The Organisation of Oral and Maxillofacial Surgical Services in the United Kingdom

A Consultation Paper

British Association of Oral and Maxillofacial Surgeons

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Membership of Sub-Group on Configuration Of Oral And Maxillo Facial Surgical Services in the United Kingdom.

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1 Summary Of Proposed Re-Organisation Of OMFS Services

1. The Joint Consultants Committee (JCC) in 'Organisation of Acute General Hospital Services' recognised that for the foreseeable future a DGH serving a population of 200,000 to 300,000 is likely to continue as the basic unit providing the majority of the emergency and elective services.

2. However some hospitals will need to provide the full range of specialist services delivered by a sufficient number of consultants and their clinical teams. Not only must these be continuously available for patient elective needs, they must also have time and facilities dedicated to the care of emergencies.

3. There are strong driving forces that encourage confederation of OMFS in-patient services into a managed network with a centralised site and the provision of outpatient, ambulatory and day surgical services at a number of satellite inter-related District General Hospitals.

4. **A population in the region of one million would provide a crtical mass for the service.** Geographical variations however, may require modification of this blueprint for re-organisation of services in order to meet local conditions.

5. It is envisaged that consultants would conduct regular peripheral clinics and be involved in day case surgical activity at designated DGHs away from the main base.

6. The service would guarantee a 24 hour response to the needs of all Accident & Emergency departments throughout the managed care network.

7. Patients would only be required to attend the central in-patient facility for advanced diagnostic techniques and treatment.

8. The majority of facial trauma would be treated at the central in-patient facility unless the facial injury was associated with multiple injuries in which case, a flying squad would attend the peripheral unit to provide definitive treatment.

9. In a few regions this configuration of services already exists and has proved to be highly successful in terms of clinical outcome and effective specialist training.

10. University academic departments would be organised on similar lines with additional staff and facilities to maintain teaching and research.

2 Preface

The Secretary of State for Health has determined that by 2004 Primary Care Trusts (PCTs). will control 75 per cent of the NHS budget while the existing 99 Health Authorities will merge into 36 new Strategic Health Authorities with a responsibility to performance managed local health care systems. In Wales, Health Authorities have already been abolished and their functions have been absorbed into the National Assembly for Wales centrally and Primary Health Groups locally.

In Scotland the 26 Trusts and 15 Health Boards merged in September 2001 to form 15 unified Boards for Scotland. Their main role will relate to governance issues, reviewing the health needs of a particular population, developing health improvement programmes and to making sure that monies are appropriately targeted to meet the health improvement demands.

The National Health Service is under increasing pressure to meet new challenges (NHS Plan) with issues centred around the availability and accessibility of resources together with the ever-increasing demands of the general public linked with clinical governance.

Inevitably as Trusts and Health Authorities merge there are pressures for confederation of smaller specialities onto fewer sites but there remain the very reasonable demands of patients for the provision of a local service brought into focus by the development of Primary Care Groups and PCTs.

Specialist Associations have a prime responsibility to inform the DOH of developments in their field particularly where such developments may have resource implications. There is also a responsibility to evaluate how their specialty may be best organised for delivery of health care in the changing NHS structure outlined above.

The British Association of Oral & Maxillofacial Surgeons presents this advisory paper for the future pattern of Oral and Maxillofacial Surgery (OMF) services in the light of the following broad changes that have taken place in the past decade.

Changes in the specialty which include new training pathways for academic oral surgeons, improved surgical training in the primary care sector (surgical dentistry) and the recognition of OMF as a specialty of surgery recognised by the Senate of Surgery of Great Britain and Ireland.

An established role in Head and Neck surgery alongside ORL and Plastic with a resulting need for local and regional centralisation of certain skills and expensive resources including maxillofacial technology.

The creation within the specialty of managed clinical networks in a few regions which have successfully brought outpatient and day-care surgery to DGHs with safer and improved quality trauma and cancer care at the “hub”.

