South East Wales Oral Surgery Managed Clinical Network

All-Wales Oral Surgery Referral Handbook

for General Dental Practitioners

2021

Version 1.5

Thanks to members of the SE Wales OS MCN (Dr Esther Brewer, Dr Joelle Mort, and Professor Vas Sivarajasingam) for putting this document together.

Table of Contents

1. INTRODUCTION

The specialty of Oral Surgery (OS) deals with the diagnosis and management of pathology of the mouth and jaws that requires surgical intervention. Care is provided by both oral surgeons and oral and maxillofacial surgeons, as the clinical competencies of these two specialties overlap.[1]

1.1 All-Wales Oral Surgery Complexity Levels

NHS England's Commissioning Guide for Oral Surgery[1] describes three levels of case complexities that are provided within the tiers of NHS services; Levels 1, 2 and 3 care descriptors reflect the competence required of a clinician to deliver care of that level of complexity. This has been taken up by all Health Boards in Wales (Figure 1).[2]

Level 1 Procedures/Condition

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

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

- Surgical removal of uncomplicated third molars involving bone removal in line with NICE guidance;
- Surgical removal of buried roots and fractured or residual root fragments;
- Management and surgical removal of uncomplicated ectopic teeth (including supernumerary teeth);
- Management and surgical exposure of teeth to include bonding of orthodontic bracket or chain;
- Surgical endodontics for incisor and canine teeth;
- Minor soft tissue surgery to remove apparent non-suspicious lesions; and
- Placement of an uncomplicated dental implant in accordance with NHS protocols.

Level 3 Procedures/Conditions

Level 3a – Procedures/conditions to be performed or managed by a clinician recognised as a specialist at the GDC defined criteria and on a specialist list; or by a consultant.

Level 3b – Procedures/conditions to be performed or managed by a clinician recognised as a consultant in the relevant specialty, who has received additional training which enables them to deliver more complex care, lead MDTs, MCNs and deliver specialist training. The consultant team may include trainees and SAS grades. Where OMS consultants are not registered with the GDC they will not be eligible for performers list. Some OMFS consultants will be included in both the GMC and GDC specialist list; others will only be included in GMC specialist register.

Figure 1. Framework of complexity levels and procedures for Oral Surgery [2]

These Levels are not exhaustive and have been revised by the two OS Managed Clinical Networks (MCNs) in Wales following feedback from Local Dental Committees (LDCs) and the Welsh Dental Committee (Appendix A). MCNs act as a leadership umbrella enabling developments of care and referral pathways and quality assurance arrangements for services spanning hospital, community and primary care settings in Wales.

For each complexity Level, an assessment of the medical status of the patient is required in addition to consideration of social factors, level of patient anxiety, and other potential complications (Appendices C and D). For example, a patient requiring a Level 1 procedure but with a complex medical history may be classified as Level 3.[2,3] **Clinicians should feel competent to provide a specific OS procedure and manage any complications that may arise before proceeding.** Complexity Levels are colour coded corresponding to the relevant care setting, as follows:

Level 1 Primary Care (General Dental Practice)

Level 2 Intermediate Care (Intermediate OS or Specialist OS Service in Primary care)

Level 3 Secondary Care (Consultant-led NHS Hospital Services)

1.2 Provision of Oral Surgery Care

OS services are typically delivered within one of three settings and by three distinct groups of clinicians. Patients should understand they may be treated in either primary care, intermediate/specialist care or hospital service: [3, 6]

Primary care general dental practice – Most **Level 1** procedures are conducted in **general practice** by **general dental practitioners (GDPs)**. Extractions of teeth and roots, including surgical treatment when appropriate, are covered under the mandatory services section of the General Dental Service (GDS) contract.[4]

Intermediate services – These services provide **Level 2** care on a referral basis and are typically delivered by a **clinician with enhanced skills and experience** who may or may not be on a specialist register. Most Level 2 procedures will be provided in intermediate oral surgery services (ImOS) in a **primary care setting** under GDS or Personal Dental Service (PDS) contracts. Health Boards may also offer these services in hospital/secondary care. Refer to Appendix E for examples of such services.

Consultant or specialist care – The commissioning guidance describes Levels 3a and 3b but, for the purposes of this guidance, **Level 3** services are **consultant-led services** delivered in, and by, **NHS Health Board hospitals** under NHS standard contracts. Although services are led by consultants, they will typically engage a wider workforce, including specialty and associate specialist-grade clinicians and those in formal training positions. Hospitals delivering OS services at Level 3 include district general hospitals, larger training hospitals, and dental hospitals that have the additional requirement to train dental undergraduates.

1.3 Purpose of Document

This guidance is intended for the use of GDPs practicing within primary care. It has been developed to direct clinicians towards the most appropriate treatment and referral pathways for their adult patients.

Whilst the document acknowledges the vital work of the Community Dental Services (CDS), as touched on in Appendices C and D, it does not make direct reference to this care setting. Therefore, it is not intended for the use of specialists/consultants in Special Care Dentistry (SCD), who provide OS care for medically compromised patients.

The document uses a summary of pre-existing guidelines (with citations and references) and organises them into quick-reference diagrammatic flowcharts, which will better inform patient case management. Flowcharts comprise of the following topics:

- Management of third molars;
- Patients taking anticoagulant or antiplatelet drugs;
- Patients at risk of medication-related osteonecrosis of the jaw;
- Patients at risks of infective endocarditis;
- Temporomandibular joint dysfunction (TMJD).

Each outcome within the flowcharts is colour coded corresponding to the relevant care setting.

Clinicians should be aware that services vary amongst Health Boards. A glossary of the available services within each Welsh Health Board can be found in Appendix F.

1.4 The Referrals Website

All referrals for OS and oral & maxillofacial surgery (OMFS) services within Wales are to be managed through the All-Wales Referral Service website (e-RMS) using the appropriate referral forms. Information is available on the website detailing how to refer, use the online system, and access online learning. Referrals can be tracked using this website by both referring practitioners and their patients using a unique reference number (URN).

To access, simply visit: https://www.dental-referrals.nhs.wales/dentists/

To sign up, please visit this link: https://www.dental-referrals.nhs.wales/dentists/signup/

1.5 Appropriate Referral Forms

The OS referral form is for adult patients only.

For surgical endodontics (apicectomy) on a single rooted tooth, please use the restorative referral form.

Please use the OMFS referral form for hard and soft tissue intra-oral lesions, soft tissue lesions of skin in the head and neck region, trauma, facial deformity, salivary gland disease, TMJD, or severe swelling.

For conditions such as atypical facial pain, atypical odontalgia and other oral medicine conditions (see All-Wales Oral Medicine Referral Guide) please use the Oral Medicine referral form.

Referrals for patients where head and neck cancer are strongly suspected should be sent via the urgent suspected cancer (USC) pathway. You will find a specific USC referral form on e-RMS that will trigger a 2-week appointment wait. Please note that this pathway is for **suspected cancers only**, not for routine investigations. Consider NICE guidance (NG12)[7] carefully and only use when appropriate.

1.6 The Decision to Refer

Patients should be referred if they present with specific difficulties that lie outside the competence of a GDP (see section 1.7). **The responsibility for making an appropriate referral rest with the referring dentist.** The referring GDP should inform the patient about the referral process and make them aware that the final decision on the care they receive rests with the clinician who will be treating them. [5]

If additional restorative dentistry is being planned as part of the patients existing treatment plan, this must be continued by the referring dentist while the patient is awaiting OS assessment and treatment, where appropriate. The referral should also indicate which 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.[6]

Referring GDPs have the responsibility for their patient's care while waiting for OS assessment and treatment, including the provision of emergency treatment prior to definitive treatment. There are OMFS on-call services based at all University Health Boards and emergency referrals to the on-call team can be made directly by phone. This is prudent in immediate life-threatening conditions, such as airway compromise.

Patients who accept an appointment but then cancel two successive appointments or "Do Not Attend" the accepted appointment without giving prior notice will be discharged back to the referring GDP. [5]

1.7 Clinician Competence

All referrals must be made in accordance with the criteria set out in this guidance. **However, this document should not be interpreted as an instruction to individual practitioners as to what procedures they should undertake.** Clinicians should only work within their knowledge, acquired skills, professional competence and clinical ability.[5]

Where treatment required is within the scope of a GDP but the dentist concerned does not feel able to undertake the procedure, they should look within the same dental practice to see if a colleague can assist before referring externally. Providers should review the skill mix amongst their performers in order to develop a system of referral between clinicians within the practice to manage all patients requiring mandatory services.[5, 6]

Providers (and their performers) are encouraged to discuss any potential training needs with their Local Health Board and the Health Education and Improvement Wales (HEIW). [5]

1.8 Radiographs

GDPs are reminded that if **diagnostic quality** radiographs exist prior to referral, the Ionising Radiation (Medical Exposure) Regulations 2017 carry the responsibility to reduce additional exposure to patients.[6] The provision of the original film or a good quality copy of a radiograph, preferentially digital, avoids unnecessary additional radiographic exposure to the patient as per FGDP Guidance.[6] Failure to provide a radiograph must be justified within the content of the referral.

1.9 Acknowledgments

Thanks go to NHS England, Yorkshire and Humber MCN, Leeds Dental Institute, and Southwest of England MCN, the Scottish Dental Clinical Effectiveness Programme, National Institute for Health and Care Excellence, Royal College of Surgeons England and Faculty of Dental Surgeons, and British Association of Oral Surgeons for the use and adaption of their existing guidance.

2. NON-THIRD MOLAR EXTRACTIONS [2, 5, 6]

Level 1 non third molar and retained root extractions should be performed in the referring practitioners' dental surgery under local anaesthetic (see Appendix A).

