

Review of Oral Surgery Services and Training

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Chairman's Foreword

Oral Surgery (OS) is an integral element of oral healthcare provision. As a distinctive branch of dentistry, OS needs to be viewed separately from the medical specialty of Oral and Maxillofacial Surgery (OMFS), albeit that there is overlap in the scope of practice of OS and OMFS. In the interests of patients and enhanced efficiency and effectiveness in the provision of OS and OMFS services, the specialties of OS and OMFS should further develop and strengthen inter-specialty, collaborative working.

In the process of the present review, the review group has collected, shared, heard and been sent a large amount of evidence. Members of the review group visited providers of OS services in South East England, Wales and Northern Ireland who have responded to the challenge of increasing referrals and associated costs by the introduction of alternative, highly effective, cost-saving arrangements in primary care settings. In addition, the review group has given consideration to the measures necessary to safeguard the future of the specialty of OS in the interests of generations of patients to come.

Faced with steadily increasing OS referrals from primary to secondary care, most of which are presently managed in OMFS units at considerable cost to the NHS, and the need to provide enhanced patient-centred, better value for money OS services, the review group has made a series of recommendations to encourage the development of more accessible and affordable OS services. The recommendations include proposals to expand OS Consultant-led services and training in the specialty. Also, consideration is given to OS training and career advice included in the undergraduate dental degree programme and vocational (DFI) training, together with provisions for practitioners to develop a special interest in OS. An integrated approach to the commissioning of services and the continuum of education in OS, as part of such arrangements in dentistry in general, would offer many advantages.

With the anticipated growth in the aging population, changes in the pattern of oral and dental diseases and many more people retaining an increasing number of teeth throughout life, the clinical practice and underpinning science of OS must continue to evolve to meet the future needs of patients. To address this challenge, OS must be a strong, vibrant, integral element of modern oral healthcare provision, let alone involved in new and emerging oral and dental science and modern approaches to specialty training and subsequent career development. The recommendations of the review group, as set out in the present report, are considered to provide the means to realise the vision for the future of OS in England.

Professor Nairn Wilson
Chairman, Oral Surgery Review Group

1: Introduction

The Review Background and Process

A review of Oral Surgery (OS) was recommended as an outcome of the Review of Training in Oral and Maxillofacial Surgery (OMFS), conducted by the Postgraduate Medical Education and Training Board (PMETB) at the request of the then-Secretary of State for Health.

The terms of reference for the review are included at **Appendix A**.

The General Dental Council's definition of the specialty of Oral Surgery can be found at **Appendix B**.

Recommended procedures suitable to be carried out by a Dentist with Special Interests in Minor Oral Surgery are at **Appendix C**

A list of review group members can be found at **Appendix D**.

The review group gathered information, evidence and opinions from:

- Written submissions – over 200 responses were submitted to the review group's consultation exercise
- Oral evidence day – representatives of 12 organisations presented evidence at two oral hearings (participants also listed at **Appendix D** and a summary of their written evidence can be found at **Appendix E**)
- Literature review – 60 articles and publications were used to generate a picture of the specialty of OS and the present provision OS services
- Site visits – members of the review team visited sites in Belfast, Croydon and Merthyr Tydfil

2. Findings and Vision

The following headings set out the review group's vision for the future provision of OS, based upon its findings from the broad range of evidence gathered and submitted to the groups in the process of its work.

Each element of the vision is followed by recommendations that the group believes will make an important contribution to enhance the future care of patients, improve access to oral surgery services, while reducing costs. It should also allow the specialty of OS to grow, develop and attract an increased number of trainees to safeguard the future of the specialty and contribute to improved patient care.

