Gloucestershire Hospitals NHS Foundation Trust
Oral & Maxillofacial Surgery

Launch of Online Referral Portal & Referral Guidelines – April 2025

www.gloshospitals.nhs.uk/glosmaxfax

Dear Colleague

The Gloucestershire Oral & Maxillofacial Surgery Team would like to take this opportunity to thank you again for your ongoing help managing referrals to our department. We have been working in partnership with colleagues including, Gloucestershire Integrated Care Board, Gloucestershire Health & Care Services and the LDC. There have been a number of positive developments locally in the recent past that will hopefully result in notably shorter waiting times for your patients.

1) "Right patient in the right place at the right time"

Please help us to ensure that your patient receives the right treatment from the right team in the right environment.

Gloucestershire has a number of service providers, so please make sure you refer to the correct service

A. **Paediatric exodontia / Special Care Dentistry**
   Please refer to Gloucestershire Health & Care Services NHSFT
   Gloucestershire Community Dental Service | GHC NHS

B. **Intermediate Minor Oral Surgery ('Tier 2' complexity procedures)**
   Please refer to Gloucestershire Health & Care Services NHSFT
   Gloucestershire Community Dental Service | GHC NHS

C. **Complex ('Tier 3') Oral Surgery, Maxillofacial Surgery & Oral Medicine**
   Please refer to Gloucestershire Hospitals NHSFT
   https://web.glos.nhs.uk/oralsurgeryreferral/

Intermediate Minor Oral Surgery & Tiers / complexity of Treatment
NHS England » Oral surgery clinical standard

Tier 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. (**i.e. GDP in primary care)**

Tier 2: 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. **(e.g. IMOS provider GH&C NHSFT as B above)**

Tier 3: Procedures to be performed or overseen by a clinician recognised as a Consultant OR where the patient has modifying factors which deem them inappropriate for Primary Care oral surgery services Modifying factors may include medical or social history or patient anxiety e.g. need for General Anaesthetic **(e.g. Oral Surgery GHNHSFT as C above)**

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2) Referral Portal

Where referral to oral surgery (for Tier 3 complexity) & maxillofacial surgery is required, all referrals must now be made via our new secure online referral portal.

https://web.glos.nhs.uk/oralsurgeryreferral/

Please note the different process for 2 week wait referrals. This is due to the fact that 2WW referrals are directly booked to clinic without triage and are administratively managed through a separate department.

This new process brings us into line with many other parts of the UK and means we can dispense with paper forms that require postage. All patient data can be uploaded via a secure platform with the following advantages:

a) Legibility
b) Guarantee that all necessary information is relayed & reduced chance of rejection
c) Sustainability
d) Digital radiograph submission (see below)
e) Immediate receipt of successful submission

Referrals will be triaged in the usual fashion but may be returned to you in certain circumstances:

a) Sufficient detail is lacking inc. radiographs
b) The referral is to the wrong service

This is based on national guidance and is not intended to be judgemental.

It is possible to request an OPT radiograph direct from radiology at GRH or CGH in advance of referral– please follow the link to the referral portal above and then the relevant tab / type of referral for full details of how to do this.

Please make your patient aware that the first appointment in the hospital setting will be for a **consultation rather than a treatment session.**

Waiting times for exodontia may be long and it is therefore **essential that all planned restorative work is carried out and not delayed until exodontia is complete.** Failure to provide this will inevitably lead to deterioration and loss of previously restorable teeth.

Many thanks for your cooperation.

