Optimising referral letters for the dental practitioner

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Key points

- Explores key criteria which need to be included in all dental referral letters.
- Highlights different levels of care in dentistry based on treatment complexity and patient factors.
- Explores essential criteria needed for different specialities, optimising patient care.

Abstract

Referrals are defined as 'a process in which a health worker at one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the help of a better or differently resourced facility at the same or higher level to assist in patient management'. Within the UK, the NHS dental service is divided into nationally defined levels of care, which provide treatment based upon complexity and patient modifying factors. Having a sound knowledge of these levels will help general dental practitioners (GDPs) make appropriate and efficient onward referrals to the correct service.

This article aims to outline the key information required for all strong GDP referrals, as well as highlighting information that may be specific to each speciality. This is with the hope of creating a key list for GDPs to use on clinic when writing referrals to reduce the incidence of missed information and subsequent rejection. The article also aims to outline the levels of NHS dental care and what factors and treatments are suitable for each to aid GDPs during their referral decision-making process.

Introduction

The World Health Organisation defines referrals as 'a process in which a health worker at one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the help of a better or differently resourced facility at the same or higher level to assist in patient management'.[1] Intra-speciality and inter-speciality communication is key to ensuring treatment is provided in the patient's best interest. The referral process embodies the General Dental Council (GDC) Standard 6, which states we should always 'work with colleagues in a way that is in patients' best interests'.[2]

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According to the NHS Constitution for England and its handbook, patients have the right to start their consultant-led treatment within a maximum of 18 weeks from their referral for non-urgent conditions.[3] General dental practitioners (GDPs) refer their patients daily through this 18-week pathway to allow access to numerous secondary care services across multiple disciplines.

Incorrect or inappropriate referrals can have a negative impact on patient morale, as they may feel that they are not receiving appropriate and timely intervention. There is also an increased risk of patients becoming lost within the system if they are rejected from certain services after being discharged from their original care. This highlights the importance of clear communication between treatment levels and clinicians and a standardised understanding of where different patients need to be seen.

Currently, there are treatment criteria for each speciality, but few resources concisely summarise these and place the information in one document. This article will aim to bring the most contemporary referral details together, to enrich GDP understanding about how to write better referral letters, but additionally to send these referrals to the correct place.

Essential information in a referral letter

Many areas and dental specialities now rely solely on electronic referral systems to secondary care. These are heavily dependent on *pro forma* templates for GDPs to follow and mandates the information to be supplied. A 2004 study showed a 29.3% increase in required information from GDPs in a restorative department when using a standard referral *pro forma* compared to a normal referral letter.[4] This shows the clear advantage of electronic referral systems, allowing for better structure compared to the previous 'open letter format'. Furthermore, by digitalising this process, the risk of referrals being lost in the post, or never reaching their intended recipient is reduced.

Box 1 includes 11 key pieces of information that are vital for all referral letters. Including details of whether an interpreter is required – either language or basic sign language – is in keeping with the 2010 Equality Act. It ensures reasonable adjustments are made to

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allow patients to make informed decisions about their care and access treatment.[5] Stating that a patient suffers from dental anxiety will give the receiving clinician the opportunity to be prepared for potential difficulties. Finally, attaching contemporary and relevant radiographs will reduce the chance of repeat exposures, which follows the Ionising Radiation (Medical Exposure) Regulations of 2017, by keeping radiograph exposures as low as reasonable possible for all patients.[6]

Alongside standard information for all referrals, certain specialties will require further information to deem a patient suitable for their services, and to decide whether they are suited for specialist or consultant-based treatment. Complying with these extra details will be the factor influencing referral acceptance, as many will be automatically rejected if information is missing. Table 1 includes specific additional information certain specialties may ask for.