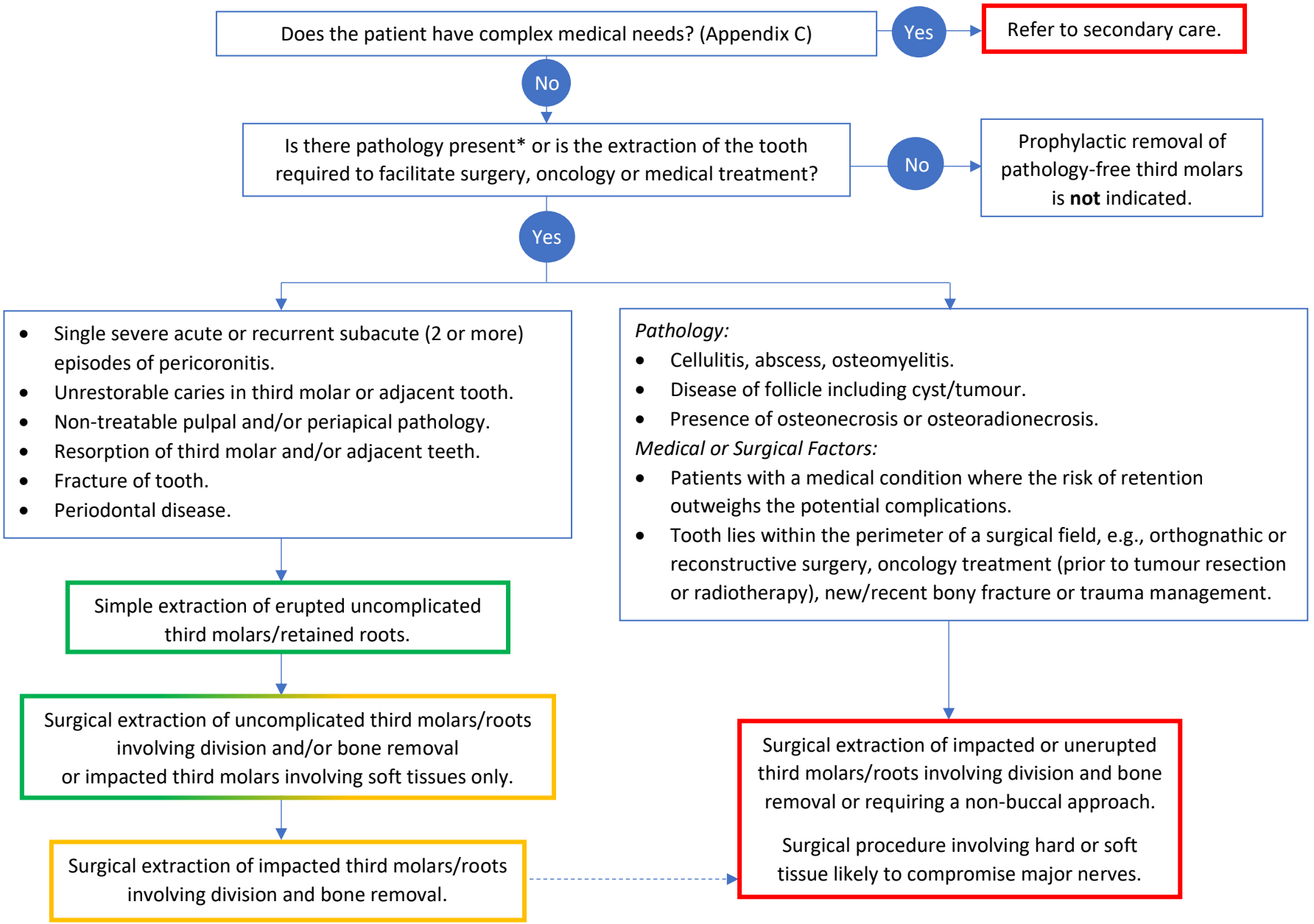
There are, however, circumstances where referral of such teeth will be accepted:

- Unsuccessful attempt at extraction by referring practitioner where a colleague within the same dental practice cannot assist with completion of extraction (please send post-extraction radiograph).
- Patients with severe dental anxiety requiring additional support that may not be available in general practice (e.g., sedation or general anaesthetic).
- Abnormal root morphology likely to compromise the ease of extraction*.
- Teeth with associated pathology that need histological analysis (e.g., significant cystic change)*.
- Extraction where there is a substantially increased risk of damage to an adjacent anatomical structure*.
- Poor access to tooth due to severely restricted mouth opening.
- Teeth with unexplained root resorption.
- Patients with complex medical needs (see Appendix C).
- Extractions from abnormal or diseased bone (e.g., patients who have received therapeutic doses of radiotherapy to the jaws).

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

*See Appendix B for radiographic examples

3. MANAGEMENT OF THIRD MOLARS [8, 9, 10]



** Plaque formation is a risk factor but is not in itself an indication for surgery. Anterior crowding alone is also not an indication for third molar removal in the absence of a specialist orthodontic opinion.*

Coronectomy [10]

Coronectomy is an alternative method for management of mandibular third molars that are in close approximation to the inferior dental canal and is effective in minimising inferior alveolar nerve injury. The risks of coronectomy include the possibility of infection and pain, and the potential future need for removal of the roots.

There are strict criteria on patient selection. Contraindications related to the tooth are:

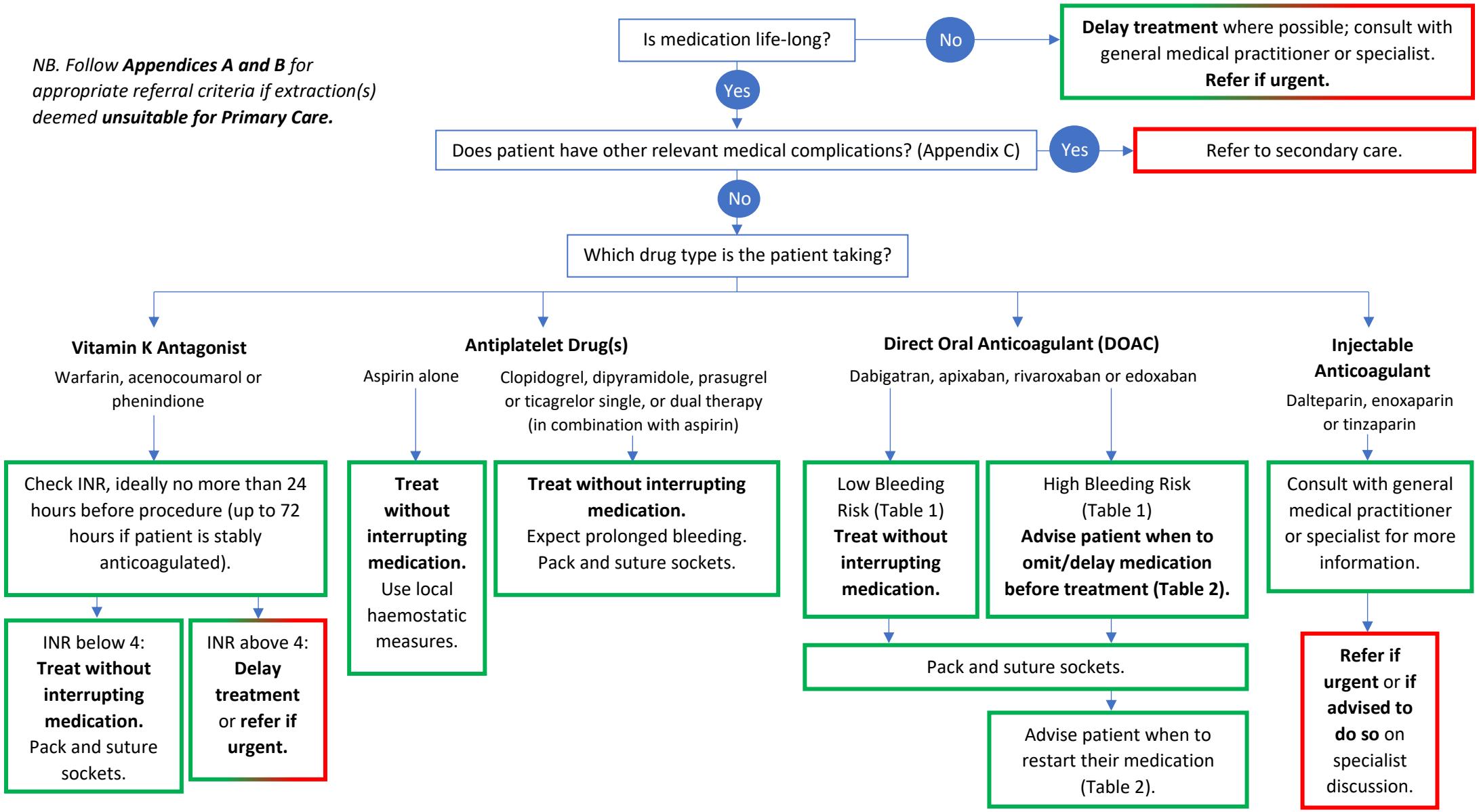
- Non-vital third molars, caries with risk of pulpal involvement, tooth mobility, apical disease, association with cystic tissue that is unlikely to resolve if the root is left in situ, and tumours.

Contraindications related to patients are:

- Immunocompromised patients, previous radiotherapy to the head and neck or treatment before radiotherapy, neuromuscular disorders, and diabetes mellitus.
- Patients who are unable to return for treatment easily should complications occur.

4. PATIENTS TAKING ANTICOAGULANT OR ANTIPLATELET DRUGS [11]

*NB. Follow **Appendices A and B** for appropriate referral criteria if extraction(s) deemed **unsuitable for Primary Care.***



General advice for all patients taking the above drugs: Plan treatment early in the day and week. Consider limiting initial treatment area and staging extensive or complex procedures. Treat atraumatically, use appropriate local measures, and only discharge the patient once haemostasis has been achieved. If travel time to emergency care is a concern, place particular emphasis on the use of measures to avoid complications. Provide patient with written post-treatment advice and emergency contact details.

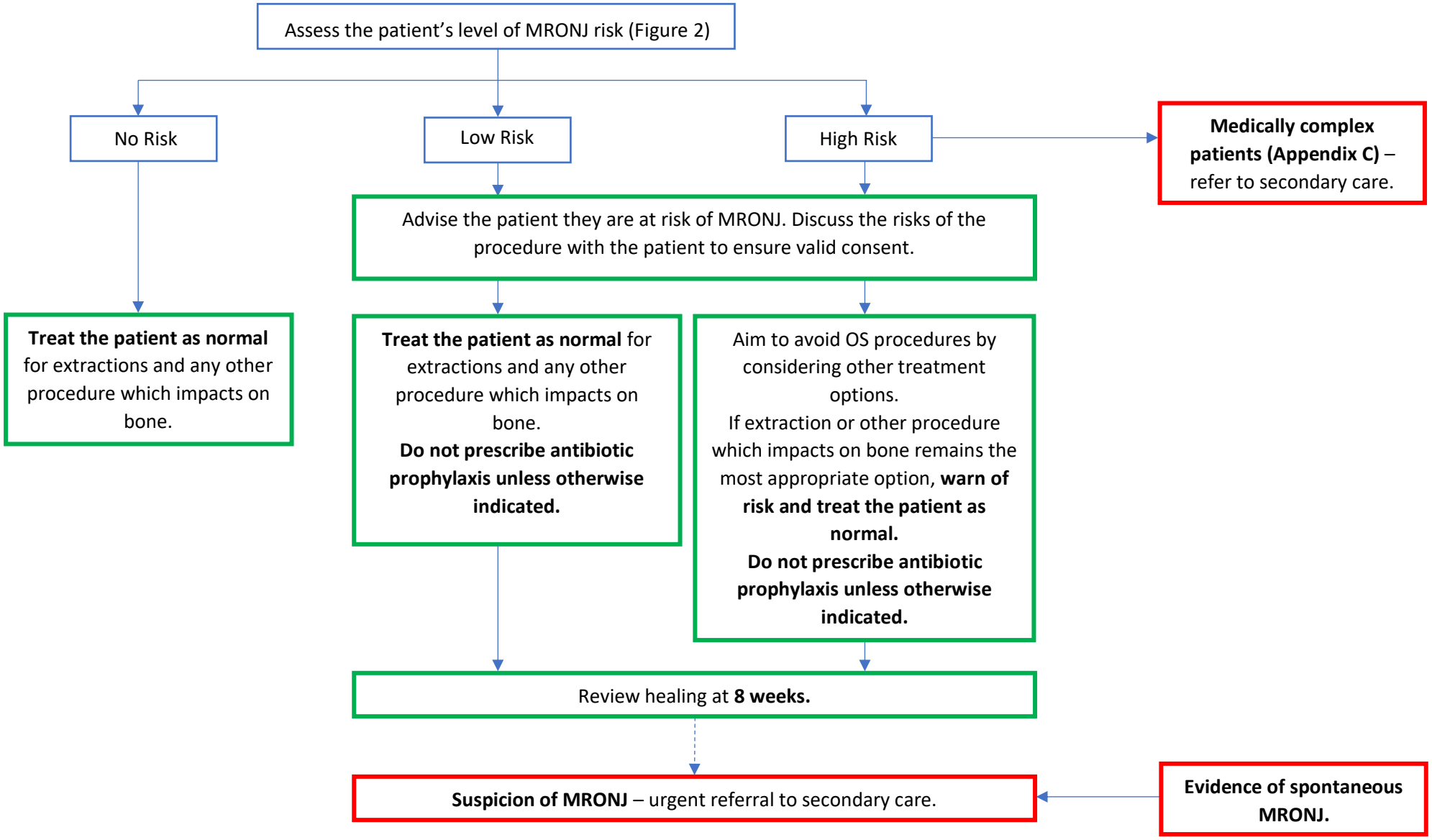
Table 1. Risk of Post-Operative Bleeding Complications for Dental Extractions [11]