The British Association of Oral & Maxillofacial Surgeons hopes that this paper, by attempting to draw together the various strands associated with the provision of Oral and Maxillofacial surgical services within a multidisciplinary environment, both in the acute hospital and primary care sectors, will be of assistance to clinicians and managers as they endeavour to reach balanced decisions within this environment of conflicting demands.

3 Oral & Maxillofacial Surgery – An International Monospecialty

3.1 Background

In most countries including the UK, Oral and Maxillofacial Surgery developed out of dentistry. In all developed countries training in both dentistry and core surgery is now mandatory which in most of Europe has to be founded on basic qualification in medicine as well as dentistry

European legislation concerned with harmonisation of medical training in the EC, together with the publication of the Calman Report on specialist medical training in the UK, have resulted, as far as the specialty of Oral and Maxillofacial Surgery is concerned, in its recognition as a medical specialty with three intimately related areas of surgery - Surgical Dentistry, Oral Surgery and Maxillofacial Surgery.

The Chief Dental Officer's report on Specialist Dental Training, and subsequent regulations from The General Dental Council (GDC) have produced anomalies for those dentally qualified practitioners who are involved either in Oral Surgery (as defined by European Dental Directives) or in Surgical Dentistry, which is a domestic dental specialty for primary care defined by the G D C.

Oral and Maxillofacial Surgery is one of nine surgical specialities recognised by the Senate of Surgery of Great Britain and Ireland. It is unique in that it is mandatory to possess registerable dental and medical qualifications, in addition to post graduate training equivalent to all other surgical specialities. Basic qualifications must be registered with both the General Medical and General Dental Councils in order to obtain both a CCST and continuing specialist listing. The Specialist Register is held by the General Medical Council and the specialty is listed as a medical specialty in the European Medical Directives

3.2 The Nature and Scope of the specialty

3.2.1 The specialty provides a comprehensive diagnostic and surgical service for congenital and acquired disabilities affecting the Face, Jaws and Mouth and any extension of these problems into associated or contiguous tissues. The scope of the specialty has been agreed internationally to include but not to be specifically limited to:

3.2.1.1 Management of Cranio-Maxillofacial Trauma (hard and soft tissues)

3.2.1.2 Dentoalveolar surgery (surgery of the tooth-bearing components of the jaws)

3.2.1.3 Pre-prosthetic surgery including implantology (surgery prior to rehabilitation of the dentition)

3.2.1.4 Surgical and non-surgical management of diseases of the Temporomandibular joint (between the lower jaw and skull-base)

3.2.1.5 The management of Head and Neck Cancer

3.2.1.6 Reconstructive surgery of the Head and Neck to include, hard and soft tissue grafts, mobilisation of regional composite flaps using where appropriate microsurgical techniques

3.2.1.7 Surgical correction of acquired and congenital facial deformity (Orthognathic surgery)

3.2.1.8 Surgical treatment of other congenital anomalies including clefts of the lip and palate

3.2.1.9 Craniofacial surgery including skull base surgery

3.2.1.10 Cosmetic facial surgery

3.2.1.11 Oral medicine (management of diseases of the jaws and soft tissues of the mouth and adjacent structures).

3.2.1.12 Interdisciplinary co-operation with a broad spectrum of other specialties, in particular ENT, Ophthalmology, Neurosurgery, Plastic Surgery, Psychiatry, Palliative Care, Clinical and Medical Oncology, Oral Medicine, Oral Pathology, Restorative Dentistry, Orthodontics and other specialised services.

3.2.1.13 Supportive care and the management of pain and anxiety

3.3 Training

3.3.1 Oral and Maxillofacial Surgery

3.3.1.1 Over a period of years the surgical Royal Colleges in co-operation with BAOMS have devised a Specialist Training programme that is equivalent to other recognised surgical specialties but also remains based on registerable dental qualification in addition to medicine.

3.3.1.2 Currently, the vast majority of individuals entering the specialty of OMFS do so from a dental base, from which certain concessions devolve during specialist training.

