Dental Public Health

Rapid Review of Dental Referral Systems

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To describe various dental referral systems in place to inform planning of dental referral systems in Wales

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Contents

1 Introduction

The National Health Service (NHS) is facing substantial increases in activity, costs and demand for secondary care services at a time when resources are strained and there is pressure on the organisation to make savings (NIHR SDO 2011). Evidence has shown that there is still a considerable volume of inappropriate referrals being made; referral letters may lack sufficient content, may be directed to an inappropriate destination or may result from professionally-induced demand rather than being based on accepted clinical guidance. The recent increases in the number of referrals from primary to secondary care, with demand outstripping supply, has become a concern and there has been growing interest in managing this problem (Davies and Elwyn 2006).

In addition, there have been reports of patient care incidents in the NHS which have been attributed to systematic failures and poor communication between clinicians, patients and their families. Investigations into these failures have recommended that there needs to be better sharing of information between clinicians and improved communication with patients, so that they are able to become more actively involved in their care (Jones 2012; Francis 2013).

The system for managing referrals has therefore been targeted as an area where there is scope for improving patient safety, quality of care and achieving a more cost-effective use of healthcare resources.

The purpose of the project is to examine the various dental referral systems and gain clinicians' and managerial perspectives on the existing referral systems in place in wales.

2 Literature review on dental referrals

A literature review, using the Ovid via Medline database, was conducted. The search was limited to papers published from 1996 to 2014. Studies which focused on the appropriateness of dental referrals or evaluated referrals systems were reviewed.

The majority of the dental literature focused on the quality of referrals rather than evaluating the existing referral systems. The literature review did not identify any published cost-benefit analyses of the various dental referral systems.

2.1 Referral appropriateness

There is a substantial body of evidence that the quality of dental referrals tends to be variable and usually poor when compared to accepted clinical guidelines. Foley et al. (2001) and DeAngelis (2010) concluded that clinical details relating to the patient's medical history were the most common deficiencies identified. Smart (1999) and Eaton (2001) identified the poorest referral behaviour amongst non-UK qualified practitioners and those General Dental Practitioners (GDPs) who had been qualified for more than 20 years. Foley et al. (2001) and Hasan and Nute (2006) concluded that GDPs needed to be better at assessing patient need before certain referrals are made.

Linden (1998) concluded that non-disease factors, such as accessibility to specialist services and the extent of postgraduate training of GDPs, have a powerful influence on the decision to refer. Coulthard (2000) supported these findings; he concluded that practitioners who had undergone some oral surgery postgraduate training were more likely to undertake more surgery in their practices, but also to refer more patients to specialist care.

2.2 Referral Guidelines and Proformas

Referral guidelines and structured referral proformas are examples of initiatives that are implemented in primary care to try and improve the appropriateness of referrals.

2.2.1 Evidence base

There is evidence that the distribution of guidelines to GDPs alone has minimal impact, if any, on the appropriateness of referrals. Indeed, Hasan and Nute (2006) showed that this initiative significantly increased professionally-induced demand for referrals, perhaps by raising awareness of certain conditions. However, Worrall (2001) concluded that guidelines

may be effective at reducing waiting lists when combined with other strategies, such as feedback from specialists.

Studies have consistently shown that proforma-based referral systems are the most effective method of improving the quality of referrals from all GDPs. Patel et al. (2011) concluded that proformas improve the efficiency of triage which may mean more successful treatment outcomes for patients, particularly those with suspected cancer. Smart (1999) showed that they are particularly beneficial for non-UK qualified practitioners and for those GDPs who have been qualified for over 20 years. By incorporating an indicator of patient need within referral proforma, Goodwin et al. (2012) showed that referral appropriateness and patient attendance rates at secondary care appointments may be improved. However, Patel et al. (2011) warned that there are risks that proformas are overused and sometimes abused by GDPs in order to get their patients seen.

The conclusions on dental referrals made above are also supported by a considerable volume of studies within the wider medical literature, detailed in a systematic review by Imison and Naylor (2010):

- Passive distribution of guidelines has only short term limited impact, if any at all (Hill et al 2000; Idiculla et al 2000; Wright et al 2006; Akbari et al 2008).

- Structured referral proformas and guidelines, in conjunction with active feedback, are particularly effective at improving the quality of referrals (Kerry et al 2000; Bennett et al 2001; Lucassen et al 2001; Navarro et al 2002; Griffiths et al 2006; Jiwa et al 2006; Kourkouta and Darbar 2006; Wight et al 2006; Junghans et al 2007; McRobbie et al 2008).

2.2.2 Advantages and disadvantages

Can increase the likelihood of practitioners referring when necessary	Minimal impact on referral behaviour (unless supported by feedback from secondary care)
Can improve the quality of referral letters	
Can increase the likelihood of practitioners directing referrals to the most appropriate setting	
Ease of implementation	

(Adapted from Imison and Naylor 2010)

2.3 Referral Guidelines, Care pathways and Feedback

Peer review and feedback from hospital specialists aim to improve the compliance with local referral pathways and guidelines to ensure that general practitioners refer appropriately and with greater consistency.

