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# Clinical Guide to Surgical Prioritisation of Patients on Oral Surgery Waiting Lists

## Introduction and Background

This guide is for short-term use in the management of Waiting Lists increased secondary to the Covid-19 pandemic. This use may be considered for two to three years.

The dental specialty of Oral Surgery is regulated by the General Dental Council (GDC) and deals with the diagnosis and management of pathology of the mouth and jaws that requires surgical intervention. Oral Surgery involves the treatment of children, adolescents and adults, and the management of dentally anxious and medically complex patients. Oral and Maxillofacial Surgery (OMFS) is a surgical specialty, regulated by the General Medical Council (GMC), that has overlap with oral surgery competencies, and additionally manaqes head and neck malignancy, soft and hard tissue trauma, and neck/tissue space infections.

As the clinical competencies of these two specialties overlap, oral Surgery care can be provided by both Oral Surgeons and Oral and Maxillofacial Surgeons.

Waiting List priorities P5 and 6 have been added (October 2020) by the NHS as part of the national validation of waiting lists. These are NOT included in the guide because they are administrative categories and not based on the patient's clinical condition. Patients in P5/6 must also be regularly reviewed clinically to assess if they need to be re-prioritised.

Oral Surgery procedures may be undertaken in primary and secondary care and may be under local anaesthesia, conscious sedation or general anaesthesia.

The level of complexity of an oral surgery procedure may change depending upon one or more of the following factors as described by the Guide for Commissioning Oral Surgery and Oral Medicine (2015):

- Medical History;
- Social;
- Patient anxiety;
- Other patient-associated modifiers.

Level 1 – Procedures/conditions to be performed or managed by a clinician commensurate with a level of competence as defined by the Curriculum for Dental Foundation Training or equivalent. This is the minimum that a commissioner would expect to be delivered in a primary care NHS Mandatory contract. Many dentists with experience have competencies above this. For more detail around levels of care, please refer to the overarching guide for commissioning specialist services.

Level 2 – Level 2 care is defined as procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register. This care may require additional equipment or environment standards but can usually be provided in primary care. Level 2 complexity may be delivered as part of the continuing care of a patient or may require onward referral. Providers of Level 2 care on referral will need a formal link to a specialist to quality-assure the outcome of pathway delivery.

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. Oral Surgery is to be delivered by Consultants in Oral & Maxillofacial Surgery who have the necessary competencies. 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.

Level 1, 2 and some level 3a procedures are usually performed in primary care settings. However, Level 1, 2 and 3 procedures may be performed in a secondary care setting if modifying patient factors or local circumstances require this e.g. requirement for skill mix and/or multidisciplinary team and/or general anaesthetic.

This guidance covers the main oral surgery procedures but it is not an exhaustive list and does not cover in detail complex, uncommon or specialised procedures. In addition, each decision needs to take into account a patient's specific circumstances, risk, urgency and requirements. Services may wish to adapt this list to create a prioritisation system which best suits their local population healthcare needs and the services they provide.
Procedures have been categorised in to the following time priority (P) levels:

P1: Emergency procedures needed within 24 hours
P2: Urgent procedures needed within 72 hours
P3: Procedures needed within 4 weeks
P4: Procedures needed within 3 months
P5: Procedures which can be carried out in more than 3 months

## Risk of delaying procedure and loss to follow up

Clear records must be kept of any decision to defer a patient's or a group of patients' treatment and a coordinated review of deferred patients must be undertaken at regular intervals to ensure patients are not coming to harm due to being deferred. Any decision to defer a patient or group of patients must evaluate the risk that patient(s) will come to harm due to deferral of their treatment.