Yours sincerely,

Gloucestershire Oral & Maxillofacial Surgery Team

3) Referral guidance

New referral portal

As detailed in 2) above, all referrals from dental care professionals must now be made via our secure online referral portal selecting the correct tab dependent on the nature of the referral.
https://web.glos.nhs.uk/oralsurgeryreferral/

Acute dental pain

- Patients who are referred for specialist care should not have to wait in pain. The hospital does not have the staff or equipment to provide an 'urgent dental pain' service
- Standard dental pain relief methods (sedative temporary dental restorations +/- pulp access & drainage) should be provided prior to referral
- If you are unable to treat the patient at your practice, they should be directed to the local urgent dental care facility via 111

https://www.sdcep.org.uk/published-guidance/management-of-acute-dental-problems-madp/

Anxiety management / General Anaesthesia (GA)

- Apprehension towards dental care is understandable but many patients can be helped to undergo treatment under LA only, if treated in a calm and unrushed environment.
- We still receive a significant number of referrals requesting dental extractions under GA. We can offer treatment under IV sedation for anxious patients and a successful outcome is seen in the vast majority of cases.
- We would therefore request that GA not be offered / discussed.
- **The default position will be that anxious patients will be offered intra-venous sedation and we would request that you advise patients as such.**

Apicectomy

- We will accept referrals for consideration of apicectomy on the upper anterior teeth (upper incisors and canines)
- Apical surgery on other teeth is difficult for a variety of anatomical reasons and subsequently is associated with poorer outcomes
- Current guidance recommends that **repeat orthograde root canal treatment** be completed where at all possible **before consideration of apical surgery** – even if further primary care cost is involved. It is inappropriate to carry out apical surgery in secondary care because there is 'no charge', over repeat RCT in primary care (with charge).

2020 FDS RCS Guidelines for Peri-radicular Surgery
www.rcseng.ac.uk/dental-faculties/fds/publications-guidelines/clinical-guidelines/

Suspected oral and head & neck cancer ('2 week wait referrals')

Patients with abnormal areas or lesions in the mouth / on the face that are suspected of being oral and / or head & neck cancer must be referred for an **urgent** Oral & Maxillofacial Consultation.

The 2WW referral form is available to download via the referral portal 2WW tab BUT must be completed and returned as described – it is NOT currently able to be submitted electronically.

The '2 week wait suspected oral and head & neck cancer referral' form must be completed and returned as instructed on the portal immediately. It is advisable to check the referral has been received.

Warning signs of oral cancer are:

- Non-healing, often painless ulcer or sore for more than three weeks.
- Lump or thickness in the cheek or elsewhere in the mouth.
- Persistent soreness of the throat or mouth.
- Difficulty chewing or swallowing.
- Numbness of the tongue or other areas of the mouth.
- Swelling of the jaw which causes the dentures to fit poorly.
- Loosening of the teeth or pain around the teeth or jaw.
- Voice changes.
- A lump or mass in the neck.
- Unintended weight loss.

Examination of the oral soft and hard tissues should be performed in line with NICE dental recall guidelines. Dental practitioners should be aware of the most common appearance, warning signs and symptoms of oral cancer. The South-West dental deanery offers regular courses on this topic.
https://www.maxcourse.co.uk/swdentalpg/guestHome.asp

Preventive advice concerning tobacco cessation, reduction of excessive alcohol consumption and healthy eating habits should be offered.

Radiographs & radiograph transfer

All images must have the following minimum standards of identification:

- **First name & last name**
- **Date of Birth**
- **NHS number (ideally)**

a) OPT / intra-oral images

- Referrals **must** be accompanied by a good quality radiograph that images the entire tooth / teeth in question
- These **must** be submitted digitally along with the referral via the portal
- File size: 20MB limit
- File type accepted: .jpg, .png & .pdf
- If your practice does not have an OPT machine but an OPT is required for the referral, then we would ask that you either request an OPT via a neighbouring practice or arrange for an OPT at the hospital (GRH or CGH – process described & forms available to download via the relevant tab on the portal) before the referral is made. **The OPT should be scrutinised by the requesting dentist prior to referral to ensure the referral is appropriate and that any incidental findings are / the need for other, unrelated dental treatment is, managed appropriately.**

b) CBCT images / datasets

- These **cannot** be submitted via the referral portal and we cannot accept CBCT images as screen-shots or via disc, memory stick or cloud service due to radiology IT security restrictions beyond our control. Regretfully we will have to return the entire referral to you
- If you wish to submit CBCT images, you will need to sign-up for a 'SECTRA Image Exchange Portal' account (several dental practices in Gloucestershire have already successfully undertaken this). This is how hospitals securely transmit radiographs. Full details are available in the 'Third Molar' or 'Dento-alveolar' referral tabs on the referral portal.