An accessible, cost efficient, patient-focused Oral Surgery service

The future provision of NHS services will be structured around patient needs. This should be foremost in the minds of those planning services

“Patients do not belong to any one professional; they are the responsibility of all who take care of them.” Bristol Inquiry, 2001

NHS policy of the past 20 years has strongly advocated an increase in patient focus and engagement to ensure that services are tailored to meet the needs of the people who use them. Reports such as *The Wanless Report*ⁱ, *The Next Stage Review*ⁱⁱ and the *NHS Constitution*ⁱⁱⁱ have outlined a vision for local, patient-centred care and committed the NHS to a set of standards that hold the service to account. The recent government White Paper *Equity and excellence: Liberating the NHS*^{iv}, has reinforced this commitment and proposes to streamline the health service, and enhance team working within the NHS workforce, to ensure that maximum resources are invested in meeting the needs of patients and that bureaucracy is kept to a minimum.

According to the Picker Institute^v, patients and the public want accessible, local, high quality healthcare that is free, or affordable, if charges are levied, at the point of access. They want to be involved in their care and have flexibility and choice in their treatment. As a consequence, arrangements in primary dental care should be such that routine OS procedures are typically undertaken as part of the service offered by general dental practitioners. Responses to the present review indicated that such provision of routine OS procedures is variable across the country.

Respondents to the consultation exercise of the present review confirmed that, in general, access to specialist OS services is also variable across England, particularly in rural areas in which there is a heavy reliance on primary care services. As a result, some patients with complex problems are not benefiting from the more highly skilled care specialists can offer. Respondents confirmed that specialist OS services are mostly accessed via departments of OMFS in which referrals are increasing, costly, and, because of the unevenness of primary care services and quality of referrals, not always found to be necessary.

A study undertaken by Coulthard et al^{vi} reports that dental practitioners refer OS cases to OMFS units for one or more of the following reasons:

- anticipated surgical difficulty (69 percent of cases)
- medical history issues (49 percent of cases)
- require a second opinion (32 percent of cases)
- practitioners do not undertake surgical procedures (29 percent of cases)
- practitioners lack appropriate facilities or staff (28 percent of cases)
- patients require emergency management of pain, swelling or haemorrhage (11 percent of cases)

Within the current fiscal constraints, the NHS is expected to deliver at least the same level and quality of service with more effective use of resources, thus the importance of guaranteeing value for money in high quality service delivery and training is paramount^{vii}. The Review Group has formed the view that there is considerable scope for efficiency gains in the provision of OS services, in particular, in respect of many of those OS services provided in departments of OMFS.

Recommendation 1: Commissioners should review how OS services are provided in their area and improve their effectiveness, accessibility and cost efficiency, in the context of the remaining recommendations in this report.

There is considerable support for the expansion and extension of OS services in the primary care setting to support local delivery of services

The majority of respondents to the consultation exercise were in favour of an expansion and the extension of the primary care provision of OS to support a move to a more accessible, cost efficient provision of services.

An expansion and extension in the provision of primary care OS services will provide more people with quick and convenient access to local treatment at a significantly reduced cost to the NHS, and will increase the time available in departments of OMFS to focus on more complex cases. Such changes in the way that service is delivered have the potential to release significant cost savings, and it is important that these savings are re-invested until there is a full range of OS services appropriate to patients' needs for routine and specialist care.

Recommendation 2: Primary care OS services should be developed to meet the needs of patients for appropriate, accessible care and to make more efficient use of NHS resources.

Recommendation 3: To ensure that enhanced primary care OS services remain attractive and accessible to patients, continuous quality improvements in the provision of services and training should be funded through any potential savings made in re-providing secondary care services in a primary care setting outside OMFS departments in hospitals.

Recommendation 4: The Government's proposal to introduce a new dentistry contract with a focus on increasing access to NHS dentistry should include provisions to increase the access to and availability of routine OS in primary care^{viii}.