3.3.2 Academic Oral Surgery

3.3.2.1 Academic departments of OMF exist in all University Dental Schools. Apart from providing the full service scope of Oral and Maxillofacial Surgery such departments have the expected research and teaching input of any other academic medical specialty.

3.3.2.2 A research degree in addition to dual qualification and specialist training takes up additional years and has presented a problem in recruitment. Since 1991 a training programme for Academic Oral Surgeons (with the expectation of an Honorary NHS Consultant post in OMFS) has been available in Dental Teaching Hospitals. The practice of this group of surgeons is essentially limited to University Dental Schools and involves teaching of undergraduates, supervision of post-graduate students and research, as well as the surgical practice of some aspects of the specialty of OMFS.

3.3.2.3 The training programme is exclusively for the teaching and research needs of University Dental Schools and not for training of substantive NHS Consultants. A PhD is a mandatory requirement for entry into this training pathway, but a medical qualification, although desirable is not obligatory.

3.3.3 Surgical Dentistry

3.3.3.1 Surgical dentistry is an embryo specialty of Dental Surgery designed and regulated by the General Dental Council and with no counterpart in any other country. It has been designed for the ambulatory care of patients in the primary sector to take some minor oral surgery out of secondary care.

3.3.3.2 It is concerned with and involves surgery of the teeth and supporting structures (dentoalveolar surgery) under local anaesthesia or sedation, the diagnosis of stomatological conditions and the surgical replacement of missing teeth with osseointegrated implants.

3.3.3.3 Training programmes in Surgical Dentistry are under the aegis of the SAC in OMFS and are currently limited to three training centres.

3.4 Interface Groups

3.4.1 These are services involving multidisciplinary professional groups located in centralised units with a large teaching and training component, of which OMF is an integral part

3.4.2 Head and Neck Oncology

3.4.2.1 The current plan for the NHS aims at a programme of centralisation of certain specialist services including cancer management. Guidelines for the management of Head and Neck Cancer are in the process of being drawn up, with a recommendation that all disciplines involved be regionally centralised

3.4.2.2 A Head and Neck interface group set up by the Joint Committee for Higher Surgical Training intends to identify units where subspecialty training could be approved. This group will lay down guidelines for the selection of suitable trainees from each of the three Head and Neck surgical disciplines (OMFS, ENT, Plastic Surgery) up to a maximum of eight to ten at any one time.

3.4.3 Cleft Lip and Palate

3.4.3.1 A similar training scheme is envisaged for the surgical management of Cleft Lip and Palate with the trainees drawn from either OMFS or Plastic Surgery. The management of Cleft lip and Palate is to be centralised on a relatively small number of units, providing a comprehensive service on a managed clinical network ('hub and spoke') basis.

3.5 Manpower & Service delivery

3.5.1 Manpower

3.5.1.1 In England and Wales there are currently 243 Consultants in Oral and Maxillofacial Surgery largely based on DGHs and providing a diagnostic and treatment service in various facets of the specialty as outlined in paragraph 3.2.1.

3.5.1.2 There are 100 specialist registrars, 500 senior house officers and in excess of 300 Non Consultant career grade staff.

3.5.1.3 The Senate of Surgery has recommended a target of 1 consultant per 150,000 of the population (i.e. approx. 360 Consultants). The current shortfall on the proposed population ratio is 103.

3.5.1.4 By 2009, it is estimated that on current expansion rates, there would be 287 OMFS consultants. However DoH projections estimate a demand for 500 consultants in the specialty by that year, which leaves a projected shortfall of 212.

3.5.2 Service Delivery

3.5.2.1 **The core OMF specialty service is the treatment of Cranio-maxillo-facial trauma** supported by maxillofacial technology and with important but limited input from associated specialties e.g. neurosurgery, ophthalmology.

3.5.2.2 For trauma as well as more major maxillofacial surgery there has been a progressive move to centralisation on particular hospitals for the reasons stated above. Where this has occurred it has proved essential to maintain an emergency basic trauma service to every A & E department.

