carry the responsibility to reduce additional exposure to patients. To provide the original or a good photographic quality copy of a radiograph with the referral to avoid unnecessary additional radiographic exposure to the patient as per FGDP Guidance. Failure to do so may be seen as a breach of regulations.** (see section 4)

1.5 Patient's valid consent should be obtained for referral and tooth removal including an explanation of risks.

1.6 If additional restorative dentistry is being planned as part of the patients existing treatment plan, this treatment must be continued by the referring dentist while the patient is awaiting Minor Oral Surgery assessment and treatment. The referral should also indicate on the referral form which additional teeth are planned to be restored and do not need to be considered for extraction. If teeth that are restorable are to be removed, indicate why.

1.7 Please fill in the patient details in full.

1.8 Patients should understand that they may be treated in either a primary care service or hospital service.

1.9 Patients who miss an appointment or cancels on 2 occasions will be discharged. The referring dentist will be informed.

1.10 It would not be expected for oral surgery procedures to be carried out under general anaesthesia if sedation or a local anaesthetic technique can be employed. Referring Practitioners must avoid promising a particular technique. If the referrer believes that the patient has a severe level of anxiety / phobia this should be formally recorded.

1.11 All suspected oral cancer cases should be fast tracked direct to the Oral Surgery Department by secure email or "Choose and Book" and their receipt confirmed

## Section 2: Extractions of teeth (excluding wisdom teeth)

Routine extractions should be performed in the referring practitioners' dental surgery under local anaesthetic.

Accepted

2.1 Unsuccessful attempt at extraction by referring practitioner (please send post extraction radiograph)

2.2 Patients with severe dental anxiety requiring additional support that cannot be provided by the GDP (eg sedation/GA)

2.3 Abnormal root morphology likely to compromise the ease of extraction

2.5 Wisdom teeth meeting NICE criteria, that are impacted so will need a flap procedure and bone removal and or surgical division (see separate section)

2.6 Teeth with significant cystic change/periapical radiolucencies that need histological analysis

2.7 Extraction where there is a substantially increased risk of damage to an adjacent anatomical structure

2.8 Poor access to tooth due to severely restricted mouth opening

2.9 Teeth with unexplained root resorption

2.10 Patients who are medically compromised

It is rare for a patient's medical history to complicate the extraction to such an extent that it needs to take place within the hospital setting. Specific examples are listed. (Appendix 2)

*If a referral is made outside these guidelines the referring dentist must justify the reasons why the treatment cannot be undertaken by them in primary dental care.*

## Section 3: Third molars (Publication of new NIHCE guidance awaited)

Criteria for extraction
3.1 Recurrent episodes of pericoronitis.

3.2 Single severe episode of pericoronitis which showed evidence of spread of infection to facial tissues.

3.3 Caries not amenable to restoration.

3.4 Wisdom tooth contributing to periodontal disease of second molar.

3.5 Risk of caries in a wisdom tooth or distal aspect of adjacent molar

3.6 Periapical pathology

3.7 Prior to orthognathic surgery

3.8 Associated with cystic change or tumour

3.9 Prior to medical treatment that would increase risk eg radiotherapy, IV bisphosphonates or chemotherapy

3.10 Patients with partially erupted teeth with a mesio angular or horizontal impaction where there is a high risk of caries in either the third molar or distal aspect of the second molar can be considered for referral for discussion of risks with a specialist. If the decision is made to leave such third molars then active surveillance with appropriate periodic intra oral radiographs is advised.
Accepted

## 3.11 Teeth meeting the criteria 3.1-3.10 above where;

anatomical considerations or associated pathology complicate the extraction
certain medical conditions exist (please see appendix 2)
the operator does not have the relevant training or experience
previous attempts at extraction have failed.

## Rejected

3.12 Unerupted asymptomatic and pathology-free wisdom teeth

3.13 Anterior crowding alone is not an indication for wisdom teeth removal in the absence of a specialist orthodontic opinion

3.14 Teeth meeting the criteria in 3.1-3.10 above but where the tooth is fully erupted and not in close proximity to the inferior dental canal; these teeth should be removed in general practice provided the clinician has the relevant training and experience

## Section 4: Other Minor Oral Surgery procedures

Accepted

2.1 Removal of or exposure of impacted teeth (not third molars) if this is part of an orthodontic treatment plan – a copy of this must be forwarded with the referral

2.2 Closure of an oro-antral communication or fistula.

2.3 Removal of root from antrum.

2.4 Pre-prosthetic surgery (eg removal of tori mandibularis) as part of a restorative treatment plan.

## Section 5: Teeth requiring endodontic or apical surgery

Orthograde root canal therapy is the first treatment option to treat periapical pathology. Non surgical re-treatment should be the preferred option for endodontic failure. The restorability of the tooth, the health of the supporting bone and periodontal tissue, and anatomical considerations such as position of neurovascular bundle should be assessed before embarking on any form of surgical endodontic therapy.