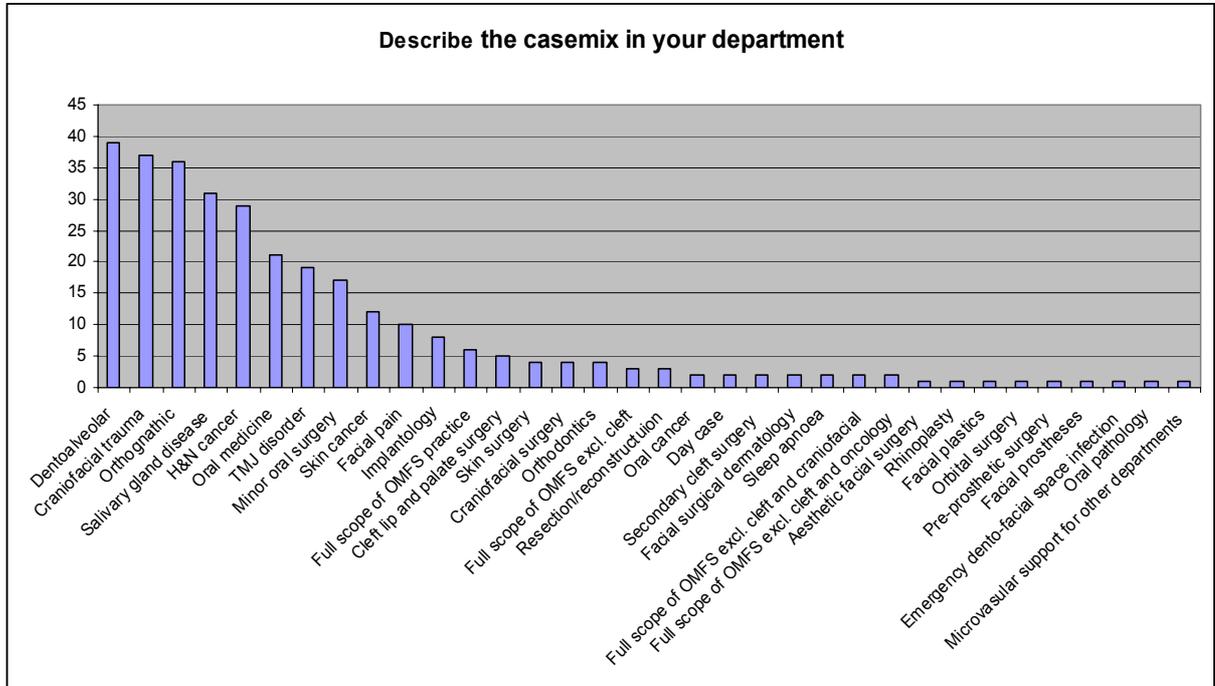
In 2008, Croydon Primary Care Trust appointed two General Dental Service (GDS) providers and introduced a referral management centre to address issues in respect of OS services. This resulted in a significant reduction in OS referrals to secondary care OMFS. After 12 months in operation, the scheme reported as follows on 3117 non-urgent referrals from Croydon general dental practitioners (GDPs) that would *all* have entered the secondary care system:

- 1137 (36 per cent) continued to be referred to the hospital OMFS department
- 1834 (59 per cent) were referred to a primary care based specialist oral surgeon for treatment¹
- Of the referrals to the primary care based oral surgeon, two per cent failed to attend, with the remaining 1798 patients being successfully treated, with no subsequent re-referrals on to secondary care

Importantly, the implementation of the referral management scheme did not result in the destabilisation of the local department of OMFS, which reported that it was better able to meet key performance indicators, and able to concentrate resources on more complex cases. Waiting times were reduced, with no patient waiting longer than eight weeks for treatment. Given data on case mix in UK departments of OMFS (see table below), the potential for similar initiatives across the country is considered to be substantial^{ix}. Where such initiatives can be implemented, the resourcing of OMFS units can focus on an enhanced delivery of OMFS services.

¹ The remaining 5 per cent could not be traced

% of PMETB consultation with Trusts and Health Boards, cases



Recommendation 5: Commissioners should review local arrangements for the provision of OS services. Where there is a high level of referrals to secondary care departments of OMFS, steps should be taken to identify which categories of patients could be treated in a primary care setting and, where practicable, make alternative provisions for the management of these referrals. The alternative provisions should enhance access and offer efficiency gains without any reduction in the quality of service.

