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Dental Public Health in Action

A description of a specialist led primary care based oral surgery service

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Aim: To describe the establishment of a referral only oral surgery service in a primary care setting together with the challenges, benefits and successes of the service. ***Problem:*** In 1994 waiting times for hospital for oral surgery and maxillofacial procedures were unacceptably long. A proposal to establish a primary care oral surgery service aimed to complement the hospital-based service, reduce treatment delays. **Outcome:** Referrals commenced immediately in response to a managed launch with local dentists recognising the service as a source of expedient and convenient treatment for their patients. The service now treats up to 1300 patients per year. ***Learning points:*** New dental services to dentistry can encompass different specialities. Initial capital investment is needed to develop a more cost-effective service. Recruitment of suitable specialist staff is a critical for success. Staffing, organisation and funding must be sustained.

Aim

This paper describes the establishment of a referral only oral surgery service in a primary care setting in South Cheshire. The initial, and ongoing challenges are discussed alongside the benefits and successes of the service.

Problem

In 1994 the population within the boundaries of Cheshire Community Healthcare Trust (CCHT) was experiencing prolonged waits for assessment and admission to hospital for oral surgery and maxillofacial procedures. The lead for Dental Public Health and senior colleagues at the Regional Health Authority office proposed that the waiting times could be reduced and provision of oral surgery increased, by the establishment of an oral surgery service in a primary care setting.

The proposed service was designed to meet the aims of:-

Improving local access to oral surgery provision

Improving skill mix across the local health economy by accepting patients requiring mainly dento-alveolar procedures to release capacity within the hospital maxillofacial department for more complex procedures.

Reducing per case costs to the health economy by reducing the need for costly out-of-hours waiting-list initiatives within the hospital sector.

The development of the primary care based oral surgery service described below owes much to the vision of the local leads in Dental Public Health in addressing these aims.

Reaction

A primary care based oral surgery service was established as part of a specialised community dental service within a wider community health care provider unit. The local community dental service was being developed to move away from the provision of paediatric dental care with a small amount of adult special needs care towards a group of local clinics providing care complementary to both the General Dental Services and hospital maxillofacial surgery department.

The oral surgery service was initially planned to employ a full-time dental surgeon across two organisational areas, accepting referrals from all three of the organisational areas then part of the South Cheshire Health Authority. The recruitment of an appropriately qualified and experienced oral and/or maxillofacial surgeon was crucial to the success of the proposal. The first successful candidate had general dental practice and teaching hospital experience and had undertaken oral surgery and IV sedation in both settings. Qualified dental nurses were also recruited to the team who immediately commenced training and education to gain dental radiography and conscious sedation post certification qualifications.

Planning, construction and equipping of the surgeries was completed including the provision of intra oral and panoral radiography machines. The planned use of IV sedation necessitated the provision of defibrillator, blood pressure monitoring, pulse oximetry and recovery facilities: a level of equipment and support not previously available elsewhere in community dental clinics. Much of this preparation was validated retrospectively by McArdle (1997) who set out circumstances in which specialist dental services could be successfully located in primary care settings, improving accessibility to oral surgery for both professionals and patients.

Letters of introduction were distributed to all local General Dental Practitioners (GDPs), inviting them to an open evening to meet the new staff and inspect the facilities. Guidance to colleagues in general practice included listing types of referral considered appropriate to the service.

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Outcome

Referrals commenced immediately in response to the invitation, local GDPs recognising the service as a source of expedient and convenient treatment for their patients. There was an element of latent, unmet need, within the population which was released and led to a significant early caseload.

By the end of the first full year for which data is available (1997) the number of patients treated was 932 with the service operating for 11.25 hours/week. This increased to approximately 1000–1300 patients per year once the team of dental surgeons and support staff was fully developed. Treatments included removal of third molars, retained roots and extractions likely to be more technically difficult than is usual, apicectomies, fraenectomies and removal of benign soft tissue lesions (Table 1). Since commencement, treatments have been offered with local anaesthetic alone or with the adjunct of intravenous Midazolam sedation.

Table 1. Oral surgery activity in primary care based service

	Year 1 1997	*Year 10 2006*
Overall count of patient appointments	1573	1782
Assessment appointments	728	927
Review appointments	257	210
I.V. sedation appointments	250	150
Third molar extractions	296	239
Other extractions	321	349
Apicectomies	127	72
Biopsies	29	29
Soft tissue	29	26
Orthodontic	37	1
Temporomandibular	111	40
Panoral xrays	365	185

Throughout most of its period of operation the oral surgery service has functioned successfully without formal external triage of referrals. GDPs are familiar with the range of treatments appropriate to a primary care setting with local anaesthetic and I.V. sedation. Inappropriate referrals have been re-referred to the local maxillofacial department or returned to the GDP with advice regarding more appropriate referral and treatment. The local Maxillofacial department now works with the primary care team to ensure that both sectors provide care to the patients most appropriate to each setting.

Challenges

Staffing has varied over the years with waiting times from referral to treatment reaching up to six months after three years. In 1996 a successful bid to the host organisation increased the dental surgeon input in response to the demand to reduce waiting times.

Since the GDC instigated a Specialist List for Oral (Surgical) dentistry the service has always been led by a clinician registered on the specialist list. Currently both senior Dental Surgeons are registered as Specialist Oral Surgeons, with the more junior clinician studying for a postgraduate MSc in Implantology.