2.3.1 Evidence base

Research from other countries, such as the Health Maintenance Organisation in the US, has emphasised that demand for secondary care cannot be effectively controlled by just altering mechanisms in primary care alone (Ham 2010).

A high-quality systematic review of the medical literature identified a considerable volume of evidence that active feedback, from both peers and hospital specialists, provides an effective educational tool to improve referral quality and is often welcomed by general practitioners (Imison and Naylor 2010). Indeed, Evans (2009) showed that weekly practice-level referral review meetings and six-weekly cluster meetings with consultants achieved a 30% reduction in hospital referrals, with patients being directed to community-based services instead.

An alternative to integrating feedback within the referral system itself is to organise "ad hoc" training for primary care practitioners, such as outreach visits or workshops led by specialists. Akbari (2008) showed that these initiatives had some effectiveness as they provide an opportunity for clinicians to discuss the secondary care services available, local referral pathways and referral letter content.

2.3.2 Advantages and disadvantages

Can increase the likelihood of practitioners referring when necessary	Might not always be effective at changing practitioner referral behaviour
Can improve the quality of referral letters	
Can increase the likelihood of practitioners directing referrals to the most appropriate setting	

(Adapted from Imison and Naylor 2010)

2.4 Referral Management Centres

Referral management centres (RMCs) have the greatest intervention in the referral process and fulfil three potential roles: to count and monitor referrals, to assess their quality and nature, and to redirect or block inappropriate referrals (Davies and Elwyn 2006).

2.4.1 Evidence base

The introduction of RMCs has been controversial since formal evaluations of their impact are scarce (Imison and Naylor 2010). There must be caution when interpreting research carried out in England, since market incentives and interventions to encourage competition between providers, such as "Choose and Book", do not exist in Wales (CRG Research/Cardiff University 2007).

A limited review by CRG research/Cardiff University (2007) showed RMCs may have some benefit in terms of capturing valuable data that can be used to inform local health plans and for commissioning services. O'Neill et al. (2012) provided some evidence that clinically–led referral management systems can work well at selecting patients for intermediate services, delivered in primary care, thereby reducing the number of referrals to hospitals. RMCs could help to divert patients to services that are under-used or more cost-effective, such as to practitioners with special interests (Salisbury et al. 2005) or community-based services (Akbari 2008).

However there are concerns with RMCs. Some authors feel that if RMCs decide if and where patients are referred, the practitioners' expertise to act as a referral agent is undermined and patients may worry about a lack of choice of care provider (Imison and Naylor 2010). Unless RMCs provide "new intelligence" on how to undertake work more efficiently, more cost effectively and with greater convenience for patients, long term they may merely impose an extra burden on resources with no real benefit apart from counting activities (CRG Research/Cardiff University 2007).

Some health boards in Wales felt that the associated costs of establishing and rolling out RMCs was disproportionate unless specific problems with referral quality were identified (CRG Research/Cardiff University 2007). Scottish Executive (2007) outlined that RMCs must be clinically-led otherwise they will not add anything to the patient journey and will become purely a mechanism to manage demand.

2.4.2 Example: Dental Referral Management Service (DRMS), Greater Manchester

In Greater Manchester, a new web-based referral management system, involving consultant-led triage, was implemented in 2012 in response to exponential increases of referrals from primary care. Each referral received is assigned a Unique Reference Number (URN) to ensure confidential patient details are not shared with the triager and to allow both patient and GDP to track the progress of the referral through a website. Initially, administrative staff check each referral for compliance to an agreed protocol and ensure a minimum dataset is achieved, otherwise the referral is returned. Then each referral is sent for consultant triage where case complexity is assessed against an agreed protocol and then triaged into the appropriate banding; appropriate for GDP (level 1), appropriate for specialist practice (level 2) or appropriate for hospital care (level 3). The patient is then offered a choice of care provider. Once the process is completed, the outcome of each referral is sent to the patient, referrer and care provider.

Anecdotally, it is estimated that the standard of referrals has improved dramatically. In addition, Pretty (2012) claims that there has been diversion of a considerable number of referrals into primary care settings; 58% of oral surgery referrals were identified as being suitable for primary care in the first 3 months, 33% identified as such from 4th month. This has led to overall savings of approximately £250,000 per month on average in Greater Manchester. Primary care managers are able to identify GDPs who consistently refer inappropriately to remind them of their contractual obligations or organise mandatory training to improve their clinical skills. In addition, data on patient need, which has been previously difficult to obtain, can now be used to inform commissioning of services. Patients like the ability to track their referral and are reassured that a consultant has assessed it.

