County Durham and Darlington NHS
NHS Foundation Trust

Referral Guideline for Community Specialist Dental Service

Version 2

Date: February 2023

Referral Guideline for County Durham & Darlington Foundation Trust Community Specialist Dental Service

Introduction

The County Durham & Darlington Foundation Trust (CDDFT) Community Specialist Dental Service provides a Consultant-led Paediatric dental service and Specialist-led adult Special Care dental service.

This guide is intended to clarify the referral process and patient acceptance criteria for General Dental Practitioners (GDPs) and other health care professionals referring individuals to this service.

Exception to Referral Criteria

We would consider accepting patients who are outside our Referral Criteria but suitable for training and treatment by our Dental Core Trainees at the discretion of the Senior Clinicians.

Who Can Refer to the Dental Service?

Referrals are only accepted from:

- GDPs
- General Practitioners (GPs) and Hospital Specialists
- Health Care Professionals e.g. Social Services and Learning Disability Teams.

Self- referrals are **not** accepted.

For referrals from non-GDPs, it is advised that in the first instance patients should be directed to access dental care with a 'high street' dentist. These dental practitioners will be able to make a referral to the Community Specialist Dental Service where appropriate.

Referral forms for GDPs are in **Appendix 1**

Referral forms for all other Health & Social Care referrers are in **Appendix 2**

Addresses of the principle clinics to which referrals can be sent are in **Appendix 5** or referrals can be emailed to ***cddft.communitydental@nhs.net***

What Geographical Area does the Dental Service Cover?

The Community Specialist Dental Service is commissioned to provide dental care to patients living within the county boundaries of County Durham & Darlington. The patient's postcode **must** be within this geographical area and checked prior to referral.

Referrals are **not** accepted for patients who:

- live outside this area, but whose GP is located within County Durham & Darlington
- Patients requesting referral to this service who do not reside within County Durham & Darlington.

Referral Criteria for Adult Patients (> 16 years old)

Referrals are accepted for adults with a range of complex additional needs that seriously affect the provision of dental care. Patients accepted for treatment may receive a full course of treatment or certain elements of care (e.g. extractions) in conjunction with their GDP.

The referring GDP continues to be responsible for urgent dental care, preventative advice and recall, unless otherwise agreed by the Community Specialist Dental Service. The majority of adult patients will be seen on a shared-care basis with the GDP.

Category	Definition
Medically Compromised	Patients with severely unstable medical conditions which put the patient at significant risk of adverse events and require dental care within a hospital setting (e.g. uncontrolled epilepsy, unstable angina) Patients whose dental management requires close liaison with medical specialties, where this is not possible in primary care (e.g. patients with significant coagulopathies, patients receiving chemotherapy with acute dental problems).
Learning Disabilities/Cognitive Impairment	Patients with moderate/severe learning disabilities or neuro-degenerative conditions (e.g. advanced dementia) who are not compliant for dental treatment within primary care.
Physical/Mobility Problems	Patients with severe physical, neurological and/or movement disabilities (e.g. Cerebral Palsy) where treatment is not possible in primary care and require specialist facilities e.g. hoist, clinical holding
Mental Health	Patients with severe/uncontrolled mental health illness (e.g. patients hospitalised or sectioned for their mental health disorder) where treatment is not possible in primary care

Dental Anxiety	Severely dentally anxious patients with **unstable** ASA III or ASA IV medical conditions requiring anaesthetist led sedation and are unsuitable for Tier 1 or Tier 2 sedation services must include evidence of why treatment has not been provided. Please include completed MDAS form with referral **(Appendix 3)**

Referral Criteria for Paediatric Patients (<16 years old)

Referrals are accepted for paediatric patients with a range of complex additional needs or anxiety that seriously affect the provision of dental care. Children accepted for treatment may receive a full course of treatment or certain elements of care (e.g. extractions) in conjunction with their GDP.

The referring GDP continues to be responsible for urgent dental care, preventative advice and recall, unless directed by the Community Specialist Dental Service that the patient will be seen on a long-term basis. The majority of paediatric patients will be discharged back to the referring GDP after the completion of a discrete course of treatment.