No or Minimal Risk	Low Risk	Higher Risk
• Local anaesthesia by infiltrations, intraligamentary or mental nerve block. • Local anaesthesia by inferior dental block or other regional nerve blocks.	• Simple extractions (1-3 teeth, with restricted wound size). • Incision and drainage of intra-oral swellings.	• Complex extractions and/or adjacent extractions that will cause a large wound or more than 3 extractions at once. • Flap raising procedures such as elective surgical extractions. • Gingival recontouring. • Biopsies.

Table 2. Medication Advice for Patients of High Bleeding Risk [11, 12, 13]

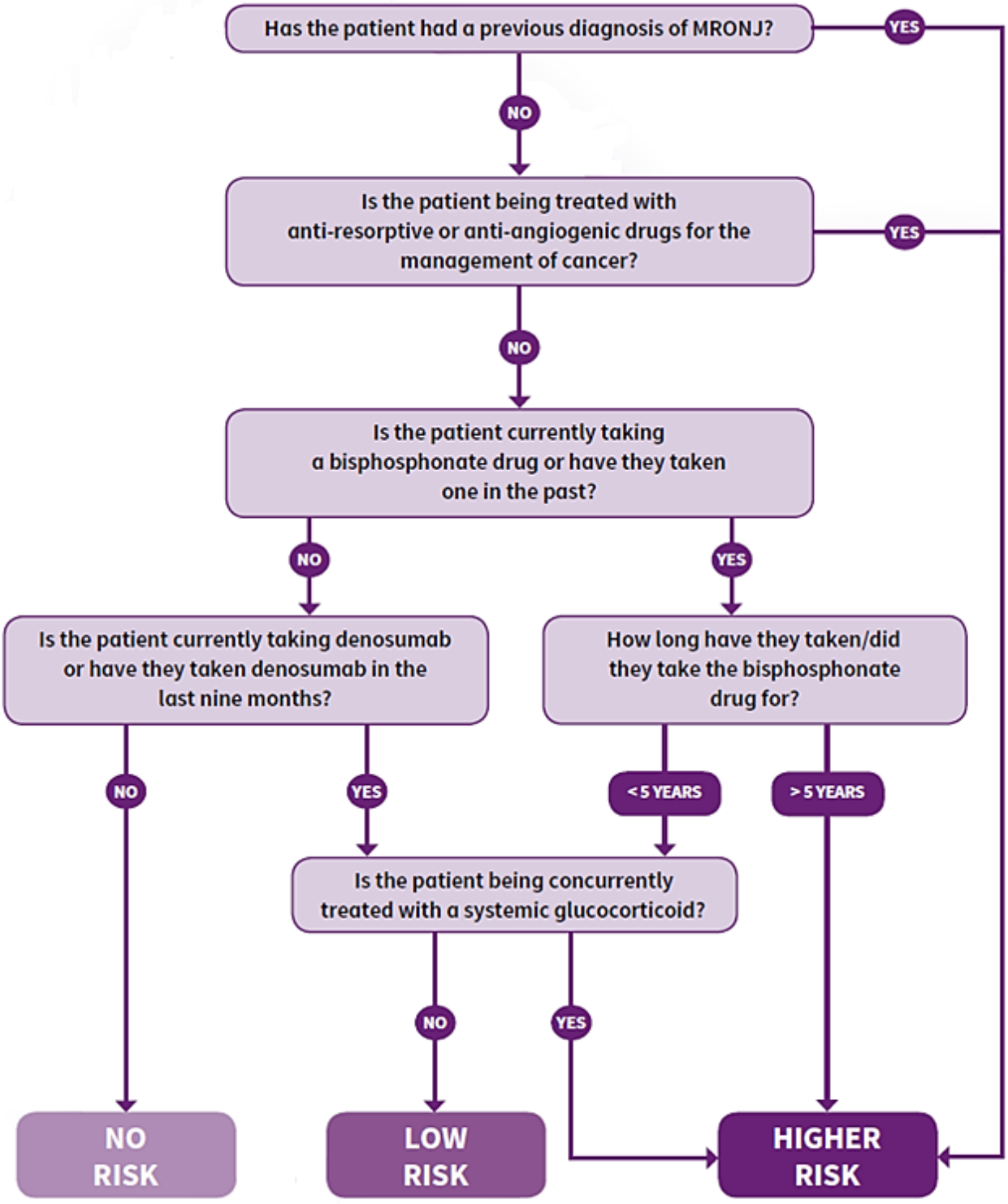
DOAC	Usual Drug Schedule	Pre-Operative Advice	Post-Operative Advice
Apixaban (Eliquis) or Dabigatran (Pradaxa)	Twice a day	Omit morning dose	Take evening dose at usual time (no earlier than 4 hours after haemostasis has been achieved); continue with usual drug schedule thereafter.
Rivaroxaban (Xarelto) or Edoxaban (Lixiana)	Once a day (morning)	Delay morning dose	Take delayed medication 4-6 hours after haemostasis has been achieved; continue with usual drug schedule thereafter.
	Once a day (evening)	Not applicable, continue usual drug schedule	Take evening dose at usual time (no earlier than 4 hours after haemostasis has been achieved); continue with usual drug schedule thereafter.

5. PATIENTS AT RISK OF MEDICATION-RELATED OSTEONECROSIS OF THE JAW (MRONJ) [14]



*NB. Follow **Appendices A and B** for appropriate referral criteria if extraction(s) deemed **unsuitable for Primary Care.***
Where extraction is suitable in the Primary Care setting, do not stop the patient's bisphosphonate medication in order to carry out treatment.

Figure 2. SDCEP MRONJ Assessment of Patient Risk [14]



NB. Be aware that any low-risk patient who continues to take bisphosphonate drugs after their five-year medication review should be reclassified as higher risk.

6. PATIENTS AT INCREASED RISK OF INFECTIVE ENDOCARDITIS (IE) [15, 16]

Does the patient have a cardiac condition from the special consideration sub-group? †

Yes or Don't Know

Offer **advice on prevention** as outlined for Routine Management.

Contact the patient's cardiology consultant, cardiac surgeon or local cardiology centre to determine if antibiotic prophylaxis should be considered for invasive procedures (Figure 2).

Does the cardiologist advise that prophylaxis should be considered for invasive procedures?

No

Yes

Discuss the potential benefits and risks of prophylaxis for invasive dental procedures with the patient to allow them to make an informed decision about whether prophylaxis is right for them.

Does the patient want prophylaxis to be prescribed for invasive procedures?

No

Yes

Non-Routine Management

If you do not hold a stock of prophylactic antibiotics in your practice, provide the patient with a prescription at the appointment prior to planned invasive procedure(s).

Suggested single stat dose antibiotic to be taken 30-60 minutes before procedure:

- **Amoxicillin 3g**
- **Clindamycin 600mg (if penicillin allergic)**

Advise the patient to bring the antibiotic with them on the day of treatment. Alternatively, the patient may choose to take the antibiotic at home.

Give advice on possible adverse effects such as hypersensitivity, anaphylaxis and antibiotic-related colitis.

No

Routine Management *

Ensure that the patient and/or their carer or guardian are aware of their risk of IE and provide advice about prevention (refer to SDCEP patient advice leaflets [17, 18]):

- The potential benefits and risks of antibiotic prophylaxis, and an explanation of why antibiotic prophylaxis is no longer routinely recommended;
- The importance of maintaining good oral hygiene and strictly following post-operative care instructions;
- Symptoms that may indicate IE and when to seek expert advice;
- The risks of undergoing invasive procedures.

† These are:

- Patient with any prosthetic heart valve, including transcatheter valve, or those in whom any prosthetic material was used for cardiac valve repair;
- Patients with a previous episode of infective endocarditis;
- Patients with congenital heart disease (CHD):
  - Any type of cyanotic CHD;
  - Any type of CHD repaired with a prosthetic material, whether placed surgically or by percutaneous techniques, up to 6 months after the procedure or lifelong residual shunt or valvular regurgitation remains.

* If an increased risk patient who is not in the sub-group (e.g., acquired valvular heart disease with stenosis or regurgitation; hypertrophic cardiomyopathy) requests antibiotic prophylaxis, consider contacting their cardiology consultant, cardiac surgeon or local cardiology centre for advice.

Figure 3. Patients at Increased Risk of Infective Endocarditis – Letter to Cardiology Services [15]

This template letter can be adapted for use when contacting a patient's cardiology consultant, cardiac surgeon or local cardiology centre. It is available to download from the SDCEP website (http://www.sdcep.org.uk/published-guidance/antibiotic-prophylaxis/).

Dental Practice Name:

Address:

Tel No:

To:

Date: _____

Dear _____

Re: _____ D.O.B.: _____

Address: _____

_____

Email: _____

I understand the above individual is under your care. I have referred to both NICE Clinical Guideline 64 and the SDCEP implementation advice on *Prophylaxis Against Infective Endocarditis* and I am writing to enquire whether, due to their heart condition, it is your opinion that this patient requires antibiotic prophylaxis against infective endocarditis before undergoing invasive dental procedures.