3.5.2.3 Maxillofacial surgery requires some specific input from other specialties such as Neurosurgery in the management of Craniofacial deformity / skull base tumours and orthodontics in the treatment of patients with clefts of the lip/palate and jaw deformity. Currently where any of these skills are not represented on site, strategic clinical liaisons have been established often on an ad hoc basis

3.5.2.4 The large volume of dentoalveolar surgery currently managed in the hospital service is increasingly carried out on a day care or ambulatory basis. However some in-patient facilities for this type of surgery have always been necessary for the treatment of medically compromised patients and other patients for whom a day stay setting is inappropriate. Increasingly, much of this work is being performed under local anaesthesia and /or sedation. The hospital service appears to have had no difficulty in recruiting Non Consultant Career Grades to support basic oral surgery service provision for which closely available consultant supervision is often desirable.

3.5.2.5 There is an ambition to transfer most minor oral surgery to primary care, either in specialised practices or the community dental service. The economic and clinical viability of this has yet to be tested. Promotion of Surgical Dentistry by the DoH has fallen short of expectations, as has recruitment into the new pilot training programmes

3.5.2.6 There appears to be a trend for dentoalveolar surgery to be concentrated in a small number of specialised primary care practices evidenced by an increase in the number of reported difficult extractions within the General Dental Services. It is not clear whether this is due to general practitioners attempting more difficult extractions involving basic oral surgery techniques, or whether the skills of simple exodontia are in decline. Surgical endodontics is decreasing as the quality of orthograde endodontic therapy is improved.

4 Recommendations

4.1 General

4.1.1 The Standing Medical Advisory Committee ('Future Patterns of Medical Care 1997') recognised the need to concentrate clinical services in the face of repeated pressure to make every specialty locally accessible for patients. However they also noted that facilities for emergency specialist care may conflict with those for elective care.

4.1.2 Recommendation:
BAOMS recommends that the provision of maxillofacial services should be based on a minimum population number of 1,000,000 to enable the highest quality of patient care to be delivered.

4.2 In patient Facilities

4.2.1 The NHS is at present seriously short of acute inpatient beds resulting from previous policy decisions. This fact constantly results in the inappropriate admission of patients onto surgical wards, notably medical patients from nursing homes, who may contaminate the surgical ward area with antibiotic resistant infections as well as place increased demands on nursing care.

4.2.2 A purpose designed in-patient facility is desirable to house maxillofacial patients. It must be staffed by nurses trained to the standards laid down by the English Nursing Board and who have obtained certification of training in OMFS.

4.2.3 Recommendation:
For a population of 1 million, a seventeen-bedded maxillofacial surgical ward has been found from experience to be appropriate.

4.3 Operating theatre Facilities

4.3.1 Summary The underlying recommendations for theatre time are based on existing experience in some parts of the country and rationale which is elaborated in later paragraphs

4.3.1.1 8 Maxillofacial trauma sessions
4.3.1.2 4 Surgical oncology sessions
4.3.1.3 3 Orthognathic surgery sessions
4.3.1.4 5 Dentoalveolar surgery sessions (not necessarily in the hub unit)
4.3.1.5 1 Facial Pain/TMJ sessions
4.3.1.6 0.5 Craniofacial sessions (excluding paediatric surgical cases)

4.4 Oral & Maxillofacial Trauma

4.4.1 A nation-wide survey of maxillofacial trauma revealed that at least 4 per cent of all A&E attendees had sustained a facial injury (This figure is accepted as being an underestimate owing to the recognised problems in obtaining good quality data). Of that group, approximately 30 per cent required admission to a specialised maxillofacial unit. Overall there were 832 facial injuries per 100,000 of the population, with falls accounting for 40 per cent, followed by assault (24 per cent), sporting injuries (21 per cent) and road traffic accidents (5 per cent). Virtually, 50 per cent of this latter group had major facial injuries. The commonest age group was 15 to 25 years.