Levels of care in NHS dentistry

NHS dentistry is divided into different levels to treat patients as safely and efficiently as possible. It is therefore important that GDPs are aware of these different service levels so they can make an informed decision about where their patients should be referred. Usually, referrals will be sent to a central consultant-led triage system, which will determine the appropriate destination for the patient to be sent.[7] Table 2 includes information about the current nationally defined levels of NHS dentistry, going from Level 1 basic care, up to Level 3b complex care by consultants in their fields.[8] Primary dental services will usually provide Level 1 and certain Level 2 care, with community dental services and secondary care NHS hospitals providing Level 2 and 3 care, utilising general anaesthetic, sedation and domiciliary services to name a few. Managed clinical networks are groups governed by NHS England to link clinicians from all tiers of care and act to communicate strategies that will improve service provision and co-ordinate patient movement.[9]

However, it is a combination of case complexity with regards to both procedural and patient modifying factors, and the skill set and competencies of the provider and their team, that determine the setting where care may be delivered. An example of a patient-modifying factor could be patient dental anxiety. The Adult Dental Health Survey 2009 revealed that 12% of all adults who had been to a dentist were classified as having extreme dental anxiety, with a further 36% having moderate dental anxiety.[10] These patients, therefore, may require sedation, or even general anaesthetics for Level 1 complex treatment, which would overall move them up to requiring Level 2 or 3 services. This is a key example of how both patient factors and treatment complexity need to be considered together, with Table 3 containing other factors which may have an influence.

Box 1 Essential criteria for all GDP dental referrals

1. Date of referral
2. Patient details: full name, date of birth, NHS number, address, phone number, email
3. Medical history: state if none, includes learning difficulties like autism or dental anxiety. It helps to include a copy of the patient's most recent prescription, should the patient have an extension medical history. Include details of any previous general anaesthetics if the patient requires this
4. Need for a translator: which language, includes BSL, state if none needed
5. General practitioner details: name, practice, address
6. GDP referrer details: name, practice, address, phone
7. Reason for referral: opinion/advice or treatment
8. Further details of reason for referral: including if this is urgent or non-urgent referral (***pro formas*** may have tick box selections)
9. Chart with teeth in question included
10. Description of any previous treatment that have been completed
11. Radiographs attached: most relevant and recent, dated.

Table 1 Additional referral information for certain specialties

Periodontics	Has a cycle of periodontal treatment been completed, are pre- and post-treatment indices attached, most recent within six months, oral hygiene level and motivation
Endodontics	Is the tooth of strategic importance, has the tooth been assessed for restorability, has root canal treatment/retreatment been attempted
Orthodontics	Presenting malocclusion, IOTN, 6S status, oral hygiene
Oral surgery	May ask specifically for social history, including smoking, alcohol, betel nut usage. Indicate if there is a need for sedation
Prosthodontics	May ask if undergraduates can complete treatment if appropriate
Paedodontics	Indicate if there is a potential need for a general anaesthetic or a form of sedation, previous dental experience
Special care	What behaviour modality will they need, for example, behaviour management, local anaesthetic, regional anaesthetic, general anaesthetic, previous dental experience

Table 2 Levels of NHS dental care[8]

Level 1	• Procedures/conditions to be performed or managed by a dentist with the level of competence as defined by the curriculum for dental foundation training • Emphasis on thorough assessment, ongoing surveillance, preventative care and straightforward treatments
Level 2	• Procedural or patient complexity requiring a clinician with enhanced skills who may or may not be on a specialist register • 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 consultant/specialist-led service
Level 3a	• Procedures/conditions to be performed or managed by a dentist recognised as a specialist by the GDC
Level 3b	• Most complex level of care and should be delivered by a dentist recognised as consultant. More likely to involve multi-disciplinary care

What treatment falls into each level for the different specialities?

Summaries will be presented with the most contemporary information about which treatments are deemed suitable for different levels of care for separate specialties. Treatments are condensed into figures for ease of use. It is to be remembered that treatment complexity

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Table 3 Patient modifying factors influencing appropriate levels of NHS care

Communication	• Difficulties due to multi-sensory or cognitive impairment • Non-verbal patients due to learning difficulties or severe cognitive impairment
Cooperation	• Patients with disability, psychological or mental health state that means: • Only limited or no examination possible • Significant treatment interruption due to inability to co-operate, inability to tolerate procedure, inappropriate behaviour leading to limited examination
Medical	• Complex medical conditions that may either require specialist service, multidisciplinary care, risk assessments • Multiple co-morbidities • ASA status of patient[11]
Access	• Patients requiring NHS transport to access dental surgery, special equipment to transfer to dental chair • Domiciliary care
Oral risk	• Access to oral cavity restricted by major positioning difficulties, inability to open mouth, dysphagia
Legal and ethical	• Doubtful or fluctuating capacity to consent • Clinician may need to make a best interest decision