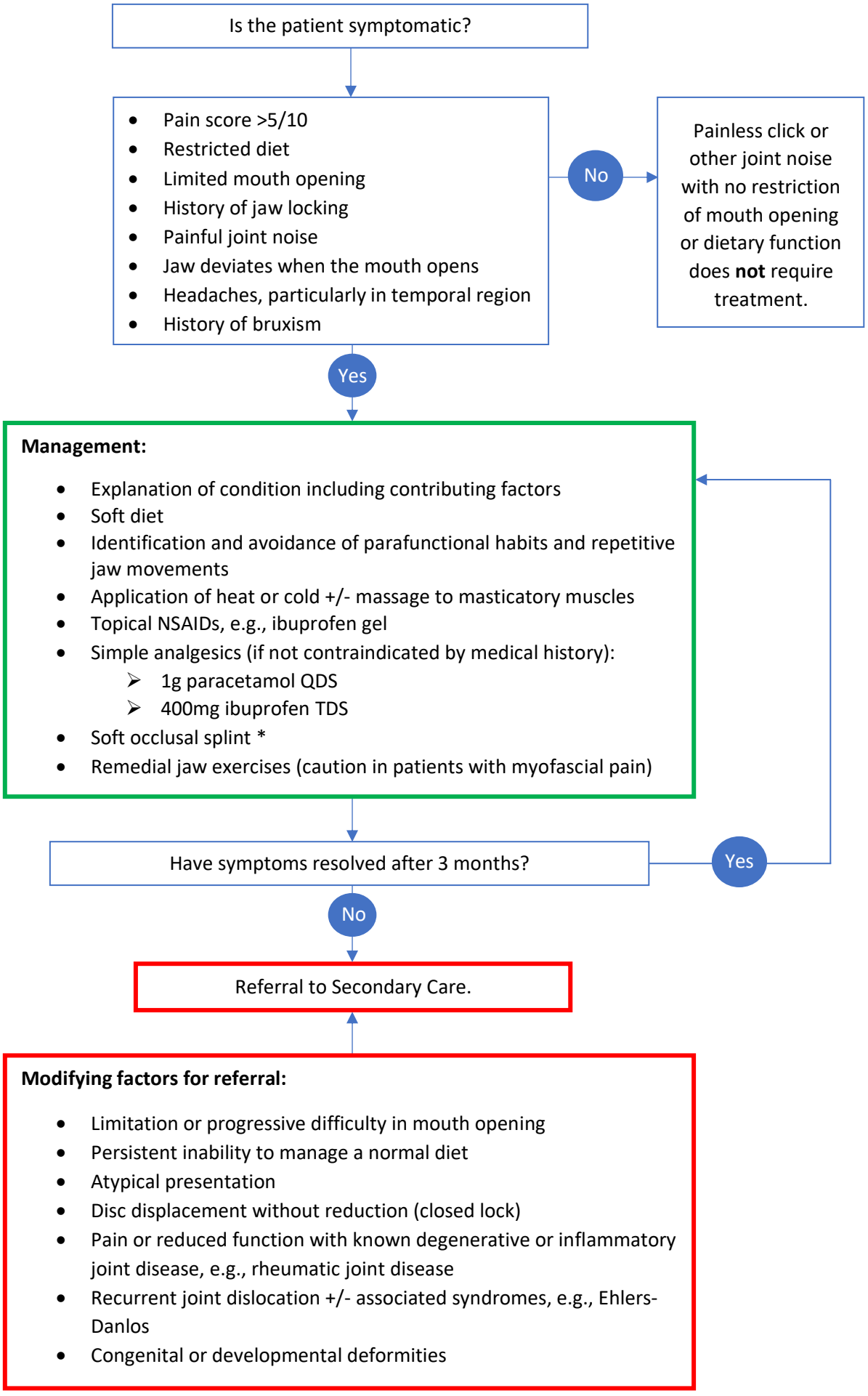
I would be very grateful if you could reply to the address above and provide details of the patient's heart condition, any related medications and whether, in your opinion, antibiotic prophylaxis is appropriate if the patient is undergoing an invasive dental procedure such as an extraction.

I have discussed the matter with [*Enter Patient/parent/carer name*] and she/he is happy that I discuss this important issue with you.

Yours sincerely,

Dental Practitioner

7. PATIENTS WITH TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJD) [6, 19, 20, 21, 22, 23]



** Bite raising appliances will not be considered essential conservative treatment prior to referral.*

Figure 4. Management of TMJD – Bite Raising Appliance Sample Leaflet

Bite Raising Appliances

Information for Patients

What is a Bite Raising Appliance?

A Bite Raising Appliance is a lightweight, thin plastic device made of a firm or soft, clear material that is worn over either the top or bottom set of teeth.

These are designed to help protect your teeth and minimise painful symptoms caused by the jaw's tendency to clench and grind, which in turn will reduce muscle tension and spasm.

Fitting and Removing

You should be able to line up your teeth with their outline in the appliance then push to seat in place. It will feel somewhat tight for a few minutes; this is normal.

To remove, simply feel for the edge of the appliance and place light finger pressure.

Any pressure to insert/remove the appliance should be placed evenly on both sides.

Wearing the Bite Raising Appliance

Unless instructed otherwise, your appliance should be worn every night. It can take up to six weeks to benefit from its effects.

At first, you may spit it out during the night but this should pass as you get used to wearing the appliance.

The appliance should feel snug against your teeth but not too tight or uncomfortable thereafter, and it should not rub against your gums. Your jaw may also feel unusual at first, but you should become accustomed to it after a period of use.

Saliva flow will increase during the first two weeks of wear; this is normal.

Please note that the appliance will naturally discolour or yellow over time.

Cleaning and Storing

Clean after each wear by using a soft toothbrush with soap and cold water. Toothpaste can scratch or discolour the material. Rinse your appliance then store it in a sealed container or bag.

You may also use diluted sterilising fluid every so often to help inhibit the growth of bacteria; be aware that this can discolour the material.

Things to Avoid

Do not wear the appliance whilst eating, drinking, cleaning your teeth, or participating in sporting activities (this is not a substitute for a sports mouth guard).

Do not leave in direct sunlight.

Do not allow the appliance to come into contact with any hot liquids or soak in household bleach, antiseptic solutions, mouthwashes or denture cleaning tablets.

Follow-up Appointments

Unless stated otherwise, a review appointment will be arranged for you in approximately 3 months' time.

Please bring your appliance with you to all future appointments.

Remember to continue with any physiotherapy exercises and/or other management advice (e.g., pain killers, heat application, soft diet) that you may have been given prior to the fit of your appliance.

If you feel that the appliance needs to be adjusted as it is rubbing or uncomfortable, or you become aware of any change in your bite, contact your clinician.

Figure 5. Management of TMJD – Sample Remedial Jaw Physiotherapy Exercises [23, 24, 25, 26]

Patients should be instructed to set aside five minutes, twice a day, at a time when they are able to relax. Exercises should be performed sitting upright in a chair, and ideally in front of a mirror to ensure manoeuvres requiring the mandible to move vertically in a downward direction are performed without deviation to either side.

It is important to warn patients that pain may become worse for a while at first but this will subside over time with continuation of exercises. If jaw joints are particularly tender, these exercises can be assisted by utilising preliminary conservative measures, e.g., application of heat, before commencing exercise. Patients may begin to notice improvements of symptoms after 2-3 weeks of consistent daily exercises.

Example exercises are as follows:

Exercise 1 – Designed to prevent clicking of the jaw joint and strengthen the muscles that pull the jaw backwards so allowing the jaw to act more like a hinge *(if performed correctly there should be no clicks or joint noise. If there is joint noise, re-start the exercise and continue practicing until it is click free)*:

1. Close the mouth biting teeth together, but do not clench. Rest the tip of the tongue on the palate just behind the front teeth.
2. Run the tip of the tongue backwards towards the soft palate as far back as it will go while keeping your teeth together.
3. Force the tongue back to maintain contact with the soft palate and slowly open the mouth until the tongue pulls away. Do not open any further and stay in this position for 5 seconds, then close the mouth and relax to complete the exercise.

Exercise 2 – Designed to produce a reflex relaxation of the jaw muscles so temporarily decreasing the load transmitted to the jaw:

1. Place hand under the point of the chin and open the mouth until the teeth are just apart.
2. Maintain firm pressure against hand resistance and hold the position for a period of 30-40 seconds or until muscles feel tired. When this point is reached remove the hand from under the chin and swallow quickly.
3. Immediately following this, place a finger of each hand just in front of the ear to support the jaw joint. Practice opening and closing the mouth smoothly and widely (do not force the mouth open), keep bottom and top teeth in line by avoiding any swing to the right or left. Remove fingers from each side and close the mouth to complete the exercise.

Exercise 3 – Designed to increase mobility of the joint where jaw opening is joint restricted *(only to be used when there is significant limitation of normal opening)*.

1. Support the left jaw joint by placing the two fingers of the left hand just in front of the left ear and placing the right hand against the right side of the jaw.
2. Move the point of the chin towards the right against the resistance of the right hand, maintaining support with the fingers of the left hand over the left jaw joint. When maximum movement has been achieved, ease the jaw back slowly into the central position.
3. Repeat on the opposite side, reversing the above movements (supporting the right jaw joint).