4.4.2 7 per cent of facial injuries had a fracture of the facial bones necessitating in-patient treatment under general anaesthesia.

4.4.3 The normally accepted ratio of soft tissue to hard tissue facial injury is 15:1 with the majority of the former being treated under local anaesthesia, either in the Accident and Emergency department or local OMFS unit. In a significant proportion of patients soft tissue injuries are extensive and require similar in-patient

resources as their hard tissue injury counterpart.

4.4.4 Some DGH units have a relatively low volume of facial trauma and concentration of activity would benefit patients with access to expert care and resources, facilitate the training and supervision of trainees, and allow compliance with both EU working time directives and NCEPOD recommendations.

4.4.5 Concentration of trauma services on centralised units has the advantage of economies of scale with regard to the provision of wound care, mental health and other support services, which are more effectively organised and delivered to a larger critical mass of patients.

4.4.6 Recommendations:
BAOMS takes the view that care of all facial injuries except for the most minor, should take place in a strategically managed framework which caters for patients in a clinical network of care facilities.
With an average operating time of two hours per case, a unit serving a population of one million would require theatre time equivalent to eight operating sessions per week to manage the current rates of facial injuries within normal working hours.

4.5 Dentoalveolar Surgery

4.5.1 Dentoalveolar surgery is carried out in both primary and secondary care. BAOMS has co-operated with the DoH and the surgical Royal Colleges in seeking means to rationalise treatment and hopefully thereby to reduce demand.

4.5.2 Removal of impacted wisdom teeth is one of the commonest surgical procedures. In spite of compliance with guidelines from NICE and the Faculty of Dental Surgery, RCS England, the demand for treatment of this problem has not been significantly reduced.

4.5.3 Implantology for replacement of missing teeth is rightly and increasingly demanded by patients. Implant surgery needs similar resources to other dentoalveolar surgery but is more expensive. In spite of 25 years of evidence based clinical success, UK patients have up to now been largely denied dental implants, which are widely dispensed in all other developed and many under developed economies throughout the world. It is inevitable that there will be an increased demand for an oral implantology service, not just, as is presently available, for patients with developmental and acquired jaw deformities, but for any patient who has lost significant numbers of teeth

4.5.4 In an attempt better to meet demand for minor oral surgery, and in response to recommendations in a Report of a Working Group on Specialist Dental Training chaired by the Chief Dental Officer in 1994, the General Dental Council has established a specialist list in Surgical Dentistry. It was hoped that this component of OMFS could be taught in isolation and would then provide a proportion of the dentoalveolar service in a primary dental care setting under local anaesthetic with or without sedation.

4.5.5 To date this development has had little impact on the secondary sector's delivery of dentoalveolar surgery. Furthermore, there are always some patients whose condition is such that treatment in a primary dental care setting is inappropriate such as those with co-morbidities which necessitate secondary sector management and also those who have received initial treatment in a primary dental care setting but developed complications requiring consultant management.

4.5.6 Recommendations:
For a population base of one million it will be necessary to provide a <u>minimum of five theatre sessions (mainly day care) per week</u>.
Some additional sessions would be provided in network hospitals convenient to the local population.
This service may be appropriately delivered by non-consultant career grade staff (NCCG) under the supervision of consultants in OMFS.

4.6 Surgical Oncology

4.6.1 The annual incidence of head and neck cancer is approximately 12 to15 cases per 100,000 population with 80 per cent involving the mouth, pharynx and larynx. Because of the importance of the face and with so many vital structures being concentrated in the head and neck, surgery and subsequent reconstruction of this anatomical region is extremely complex, generally requiring a team approach. Treatment is in the main provided by the two disciplines of Oral and Maxillofacial surgery and Oto-Rhino-Larnygology (ORL/ENT).

4.6.2 A service based on a population of 1 million would be expected to produce a minimum of 80 new cases between the two main surgical disciplines. A caseload at or above this figure is needed to train future specialists in the field and to collect meaningful data for research.