These improvements are unlikely to be achieved without support for the development of education and training as recommended later in this review.

There remains a need for some specialist OS services to be provided in secondary care

Departments of OMFS are, in general, highly reliant on Staff and Associate Specialist (SAS) grades to deliver OS service^x. In 2006, the British Medical Association (BMA) reported that SAS grades made up 42 per cent of staff practising in departments of OMFS (52 per cent of OMFS staff overall). This level of SAS staffing is the highest of any surgical specialty, with the average across healthcare being 23 per cent.^{xi} Significantly, 80 per cent of SAS staff report that their current grade is not their career goal; it is clear, therefore, that a highly motivated cadre of experienced clinicians are seeking opportunity for further career development^{xii}.

Although there is clearly scope to manage a large proportion of OS referrals in the primary care sector, the scope of OS spans the management of a wide range of conditions of varying complexity. To ensure that patients with complex needs, together with those requiring general anaesthesia, are managed appropriately, the review group confirms the view that some specialist OS services continue to be provided in hospital, delivered by Consultants in OS rather than by SAS staff. To help achieve this goal SAS staff with appropriate skills should have opportunity to further their careers.

Recommendation 6: To meet the needs of patients, specialist OS services should be Consultant-led, ideally by Consultant Oral Surgeons, and provided in both primary and secondary care settings, with the services in secondary care being Consultant-delivered, possibly by existing SAS grades who have had the opportunity to undertake further career development leading to appointment to the Consultant grade.

Recommendation 7: OS referrals from primary care should, through clinical networks, reflect best practice, thereby allowing departments of OMFS to focus on complex care.

Recommendation 8: Commissioners and NHS hospital trusts should evaluate existing arrangements for the provision of OS services and, where appropriate, develop an action plan for the more efficient, effective delivery of these services in accordance with the above recommendations.

3: Commissioning

When cases that can and should be managed in primary care are referred to hospital, patients are inconvenienced and the efficiency of the service is compromised.

The Quality and Productivity Challenge (QPC) challenges commissioners and NHS managers to use resources in the most efficient way without loss of quality. In the spirit of this challenge, value for money in providing a high quality service has been an underpinning principle in conducting this review.

It was demonstrated in a recent study in Havering PCT that there are considerable savings to be made by utilising dentists with a special interest (DwSIs) in OS to deliver services that were generally referred to local secondary care. Of 83 referrals received, 51 (five for consultation and 46 for extractions) were seen by one of three DwSIs. The average waiting time between referral and treatment was 36 days, with the cost of treating the 51 cases totalling £8,020. The cost for these treatments to have been delivered in secondary care would have been £43,608, a difference of £35,588, with a projected annual difference of £142,352. Eighteen patients were interviewed following treatment, with 83% rating their treatment as good to excellent^{xiii}.

The 2008/9 Payment by Results tariff for 'minor mouth procedure' in the OMFS specialty code 144 reveal the financial implications of an unnecessary referral to a secondary care OMFS unit. Most OS procedures are charged under one of two codes, with tariffs of £558 and £789. When compared with the cost of primary care provision of around £265 per case achieved in the Croydon project, there are potentially significant economies to be made^{xiv}.

It should be noted, however, that costs can vary in both primary and secondary care, depending on the extent of treatment required and the arrangement for the payment for associated support services, but there still remains the potential for a significant opportunity for cost reduction. Departments of OMFS are presently managing a significant amount of OS work, with estimates suggesting that OS procedures constitute 80% of the caseload in many departments. The available evidence indicates that much of this work need not be undertaken in hospital. Alternative arrangements for this care, would in addition to opportunity for cost reduction, free up time in departments of OMFS to focus on the complex care these departments exist to treat.