Referral for apicectomy of a tooth with an inadequate root filling will not be accepted without exceptional circumstances. Re-root filling by the referring dentist or a specialist endodontist is the best solution to most failed root fillings.

Accepted

5.1 Symptomatic teeth with conventional endodontic treatment on incisor, canine or premolar tooth where there is evidence of re-root treatment, and an adequate coronal seal. The roots should show successful and complete obturation throughout its width and length.

5.2 Where visualisation of the periradicular tissues for biopsy is required

5.3 Where there is significant cyst formation (>5mm diameter)

Considered

5.4 Periradicular disease in a root-filled tooth where re-root treatment has been carried out or on exception non-surgical root canal retreatment cannot be undertaken or has failed.

5.5 Teeth with iatrogenic or traumatic damage, or resorption where surgery offers the opportunity to retain the tooth.

5.6 When apical transverse root fracture post trauma is suspected and the coronal portion of the root can be root filled.

5.7 Teeth with a post crown where the post fits the root canal well and is of an appropriate length (normally 10mm+) and there is no history of cementation failure and where the coronal seal is adequate and apical root canal obturation is present but there is symptomatic apical pathology.

Considered

5.4 Periradicular disease in a root-filled tooth where re-root treatment has been carried out or on exception non-surgical root canal retreatment cannot be undertaken or has failed.

5.5 Teeth with iatrogenic or traumatic damage, or resorption where surgery offers the opportunity to retain the tooth.

5.6 When apical transverse root fracture post trauma is suspected and the coronal portion of the root can be root filled.

5.7 Teeth with a post crown where the post fits the root canal well and is of an appropriate length (normally 10mm+) and there is no history of cementation failure and where the coronal seal is adequate and apical root canal obturation is present but there is symptomatic apical pathology.

*Rejected*
*5.8 When lateral perforation, vertical or mid root fracture is suspected.*

*5.9 Repeat apicectomy.*

*5.10 Where the root canal is inadequately obturated and there is access to the root canal system.*

*5.11 Patient requests general anaesthesia without clinical indication.*
*5.12 Apicectomy of molar teeth.*

*5.13 Where patients have poor oral hygiene and active periodontal disease or uncontrolled dental caries.*

*5.14 Unrestorable tooth, or one with inadequate bony support.*

*5.15 Teeth with a post crown where the post is inadequately designed eg short or deviated, does not fit the canal, where there is no evidence of apical root obturation or the post has been re-cemented on several occasions.*

*5.16 Risk to adjacent anatomical structures is high eg neurovascular bundle.*

*5.17 Patients who are medically compromised.*

*The guidelines above reflect those of the Faculty of Dental Surgery of the Royal College of Surgeons of England, available at https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/surgical_endodontics_2012.pdf*

## Section 6: Radiographs

Essential criteria

6.1 Panoramic or periapical radiographs that demonstrate the whole tooth

6.2 In the case of lower third molars where panoramic imaging is unavailable, periapical radiographs should be submitted. They need not show the entire tooth but they should give a clue to the nature of the impaction and demonstrate/exclude distal caries in the second molar

6.3 Radiographs should ideally be submitted using DICOM format and password protection

6.4 Printed digital radiographs should be of diagnostic quality. It is recommended that they are printed on photographic paper at a resolution of at least 600dpi.

6.5 Printed radiographs must be labelled with

- Full name of patient
- Date of birth
- Date of exposure
- A laterality marker for panoramic images

6.6 Where no radiograph is supplied, a full explanation of the reason for omission must be submitted.

## Section 7: Management of Temporomandibular Joint Dysfunction

*Current national guidance is accessible from the Faculty of Dental Surgery of the Royal College of Surgeons of England.*
https://www.rcseng.ac.uk/dental-faculties/fds/publications-guidelines/clinical-guidelines/

7.1 Guidelines support that before referral a patient should be managed in primary care. This should include the provision of advice, analgesics and occlusal assessment together with any necessary supporting bite appliances. (Appendix 3)

7.2 Referral without evidence of the above will be rejected unless there is justified clinical reasons.

7.3 Initial management of Temporomandibular Joint Dysfunction may involve supportive patient education on avoidance of clenching and grinding, relaxation and a soft diet.