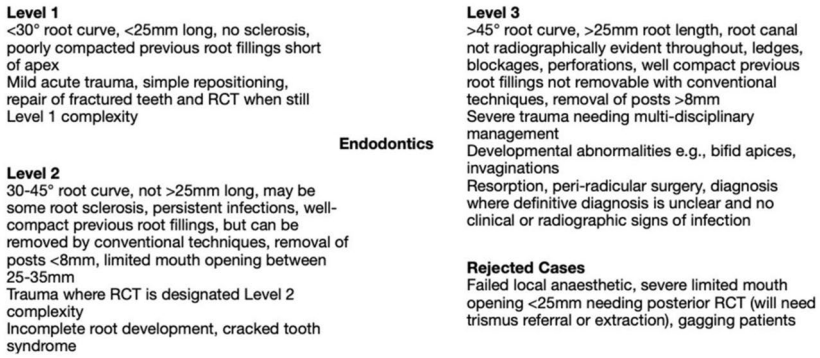

Fig. 1 Treatment complexity for endodontic levels of care[7]

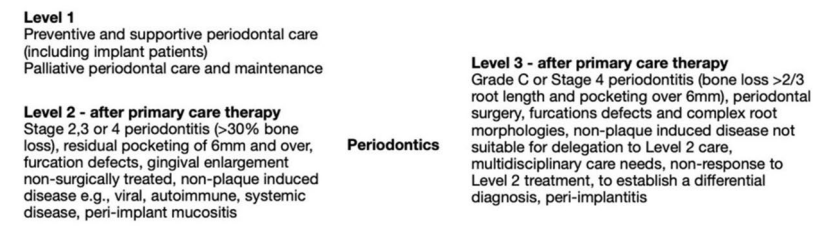

Fig. 2 Treatment complexity for periodontic levels of care[12]

forms a portion of the determining factors for patient referral, and behaviour, medical history and access all need consideration too.

Endodontics

If patients are suitable for Level 2 or 3 endodontic care, they will then usually be discharged back to the GDP for provision of indirect cuspal coverage if deemed necessary and suitable for primary care. Patients who are requiring secondary care due to reasons other than treatment complexity may have further treatment completed in this setting before discharge.

All patients should have a stable oral environment, with all active disease stabilised. All teeth should be predictably restorable, which can be determined by dismantling any restorations present and checking for tooth tissue circumferentially, with a minimum height of 3 mm and thickness of 2 mm before referral.[7] Details of this should be included within the referral. An appropriate long-cone peri-apical should also be included with the referral. Figure 1 summarises the factors that influence where patients should be referred for their endodontic treatment.

Periodontics

Success of any form of periodontal treatment is greatly increased by patient engagement and long-term maintenance. The British Society of Periodontology (BSP) released a new classification system in 2017, which helps categories patients into subgroups and defines which patients are suitable for onward referral.[12]

Patients should always give consent to be referred to specialist services and should all receive initial non-surgical periodontal care, with lifestyle and behaviour risk factors managed appropriately.[13] Specific factors, including smoking status and control of diabetes, need to be documented, if appropriate. Figure 2 summarises the BSP's guidance on which patients require onward referral.[12]

Paedodontics

Dental anxiety and patient co-operation are key factors that will influence the decision about where patients will be managed. Decisions need to be made as to whether the patient would benefit from conscious sedation or general anaesthetic services. Utilising these services appropriately is essential, as it has been shown that traumatic dental experiences during childhood are strongly associated with poor oral health in adulthood.[14] While trauma can be managed in both primary and secondary care, it is of upmost importance to refer to the most contemporary International Association for Dental Trauma guidelines for trauma management.[15] Figure 3 provides guidance on which treatment is appropriate for different levels of care and should be considered in combination with patients' medical history, social factors and co-operation.[16]