OMFS departments are managing a significant amount of OS work, some of which could be moved elsewhere, to free up time to focus on complex care

OMFS has one of the longest training programmes of all the medical specialties and is the only specialty that requires primary qualifications in both medicine and dentistry. OMF surgeons are responsible for the diagnosis and surgical management of patients with severe craniofacial trauma, head and neck cancers, salivary gland disease, facial disproportion and other oral and maxillofacial conditions, both congenital and acquired.

Developing clinical networks

The development of managed clinical networks (MCN) offers new ways of delivering services to patients, with a focus on services and patients rather than upon buildings and organisations. It involves clinical staff working with commissioners across boundaries between the different professional groupings and NHS organisations. The aim is to ensure that existing health service resources and staff are allowed to focus on what matters: notably patients and their health care needs. The emphasis should always be on partnership and distribution of resources to match patient need. MCNs can help to break down barriers between primary, secondary and tertiary care. Such networks may evolve or develop as an extension of referral patterns, but the key emphasis must be on providing the highest quality of care for patients through coordinated referral pathways in the safest and most convenient location^{xv}.

Where dental referral management systems have been established and OS developed in primary care, Trusts have seen a substantial reduction in OS referrals to departments of OMFS.

Recommendation 9: Managed clinical networks and referral management systems should be established to ensure that patients requiring treatment by OS and OMFS surgeons are assessed and referred to the most appropriate primary or secondary care provider.

Recommendation 10: OS and OMFS referral criteria should be developed and applied in managed clinical networks, together with referral management systems, to ensure that patients requiring the surgical management of oral and maxillofacial conditions are treated according to their needs.

Recommendation 11: Consideration should be given to making arrangements for the appointment and commissioning of combinations of DwSIs and specialists in OS who work across a primary and/or secondary care setting to contribute to OS services, based upon existing criteria^{xvi}.

4: Developing the Oral Surgery Workforce

The present provision of education and training in Oral Surgery (OS) is insufficient to meet the needs of the service

According to the Dental Schools Council (DSC), the majority of undergraduate OS training is delivered by clinical academics in OS and to a diminishing extent OMFS, and that there is a shortage of individuals to fill future clinical academic positions in OS^{xvii}. Basic skills in OS are taught as part of undergraduate training and reinforced in foundation training.

The Workforce Review Team's 2008 summary of OS indicated that to realise the benefits of the speciality, deaneries and employers would need to establish new training posts and pathways to support the development of OS services in both primary and secondary care settings.

While there is a continuing shortage of clinical academics in OS, there will be a reliance on OMF surgeons to provide training in OS. Notwithstanding the desirability of training and career advice being led by suitably qualified trainers in the specialty, such arrangements are considered important to career development and the recruitment and retention of individuals in OS.

There is an urgent need for succession planning in OS.

With many existing OS clinicians and academics approaching retirement, there is a significant need for investment in training to secure the future of the specialty. The current lack of career development opportunities in OS may impact on the specialty's continuing ability to attract and retain a high quality, motivated workforce of sufficient size to meet future population needs. This presents an excellent opportunity for the NHS to revise existing arrangements for OS services and to train a future workforce that meets the needs of the public, whilst providing a cost efficient service.

Fundamental to the development of OS services will be:

- the creation of appropriate numbers of training programmes and posts
- the education of the next generation of academics and trainers in OS
- intelligent commissioning to develop new arrangements for the provision of services across primary and secondary care
- the creation of career development opportunities and attractive career pathways for those interested in joining the specialty, including the opportunity for specialists in OS to develop their clinical practice to include one or more of the extended competencies^{xviii}
- a commitment that the reconfiguration of OS services does not result in a detrimental reduction in the number of cases required for teaching in dental teaching hospitals

Recommendation 12: There should be a substantial increase in the number of training posts in OS, together with provision for additional career development to satisfy requirements for appointment to the Consultant grade. The working group supports the recommendations of the Joint Committee for Specialist Training in Dentistry (JCSTD), now reconstituted as the Joint Committee for Postgraduate Training in Dentistry (JCPTD) in respect of the competencies, including extended competencies relevant to the specialty of OS. Where a local need is identified and training capacity is available, that specialists in OS should have the opportunity to acquire these competencies in order to equip themselves for appointment to the Consultant grade.