Not all referrers have used the primary care based service. Individual practitioners have tended to follow a certain referral pathway, with some never referring patients to this primary care setting, others referring all of their oral surgery patients to primary care for initial assessment and treatment planning. The referral patterns into this service support the findings of Coulthard *et al.* (2000). Overall from April 1st 2010 to March 31st 2011 General Dental Practices within the area referred 1,397 patients to primary care oral surgery providers and only 576 to secondary care services. It is intended to survey local GDPs to determine which factors influence their referral pathway.

At the start of the service there was some local professional concern that the primary care clinicians may not be fully competent and that there would be a potential increase in out-of-hours complications. Patient and professional experience refuted any initial concerns within a few months of the service commencing. Liaison between secondary and primary care was limited in the early years, but this has developed into a productive dialogue which has informed the progress of the service since 2009. Doubts about recruitment of suitably experienced dental surgeons and dental care professionals were allayed by the calibre of applicants to those first posts and subsequently.

Concerns about succession planning to ensure the service continues with suitably qualified and experienced staff is an ongoing challenge each time staff leave or reduce their hours. Heading the service with registered specialists gives confidence to potential applicants whenever we are recruiting to posts.

Future development

The NHS is undergoing a period of financial and organisational change in response to global economic pressures. This is forcing the NHS to seek more efficient methods of supplying healthcare to a demanding and ageing population. It is likely that other commissioners will seek alternative sources of care in primary care settings to establish financial savings within the health economy. Local service commissioners have recognised the economic contribution made to oral surgery provision by the service described and extended contracts for oral surgery to several independent contractors in local high street practices. These various primary care services have reduced waiting times for oral surgery alongside the 18 week waiting targets in the Acute Sector.

Developing this service, over almost 20 years, has been challenging, from the initial reservations of professionals to doubts about recruitment of suitably experienced dental surgeons and dental care professionals. There is now effective, open liaison between local hospital consultants, dental commissioners and salaried primary care oral surgery services aiming to increase effectiveness and efficiency of the commissioning process, improving access to oral surgery within an economic framework. The benefits of such liaison were indentified by Kendall (2009) who reported that collaborative working between

all sectors of the profession, including a public health consultant, had resulted in sustainable benefits to the NHS and patients in the provision of oral surgery.

The service opened at a time of financial pressure and required considerable capital funding and revenue to establish the clinics. There was little previous data or experience to indicate that the service was likely to be successful. Future untested options may need to be implemented to address such situations, but we should not necessarily oppose their establishment before they are piloted – some will be successful.

Recruitment and successional planning are vital aspects of service provision. The Review of Oral Surgery Services and Training (Medical Education England, 2010) identified future development of oral surgeons and successional planning as particular potential problems. More recent graduates developing an interest in Oral Surgery may be diverted into private provision of implantology and away from NHS care. Mentoring and training must be funded within current services to ensure their future survival.

When this service commenced there was no separate GDC Specialist registration for oral surgery/surgical dentistry, only for oral and maxillofacial facial surgery. The dental surgeons had gained their oral surgery expertise via hospital based Senior House Officer posts and developed it further in practice or in part time teaching hospital oral surgery departmental posts because of their personal interest.

McArdle (1997) recognised that primary care services for oral surgery could only achieve professional recognition and acceptance when a more structured approach to post graduate education became available. In April 1998 the General Dental Council established a specialist list for Oral Surgery, distinct from Oral and Maxillofacial Surgery, to which dentists were successfully included via a grandparenting process. More recently, dental practitioners with a special interest in minor oral surgery (DPwSI) have begun to work in the primary care setting in some areas.

It is recognised that a DPwSI could be successfully employed in the service described here and provide a good service for patients in the primary care setting (Pau *et al.*, 2010). Education and training to develop Oral Surgeons for inclusion on the GDC Specialist List is expensive and challenging for a local, community based, patient service. However, the 2010 report of the Dental Programme Board of Medical Education England 'Review of Oral Surgery Services and Training' recommended a substantial increase in the number of training posts in oral surgery, together with provision for additional career development to satisfy requirements for appointment to the consultant grade.

Subsequent Dental Public Health postgraduate training leads need the foresight of their former colleagues to secure funding for training posts for succession planning in oral surgery. These must include significant exposure to, and placement in, the primary care setting to ensure the continuation of the speciality in primary care.

Consultant grade posts have already been established in community provider units for Special Care Dentistry, a situation which could be replicated in oral surgery to reflect arrangements for the local delivery of care and population oral health needs.

The above demonstrates why the profession should continue to develop specialist oral healthcare provision in primary care settings for patients who are generally ambulant and can safely undergo surgical intervention without the need for admission to hospital either as outpatients or inpatients.

Learning points

In establishing new services to dentistry it is essential that we look at healthcare provision across different specialities to investigate new ways of service delivery.

Recruitment of specialist staff, with excellent interpersonal skills, at all grades, is the most important factor in the success of a new venture.

A successful service can only continue through staff, organisation and funding change with timely successional planning.

Finally, it is often essential to invest funding into premises, facilities, equipment and staff with expensive expertise in order to successfully establish a service that in the long run will contribute to a more economic provision of healthcare to a population.

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