8. REFERENCES

1. NHS England. (2015). Guide for Commissioning Oral Surgery and Oral Medicine. https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/guid-comms-oral.pdf (Accessed July 2019).
2. NHS Wales. (2017) South East Wales Oral Surgery and Oral Medicine Managed Clinical Network. http://www.wales.nhs.uk/oralsurgeryandoralmedicinemanagedclinicalnetwork (Accessed July 2019).
3. Goldthorpe, J., Walsh, T., Tickle, M., *et al.* (2018). An Evaluation of a Referral Management and Triage System for Oral Surgery Referrals from Primary Care Dentists: A Mixed-Methods Study. *Health Services and Delivery Research* **6(8)**, pp.1-158. DOI: 10.3310/hsdr06080.
4. NHS England. (2018). Standard General Dental Services Contract. https://www.england.nhs.uk/wp-content/uploads/2018/08/general-dental-services-contract-2018.pdf (Accessed August 2019).
5. NHS England. (2016). West Yorkshire Oral Surgery and Oral Medicine Service Referral Handbook. https://www.dental-referrals.org/wp-content/uploads/2016/09/Referral-Guidance-Document.pdf (Accessed July 2019).
6. NHS England. (2019). Oral Surgery Referral Guidelines for GDPs. https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/ (Accessed August 2019).
7. National Institute for Health and Care Excellence. (2017). NG12 Suspected cancer: recognition and referral. https://www.nice.org.uk/guidance/ng12 (Accessed August 2019).
8. National Institute for Health and Care Excellence. (2000). Guidance on the Extraction of Wisdom Teeth. https://www.nice.org.uk/Guidance/TA1 (Accessed July 2019).
9. Liverpool Reviews and Implementation Group. (2016). Prophylactic Removal of Impacted Third Molars.
10. Royal College of Surgeons Faculty of Dental Surgery. (2020). Parameters of care for patients undergoing mandibular third molar surgery. https://www.rcseng.ac.uk/-/media/files/rcs/fds/guidelines/3rd-molar-guidelines--april-2021.pdf (Accessed June 2021).
11. Scottish Dental Clinical Effectiveness Programme. (2015). Management of Dental Patients Taking Anticoagulants or Antiplatelet Drugs. https://www.sdcep.org.uk/wp-content/uploads/2015/09/SDCEP-Anticoagulants-Guidance.pdf (Accessed July 2019).
12. British National Formulary. (2019). https://bnf.nice.org.uk/ (Accessed July 2019).
13. National Institute for Health and Care Excellence CKS. (2021). Anticoagulation – oral. https://cks.nice.org.uk/topics/anticoagulation-oral/ (Accessed June 2021).
14. Scottish Dental Clinical Effectiveness Programme. (2017). Oral Health Management of Patients at Risk of Medication-related Osteonecrosis of the Jaw. http://www.sdcep.org.uk/wp-content/uploads/2017/04/SDCEP-Oral-Health-Management-of-Patients-at-Risk-of-MRONJ-Guidance-full.pdf (Accessed July 2019).
15. Scottish Dental Clinical Effectiveness Programme. (2018). Antibiotic Prophylaxis Against Infective Endocarditis. http://www.sdcep.org.uk/published-guidance/antibiotic-prophylaxis/ (Accessed August 2019).
16. Habib, G., Lancellotti, P., Antunes, MJ., et al. (2015) ESC Guidelines for the management of infective endocarditis. *European Heart Journal* **36**, pp.3075-3123. DOI: 10.1093/eurheartj/ehv319.
17. Scottish Dental Clinical Effectiveness Programme. (2018). Points to cover during antibiotic prophylaxis discussion with patient. http://www.sdcep.org.uk/published-guidance/antibiotic-prophylaxis/ (Accessed August 2019).
18. Scottish Dental Clinical Effectiveness Programme. (2018). Dental advice for people at increased risk of infective endocarditis. http://www.sdcep.org.uk/published-guidance/antibiotic-prophylaxis/ (Accessed August 2019).
19. Royal College of Surgeons England. (2014). Temporomandibular Joint Disorders (TMJ) - Commissioning Guide. https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/tmj-commissioning-guide/ (Accessed July 2019).
20. NHS England. (2018). TMJ Guidance. https://www.dental-referrals.org/wp-content/uploads/2018/11/NHS-England-TMJ-Guidance.pdf (Accessed July 2019).
21. Rajapakse, S., Ahmed, N., Sidebottom, AJ. (2017). Current Thinking about the Management of Dysfunction of the Temporomandibular Joint: A Review. *British Journal of Oral and Maxillofacial Surgery* **55**, pp.351-356. DOI: 10.1016/j.bjoms.2016.06.027.

22. Durham, J., Aggarwal, V., Davies, S., et al. (2013). Temporomandibular Disorders (TMDs): an update and management guidance for primary care from the UK Specialist Interest Group in Orofacial Pain and TMDs (USOT). https://www.rcseng.ac.uk/dental-faculties/fds/publications-guidelines/clinical-guidelines/ (Accessed July 2019).
23. British Associations of Oral Surgeons. (2019) Temporomandibular Joint Dysfunction. https://www.baos.org.uk/wp-content/uploads/2019/03/Temporomandibular-Joint-Dysfunction-website-text.pdf (Accessed August 2020).
24. Lawson, E. (2014) Specialist Surgery TMJ Exercises Information for Patients. Oxford University Hospitals NHS Trust. https://www.dental-referrals.nhs.wales/wp-content/uploads/2015/07/files-120417tmjexercises.pdf (Accessed August 2020).
25. King's College London. (2019) Temporomandibular Joint (TMJ) Exercises. King's College Hospital NHS Foundation Trust. https://www.kch.nhs.uk/Doc/pl%20-%20868.1%20-%20temporomandibular%20joint%20(tmj)%20exercises.pdf (Accessed August 2020).
26. Cardiff and Vale University Health Board. (2020) Jaw Joint and Facial Pain Exercises. University Dental Hospital Wales. Available on request.
27. NHS England. (2018). Oral Surgery Criteria for Central Midlands. https://www.dental-referrals.org/wp-content/uploads/2018/03/OS-Criteria-2018.pdf (Accessed August 2019).
28. American Society of Anaesthesiologists. (2014). ASA Physical Status Classification System. https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system (Accessed January 2021).
29. Welsh Government. (2021). Revised National Steroid Treatment Card. WHC 2021/008. https://gov.wales/revised-national-steroid-treatment-card-whc2021008 (Accessed June 2021).
30. Addison's Clinical Advisory Panel. (2021). Surgical Guidelines for Addison's Disease and Other Forms of Adrenal Insufficiency. Addison's Disease Self Help Group. https://www.addisonsdisease.org.uk/Handlers/Download.ashx?IDMF=b1278634-5c59-4252-a0e1-8b93e4647a75 (Accessed June 2021).
31. NHS Wales & Welsh Government. (2018). Service Standards for Conscious Sedation in a Dental Care Setting WHC (2018)009. https://gov.wales/sites/default/files/publications/2019-03/service-standards-for-conscious-sedation-in-a-dental-care-setting.pdf (Accessed October 2019).
32. Dental Sedation Teachers Group (DSTG). (2019). Indicator of Sedation Need (IOSN) Form. https://www.dstg.co.uk/index.php/documents/document/iosn-form-pdf (Accessed October 2019).
33. Scottish Dental Clinical Effectiveness Programme. (2017). Conscious Sedation in Dentistry (3rd Ed). http://www.sdcep.org.uk/published-guidance/sedation/ (Accessed October 2019).
34. Medical Education England. (2010). Review of Oral Surgery Services and Training. https://www.baos.org.uk/resources/MEEOSreview.pdf (Accessed October 2019).
35. Cardiff and Vale University Health Board. (2021). Shaping Our Future Clinical Services. https://shapingourfuturewellbeing.com/shaping-our-future-clinical-services/ (Accessed October 2021).

APPENDIX A. SUGGESTED APPROPRIATE SERVICE FOR ORAL SURGERY PROCEDURES [1, 2, 5, 6]

The following list of OS procedure types, complexity levels and venues have been formulated following feedback from Wales OS MCNs, LDCs and the Welsh Dental Committee. **These are for guidance and are not meant to be prescriptive**. Deviation from this guidance may be appropriate if circumstances allow, for example, closure of an oro-antral communication/fistula in general dental practice undertaken by a primary care practitioner competent in undertaking such procedures, or a Level 3 procedure undertaken by an OS/OMFS consultant in an intermediate care setting.

Clinicians should be aware that services vary amongst Health Boards in Wales – Please refer to LHB Directory of OS Services.

NB. Level 2 has been separated into intermediate OS (Level 2a) and specialist OS (Level 2b) care to adequately reflect the scope of treatments provided in ImOS (by DwSI) and OS specialist services (by OS Specialist) in primary care. However, the scope of treatments provided will depend on qualification and level of experience.

Procedure Type	**Sub-Type**	**Suggested Appropriate Service**			
		Level 1 **Primary Care (General Dental Practitioner)**	**Level 2a** **Intermediate Care (ImOS; Primary Care)**	**Level 2b** **Specialist Care (Primary Care)**	**Levels 3a and 3b** **Secondary Care (NHS Hospital Services)**
Management and extraction of erupted tooth/teeth	All procedures	**Y**			
Management and extraction of erupted uncomplicated third molars in line with NICE guidance	All procedures	**Y**			
Surgical removal of teeth or roots (including uncomplicated third molars) likely to:	Involve soft tissue only	**Y**			
	Involve division and/or bone removal	**Y**	**Y**	**Y**	
	Be close (within 2mm on x-ray) to maxillary antrum	**Y**	**Y**	**Y**	
	Involve a palatal or lingual approach			**Y**	**Y**
	Involve unerupted ectopic or supernumerary teeth			**Y**	**Y**

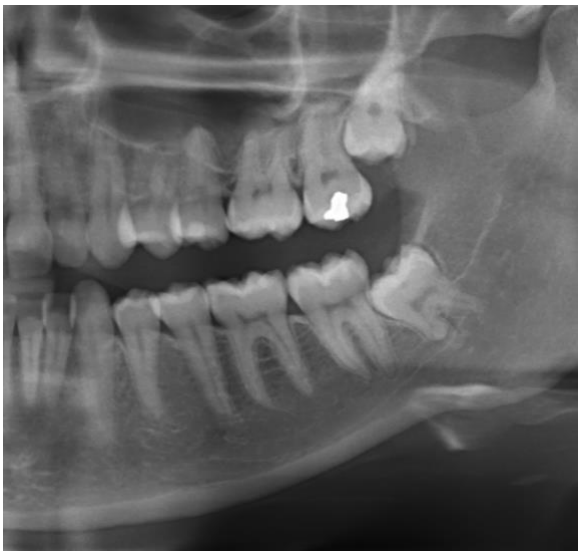
Closure of oro-antral communication or fistula	Without antral access for tooth or root retrieval	**Y**	**Y**	**Y**	**Y**
	With antral access for tooth or root retrieval, e.g., Caldwell Luc			**Y**	**Y**
Surgical removal of impacted third molar likely to:	Involve soft tissue only	**Y**	**Y**	**Y**	
	Involve bone removal		**Y**	**Y**	
	Involve tooth or root division		**Y**	**Y**	
Coronectomy of third molar	All procedures		**Y**	**Y**	**Y**
Procedures involving hard or soft tissue likely to compromise major nerves	All procedures			**Y**	**Y**
Removal of supernumerary teeth	Erupted requiring simple extraction	**Y**			
	Unerupted/ impacted/ ectopic requiring surgical extraction			**Y**	**Y**
Surgical exposure of tooth	Buccal/labial approach +/- bonding of orthodontic bracket		**Y**	**Y**	**Y**
	Palatal approach			**Y**	**Y**
Enucleation of cysts of jaw	Non-suspicious radicular (periapical) cysts not likely to compromise major nerves	**Y**	**Y**	**Y**	
	Odontogenic and non-odontogenic cysts			**Y**	**Y**
Apicectomy of tooth *	Single-rooted anterior teeth where root canal is adequately obturated		**Y**	**Y**	**Y**

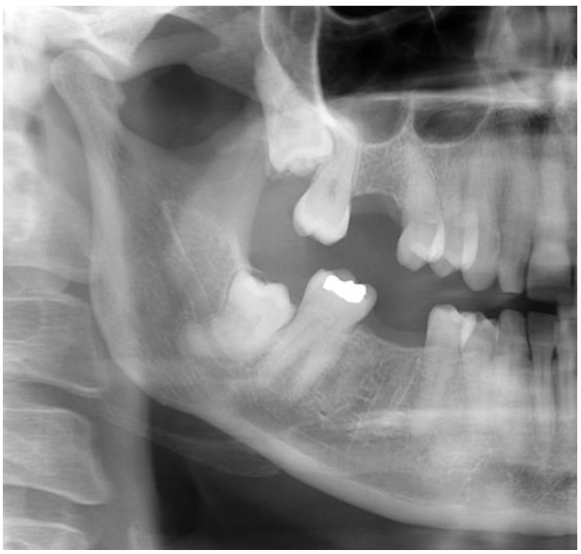
Excision of non-suspicious lesion of oral soft tissues (See All-Wales Oral Medicine Referral Guide)	For example, apparent denture-induced hyperplasia, fibro-epithelial polyp, mucocele	**Y**	**Y**	**Y**	**Y**
TMJD	Initial management	**Y**			
	Management that has not responded to simple interventions or meets modifying factors for referral				**Y**
Understand and assist in early referral of patients with possible pre-malignant or malignant lesions	All conditions	**Y**			
Management of dental trauma including re-implantation of avulsed tooth/teeth	All conditions	**Y**			
Drainage of dentoalveolar abscess	Intra-oral approach	**Y**	**Y**	**Y**	
	Extra-oral approach				**Y**
Management of haemorrhage following tooth/teeth extraction	All conditions	**Y**			
Placement of an uncomplicated dental implant in accordance with NHS protocols	All procedures	**Y**	**Y**	**Y**	**Y**

* Multirooted teeth are not suitable for apicectomy.