Recommendation 13: Postgraduate Dental Deans should work with commissioners to assess existing training needs and create a sufficient number of training posts to meet these needs.

Recommendation 14: Undergraduate courses should contain sufficient training in routine OS to prepare new graduates to practise these skills during foundation training. DF1 trainers must be capable of further developing OS skills during foundation training.

5: Leadership in Oral Surgery

The future NHS will provide Consultant-delivered care. OS should not be excluded from this model.

As part of the consultation exercise, the review group invited opinion on whether there is a need for a consultant-led OS service. The responses were broadly grouped by specialty background. There was strong support for such arrangements from Oral Surgeons, based on the need to deliver high quality easily accessible patient care, career progression for OS specialists, and to safeguard and train the future OS workforce. The development of Consultant-led OS services was considered unnecessary by most OMFS respondents, on the grounds that leadership is already being provided by Consultants in OMFS with support from SAS grade staff – normally, singly qualified oral surgeons – and concerns about the management of medically compromised patients by oral surgeons. Given the polarity of responses, the group looked to evidence from recent reports on the future role of the Consultant in the delivery of services.

Time for Training, NHS Medical Education England's review of the impact on training of the implementation of the European Working Time Directive (EWTD) concludes that it is 'imperative' that the NHS develop in each recognised specialty a 'consultant-delivered service'. The report recommends that individuals who are 'clinically responsible for service delivery should be employed in substantive posts under the consultant contract'^{xix}, and that 'nearly all medical professional bodies interviewed came out in strong support of a consultant-delivered service'.

The Royal College of Surgeons considers a Consultant-delivered service is vital for delivery of quality care, training of a competent future workforce, effective use of resources and patient choice^{xx}. The British Medical Association (BMA) cites a Consultant as someone who 'promotes new practices and leads innovation in new models of care for patients, new forms of treatment, and use of new technologies'^{xxi}

Patient safety and the provision of high quality care is the driving force behind the present review, aimed at the provision of locally available, cost efficient OS services to patients. Accordingly the group concluded that the future provision of comprehensive OS services, let alone the sustainability of OS as a specialty, would depend to a large extent on the development of Consultant-led and Consultant-delivered care in OS, reflecting local arrangements and patient needs.

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| <p>Recommendation 15: There should be an increase in the number of Consultants in Oral Surgery.</p> |
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Recommendation 16: To develop Consultant-led and Consultant-delivered care in OS working across both primary and secondary care, specialists in OS in both NHS and academic posts should be supported in the continuum of development necessary to become eligible for appointment to the Consultant grade.

APPENDIX A

Terms of Reference

The group's terms of reference were:

- To understand the background of how the specialty of OS has developed to date and its relationship to OMFS
- To examine the service implications of the development of the specialty of OS in both the primary and secondary care sectors
- To identify the needs and expectations of patients and the public
- To assess the availability and accessibility of specialist services in both OS and OMFS, with a specific focus on how the needs of patients and the public are currently met
- To examine the current and future provision of education and training in OS
- To identify the needs of clinical academic oral surgery for research and undergraduate teaching and training
- To assess the cost implications of the development and commissioning of OS
- To consider the implications for the specialty of OMFS of the development and commissioning of OS services
- To consider the implications of any recommendations made by the OS review group and their feasibility

APPENDIX B

General Dental Council Specialty Definitions: Definition of Oral Surgery

Oral Surgery

Deals with the treatment and ongoing management of irregularities and pathology of the jaw and mouth that require surgical intervention. This includes the specialty previously called Surgical Dentistry.