7.4 Pharmacological pain relief with Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and remedial jaw exercises can also be of value. For patients with persistent pain, stabilising splints or bite raising appliances may help, but permanent occlusal adjustments should be avoided.

7.5 It is important to read through Appendix 3 on TMJ treatment and to refer only if symptoms persist after conservative measures, including the provision of a soft splint.

7.6 Referral to specialist care may be necessary for clarification of diagnosis where there is underlying joint disease, limited opening in isolation or if the patient has persistent Temporomandibular Joint Dysfunction or psychological problems.

## Section 8: The management of abnormal soft tissue and bony lesions:

8.1 The Oral & Maxillofacial Surgery service will receive referrals for any soft tissue lesions of the skin in the head and neck region, and abnormal hard and soft intra-oral lesions.

8.2 Abnormal lesions should be referred to specialist services when the diagnosis is in doubt or if they interfere with dental treatment. If a clear and adequate history is provided on the referral form, some units may offer a service where the patient is seen and treated under local anaesthetic during a single appointment.

8.3 Abnormalities due to infections of the oral cavity should be treated in line with antimicrobial guidelines with a simultaneous treatment to remove the cause of the infection if known.

**8.4 All suspected oral cancer cases should be "fast tracked" direct by secure email or "Choose and book" and their receipt confirmed (see Appendix 4).**

## Section 9: Oral cancer

9.1 Patients with abnormal areas or lesions in the mouth that are suspected of being oral cancer must be referred for an urgent Oral & Maxillofacial consultation. The oral cancer referral form must be completed and faxed within 24 hours directly to the Oral & Maxillofacial Surgery Department. It is advisable to check the referral has been received.

9.2 All suspected cancer referrals are subject to the "Two Week Wait" cancer waiting times. Warning signs of oral cancer are:

- Non healing, often painless ulcer or sore for more than three weeks.
- Lump or thickness in the cheek or elsewhere in the mouth.
- Persistent soreness of the throat or mouth.
- Difficulty chewing or swallowing.
- Numbness of the tongue or other areas of the mouth.
- Swelling of the jaw which causes the dentures to fit poorly.
- Unexplained loosening of the teeth or pain around the teeth or jaw.
- Voice changes.
- A lump or mass in the neck.
- Unexplained weight loss

9.3 Examination of the oral soft and hard tissues should be performed in line with NICE dental recall guidelines. Dental practitioners should be aware of the most common appearance, warning signs and symptoms of oral cancer.

9.4 Preventive advice concerning tobacco cessation, reduction of excessive alcohol consumption and healthy eating habits should be offered.

# APPENDIX 1

## Section 10: Provision of Conscious Sedation/General Anaesthetic for minor oral surgery procedures

### 10.1 Provision of Conscious Sedation for minor oral surgery procedures

Since 1998 there has been a sea change in the provision of pain and anxiety management in dentistry in the UK. This has resulted in an increased emphasis on the safe provision of conscious sedation instead of a reliance on general anaesthesia that is demand led. General anaesthesia should only be provided in response to clinical need. The publication of *'A Conscious Decision'* in 2000 resulted in the cessation of general anaesthesia for dentistry in the primary care setting.

Conscious sedation is available in primary and secondary care settings.

### 10.2 Provision of Conscious Sedation/General Anaesthesia for minor oral surgery procedures

- those who have had an aborted procedure due to 'failed anaesthesia' or technical difficulties, who for justifiable reasons are reluctant to try LA in isolation again
- lengthy procedures in an otherwise non-anxious individual e.g multiple exodontia
- anticipated 'surgically traumatic' procedures which may cause distress to an otherwise non anxious individual.
- where there is restricted access/ limited opening/ lack of cooperation
- Large or infected cysts where obtaining local anaesthetic is difficult.
- Young Children with inadequate cooperation.
- Extreme dental phobics. These would be patients who are unable to tolerate local anaesthesia for any procedures.
- Patients with learning difficulties who are unable to tolerate normal dental procedures.
- Confirmed sensitivity or allergy to Local Anaesthetics ( very rare)
- Emergency dental extractions carried out in conjunction with extra- or intra- oral drainage of abscess usually associated with trismus and/or a threat to the airway.
- Patients with movement disorders and learning difficulties can also be referred to special needs

10.3 Cornwall: If a General Anaesthetic/Conscious sedation has been requested please complete the "GA or Sedation Request" (form 2) This must accompany the Oral Surgery Referral Form.