Category	Definition
Medical Problems	Children with medical problems affecting the delivery of dental care requiring Consultant-led treatment planning.
Extensive Dental Decay	Young children under 5 years with early childhood caries unable to tolerate treatment under local anaesthetic and sedation. Children with multiple caries in 3 or more quadrants.
Social Problems/Looked After Children	Social problems requiring professional input. Referrers in these cases will be expected to be proactive in ensuring attendance.
Learning Disability/Autistic Spectrum Disorders	Children with a learning disability or autism where co-operation for dental examination and treatment is significantly compromised.
Anxiety/Phobia	Children with dental anxiety or phobia requiring treatment after failed attempts under Tier 1 and 2 sedation providers must include evidence of why

	treatment has not been provided Please include completed MDAS form with referral **(Appendix 3, 4)**
Mobility Problems	Children with significant physical disability requiring specialist facilities to gain access to dental services e.g. Hoist for transfer
Other Dental Conditions requiring Consultant-led Care	Developmental defects, dental anomalies, complex dental trauma, periodontal disease, soft tissue pathology

Referral Exclusion Criteria

To prevent inappropriate referral of patients to the Community Specialist Dental Service the following table illustrates patient referrals that do not fulfil the referral criteria and will be not be accepted for care.

Patient Category	Referral Exclusion Criteria
All Patients	**Out of Area Referrals**. Only patients living within the county boundaries of Durham & Darlington will be eligible for treatment
All Patients	**Inappropriate referrals,** including incomplete, illegible or insufficient information e.g. “see and treat”, failure to provide radiographs when this would be reasonably expected
All Patients	Patients whose needs could be met by a GDP Patients referred for volume of dental work required only
All Patients	Patients that the GDP has not described any attempt to carry out acclimatisation/stabilisation or treatment where appropriate
Adult Patients	Patients with **dental anxiety or phobia**, who are fit & healthy, have stable medical conditions (ASA I, II, stable ASA III) or mild learning disability.

	These referrals should be directed to the commissioned Tier 1 and Tier 2 sedation providers. Referrals for general anaesthetic for these patients will not be accepted. Tier 1 services accept a maximum BMI: 40 Tier 2 Services accept a maximum BMI: 42
Adult Patients	Patients with **complex but stable medical conditions/polypharmacy** which do not affect the provision of dentistry in primary care
Adult Patients	Extractions for patients taking **oral bisphosphonates**. Please refer to SDCEP Guidelines (March 2017) *"Oral Health Management of Patients at Risk of Medication-related Osteonecrosis of the Jaw"* for guidance.
Adult Patients	Patients taking **anticoagulants** unless other coagulopathies exist. Please refer to SDCEP Guidelines (August, 2015) *"Management of Dental Patients taking Anticoagulants or Antiplatelet drugs"* for guidance.
Adult Patients	**Domiciliary Dental Care**. All domiciliary referrals should be made to the commissioned Domiciliary dental provider who will refer to the Community Specialist Dental Service where appropriate.
Paediatric Patients	**Orthodontic Extractions.** It is normally expected that these would be carried out under local anaesthetic by the GDP and only referred in exceptional circumstances, when such treatment would not be feasible or appropriate. Referrals must include an orthodontic treatment plan and up to date radiographs. Orthodontic extractions are not provided under general anaesthesia.
Paediatric Patients	**Anxiety/Phobia.** Fit and healthy Patients requiring dental treatment who are dentally anxious should be referred to the locally Commissioned Tier 1 or 2 Sedation Services for treatment.

What Information should be Included on the Referral?
The referral forms must be fully completed with as much detail as possible to aid appropriate triage. Failure to fully complete the referral form may lead to rejection of the referral or delay patient treatment.

Radiographs
High quality radiographs should be provided for all referrals. If radiographs are not included it must be indicated why they have not been provided. Original film radiographs should be sent with the referral letter and digital radiographs should be sent on CD with the referral letter or emailed to our secure email address with the patient's name and date of birth.

Secure email address: ***cddft.communitydental@nhs.net***

Printed radiographs will only be accepted if they are high quality and diagnostic. Radiographs should be less than 12 months old. All non-digital films will be returned to the referring practitioners once treatment is complete.

NHS Charges
Patients referred to the Community Specialist Dental Service will receive NHS treatment and will be required to pay NHS charges unless they fulfil the exemption criteria.

Where Referrals Should Be Sent?
All referrals should be sent by post to one of our principle clinics **(Appendix 5)** or emailed to our secure email address (***cddft.communitydental@nhs.net***).

