A relentless pursuit

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You may not have heard of Kaizen but, defined as 'The relentless pursuit of the elimination of waste' it is a philosophy, pioneered by Toyota in the 1980s, which has now reached my oral surgical secondary care corner of the NHS in the form of LEAN (a slimming down). The aims of this philosophy could be summarised as: the delivery of a product in a shorter timescale, at a lower cost, of the same or improved quality. This is to be achieved through the removal of unnecessary and duplicated processes, the targeting of resources to bottlenecks and quality control (monitored through audit). Is it appropriate to compare patient management to a car production line? Well, we prefer to call it 'the patient pathway' and the product very often is a single item of treatment, for example the removal of a third molar.

The patient usually enters the pathway via a referral letter. Herein lies a process open to failure and delay (particularly in December) since snail mail is unreliable, Royal or not. Our medical practitioners all appear to be able to refer electronically whereas the facility is not yet available to our referring general dental practitioners. We really do need to move over to e-referrals; we are not quite ready yet but trust it will be soon. Assuming your referral does reach us, it is date stamped and the clock starts ticking against a waiting time target which then puts the onus on us to triage and move the patient onto the most appropriate pathway. A fast track referral marked 'suspected malignancy' will be moved along a specific pathway whereas all other referrals will be directed along other routes. We could negotiate further along the patient pathway but with cost savings taking centre stage at this present time, I might indulge in a little discussion of some economic initiatives. These I have included under two headings and, I might add, could be applied to a number of fields of medicine and dentistry:

- Adoption of alternative low tech/low cost procedures
- Reduction in acceptance of procedures.

LIGHTING UP A HOSPITAL MANAGER'S EYES

An example of a low tech/low cost procedure is the management of a cystic lesion of the jaw with decompression in preference to enucleation. Where is the cost saving in this? you may ask. There is the cost of production of a decompression stent, the often multiple return visits not to mention the risk of a repeat surgical procedure. Weigh this against a one-off enucleation; no competition you may argue. The attractiveness of the procedure, however, is its relative low technical, minimally invasive nature, which allows it to be more readily performed under local anaesthesia in preference to general anaesthesia. In fact any procedure allowing treatment of a condition using local anaesthetic in preference to general anaesthetic (GA) is likely to make a hospital manager's eyes light up. We are talking about not only saving the considerable cost of utilising an operating theatre but also a reduction in requirement for surgical beds. I am not arguing necessarily that the venue for such outpatient-based care should be situated outwith a hospital environment, in fact the ready availability of medical and surgical 'back up' would be attractive.

Another issue is restriction of access. A referral requesting specialist or secondary care where a local, regional or national guideline exists that supports management in primary care may be declined. For example, a simple procedure required in an anti-coagulated patient or those having received oral bisphosphonates in which the referring practitioner may be in a position to treat the patients. We are aware that some practitioners claim to perform all their own minor oral surgery, referring us nothing, making such a procedure possible, whereas others appear not to own a pair of dental forceps, for which the answer is probably no, not all.

In relation to restricting access for adult general anaesthesia, for procedures deemed manageable using local anaesthesia (with or without sedation), I for one would be sorry to lose this option, the clearance in the dental phobic being a case in point. Although the ready availability of the GA option for dento-alveolar surgery may encourage overuse of this resource-hungry option, a restriction of access is likely to result in some patients going untreated. This may be because they will not or cannot accept treatment without a GA or the resources (manpower, skills and facilities) are not in place to provide the non-GA option. For whatever the reason non-treatment is likely to result in some dissatisfied patients and an increase in dental and medical acute admissions with concomitant costs. However, this may be a 'price' the health service is prepared to pay in the name of apparent cost effectiveness.

My intention is primarily not to upset patients, or colleagues, but to propose some *'clinician led'* cost saving initiatives rather than have to accept the alternative of our managers deciding where to make the painful cuts. As I return to the fray I will leave you with one word; Kaizen!

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