4.6.3 The British Association of Head & Neck Oncologists (BAHNO) has recommended multidisciplinary centralisation of services to maximise expertise for patient care irrespective of whether the primary modality of treatment is surgery or radiotherapy and/or chemotherapy. This would also facilitate efficient utilisation of scarce infra-structural support, including diagnostic imaging, counselling, speech therapy, dietetics and other rehabilitation including family support.

4.6.4 With improved outcome in terms of both function and survival, comprehensive rehabilitation of these patients has become increasingly important (Rogers SN 2001). Full functional and aesthetic rehabilitation is only possible if patients are allowed to benefit from advances in implantology and restorative dentistry, which enable sophisticated restoration of the Oro-facial region and vastly improved quality of life. This service requires a consultant in Restorative Dentistry with technical support.

4.6.5 The Department of Health is about to issue guidelines on the management of cancer of the Head and Neck.

4.6.6 Recommendations:
A Maxillofacial service for 1 million population would expect to treat 42 major cancer cases per year each case needing at least three operating sessions.
This figure translates to 3 operating theatre sessions per week
One additional theatre session per week- should be allocated for evaluation and diagnostic procedures both pre and postoperatively.

4.6.7 Collaboration with ENT and other medical and surgical specialities will enable a designated Head and Neck Unit to comply with the recommended baseline figure of 80 new cases per year, which is needed for the acquisition of meaningful data and for adequate training.

4.6.8 Future plans need to take account of the variation in incidence of oral cancer in different areas of the UK. OPCS data shows a four fold variation between the 'home counties' and the industrial north. Socio-economic and geographic factors influence the length of in-patient hospital stay and bed allocations.

4.7 Disorders of Oral and Facial Development

4.7.1 Orthognathic Surgery

4.7.1.1 Facial imbalance and asymmetry are quite often not wholly treatable by orthodontic techniques. Apart from the more extreme facial anomalies exemplified by cleft lip and palate there is a significant demand for the surgical correction of other facial deformity both developmental and post trauma. This constitutes Orthognathic surgery.

4.7.1.2 Orthognathic treatment requires a symbiotic relationship between consultants in Orthodontics and OMFS. Joint pre and post surgical clinics are required together with purpose-designed facilities. Infra-structural support is an extension of that required for a hospital orthodontic department and includes oral hygiene, specialised PCDs including dental nurses as well as a maxillofacial laboratory.

4.7.1.3 Demographic data has shown that major maxillofacial units currently treat about 100 surgical cases per year, each needing a single theatre session with additional capacity for the treatment of surgical

complications.

4.7.1.4 Recommendations:
Operating theatre support for Orthognathic surgery treating 100 patients per year should be in the order of 150 sessions per year or three theatre sessions per week. Each must be supported by appropriate staff and instrumentation as well as full facilities for both pre and post surgical joint clinics as described above. Access to a comprehensive maxillofacial laboratory is an absolute prerequisite.

4.8 Craniofacial Surgery

4.8.1 The term Craniofacial surgery can be confusing as it encompasses the management of a disparate group of conditions, including congenital and acquired deformities of the Craniofacial skeleton and skull base as well as neoplastic conditions which involve the face by extension downwards from the cranium or vice versa.

4.8.2 The DoH however, has now restricted the definition to congenital and acquired anomalies of the Craniofacial skeleton in children and services are located in 4 highly specialised centres in Liverpool, Oxford, Birmingham and London. Centralisation of such activities on a tertiary referral basis is fundamental to the organisation of managed care within the strategic framework. The remaining broader aspects of the Craniofacial service are not officially defined as supraregional and many units provide maxillofacial expertise usually in a multidisciplinary setting.

4.9 Facial Pain and Disorders of the Temporomandibular Joint

4.9.1 A considerable amount of time is devoted to the investigation and relief of facial pain, which may arise from and within a number of structures in the head and neck region. Currently as Oral Medicine is a Dental Teaching Hospital based specialty with a very low number of consultants, OMFS provides the vast majority of the specialised service in this field.