10.4 Please make sure that the reason has been fully explained to the patient and that they have signed the form.

10.5 Services for young children are often limited. Please contact your local hospital for advice. In Bristol please contact the dental paediatric department at the Dental Hospital.

10.6 Following the guidance from the GDC and Royal College of Anaesthetists, It is important when referring children that you sign to explain that you have discussed all other option and alternatives for treatment.

Guidelines for the Management Of Children Referred For Dental Extractions Under General Anaesthesia
https://www.rcoa.ac.uk/system/files/PUB-DentalExtractions.pdf

# APPENDIX 2

## Section 11 : Medical Conditions and Minor Oral Surgery

**11.1 Anticoagulated Patients:-**

*Refer to the guidelines of the Scottish Dental Clinical Effectiveness Programme*
*http://www.sdcep.org.uk/wp-content/uploads/2015/09/SDCEP-Anticoagulants-Guidance.pdf*

- Patients on anticoagulant therapy can usually be managed in primary care. There are very few exceptions for routine extractions where three teeth or less are being removed. If more extractions are required divide the treatment into a number of appointments

  It is best to plan to see patients early in the week and at a morning appointment.

  In all cases local measures are advised, including the use of haemostatic agents (such as Surgicel© and sutures)

- Warfarin
  Extraction for patients with a stable INR less than 4.0 should be carried out in primary care

  An INR obtained within 36 hours before treatment is acceptable

- Patients taking the new oral anticoagulants (NOACS) dabigatran, apixaban, and rivaroxaban can have simple extractions carried out in primary care with local measures.

  The guidelines support omission of the dose before treatment. See guidance for further details.

**11.2 Steroids**

***Nice guidelines 19th January 2016***
***https://patient.info/doctor/precautions-for-patients-on-steroids-undergoing-surgery***

- Patients on 10mg or less of prednisolone and less than 3 months will not require cover

Many patients taking more than 10 mg of prednisolone can be managed by asking them to take additional oral steroids often 5 – 10 mg depending upon dose.

Patients on high long term doses should be referred for advice

**11.3 Addison's disease and steroid cover**

Most Addison's disease patients on long term steroid supplements can be treated in general practice for most procedures. Refer to the guidance below.

Guidance: Addison's Society web site
https://www.addisons.org.uk/files/file/4-adshg-surgical-guidelines/

**11.4 Bisphosphonates and monoclonal antibodies**

**Osteoporosis management or metastatic disease.** (Breast, prostate, multiple myeloma)

*Guidance Scottish Dental Clinical Effectiveness Programme March 2017*
*http://www.sdcep.org.uk/published-guidance/medication-related-osteonecrosis-of-the-jaw/*

*NICE Guidance Feb 2018*
*https://www.nice.org.uk/guidance/ta464*

**Consider referring**

- Patients who have had or are receiving Intravenous bisphosphonate medication and Anti-TNF treatments (Rheumatoid Arthritis) and therefore at high risk of osteonecrosis.
- Patients on oral bisphosphonates with other immunosuppressives such as steroids or chemotherapeutic agents who are at a high risk of osteonecrosis
- Patients on oral bisphosphonates who smoke or are diabetics

**Patients who may be suitable for treatment in primary care**

- Patients who have commenced oral bisphosphonates or anti-TNF factors where the treatment is two years or less and no other immunosuppressive medications are co-prescribed.
- Also for the above category of patient consideration of a drug holiday at the time of extraction until patient has healed.

**Oncology patients:** Head and neck surgery / radiotherapy

- Patients at risk of Osteoradionecrosis. (patients with a history of head and neck radiotherapy)
- Patients with limited oral access e.g. head & neck cancer patients with microstomia or severe trismus.

## Section 12. Patients suitable for treatment in a hospital setting

12.1 Unstable/severe cardiovascular disease.

12.2 Respiratory function decreased to the extent the patient has to have home oxygen therapy.

12.3 Unstable epilepsy.

12.4 Uncontrolled diabetes.

12.5 Any medical condition such as liver/ kidney disease that requires additional investigations prior to extraction.

12.6 Patients with coagulation disorders such as Haemophilia, and Von Willebrands disease.

12.7 Patients on Warfarin whose INR >4, or whose INR is unstable or requires multiple extractions.

12.8 Patients undergoing chemotherapy who are in acute pain requiring extraction.

12.9 Patients who have had radiotherapy to the head and neck.

12.10 Patients on oral bisphosphonates and have an additional comorbidity such as diabetes, steroid or other immunosuppressive therapy.