For referrals sent by post please ensure they are sent to the clinic address which is closest to the patient's place of residence. Patients should be advised that the clinic to which the referral is sent may not always be where treatment will be provided. **Appendix 6** has information of all clinical sites within the Service. If you are unsure where to send the referral please phone one of our clinics for advice.

Referral Process
Patient referrals will be triaged by an appropriate clinical member of staff. Following the triage process one of the following outcomes will result:

1. Acceptance of the referral and a new patient assessment appointment will be sent to the patient by post. The period of time that a patient will wait for an assessment appointment will be dependent on current waiting lists, but an appointment should be received within 18 weeks.

2. Rejection of the referral with written letter sent to the referrer to explain why the referral was not accepted.

3. Request of missing information from the referrer e.g. radiographs. An appointment will not be sent to the patient until this information is received.

Patient Journey

Following an assessment appointment patients meeting the referral criteria will receive a treatment plan and appropriate arrangements will be made to undertake their dental care. For some patients this treatment may be for certain elements of their care only e.g. extractions, which cannot be undertaken in primary care.

The referring dental practitioner will be expected to provide urgent dental care, preventative care and recall whilst the patient is on the waiting list and receiving dental treatment from the Community Specialist Dental Service.

Patients found not to fulfil the criteria of the Community Specialist Dental Service will be discharged with a written letter to the referrer with advice on where the patient may be more appropriately referred or with a treatment plan for their GDP to provide care.

Patients Who Fail To Attend Assessment Appointments

For all patients who fail to attend their assessment appointment:

- Written letter will be sent to the patient (with copy to the referrer) to notify them of their missed appointment.

- The patient will be given 2 weeks to contact the Community Specialist Dental Service to organise a further appointment.

- Should the appointment not be rearranged the patient will be discharged back to the original referrer. Safeguarding concerns will be managed in accordance with local policy.

- To re-refer the patient a new referral letter will be required.

Discharge Process

- The majority of patients will be referred back to the referring GDP for continuing care on completion of a course of treatment. A written discharge letter will be sent to all referring GDPs.

- For patients who cannot tolerate invasive dental treatment, or it is not appropriate within primary care due to the patient's medical status, a shared care approach will be adopted. Patients will be discharged with a letter back to their GDP once treatment has been completed for ongoing routine recall and prevention advice. As further treatment is required these patients can be referred back to the Community Specialist Dental Service.

- For patients with significantly severe complex needs that are unable to access continuing care through their GDP, they may be seen on a long term basis by the Community Specialist Dental Service. This would be clarified by letter to the referring practitioner that all ongoing dental care will be provided by the Community Specialist Dental Service.

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Appendix 1: Community Specialist Dental Service Referral Form
Referral from: GENERAL DENTAL PRACTITIONER (GDP)

Please check our **Referral Guidelines** to ensure the referral is appropriate for the remit of our service. Complete the form in full as failure to do so will delay the referral process. Send by email: cddft.communitydental@nhs.net or post to the clinic nearest to patient's postal address.

❑ **Adult Patient Referral** ❑ **Child (15 years and under) Patient Referral**

Patients Details Surname: First Name: Date of Birth: Sex: M / F Address: Postcode: Contact Tel:	
Dental Practice Address	**Referring Dentist Name:** **GDC No:** Practice Tel. No: Date:

Carer Details (if applicable) Parent/Guardian/Carer: Contact No: Relationship to patient:	
General Medical Practitioner Name: Contact No: Address:	

Reason for Referral - details must be provided for all that apply

❑ Complex/unstable medical condition (provide full details in medical history section)

❑ Learning Disability/Autism/Cognitive impairment, details:

❑ Physical/Mobility issues, details:

❑ Mental Health problems, details:

❑ Dental Anxiety/problems with co-operation* details:

***(Ensure does not meet Tier 1 or 2 Sedation criteria and include evidence of why treatment has not been provided and a completed MDAS form.)**

❑ Looked after child/social problems, details:

❑ Other, please specify:

Further Information (complete all sections):
Known history of dependency drugs/alcohol No ❑ Yes ❑ **Details:**

Interpreter required Yes ❑ **Language:** **Patient Height:** **Weight:**

Known history of challenging/violent/intimidating or inappropriate behaviours No ❑ Yes ❑
Details:

(If **'Yes'** please notify patient/carers that they will be contacted to complete risk assessment prior to first appointment)

Has the patient previously had treatment within our Dental Service? No ❑ Yes ❑

If Yes, please give date: Clinic

Is the patient suffering dental pain?
No ❑ Yes- mild/intermittent ❑ Yes-severe/continuous ❑

Have antibiotics been required?
No ❑ Yes ❑ number courses:.....