4.9.2 Disease and disturbances in function of the Temporomandibular (jaw) joints are common and require sophisticated investigation and treatment. A proportion requires specialised surgical treatment including arthroscopy and joint replacement and this constitutes a significant workload for all Oral and Maxillofacial Surgeons.

~~4.9.3~~ Recommendations:
The equivalent of one theatre session per week is required

4.10 Additional Services

4.10.1 Skin Cancers of the Head and Neck

4.10.1.1 The facial region is the most common site for skin cancer. This is reaching epidemic proportions as the population increases in age. In addition, changes in social habits have led to an increase in the incidence of malignant melanoma with 25 per cent of cases affecting the head and neck. It is important that patients with malignant skin disease in this region are managed in a multidisciplinary surgical environment based on the head and neck service provided by Maxillofacial and ORL/ENT surgical specialities.

4.10.2 Cleft Lip and Palate

4.10.2.1 The specialty is intimately involved in the overall management of these anomalies and the situation is currently being reformed on the recommendations of the Cleft Implementation Group. It is almost certain that this activity will be placed on a supra-regional basis and the requirements for such units are outside the scope of this document.

4.10.3 Cosmetic Facial Surgery

4.10.3.1 Surgery of the ageing face is part of cosmetic surgery, which is one of the fastest growing subspecialty areas. Unfortunately due to financial constraints it is not possible to perform this surgery under the current regulations within the NHS. However many of the techniques employed are relevant to other

conditions including posttraumatic deformity, congenital and developmental facial asymmetry and reconstructive surgery. Specialist Registrars need to be exposed to these procedures during their training and a limited amount of work will need to be carried out in the NHS for this purpose.

4.10.4 Paediatric Services.

4.10.4.1 The vast majority of Oral and Maxillofacial paediatric services may be provided in either a central or peripheral unit on a day bed basis, providing there are appropriate anaesthetic and nursing facilities available.

4.10.4.2 In the case of paediatric maxillofacial trauma or oncology, these relatively rare cases should be treated in appropriate centralised units by named consultants who have appropriate training and experience.

4.11 Non Surgical diagnostic Service---Out patient facility.

4.11.1 The specialty receives between 50 and 60 per cent of referrals from the dental profession with the remaining 40 to 50 per cent from either general medical practitioners or hospital doctors.

4.11.2 There is evidence that the number of outpatients in OMFS is increasing (DoH Statistical Returns 1997 to 2000: SNAP – report on Oral and Maxillo Facial Surgery 2000)

4.11.3 Some of these referrals may be for diagnosis and opinions only, but the translation rate onto surgical lists is high. The outpatient facility must therefore be appropriately staffed and equipped to deal with this wide activity.

4.11.4 Recommendations:
The outpatient facility in each component of a clinical network should be capable of providing:

4.11.4.1 A complete dentoalveolar surgical service to include osseointegrated dental implants

4.11.4.2 A biopsy and fine needle aspiration service.

4.11.4.3 Temporomandibular joint injection, aspiration and arthrocentesis.

4.11.4.4 Space and equipment for multidisciplinary clinics which ideally should be purpose built.

5 Consequences of Centralising the Service

The provision of a comprehensive Oral and Maxillofacial Surgery service for a population base in excess of one million and which included specialist training at all levels would require a managed clinical network.

Such a clinical network would need to be based on a group of DGHs with centralised in-patient and trauma services

It would need peripheral day care and consultation facilities with possible development of telemedicine to assist in remote diagnosis and assessment

There would be implications for provision of consultant cover and implications for training staff and NCCG rotas.

There would be responsibility for -ensuring the continuation of clinical audit

The structure would be a stimulus for increasing sub-specialisation

It would have significant implications for education and training at both general professional (GPT) and specialist (SpR) levels

6 Academic Oral and Maxillo Facial Surgery

Without research, there is no foundation for advancing knowledge and the speciality would be in danger of becoming no more than the provider of a clinical service. The shortage of entrants into academic posts is a crisis shared with other surgical disciplines.