APPENDIX C

Recommended procedures suitable to be carried out by a DwSI in Minor Oral Surgery^{xxii}

1. Routine extraction of single and multi-rooted erupted teeth.
2. Removal of buried roots and fractured or residual root fragments
3. Removal of simple impacted/ectopic/supernumerary teeth
4. Exposure of teeth.
5. Minor soft tissue surgery:
 - 5.1 Removal of simple fibro-epithelial polyps.
 - 5.2 Removal of simple mucocoele.
 - 5.3 Removal of uncomplicated denture induced mucosal hyperplasia.
6. Management of minor dental trauma including the re-implantation of avulsed teeth.
7. Surgical endodontics on single rooted anterior teeth
8. Management of cranio-facial pain.

APPENDIX D

Review group membership

Nairn Wilson, Chairman, Dean and Head of Dental Institute King's College, London
Keith Altman, Consultant Oral & Maxillofacial Surgeon, Brighton and Sussex University Hospitals NHS Trust
Barry Cockcroft, Chief Dental Officer England
Paul Cook, Postgraduate Dental Dean Yorkshire
Chris Franklin, Chair Committee of Postgraduate Deans and Directors (COPDEND)
Michael Hahn, Specialist in Oral Surgery
Richard Hayward, Specialist in Oral Surgery
Rachel Noble, Project Manager
James Parker, Specialist in Oral Surgery
Jerry Read, Department of Health
Bernard Speculand, Consultant Oral & Maxillofacial Surgeon, University Hospital, Birmingham
Margie Taylor, Chief Dental Officer Scotland
Derrick Willmot, Dean of the Faculty of Dental Surgery of the Royal College of Surgeons England

Organisations present at evidence days

Association of British Academic Oral and Maxillofacial Surgeons (ABAOM)
British Association of Oral and Maxillofacial Surgeons (BAOMS)
British Association of Oral Surgeons (BAOS)
British Dental Association (BDA)
Conference of Postgraduate Dental Deans (COPDEND)
General Dental Council (GDC)
National OS Advisor, Royal College of Surgeons of England
Specialist Advisory Committee for Oral and Maxillofacial Surgery (SAC OMFS)
Specialty Advisory Committee for Oral Surgery (SAC OS)
Trainee Representatives, SAC OMFS
Trainee Representatives, SAC OS
Workforce Review Team (WRT)

APPENDIX E

Summary of written evidence from evidence day attendees

Submissions of written evidence to OS review evidence day²

| Question | Is the provision of education sufficiently available to meet the needs of the service? | Is there a need for a Consultant-led service in OS? | What are the implications for OMFS if OS is developed? | What are the cost implications of the development and commissioning of OS? |
|---------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Organisation | | | | |
| ABAOMS | No | Yes | Numerous benefits | Long term significant practical and economic benefits |
| BAOMS | No consistent standard | Need for a specialist delivered service, which should be delivered by an integrated team and led by OMFS Consultants | Could compromise the ability to provide 24/7 care, reduce the capacity to train in OS, reduce cost effectiveness | High set up and training costs, and potential duplication of services |
| BAOS | No | Yes | Numerous benefits: would free OMFS Consultants to focus on more specialist procedures; majority of caseload in OMFS departments does not require such extensive training | Potentially large savings resulting from providing care in PCT setting, and this could be invested in increasing trainee numbers, post CCST development programmes, development of specialist OS services |
| BDA | No | Yes | Given the high demand for OS service, OMFS alone cannot manage this caseload | The majority of hospital units within the UK are currently undertaking regular extra clinical sessions and waiting lists to manage the volume of work at a great extra cost. Commissioners should consider the economics of provision of OS in secondary versus primary care. |

² The NHS Workforce Review Team (WRT) submitted their published document *Workforce Review: Oral Surgery*, therefore specific questions were not addressed in their submission