All procedures in the priority levels below have been colour coded according to the risk of harm to the patient of any decision to defer the procedure:

| **Level of Risk** | **Colour Code** |
|---|---|
| High Risk | |
| Medium Risk | |
| Low Risk | |

Although these procedures have been coded, individual patient circumstance may mean that a patient does not fall under the same risk category as highlighted below and oral surgeons must have the discretion to assign risk based on clinical judgement.

| Priority Level | | Conditions meeting priority criteria |
|---|---|---|
| 1a | Emergency procedure to be performed <24 hours | **Dental sepsis**/conditions not responsive to conservative management and threat to life/airway/swallow/sight/brain (surgical intervention usually managed by OMFS)<br><br>**Haemorrhage** from dental cause or trauma not responsive to conservative management (surgical intervention usually managed by OMFS)<br><br>**Dislocation of mandible** not responsive to conservative management |
| 1b | Procedures to be performed in <72 hours | **Soft and hard tissue trauma**, not suitable for conservative management (usually managed by OMFS)<br><br>**Severe dental pain** unresponsive to conservative management or in patients with additional needs so pain resulting in self-harm or other disruptive or detrimental behaviours |
| 2 | Procedures to be | **Suspected malignancy – usually managed by OMFS** |

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| | performed in <1 month | **Trauma** where delay will seriously worsen prognosis or primary dentition likely to effect permanent dentition requiring GA<br><br>**Tooth removal** for:<br><br>1) Severe pain/ infection unresponsive to conservative management<br><br>2) Under 3yrs of age<br><br>3) History of 3 episodes of acute infection<br><br>4) Social/ safeguarding needs<br><br>5) Orthodontic treatment<br><br>**Dental infection/pain** with pre-existing high medical need (e.g., Immune/ metabolic disorders, cardiac, diabetes, epilepsy, oncology, bisphosphonate treatment etc.)<br><br>**Soft or hard tissue biopsy**<br><br>**Surgical management of salivary gland disease** associated with severe pain and infection (usually managed by OMFS)<br><br>**Surgical removal or exposure of uncomplicated ectopic teeth** where delay will lead to adverse outcome such as adjacent root resorption |
| 3 | Procedure to be performed in <3 months | **Tooth removal** for:<br><br>1) Severe pain/ infection unresponsive to conservative management<br><br>2) Under 3yrs of age<br><br>3) History of 3 episodes of acute infection<br><br>4) Social/ safeguarding needs<br><br>5) Orthodontic treatment<br><br>**Dental infection/pain** with pre-existing high medical need (e.g., Immune/ metabolic disorders, cardiac, diabetes, epilepsy, oncology, bisphosphonate treatment etc.)<br><br>**Soft or hard tissue biopsy** -suspicious |

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| | | **Surgical management of cyst** – large and associated vital anatomy<br><br>**Surgical removal or exposure of uncomplicated ectopic teeth** where delay will lead to adverse outcome such as adjacent root resorption<br><br>**Dental implant placement** – if prior bone augmentation undertaken<br><br>**Trigeminal Neuropathic Pain**<br><br>**Removal of tooth from maxillary sinus** - symptomatic |
| 4 | Procedures to be performed with waits longer than 3 months | **Tooth removal** when:<br><br>1) No severe pain/ infection unresponsive to conservative management<br><br>2) Not under 3yrs of age<br><br>3) No history of 3 episodes of acute infection<br><br>4) No social/ safeguarding needs<br><br>5) Not for orthodontic treatment<br><br>**Soft or hard tissue biopsy – not suspicious**<br><br>**Surgical management of cyst** – not large or associated vital anatomy<br><br>**Surgical management of salivary gland disease not associated with severe pain and infection**<br><br>**Surgical removal or exposure of uncomplicated ectopic teeth** where delay will not lead to adverse outcome such as adjacent root resorption<br><br>**TMD**<br><br>**Dental implant placement** – if no prior bone augmentation undertaken<br><br>**Bone augmentation** for dental implant placement<br><br>**Removal of tooth from maxillary sinus – asymptomatic** |

The development of this guideline was led by and approved Paul Coulthard and Judith Jones on behalf of the British Association of Oral Surgeons and Peter Brennan, on behalf of the British Association of Oral and Maxillofacial Surgeons

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## Associated Documents

Federation of Surgical Specialty Associations. Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic

https://fssa.org.uk/covid-19_documents.aspx

https://www.rcophth.ac.uk/about/rcophth-guidance-on-restoring-ophthalmology-services/