Medical History **(please provide information of all medical conditions, attach separately if required)**

Prescribed Medications:

Known Allergies No ❑ Yes ❑ details:.....

Details of Patient Co-operation
Has a dental examination been possible with the patient lying supine? No ❑ Yes ❑

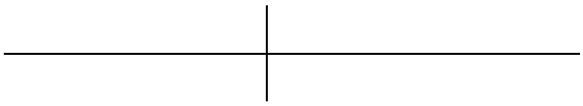
Please state what treatment has been undertaken/attempted: …….....

Which aspects of treatment is the patient unable to tolerate?
❑ Air/water/suction ❑ Sensation of instruments ❑ Local Anaesthetic ❑ X-rays

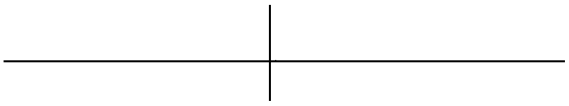
❑ Other, details:

Suggested Treatment Plan

Teeth for extraction:



Teeth for restoration:



Other Treatment:.....

Radiographs must be included for all teeth requiring treatment, be less than 12 months old and diagnostic quality. Please attach or email to cddft.communitydental@nhs.net

For children bitewings should accompany each referral, also an OPG if patient is in mixed dentition.

If radiographs are not available, why was this not possible?.....

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Appendix 2: Community Specialist Dental Service Referral Form

Referral from: OTHER HEALTH or SOCIAL CARE PROFESSIONALS

Please refer to our **Referral Guidelines** to ensure the referral is appropriate for the remit of our service. Complete the form in full as failure to do so will delay the referral process. Send by email: cddft.communitydental@nhs.net or post to the clinic nearest to patient's postal address.

❑ **Adult Patient Referral** ❑ **Child (15 years and under) Patient Referral**

Patients Details
Surname: First Name:

Date of Birth: Sex: M / F

Address:

Postcode: Contact Tel:

Carer Details (if applicable)
Parent/Guardian/Carer:

Contact No: Relationship to patient:

General Medical Practitioner
Name: Contact No:

Address:

Reason for Referral - details must be provided for all that apply

❑ Complex/unstable medical condition (please attach full medical history)

❑ Learning Disability/Autism/Cognitive impairment, details:

❑ Physical/Mobility issues, details:

❑ Mental Health problems, details:

❑ Dental Anxiety/problems with co-operation, details:

❑ Looked after child/social problems, details:

❑ Other, please specify:

Further Information (complete all sections):
Known history of dependency drugs/alcohol No ❑ Yes ❑ **Details:**

Interpreter required Yes ❑ **Language** **Patient Height:** **Weight:**

Known history of challenging/violent/intimidating or inappropriate behaviours Yes❑ No ❑

Details:

(If **'Yes'** please notify patient/carers that they will be contacted to complete risk assessment prior to first appointment)

Care Coordinator's Details

Name Contact Tel:

Email:

Address:

Social Worker Details (if applicable) Name: Tel:

Next of Kin Details (if applicable) Name: Tel:

Does the patient have any dental/oral pain?

❑ Yes-severe/continuous ❑ Yes-mild intermittent ❑ No ❑ Don't know

Tolerance/Co-operation Problems
Are there any aspects of a dental appointment which the patient may be unable to tolerate or find distressing, resulting in unusual or challenging behaviour?

❑ Loud noises ❑ Bright lighting ❑ Smells tastes or textures ❑ Being touched

❑ Movement of dental chair ❑ Prolonged waiting

❑ Other (please state):

Attachments Required

❑ Full Medical History, including medication and known allergies

❑ Behaviour Plan (if applicable)

❑ Disability Distress Assessment Tool (if applicable)

Referring Health, Social Care or Educational Professional

Name: Job Title:

Email:

Address:

Contact Number: Date:

Appendix 3

Modified Dental Anxiety Score Questionnaire

To be completed for all patients >12 years old referred with dental anxiety and include with referral letter.

CAN YOU TELL US HOW ANXIOUS YOU GET, IF AT ALL, WITH YOUR DENTAL VISIT?