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|----------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| COPDEND | No consistent standard, and quite limited in some areas | Dependent on how OMFS services develop | Dependent on how OS and OMFS are commissioned in future | Could add value to services |
| DSC | Of a high standard but insufficient capacity | Yes | Release OMF surgeons to concentrate on more complex cases. No evidence that it would diminish status or workload of OMFS | Would reduce costs in undergraduate training, allow more cost effective use of OMFS, reduce costs of OMFS training |
| Lay | No consistent standard, with a need for revalidation | No | Possible impact on career development | Costs are likely to be significant, and would require a full costing exercise to ensure value for money |
| National Clinical Advisor, OS, Royal College of Surgeons of England | Limited opportunities for practical experience, lack of quality assurance | Yes | Likely that OMFS will be subsumed into Head and Neck services, and may result in a reduction in Consultant and trainee numbers | |
| SAC OMFS | Severe shortfall in the provision of training | No | If OS flourishes in PC, this would remove a significant number of inappropriate referrals to SC OMFS | Costs inherent in establishing PC services, but would be cheaper in the long term than providing the same service in SC |
| SAC OS | No | Yes | Reduction in OMFS waiting times, with the ability to focus on more complex caseload | Cost savings in the long term with move from SC to PC provision |

References

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- ⁱ *Securing Good Health for the Whole Population, 2004*
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4076134.pdf
- ⁱⁱ *Our NHS Our future: NHS next stage review*, Department of Health, 2008
- ⁱⁱⁱ *The NHS Constitution: securing the NHS today for generations to come*, Department of Health, 2009
- ^{iv} *Equity and excellence Liberating the NHS, 2009*
- ^v *What do patients and the public want from primary care?*, Angela Coulter, British Medical Association, 2005
- ^{vi} *Referral patterns and the referral system for oral surgery care. Part 1: general dental practitioner referral patterns*, Coulthard P, Kazakou J, Koron R, Worthington HV, 2000, British Dental Journal, 188, 142-145
- ^{vii} *Time for Training A Review of the impact of the European Working Time Directive on the quality of training* Medical Education England April 2010
- ^{viii} *Equity and excellence Liberating the NHS, 2009*
- ^{ix} *Improving Access to Oral Surgery Services in Primary Care* Kendall, Dental Primary Care 2009;16(4)
- ^x *Oral Surgery – an assured future*, Ann R Coll Surg Engl (Suppl) 2009;91:175, Louis McArdle
- ^{xi} *The role of Staff and Associate Specialist doctors in the UK*, BMA, 2006
- ^{xii} *BMA survey of SAS doctors' workload and career progression*, BMA, November 2009
- ^{xiii} *Evaluation of dental practitioners with special interest in minor oral surgery*, A. Pau, S. Nanjappa, and S.Diu, British Dental Journal, Vol 208, No. 3, Feb 13, 2010
- ^{xiv} *Improving Access to Oral Surgery Services in Primary Care* Kendall, Dental Primary Care 2009;16(4)Kendall
- ^{xv} *Lambeth, Southwark and Lewisham Managed Clinical Network for Oral Surgery*
- ^{xvi} *Guidelines for the appointment of Dentists with Special Interests (DwSIs) in Minor Oral Surgery* Department of Health/Faculty of General Dental Practice (UK)
- ^{xvii} Dental Schools Council's response to the Review of OS consultation exercise, December 2009
- ^{xviii} *Career Development Framework For Consultant Appointments In Oral Surgery*
http://www.rcseng.ac.uk/fds/jcptd/higher-specialist-training/documents/CDFCA_OS_2010.pdf
- ^{xix} *Time for Training A Review of the impact of the European Working Time Directive on the quality of training* Medical Education England April 2010
- ^{xx} *The Consultant Surgeon and Consultant-Delivered Service*, Royal College of Surgeons
- ^{xxi} *The Role of the Consultant*, BMA Central Consultants and Specialists Committee, July 2008
- ^{xxii} *Guidelines for the appointment of Dentists with Special Interests (DwSIs) in Minor Oral Surgery* Department of Health/Faculty of General Dental Practice (UK)