12.11 Patients who have had or are receiving IV bisphosphonates, antiresorptive drugs (eg Denosumab) or Anti-TNF treatment (Rheumatoid Arthritis) and therefore at high risk of osteonecrosis.

12.12 Patients who have severe immune dysfunction.

12.13 If a patient suffers from a condition not mentioned in the above and you feel should be seen in the hospital setting, please complete the referral form and enter the condition in section 4. Please be aware that patients with BMI greater than 40 will require specialist assessment and may not be offered GA or sedation.

# APPENDIX 3

## Section 13: Guidance for the management of Temporomandibular Joint Pain Dysfunction Syndrome (TMJPDS) in primary dental care

*Current national guidance is accessible from the Faculty of Dental Surgery of the Royal College of Surgeons of England.*
*https://www.rcseng.ac.uk/dental-faculties/fds/publications-guidelines/clinical-guidelines/*

13.1 The majority of patients presenting with TMJ problems will be suffering from TMJPDS (Temporomandibular Joint Pain Dysfunction Syndrome) or myofacial pain. These patients can, in most cases, be effectively managed in primary care without referral.

13.2 The most common symptoms are:

**Pain** – usually a dull ache in and around the ear. The pain may radiate, ie move forward along the cheekbone and downwards into the neck.
**Joint noise** – such as clicking, cracking, crunching, grating or popping.
**Limited mouth opening**
**Headache**, especially in the temporal region.
Some patients report mild/transient **facial swelling** which may be worse in the morning.

13.3 Most cases of TMJPDS are made worse by chewing and are aggravated at times of stress.

13.4 The initial management of TMJPDS in primary care includes the following measures:

Explanation of the condition and provision of relevant patient leaflet.

Reassurance that TMJPDS is not serious and that it usually responds to simple measures. Symptoms may recur from time to time.

Application of heat to the side of the face, eg a warm hot water bottle (avoid boiling water) wrapped in a towel applied to the side of the face. This can be combined with simple massage to the tender muscle areas and relaxation techniques.

Advice concerning the use of painkillers. Non-steroidal anti-inflammatory drugs (NSAIDs), eg ibuprofen, are often helpful, unless contra-indicated because of the patient's medical history. These should be taken regularly for a two to three week period, not just PRN. NSAID gel can be applied topically to the area over the joint or the muscles of mastication.

The identification and avoidance of parafunctional habits, such as clenching or grinding (particularly at night), nailbiting, lip/cheek biting and posturing the jaw.
Rest for the TMJ, including soft diet, particularly if there are acute phases.

Acknowledgement that the condition can be related to anxiety and stressful events.

Provision of a soft occlusal splint, which can be worn at night – this is particularly useful for patients who grind their teeth at night.

*NB: Irreversible procedures such as occlusal adjustment should only be undertaken if there is a clear indication.*

**13.5 Patients with TMJPDS who should be referred for management in secondary care:**

Those with an atypical presentation (e.g. numbness of the face, marked/persistent facial swelling, severe trismus which is unrelated to surgical intervention or injury).

*Multiple unsuccessful treatments*

*Psychological distress*

*Occlusal preoccupation*

*Chronic wide spread pain*

*Disc displacement without reduction (closed lock).*

Referrals should be made to an Oral & Maxillofacial Surgeon or Consultant in Restorative Dentistry. Please indicate the measures you have already undertaken to manage the patient's TMJPDS.

13.6 It will be expected that initial primary measures 1 – 8 will have been carried out in general practice prior to referral. If this has not been carried out referrals may be returned.

NB: Patients should not be referred for the provision of an occlusal splint – these can be provided in primary dental care

# APPENDIX 4

**Section 14. "To whom should I refer?"**

Currently patients referred for oral surgery procedures are treated either in a secondary care setting which means one of the main hospitals in South West or by a specialist provider based in a primary care setting.

Secondary Care providers are able to offer the full range of operative and diagnostic treatment including 2 week waits for suspected cancer patients and general anaesthesia.

Primary care providers are able to offer a more limited range of surgical procedures, with or without sedation. (**Appendix 1**)

**14.1 "Where should I send the referral form?"**

**All the referrals for the Devon, Torbay and Plymouth** areas should be sent to Devon Access and Referral Centre DART on the DCIoS Oral Surgery Referral form (**Form 1**). Their address, email and telephone number are on the form.