APPENDIX B. RADIOGRAPHIC EXAMPLES OF LEVEL 2 AND 3 APPROPRIATE TEETH

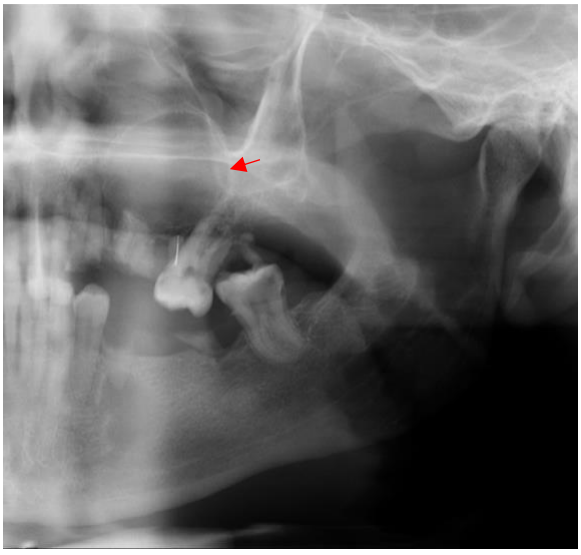
Impacted wisdom teeth intimately close to IDC

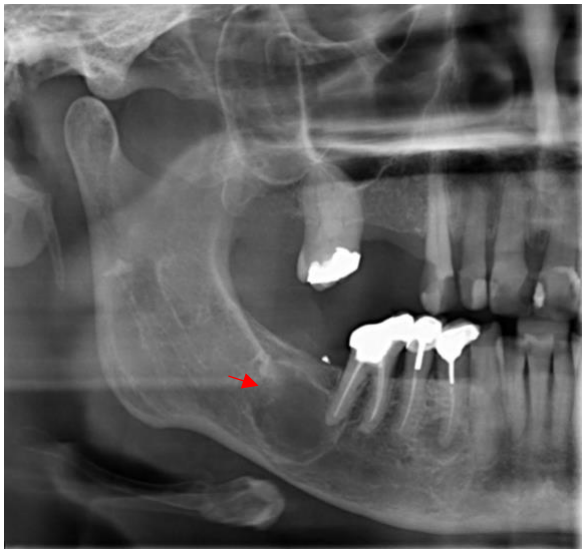




Abnormal root morphology likely to compromise ease of extraction

Teeth with associated pathology that need histological analysis





All images kindly provided by Mr N Drage, Consultant in Dental and Maxillofacial Radiology, UDH Cardiff

APPENDIX C. MEDICAL CONDITIONS INDICATING TREATMENT IN PRIMARY, INTERMEDIATE, AND SECONDARY CARE [5, 6, 27, 28]

Well-controlled medical comorbidities (e.g., well-controlled hypertension (HTN), asthma, diabetes (DM), and epilepsy) are not an indication for referral unless the complexity of procedure dictates. Unstable or uncontrolled medical conditions are more suitable for referral to the hospital setting.

An assessment of medical conditions should be made using the American Society of Anaesthesiologists (ASA)[28] physical status classification system. The ASA status of each patient and complexity of treatment required will guide the referring dentist as to the best setting for patient treatment *(NB. this is not prescriptive and patients should be assessed on a case-by-case basis)*:

ASA I (fit & well) and ASA II (mild systemic disease) requiring interventions in Level 1.

ASA I (fit & well) and ASA II (mild systemic disease) requiring interventions in Level 2.

ASA III (significant systemic disease) requiring interventions in Level 1 or above;
Above ASA III (significant or life-threatening disease) requiring any OS procedure.

Table 3. Current Definitions and Adult ASA-Approved Examples [28]

ASA Classification	Definition	Adult Examples, Including but not Limited to:
I	A normal healthy patient.	Healthy, non-smoking, no or minimal alcohol use.
II	A patient with mild systemic disease, without substantive functional limitations.	Current smoker; social alcohol drinker; obesity; well-controlled DM, HTN, dysrhythmias, and lung disease; mild/moderate obstructive sleep apnoea (OSA); oncologic state in remission; pregnancy inc. well-controlled gestational HTN and diet-controlled gestational DM.
III	A patient with severe systemic disease; One or more moderate to severe diseases with substantive functional limitations.	History (<6 months) of MI, CVA, TIA, or CAD/stents; active hepatitis; alcohol dependence/abuse; heart failure with moderately reduced ejection fraction; end-stage renal disease (ESRD) undergoing regular dialysis; poorly-controlled lung disease, epilepsy, and insulin dependent DM; morbid obesity; severe OSA; gestational DM with complications or high insulin requirements.
IV	A patient with severe systemic disease that is a constant threat to life.	Recent (<3 months) MI, CVA, TIA or CAD/stents; symptomatic congenital cardiac abnormality; ongoing cardiac ischemia or congestive heart failure; shock; sepsis; disseminated intravascular coagulation (DIC); ESRD not undergoing regular dialysis; automatic implantable cardioverter-defibrillator; advanced oncologic state.

Corticosteroids, Addison's Disease and Adrenal Patients Under Specialist Care

The majority of patients on corticosteroid medications (steroids) can normally be treated in primary or intermediate care depending on treatment complexity. In Wales, a steroid treatment card should be carried by those patients receiving exogenous glucocorticoids who are at risk of adrenal insufficiency.[29] Reference can be made to the ADSHG Surgical Guidelines[30] for steroid cover protocols for these patients, however it should be noted that these guidelines were written with secondary care procedures under sedation or general anaesthetic (GA) in mind. Currently no guidelines exist for the treatment of such patients within the primary care setting, although this is under review. Good communication with the patient's specialist or prescribing clinician is strongly advised.

Bleeding Risks [6, 11]

Certain medical conditions are known to be associated with an increased bleeding risk, due to effects on either coagulation or platelet function. These include, but are not limited to chronic renal failure, moderate to severe liver disease, haematological malignancy or myelodysplastic disorder, recurrent or current chemotherapy, advanced heart failure, inherited bleeding disorders, idiopathic thrombocytopenic purpura (ITP).

Although these effects are not dependant on the patient's anticoagulation medication, it is important to recognise these as additional risk factors that can contribute to post-operative bleeding complications in patients taking anticoagulants or antiplatelet drugs. For medically complex patients such as these, the patient's general medical practitioner or specialist should be consulted to establish the extent of the disease in order to assess the likely impact on bleeding risk for the dental procedure. OS referral to Secondary Care is acceptable where appropriate.

Patients with coagulation disorders (e.g., Haemophilia and von Willebrand disease) or a medical condition requiring additional investigations prior to extractions (e.g., moderate to severe liver disease) are also suitable for OS referral and treatment in a hospital setting.

Other Complex Needs

It is expected that the majority of patients who receive routine dental care with a General Dental Practitioner in the primary care setting who have complex histories associated with their ability to communicate, access to oral care, oral health risk factors, or who have legal and ethical barriers to care, could be managed in accordance with the criteria outlined within this document. This may also apply to patients receiving care provided by the Salaried Primary Dental Care Service, based on the individual's case.

Patients requiring OS procedures who, in the opinion of the referring clinician, have exceptional circumstances or complex needs may need to be allocated to secondary care. These referrals will be subject to individual case assessment prior to allocation.

APPENDIX D. ASSESSMENT OF SEDATION NEED [27, 31, 32, 33]

Particular care must be taken when referring patients for treatment under GA as this carries an increased level of risk and should not be offered to patients as a routine alternative.[6] Conscious sedation is an effective alternative in many cases and can make untoward events less likely in some patients. In addition, conscious sedation may enable treatment in patients with movement disorders or who have a learning disability or other cognitive impairment.

The Index of Sedation Need (IOSN)[32] can be a useful tool when assessing the need for referral for sedation. IOSN is composed of three main elements: Modified Dental Anxiety Scale (MDAS), medical and behavioural indicators, and dental treatment complexity. A MDAS Score of 19 correlates with the definition of dental phobia. Patients scoring a **MDAS level of 12 and above** may require additional support such as behavioural management or pharmacological anxiolytics as described in WHC (2018)009[31].

The responsibilities of the referring clinician are described in the Scottish Dental Clinical Effectiveness Programme guidance[33]. **Comprehensive details must be provided to support any referral[31]:**

- A fully recorded medical history (including prescribed and non-prescribed drugs and any known allergies) and ASA status.
- A dental and social history, and any relevant conscious sedation and general anaesthetic history.
- The dental treatment plan proposed.
- Assessment of anxiety or sedation need – the MDAS assessment must be completed within the e-RMS OS referral questionnaire.
- Any individual patient requirements. A full justification of why treatment cannot be provided by any other means is required for patients requesting GA.
- A body mass index (BMI) value must be included in a free-type box on the OS referral form for all requests under sedation or GA.

Patients who require Level 1 or Level 2 procedures carried out under sedation because of a demonstrable severe psychological state affecting their ability to receive treatment will be allocated to either the GDS sedation provider, CDS, Level 2 ImOS or Level 3 Hospital services, dependent upon ASA status. Such patients would be characterised by:

1. Considerable difficulty in co-operation
2. Limited examination only possible
3. Considerable interruption which disrupts provision of treatment due to anxiety
4. Patient has received two or more behaviour modification/acclimatisation visits without success

When considering where to refer, dentists should be aware that Level 2 services in GDS/CDS do not usually include surgical third molars or surgical endodontics, but are most often carried out as part of a mixed treatment plan. An example of a mixed treatment plan might be surgical removal of non-third molar teeth and completion of restorations or endodontics. Likewise, referral for Level 2 or Level 3 purely surgical work should be made to the appropriate Level 2 ImOS or Level 3 hospital services.