PLEASE INDICATE BY INSERTING 'X' IN THE APPROPRIATE BOX

1. **If you went to your Dentist for TREATMENT TOMORROW, how would you feel?**

   Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

2. **If you were sitting in the WAITING ROOM (waiting for treatment), how would you feel?**

   Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

3. **If you were about to have a TOOTH DRILLED, how would you feel?**

   Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

4. **If you were about to have your TEETH SCALED AND POLISHED, how would you feel?**

   Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

5. **If you were about to have a LOCAL ANAESTHETIC INJECTION in your gum, above an upper back tooth, how would you feel?**

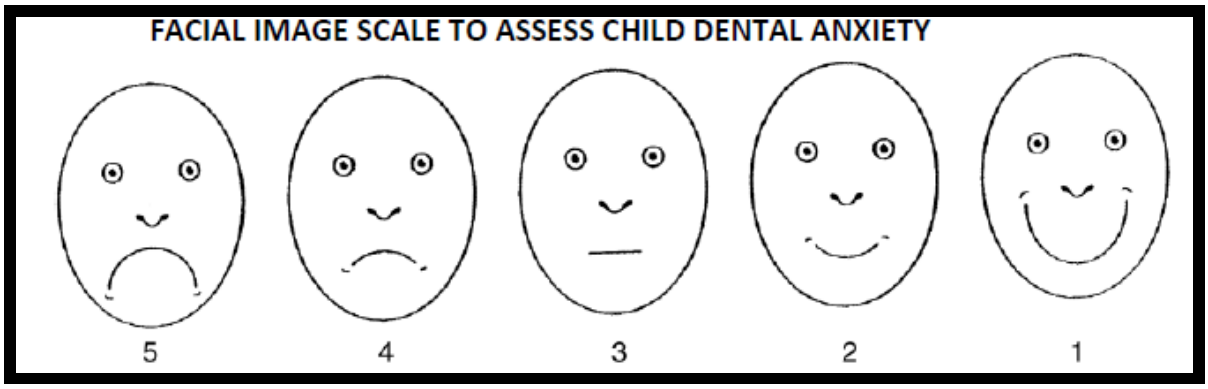
   Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

Appendix 4

Modified Dental Anxiety Score Questionnaire
For Children

To be completed by children <12years old referred with dental anxiety.

Please ask the child to point to the picture that best represents how they feel about receiving dental treatment. Circle the image selected and include completed form with patient referral



Appendix 5

Principle Clinic Addresses for Patient Referral Letters

Please send referral letter to the closest principle clinic to the patient's home address.

Bishop Auckland
Dental Department - 2nd Floor
Bishop Auckland Hospital
Cockton Hill Road
BISHOP AUCKLAND
DL14 6AD

Tel: 01388 455767

Stanley
Dental Department
Stanley Primary Care Centre
Clifford Road
STANLEY
DH9 0AB

Tel: 01207 285565

Chester Le Street
Dental Department
Chester le Street Community Hospital
Front Street
Chester Le Street
DH3 3AT

Tel: 0191 3876305

Darlington
Dental Department
Park Place Health Centre
DARLINGTON
DL1 5LW

Tel: 01325 342150

Appendix 6

All Community Specialist Dental Service Clinic Sites

****Please only send referrals to the principle clinics listed in Appendix 5****

Bishop Auckland
Dental Department - 2nd Floor
Bishop Auckland Hospital
Cockton Hill Road
BISHOP AUCKLAND
DL14 6AD

Tel: 01388 455767

Stanley
Dental Department
Stanley Primary Care Centre
Clifford Road
STANLEY
DH9 0AB

Tel: 01207 285565

Darlington
Dental Department
Park Place Health Centre
DARLINGTON
DL1 5LW

Tel: 01325 342150

Barnard Castle
Dental Department
Richardson Community Hospital
Victoria Road
Barnard Castle
DL12 8HW

Tel: 01833 696586

University Hospital North Durham
Dental Department
University Hospital North Durham
North Road
Durham
DH1 5TW

Tel: 01207 285565

Chester Le Street
Dental Department
Chester le Street Community Hospital
Front Street
Chester Le Street
DH3 3AT

Tel: 0191 3876305

Chester Le Street
Dental Department
Chester le Street Community Hospital
Front Street
Chester Le Street
DH3 3AT

Tel: 0191 3876305

General Anaesthesia provided:

University Hospital North Durham

Darlington Memorial Hospital

Bishop Auckland Hospital (children only)