**NOTE: GDPs who currently refer directly to Derriford or Plymouth based primary care should now refer all patients through DART**.

**All the referrals for the Cornwall** area should be sent to Kernow Health Referral Management Service RMS on the DCIoS Oral Surgery Referral form (**Form 1**). Their address, email and telephone number are on the form.

**For Somerset** the referral should be sent to the relevant secondary care providers in your area usually accessed via Musgrove Park Hospital, Community salaried services or Care UK.

**For Bristol and South Gloucestershire** referrals should be sent to Bristol Dental Hospital, Care UK (Emersons Green), Bristol Dental Anaesthetic Clinic or Apple Dental Practice in Yate

**14.2 "How should I refer a suspected cancer case?"**

**A suspected cancer case should be referred without delay directly to your nearest hospital**. The referral should be faxed and the numbers are on the referral forms. A paper copy or telephone call should follow as a backup.

**For North Devon and Exeter** you should use the Oral and Maxillofacial Surgery Referral Form (**Form 1**) - Fax number: 01392 402199.

**For Plymouth use the Plymouth** 2WW form (**Form 3**) – Fax number: 01752 430912 telephone number: 01752 437506.

**For Cornwall use the Cornwall Hospitals Trust** urgent two week wait form (**Form 4 or 4a electronic**) – Fax number: 01872 252300, if you have any problems please ring 01872 252323.

**Taunton & Somerset**
Referral form for Possible/Suspected Cancer – "Suspected Head & Neck Cancer Referral Form".
Please fax to : 01823 343417. Cancer services are available on 01823 343315

**For Torbay** book via choose and book if possible, otherwise use the South Devon Healthcare Trust urgent two week wait form (**Form 5**) and fax to the Patient Access Centre – Fax number: 01803 654981.

**For Bristol** please access the Fast Track Referral office at UHBristol
either via Choose & Book if you are a GP or via fax on 0117 342 3266 using the designated ***Fast Track Referral*** Form for Suspected. ***Head and Neck Cancer***, which can be found on the website.
http://www.uhbristol.nhs.uk/media/2357035/1b. general oral surgery referral form v1.2.docx

**14.3 "What happens if I encounter problems and am unable to complete a surgical procedure?"**

Firstly you should ask a colleague in your practice to assist but if that is not possible then you can ring your local secondary care oral surgery department or primary care specialist for advice.

Royal, Devon and Exeter NHS trust: 01392 411611 to the operator and then ask for the on-call SHO on bleep 476.

For North Devon District Hospital: "daytime" ring the secretary on 01271 322477.

Derriford Hospital, Plymouth: 01752 202082 and ask for the on call maxillofacial SHO.

Plymouth Community Dental Services: 08451558070

Taunton & Somerset NHS Foundation Trust on 01823 333444 and ask for the on-call Oral and Maxillofacial Surgeon.

Royal Cornwall Hospital, Truro: 01872 250000 - switchboard for on call Oral and Maxillofacial Surgery Resident. Daytime urgent requests can also be to secretarial team: 01872 253986

Torbay Hospital: The on call SHO via the switchboard 01803 614567 and bleep #6313.

Bristol Dental Hospital during the day on 0117 3424371 or the on call SHO out of hours via the Bristol Royal Infirmary on 0117 9230000.

### 14.4 "What will happen if a referral is rejected?"

A referral will only be returned to the referring practitioner after a clinician has reviewed it. The referring practitioner will be sent a letter stating the reason for the rejection and the patient will also be informed. It is then up to the practitioner to provide more details of why the referral is appropriate or undertakes the procedure in practice. The Area Team will be auditing a number of these cases to ensure that the patient reaches a satisfactory conclusion.

### 14.5 "Will I get my radiographs back?"

We are aware that radiographs have not always been returned in the past but in future every effort will be made to return original radiographs with correspondence. Digital radiographs should be printed on good quality photographic paper.

### 14.6 "How can I improve my extraction skills?"

Health Education England provides high quality postgraduate dental education across the South West. We understand that oral surgery can be challenging, and offer regular hands on courses for dentists to improve their oral surgery skills. These can be accessed at : dental.southwest.hee.nhs.uk

Other opportunities include the Bristol University Open Learning for Dentists (BUOLD) unit in oral surgery, the Postgraduate certificate in Clinical Oral Surgery at Bristol University and the Diploma in Oral Surgery at Peninsula University.