In addition, patients who have a physical condition, such as a severe gag reflex or a movement disorder such as Huntington's Disease or Cerebral Palsy, who need to be treated under sedation will also be allocated to either the CDS, GDS Sedation Providers, Level 2 ImOS or Level 3 Hospital services, dependent upon ASA status and the degree of complexity of the surgery.

APPENDIX E. EXAMPLES OF GOOD PRACTICE – ORAL SURGERY SERVICE DEVELOPMENT

OS services need to be integrated and delivered around the needs of patients rather than organisations or training programmes – *"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"*.[34] Emerging care pathway frameworks aim to expand and strengthen primary and "out of hospital" care, alongside focusing on creating and protecting health, not just treating ill health and providing isolated episodes of care.[1]

Welsh Government's policy drivers provide a clear vision of strengthening Primary Care Services through the development of intermediate services, in order for patients to receive care closer to home and for hospitals to focus on more complex cases. This is also in the context of recovery from the Covid-19 pandemic and establishing new service models for the future.[35]

Below are two examples of developing ImOS services within the community.

Case 1 – Cardiff and Vale UHB (CVUHB)

Background

Increase in demand for CVUHB OS services has been recognised for several years, as well as a rise in the number of referrals from primary to secondary care. Demand for OS regularly outstrips capacity for service provision, resulting in further delays in treatment. Deployment of e-RMS in 2019 allowed the capture of Health Board specific OS referrals and categorisation into levels of complexities (1 to 3), including the need for conscious sedation.

Pre COVID-19 pandemic, waiting times for OS care exceeded over and above what will be considered acceptable. The pandemic induced backlog further increased waiting times, resulting in over 2,500 patients waiting for their first OS appointment following referral, with RTT times exceeding 80 weeks. e-RMS and audit data suggested that of the 7,200 referrals from primary care to the OS Department at the University Dental Hospital (UDH) each year, approximately 70% of patients can be treated in primary and intermediate care. CVUHB required a longer-term solution for OS service-needs and there was scope for new ways of working within OS.

e-RMS Data Identified Referral Clusters

Analyses of UDH OS e-RMS referral data by patient residence revealed referral clusters. Engagement with Primary, Community and Intermediate Care Board revealed that the Health Board's dental surgery facilities at Llandough and Barry Hospitals (identified in blue in Figure 6) were not used to maximal capacity. Barry and Sally/Penarth, areas SW of Cardiff, represented reasonable clusters for referrals and establishing intermediate OS services in these locations was supported.

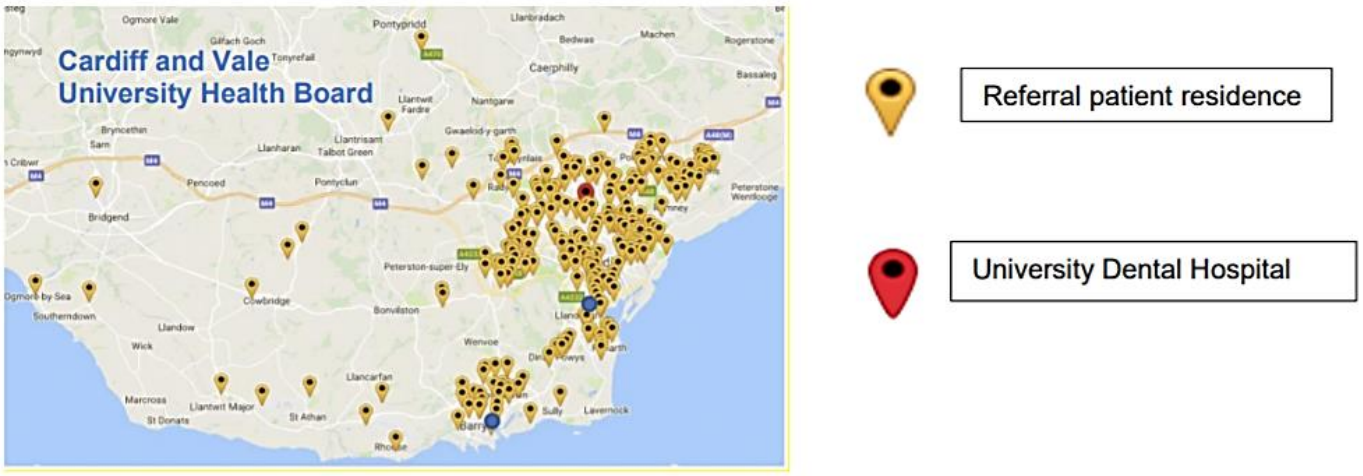


Figure 6. Distribution of UDH OS Referral Patient Residence and ImOS Services (Barry and Llandough)

Aim of ImOS

To deliver a high-quality OS service from an Intermediate Care setting

Primary Objectives

- To deliver OS procedures (Level 2 and 3 complexities) under LA with or without conscious sedation.
- OS service to be structured around patient needs.
- Ensure patients receive OS care closer to home.
- Ensure patients are seen in the most appropriate care setting.
- Reduce waiting times.
- Free up secondary care capacity for patients with complex needs.
- Promote the most efficient use of CVUHB resources.

Secondary Objectives (Teaching and Training Opportunities)

Overseen by HEIW, OS MCN, and Cardiff School of Dentistry, the development of ImOS services also provide new opportunities for education and training.

- Provide training for GDPs contracted with the HB to attain 'Dentists with Enhanced OS Skills' status via clinical attachments. This was supported by the Office of Chief Dental Officer (Wales) and HEIW and will offer "a career pathway in the General Dental Service".
- Rotate Dental Core Trainees (DCTs) for 1:1 teaching and training in OS.
- Provide supervised clinical experience of conscious sedation for DCTs as part of proposed sedation training in Wales.
- Provide training opportunities for dental nurses in OS and conscious sedation.
- Breakdown barriers between primary and secondary care.

Patient Care Pathway

An envisioned patient care pathway was developed (Figure 7). All referrals from primary care practitioners were to a central electronic repository in UDH where they are screened and vetted by the Consultant staff. This will act as a central triage point for the HB, whereby suitable cases can be directed to the ImOS services in Barry and Llandough, based on case complexity and patient's area of residence.

Audit and Clinical Governance

It is vital that the proposed service is not delivered in isolation and is linked into secondary care (UDH) for audit, peer review and governance. ImOS Service will be monitored under the auspices of the SE Wales OS MCN which has developed GDP guidance on OS referrals. Development of an all-Wales OS specific PROMs and PREMs is underway. Ongoing evaluation of process and outcomes will be via information received from the e-RMS and focus group discussions with practitioners and patients.

Summary

There is a drive to move, where clinically appropriate, OS care out of secondary care. Based on the analyses of current OS activity and research in other areas in Wales and across the UK, significant proportion of OS care could be appropriately provided out of the secondary care setting by appropriately trained clinicians. HBs will be able to demonstrate value for money in the long term. The CVUHB ImOS development is about using HB resources in a more efficient and effective way by shifting care out of the hospital setting. It should be seen as an extension of UDH OS delivery in a more appropriate setting to benefit patients and offer UG and PG training opportunities. ImOS 'facility' will be timetabled into diaries for clinical delivery.

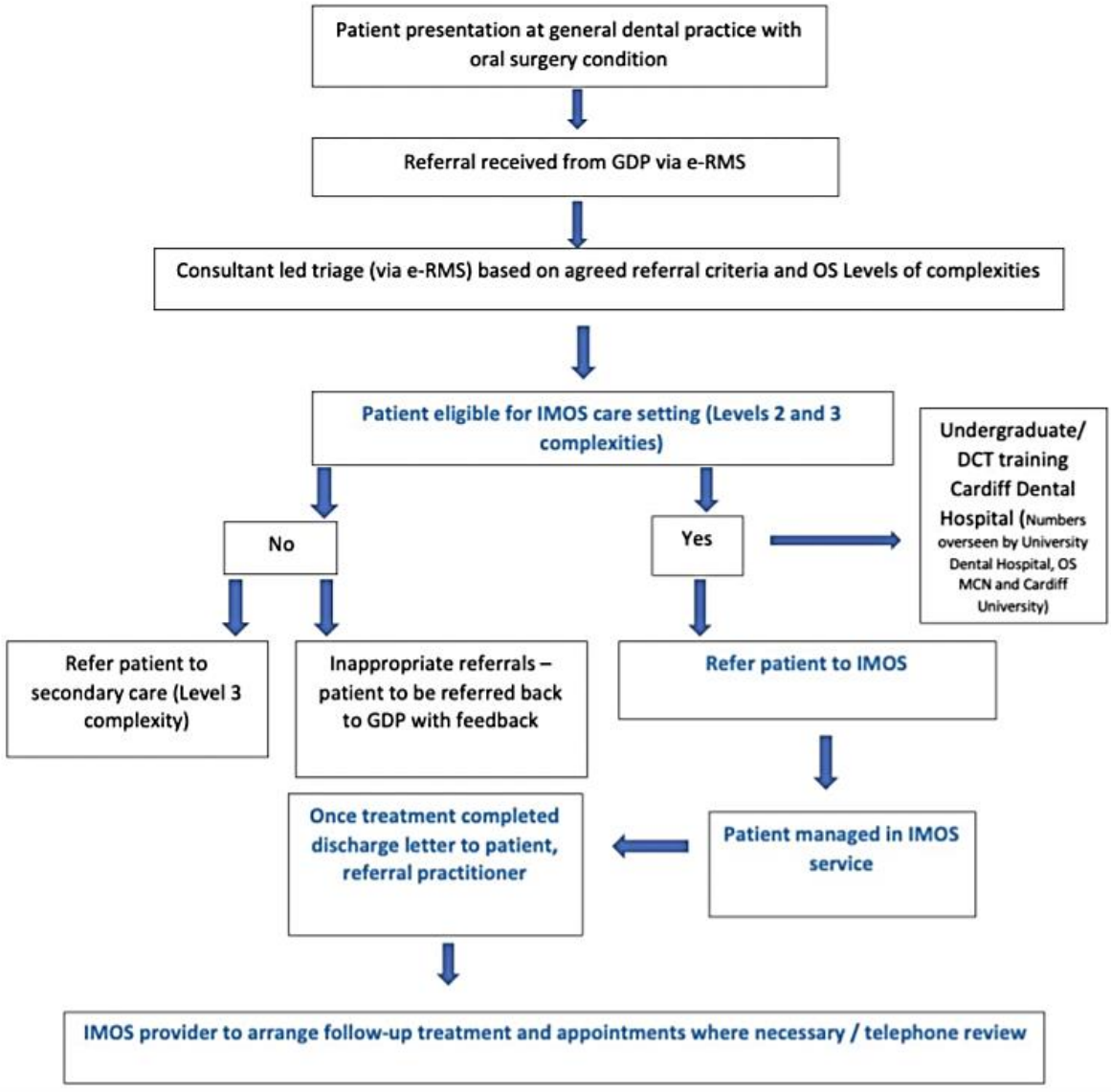


Figure 7. Patient Referral and Flow CVUHB

Case 2 – Cambria Specialist Dental Practice

Background

Cambria was opened in 2005, prior to contract reform. The vision was provision of Specialist OS services in a Primary Care setting, aiming to provide the correct treatment, for appropriate patients, in a convenient location. This idea was soon echoed by the Welsh Government's vision, which has been to develop intermediate services, moving patients out of Secondary Care and freeing up hospital services.