Orthodontics

All patients under the age of 17 are entitled to an NHS orthodontic assessment, independent of the severity of their malocclusion. Therefore, after assessment, patients who GDPs believe will be eligible for NHS orthodontic treatment should have timely and accurate referrals to a primary care orthodontic provider. Orthodontic treatment acceptance is based upon the Index of Orthodontic Treatment Need (IOTN), which is divided into the dental health component (DHC) and an aesthetic component. In summary, patients falling into Grade 4 and 5 of the DHC are eligible for NHS treatment, and patients with Grade 3 DHC who have an aesthetic component over Grade 6 will be deemed appropriate.[17]

Orthodontic treatment can be delivered in both primary settings with specialist

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orthodontists, and within hospital settings if the treatment is complex. Figure 4 outlines the different levels of complexity. Level 1 and 2 can be provided in primary care, with Level 3 in hospital settings (or primary care with close liaison with hospital departments).[18]

Prosthodontics

Prosthodontic care encompasses crowns, bridges, dentures and implant-retained restorations. Onward referral to secondary care of this nature could be purely for opinion and advice, or may be requesting treatment to be completed. This needs to be explicitly outlined on the referral letter from the GDP. In certain scenarios, delivery of treatment may be straightforward, but the planning stage may be complex. Utilisation of specialist services can allow patients to have certain teeth restored rather than extracted.

Secondary care services are also appropriate for patients who may be embarking on radiotherapy, chemotherapy, or bisphosphonate therapy, which can have multiple oral implications that need to be considered before starting treatment.

Figure 5 outlines the complexity assessment for levels of prosthodontic care.[19]

Oral surgery

The following oral surgery information does not include two-week wait oral cancer referrals. For these patients, follow separate local referral proformas for urgent oncology clinics.[20]

Figure 6 outlines the categories of surgical complexity for each level of care.[21] National Institute of Care and Excellence guidance regarding extraction of wisdom teeth should be followed to establish whether patients are suitable for removal in the first instance.[22]

Patient medical history will form a key aspect of the referral decision. The patient's American Society of Anethesiologists (ASA) physical status should be assessed to determine the patient's pre-anaesthetic medical co-morbidity. ASA 1 and 2 patients requiring Level 1 intervention can be treated in primary care. ASA Grade 3 patients and above should all be referred to secondary care. Patient bleeding risk should also be considered, and the Scottish Dental Clinical Effectiveness Programme (SDCEP) anticoagulant guidelines should be reviewed.[23] Patients posing a low risk of prolonged bleeding can be treated in primary care and the decision to refer is guided by procedural complexity. High-risk patients

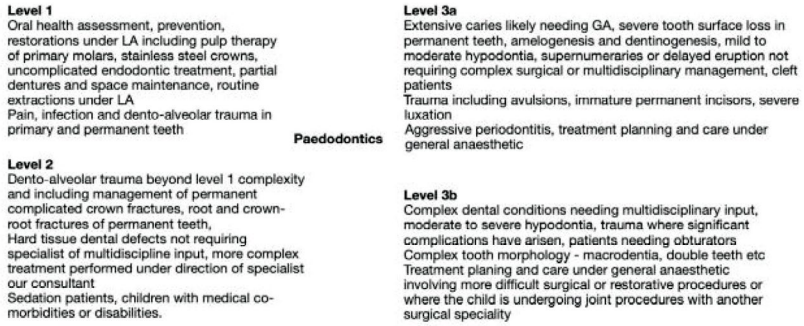

Fig. 3 Treatment complexity for paedodontic levels of care[16]

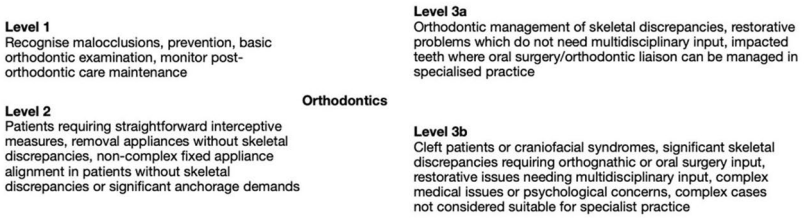

Fig. 4 Treatment complexity for orthodontic levels of care[18]