The particular problems related to salaried university academic Oral Surgeons and Oral and Maxillofacial Surgeons have been highlighted under 3.3.2. It is highly desirable for senior academic staff to have had equivalent surgical training and experience as their NHS counterparts. Unfortunately, the extra time involved in research and teaching is not adequately rewarded and this currently discourages recruitment.

The main additional role of academic colleagues in OMFS is to initiate and supervise research in the specialty and to teach, particularly undergraduates, in University Medical and Dental Schools, where OMFS should be a part of the dental undergraduate curriculum. Appropriate sessions should be devoted to teaching medical undergraduates and introducing them to the nature and scope of the specialty.

Academic OMF departments all have a service role, which in some locations amounts to a managed clinical network with appropriate honorary NHS grading. There is now a number of consultant Academic Oral Surgeons (see paragraph 3.3.2) and it has become important to ensure that the role of this grade in teaching and research is clearly defined. They should not take the place of NHS staff in manpower planning and interfere with process of Consultant expansion.

7 Manpower Projections

7.1 General

7.1.1 The recommended team structure for an Oral and Maxillofacial surgical unit providing a service for a population of one million is as follows:

7.1.1.1 7 Consultants

7.1.1.2 4 SpRs

7.1.1.3 4 NCCGS

7.1.1.4 10 Senior House Officers

7.2 Consultants

7.2.1 The stated aim of the Government in The NHS Plan of July 2000 is for a service delivered by fully trained doctors. Implementation of the preferred (albeit second) option of a consultant delivered service is highly dependent on recruitment to achieve adequate consultant expansion.

7.2.2 The Governments projections for 2009 demonstrate enormous shortfalls in Consultant numbers and radical re-thinking of training programmes will be required to address this problem, particularly if standards are to be maintained.

7.2.3 Current consultant expansion in OMF surgery is less than 2 per cent per annum. Central negotiations continue in an endeavour to achieve a higher rate up to 5 per cent (Working Party on the Provision of Acute Surgical Services RCS) with the aim of developing a ratio of one consultant to 150,000 population.

7.3 Non Consultant Career Grade (NCCG)

7.3.1 Current expansion in all specialties is between 17 and 25 per cent per year with OMFS showing the highest rate.

7.3.2 Coincidentally there has been a reduction of “non-standard” (e.g.: “Trust”) appointments facilitated by revised terms and conditions of service for the Staff Grade.

7.3.3 The NCCG in all specialties needs appropriate training, a career structure and CME. Because of the integration of primary and secondary care in dentoalveolar surgery, which is unique to a dentally based specialty, the NCCG is particularly valuable to the maxillofacial team. It must remain well motivated, stimulated and equipped to deliver an effective service to the public. These practitioners have an important potential role in the continuing post graduate surgical training of dentists in primary care.

7.4 Specialist Registrars (SpR)

7.4.1 Current numbers are based on SWAG projections which in turn are intended to accommodate a 1.5 per cent year by year expansion of Consultants in Oral and Maxillofacial Surgery. As indicated previously this is likely to prove grossly inadequate, particularly if a consultant delivered service is intended in line with DoH manpower projections for 2009 (paragraph 3.5.1.4)

7.5 Senior House Officers

7.5.1 Currently in all other medical specialties expansion of the SHO grade is severely curtailed.

7.5.2 A Guide to the Management and Quality Assurance of Postgraduate Medical Education (AoMRC, COPMeD, COGPED and COPDenD August 2000 Page 32 Para 6.3) presently exempts the dental specialties from these restrictions. Unfortunately, this exemption is not having significant effect on numbers.

7.5.3 The Chief Medical Officer is currently chairing a group, which will report on modernising the SHO Grade. It is expected that the present level of service delivery by SHOs will be considerably reduced. Parallel recommendations on training and opportunities for the NCCG grades are expected to follow.

8 References

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