  iephelpdesk@sectra.co.uk

Third molar (wisdom teeth) exodontia

- Referrals requesting removal of third molar teeth must be compliant with the current national guidelines. If the referral does not state the justification for removal of the third molar, then it may be returned.
  Microsoft Word - FDS M3M guidelines April 2021

- Referrals for removal of third molars should be made to the IMOS service in the first instance if there are no significant medical complicating circumstances and the patient is happy to undergo treatment under local anaesthetic and there are no radiographic signs of intimate involvement with the inferior alveolar nerve. Please see their website for the latest inclusion criteria.
  Gloucestershire Community Dental Service | GHC NHS

Non-third molar exodontia

If a General Dental Practitioner does not feel competent to perform a routine dental extraction, then the patient should be referred to another dentist within the same practice for this treatment in the first instance. Mentoring is strongly encouraged so a more experienced dentist may share their knowledge and expertise. In addition, the South-West dental deanery offer courses to help develop extraction and socket / gingival suturing skills.
https://www.maxcourse.co.uk/swdentalpg/guestHome.asp

If referral is needed then the patient should in the first instance be referred to the IMOS service hosted by Gloucestershire Health & Care Services if their inclusion criteria are met. Gloucestershire Community Dental Service | GHC NHS

If the patient is not suitable for the IMOS service then referral to Gloucestershire Hospitals Oral Surgery service is indicated.
https://web.glos.nhs.uk/oralsurgeryreferral/

It is the responsibility of the referrer to formulate a treatment plan for all teeth that require treatment – we cannot make decisions regarding restorative treatment options. Any restorative treatment should be started as soon as possible and NOT left until the extractions have been completed.

Where extraction under local anaesthesia has been attempted but inadequate anaesthesia achieved, the GDP must try for **at least one more occasion** (two in total) before a referral is made. First stage RCT / pulp therapy and provision of a sedative dressing should be placed in the interim if necessary.

Medical Comorbidities

It is rare for a patient's medical and / or drug history to complicate extractions to such an extent that it needs to take place in a hospital setting. Details of relevant national guidelines on the management of patients on anti-coagulant and anti-resorptive medications are available on the Scottish Dental Clinical Effectiveness Programme website www.sdcep.org.uk. In addition, many 'disease-specific' national society websites also have resources that may be of help.

Anti-platelet & anti-coagulant medicines

Patients on the following medications can and should be managed in primary dental care with liaison with the patients' GP if necessary.

Warfarin

- Straightforward extractions can be carried out in dental primary care so long as the INR is <4.0 within 24 hours of the planned extraction. Liaise with patients GP regarding timing of INR. Surgicel and a suture/s should be placed.
- No patient should have an INR >4. If it is, then defer extraction until INR <4. Liaise with GP.
- Multiple extractions should be staged and carried out over several appointments; the recommendation is that no more than 3 teeth are removed at any one time.
- Local haemostatic measures **must** be used e.g. Surgicel & sutures

NOACs (dabigatran, apixaban & rivaroxaban)

- These drugs are not monitored in the same way as Warfarin and have a short half-life. Straightforward extractions can be carried out in dental primary care. Give consideration to stopping the drug for 1 day / dose prior to extraction **with the agreement of the patient's GP**
- Local haemostatic measures **must** be used e.g. Surgicel & sutures

www.sdcep.org.uk/published-guidance/anticoagulants-and-antiplatelets/

Anti-resorptive medication / bisphosphonates

- Patients on oral bisphosphonates or other orally administered anti-resorptive medications that require dental extractions should be managed in primary care.
- There is currently no strong evidence recommending the use of antibiotics or oral antiseptics; their use is at the discretion of the GDP.
- If multiple extractions are required, then these should be staged and carried out over several appointments.
- If the extraction socket is not healed at 8 weeks and MRONJ is suspected, then referral to Oral & Maxillofacial Surgery is indicated.