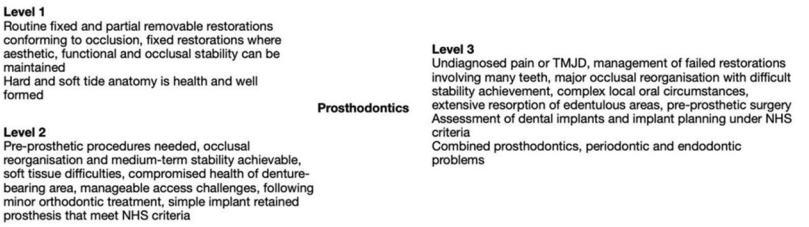

Fig. 5 Treatment complexity for prosthodontic levels of care[19]

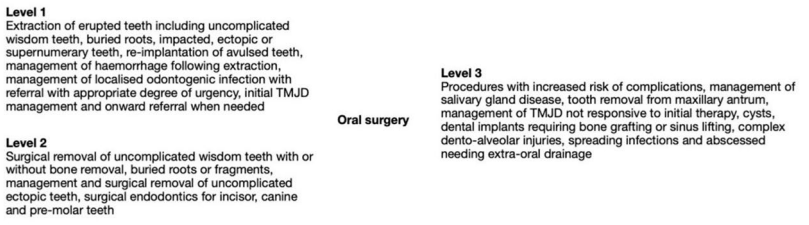

Fig. 6 Treatment complexity for oral surgery levels of care[21]

may warrant liaison or onward referral. Patients prescribed anti-resorptive and anti-angiogenic medication will need treatment planning alongside the relevant SDCEP's management of patients on bisphosphonate therapy guidelines, and referral should be based on needs of the patients and the current evidence in the field.[24]

Special care

Special care dentistry encompasses patients with physical, medical, learning, mental or anxiety-driven disabilities who are not suitable for primary care. It also accounts for patients who require the use of bariatric equipment, are homeless, or require domiciliary visits. A portion of the referral decision will also depend

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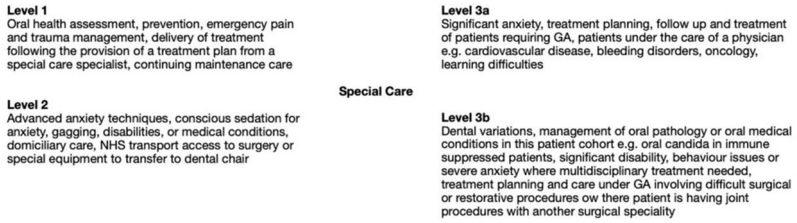

Fig. 7 Treatment complexity for special care levels of care[25]

on the transport needs of the patient, and whether they will require specific equipment for treatment. Figure 7 outlines situations which would dictate the level of referral a patient may require.[25]

Conclusion

Appropriate utilisation of the NHS dental referral system is vital for successful patient outcomes. Having an awareness of the combining influence of treatment complexity and patient-modifying factors to determine where a patient is best treated will lead to direct referrals to the correct service. Not only will this enable GDPs to have the required support for their patient cohort, but it will prevent unnecessary disruption to patients' day-to-day lives, as well as ensure all onward referral services are filled with the correct demographic.

Knowledge of the key patient factors to be looking out for, including anxiety, medical comorbidities and social engagement, will empower GDPs to ask targeted history questions to establish information that is vital in referral decisions. On top of this, having reference tables for each speciality, and the ability to access full guidance handbooks, will provide a sound foundation for decision-making in clinical settings.

There is also a hope that GDPs with a better understanding of the referral criteria will be less likely to perform 'economic referrals'. These allude to inappropriate referrals made in situations such as patients not being able to afford treatment, or the treatment patients require not being cost-effective for the referrer to provide.

Overall, GDPs need to be aware of their local Level 2 and Level 3 service providers. By doing this, they will be able to inform patients of where they may potentially receive treatment and can also contact these establishments to gain advice during uncertainty.

Ethics declaration

The authors declare no conflicts of interest.

Author contributions

Hannah Gorman and Kishan Patel discussed together the ideas for the article. Hannah Gorman drafted the initial manuscript with contributions from Kishan Patel. All authors revised draft versions of the manuscript and gave approval for the final version to be published.

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