Over the last 16 years, the OS service provision has expanded to cover both Swansea Bay and Hywel Dda Health Boards. Demand for OS services has steadily increased over this time.

Aim of Cambria

To deliver a high-quality OS service from a Primary Care setting.

Primary Objectives

- To deliver OS procedures (Level 2 and 3 complexities) under LA with or without conscious sedation.
- The OS service would be structured around the needs of the patient.
- Aim to provide treatment in a move convenient location with a reduced waiting time.
- Free up secondary care capacity for patients with complex needs.

Secondary Objectives (Teaching and Training Opportunities)

- Provision of teaching and training opportunities for DCTs and our dental colleagues.
- Improving communication between Primary and Secondary Care services, leading to an improvement in patient experience through shared care pathways.
- Working with the Local Health Board to fully develop the potential of Primary Care Service.

Patient Care Pathway

The patient care pathway has evolved over the last 16 years (Figure 8).

All referrals from primary care practitioners are submitted vie e-RMS. These are scrutinised by a cohort of Oral Surgeons who are ultimately involved in providing the treatment for the patients. Once the referrals are assessed and accepted, suitable cases are directed to the OS Provider chosen by the referring dentist.

Summary

Provision of quality OS services within the Primary Care Sector has always been the main goal for Cambria. We have led the way in developing this pathway and strongly advocate for the development of appropriate ImOS services, staffed with appropriately trained clinicians, within the Primary Care Sector. The advantages of developing this service are not only the improved patient pathway and training opportunities but also the opportunity to maximise use of the Health Boards resources.

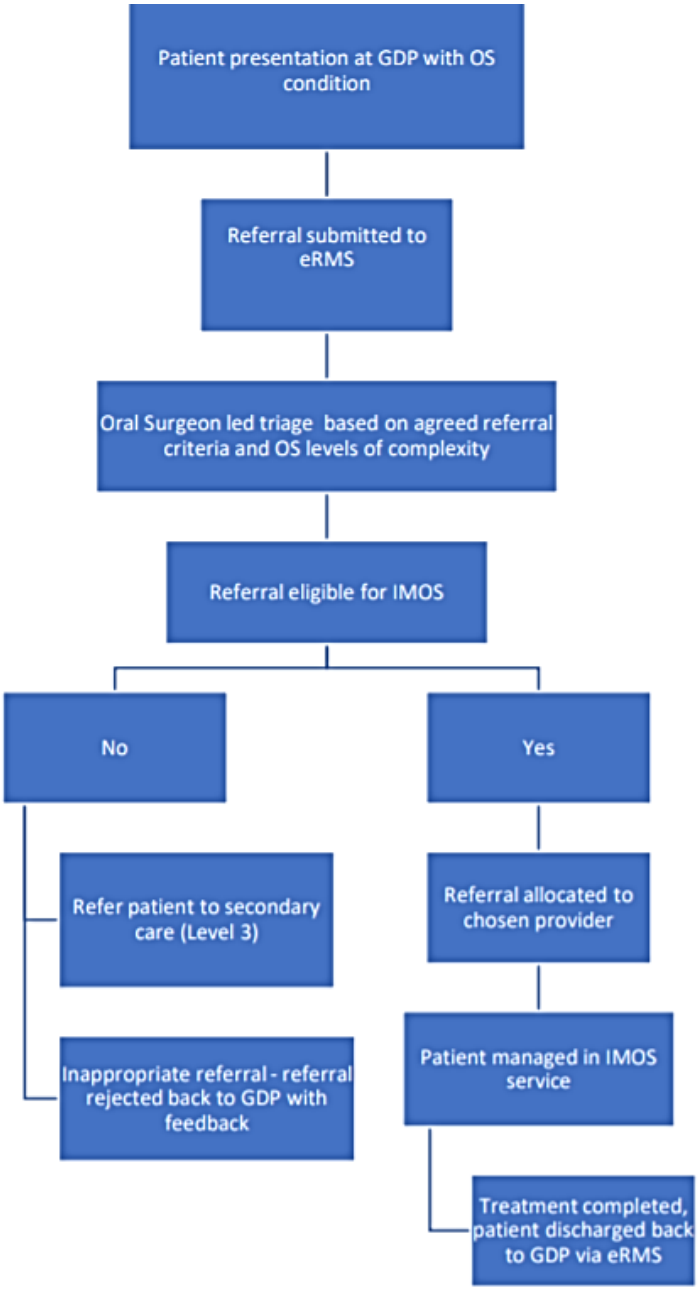


Figure 8. Patient Referral Pathway

APPENDIX F. GLOSSARY OF LEVEL 2 AND 3 NHS WALES ORAL SURGERY SERVICES

Aneurin Bevan University Health Board

Level 3 *LA, Sedation, GA*	Oral and Maxillofacial Surgery Department Royal Gwent and Grange University Hospital Cardiff Road, Newport, Gwent, NP20 2UB Tel: 01633 234234
Level 2 & 3 *LA*	Oral and Maxillofacial Surgery Department Nevill Hall Hospital Brecon Road, Abergavenny, Gwent, NP7 7EG Tel: 01873 732732
Level 2 *LA, Sedation*	Kensington Court Clinic 197 Chepstow Road, Newport, Gwent, NP19 8GH Tel: 01633 277263
Level 2 *LA*	Blackwood Dental Centre 169/171A High Street, Blackwood, Gwent, NP12 1AA Tel: 01495 222697
Level 1 *Sedation*	Gateway Conscious Sedation Service (ASA 1 & 2; ASA 3 considered for RA) 44 Cross Street, Abergavenny, NP7 5ER Tel: 01873 737737

Betsi Cadwaladr University Health Board

Level 3 *LA, Sedation, GA*	Oral and Maxillofacial Surgery Department Ysbyty Glan Clwyd Rhuddlan Road, Bodelwyddan, Rhyl, Denbighshire, LL18 5UJ Tel: 01745 583910
Level 3 *LA, Sedation, GA*	Oral and Maxillofacial Surgery Department Wrexham Maelor Hospital Croesnewydd Road, Wrexham, LL13 7TD Tel: 01978 261100
Level 3 *LA, Sedation, GA*	Oral and Maxillofacial Surgery Department Ysbyty Gwynedd Penrhosgarnedd, Bangor, LL57 2PW Tel: 01248 384 384
Level 2 *LA*	Intermediate Oral Surgery Service North Wales Community Dental Service Royal Alexandra Hospital, Marine Drive, Rhyl, LL18 3AS Tel: 03000 856 235

Cardiff and Vale University Health Board

Level 2 & 3 *LA, Sedation, GA*	Oral and Maxillofacial Surgery Department University Dental Hospital Heath Park, Cardiff, CF14 4XY Tel: 029 2074 7747
Level 2 & 3 *LA, Sedation*	Oral Surgery Service Barry Community Hospital Colcot Road, Barry, CF62 8YH Tel: 01446 704000
Level 2 & 3 *LA*	Oral Surgery Service University Hospital Llandough Penlan Road, Llandough, Penarth, CF64 2XX Tel: 029 2071 1711
Level 2 *LA*	Oral Surgery Service St David's Hospital Cowbridge Road East, Canton, Cardiff, CF11 9XB Tel: 029 2053 6819

Cwm Taf Morgannwg University Health Board

Level 3 *LA, Sedation, GA*	Oral and Maxillofacial Surgery Department Prince Charles Hospital Gurnos Road, Merthyr Tydfil, CF47 9DT Tel:01685 721721
Level 3 *LA*	Oral and Maxillofacial Surgery Department Royal Glamorgan Hospital Ynysmaerdy, Llantrisant, CF72 8XR Tel:01443 443443
Level 3 *LA, GA*	Oral and Maxillofacial Surgery Department Princess of Wales Hospital Coity Road, Bridgend, CF31 1RQ Tel: 01656 752752
Level 2 *LA, Sedation*	Porth Dental Teaching Unit Leith House, Pontypridd Road, Porth, CF39 9PH Tel: 01443 680168
Level 2 *LA*	Cefn Coed Dental Practice 148 High Street, Cefn-coed-y-cymmer, Merthyr Tydfil, CF48 2PL Tel: 01685 723377

Hywel Dda University Health Board

Level 2 & 3 *LA, Sedation (all patients)* *GA (adult only)*	Parkway Clinic (patients aged 3-17 and adults) Lamberts Road SA1, Waterfront, Swansea, SA1 8EL Tel: 01792 455780
Level 2 *LA, Sedation*	Cambria Dental Surgery 25 Eversley Road, Sketty, Swansea, SA2 9DB Tel: 01792 202229
Level 2 *LA*	Dew Street Dental Practice 31 Dew Street, Haverford West, Pembrokeshire, SA61 1ST Tel: 01437 762709

Powys Teaching Health Board

Level 3 *LA, Sedation, GA*	Oral and Maxillofacial Surgery Department Brecon War Memorial Hospital Cerrigochion Road, Brecon, LD3 7NS Tel: 01874 622443
Level 2 & 3 *LA, GA*	Park Street Oral and Maxillofacial Service Park street, Newtown, Powys, SY16 1EG Tel: 01686 617394
Level 2 & 3 *LA, Sedation*	Parkway Clinic (patients aged 3-17 only) Lamberts Road SA1, Waterfront, Swansea, SA1 8EL Tel: 01792 455780

Swansea Bay University Health Board

Level 3 *LA, Sedation, GA*	Oral and Maxillofacial Surgery Department Morriston Hospital Heol Maes Eglwys, Morriston, Cwmrhydyceirw, Swansea, SA6 6NL Tel: 01792 702222
Level 3 *LA, GA*	Oral and Maxillofacial Surgery Department Princess of Wales Hospital Coity Road, Bridgend, CF31 1RQ Tel: 01656 752752
Level 2 *LA, Sedation*	Cambria Dental Surgery 25 Eversley Road, Sketty, Swansea, SA2 9DB Tel: 01792 202229
Level 2 & 3 *LA, Sedation*	Parkway Clinic (patients aged 3-17 and adults) Lamberts Road SA1, Waterfront, Swansea, SA1 8EL Tel: 01792 455780