www.sdcep.org.uk/published-guidance/medication-related-osteonecrosis-of-the-jaw/

Temporomandibular Problems

The Faculty of Dental Surgery (RCS Eng) has published excellent updated guidance on this subject in 2023.
Comprehensive-guideline-Management-of-painful-Temporomandibular-disorder-in-adults-March-2024.pdf
TMD-Clinician-summary-document-March-2024.pdf

The majority of patients with TMJ problems will be suffering from TMPDS (Temporo-mandibular pain dysfunction syndrome) / myofascial pain. **In most instances these patients can be managed well in dental primary care without the need for referral.**

The most common symptoms are:

- **Pain** – usually a dull ache in and around the ear. The pain may radiate along the cheekbone and downwards into the neck
- **Joint noise** – such as clicking, cracking, crunching, grating or popping
- **Limited mouth opening**
- **Headache**, especially in the temporal region
- Some patients report mild/transient **facial swelling** which may be worse in the morning

Most cases of TMJPDS are made worse by chewing and are aggravated at times of stress.

The following initial management advice can be provided in dental primary care

- Explanation of the condition and provision of relevant patient leaflet.
- Reassurance that TMPDS is not serious and that it usually responds to simple measures. Symptoms may recur from time to time.
- Application of heat to the side of the face, e.g. a warm hot water bottle wrapped in a towel applied to the side of the face. This can be combined with simple massage to the tender muscle areas and relaxation techniques.
- Advice concerning the use of painkillers. Non-steroidal anti-inflammatory drugs (NSAIDs), e.g. ibuprofen, are often helpful. These should be taken regularly for a two to three week period, not just PRN. NSAID gel can be applied topically to the area over the joint or the muscles of mastication.
- The identification and avoidance of parafunctional habits, such as clenching or grinding (particularly at night), nail-biting, lip/cheek biting and posturing of the jaw.
- Rest for the TMJ, including soft diet, particularly if there are acute phases.
- Provision of a soft lower occlusal splint, which can be worn at night – this is particularly useful for patients who grind their teeth at night.

Patients who should be referred for management in secondary care:

Diagnostic doubt / atypical presentation (e.g. numbness of the face, marked/persistent facial swelling, severe trismus which is unrelated to surgical intervention or injury).

- Patients who fail to respond to conservative measures, including the provision of a soft splint with persistent trismus at 3 months or intractable pain at 3 months.

Oral Medicine

Oral medicine involves specialist care of patients with symptoms arising from the mouth that often do not relate directly to teeth / jaws and where management is not primarily surgical. The symptoms are often chronic and may have significant psychological as well as physical impact on the patient's quality of life.

The Oral & Maxillofacial Surgery department will provide a diagnostic assessment with subsequent advice and management for soft tissue disease of the mouth and jaws, chronic facial pain, and the oral manifestation of systemic disease. These systemic medical conditions may include diseases of the gastrointestinal tract, rheumatological and haematological conditions and immunological disorders.

Conditions to be referred for diagnosis & initial treatment

- Ulceration lasting more than two weeks **(see Oral H&N cancer above)**
- Recurrent oral ulceration
- Blistering conditions of the oro-facial region and oral mucosa
- White or red patches of the oral mucosa (including lichen planus)
- Pigmented conditions of the oral mucosa (consider x-ray for amalgam tattoo)
- Oro-facial pain of non-dental origin (burning mouth syndrome, trigeminal neuralgia and unexplained oro-facial pain
- Other altered oro-facial sensations
- Soft tissue swelling of the oro-facial region
- Oro-facial manifestations of systemic disease
- Candidiasis or angular cheilitis (although suitable for primary care management)
- Dry mouth and other symptoms related to salivary glands (although please consider medication as a potential cause)

Please refer these patients using our 'Oral Medicine & Intra-oral Soft Tissue' form which includes a 'mouth map' for accurate localisation / description of the area in question.