There are a number of risks that need to be appreciated. DRMS has an additional cost of £8 per referral handled (£35,000 per month in total) so once care pathways are working and referral behaviour improves, GDPs will earn autonomy for their referrals and the need for DRMS reduces. Therefore DRMS may work best as a transitional measure.

In addition those involved with the project have great concerns that RMCs, which are not part of complete end-to-end system redesign and do not involve consultant-led triage, will have huge disadvantages. These RMCs will have limited impact on reducing inappropriate referrals, will introduce the risk that patients may not be directed to the correct level of care and may destabilise the learning opportunities for trainees working in secondary care facilities.

2.4.3 Advantages and disadvantages

Can filter out inappropriate referrals	May increase overall costs
Can direct referrals to the most appropriate setting	May return referrals to practitioners when the referral is, in fact, needed
Can improve the quality of referrals	May delay patients being seen by specialists or referrals may be lost in the system (in the absence of robust governance)
Can develop a body of expertise and guidance about local services	May misdirect referrals to an appropriate specialist (at the behest of the RMC)
Can provide evidence to support commissioning decisions	May create a barrier to closer working between practitioners and consultants
	May demotivate local practitioners
	Concerns that referring to RMCs may breach patient confidentiality

(Adapted from Imison and Naylor 2010 and Old 2013)

3 Comments on the current dental referral systems in Wales

Various clinical and managerial stakeholders were contacted by email, telephone interview and in person to provide their perspective on the current dental referral systems in Wales. The aim was to attain local flavour of the dental referral systems in place.

3.1 Perspective of Primary Care Referrers

- There was a concern that existing referral systems can act as barriers in complying with General Dental Council Standards; especially Standards 6.5 and 2.3.11 (GDC 2013).

- Primary care practitioners generally accept the implementation of referral proformas. This method provides them with guidance on content required for referral to secondary care or specialist services. However, they generally take longer to complete.

- While some specialist practices in primary care are very good at keeping referrers informed, the quality of correspondence from secondary care varies between hospitals and even between departments at the same hospital. Generally there is often no acknowledgement of the referral being received and no indication of the waiting time for the patient to be assessed and/or treated. The importance of this communication is highlighted when the patient's care is affected by referrals lost in the post or the secondary care system.

- The majority of GDPs have never had any feedback on the quality of their referrals from a secondary care specialist or consultant. This issue has been discussed in one of the LDCs in South Wales with the view of improving the quality and appropriateness of referrals.

- The establishment of a RMC in a Health Board has led to some referrals being more difficult to organise and has acted as a barrier to urgent non-cancer referrals, such as for the management of a fractured tuberosity or an oro-antral communication. These conditions have reduced morbidity, reduced healthcare costs and better outcomes for patients if they are treated at an early stage.

- As a result of the current dental contract, there are problems with patient flow and the present system does not work in the patient's favour. Primary care practitioners feel that patients are being bounced back and forth between primary and secondary care; GDPs feeling their patient's treatment needs are too advanced,

consultants or specialists feeling the patient's needs are insufficient to qualify for advanced care. There is a lack of intermediate services available to meet this need.

- Primary care dental practitioners also report that there is inequity in dental service provision, especially specialist or consultant services between Health Boards. Dental practitioners face difficulties explaining to patients when specialist services are not available locally and there are not any agreed regional care pathways. This is exacerbated by a lack of accessible information about the availability of services locally, regionally and nationally.

- Primary care dental practitioners feel that secondary care providers, similar to dental practices, should produce detailed information about the service provision, the specific services available and clear criteria for acceptance of referrals. This will help GDPs to correctly refer patients to the most suitable provider. Health Boards should publish this information on their website for referring practitioners and patients should have access to the same information from various locations or media.

3.2 Perspective of Secondary Care providers

- Secondary care specialists and consultants feel that the traditional system using referral letters is not working. They receive large numbers of inappropriate and poor quality referrals; often there is a complete lack of dental, medical and surgical information, the reason for referral is not always included, or the referrer does not state why the case is unsuitable for treatment within primary care. In addition, some general dental practitioners ignore published guidelines such as the management of patients taking warfarin or early referrals for orthodontic treatments.

- In secondary care units where structured referral forms are used, feedback is universally positive and there is greater satisfaction with the referral system in place. Referrals have a standardised, logical layout so they are clearer to read and more efficiently triaged. They take the referrer through steps so the referral is far more likely to have important details included and, in conjunction with acceptance criteria, make the practitioner think more about the referral. Subsequently the quality of the referrals has improved but this does not necessarily mean that they are always appropriate or valid. As a consequence of this system, orthodontic patient bases mainly consist of complex cases that should be treated in secondary care.

- In units, which are linked to a RMC, there is dissatisfaction that the system is not working effectively. Clinicians feel that the RMC can manage routine cases satisfactorily but complex cases need more

professional support. It is felt that the RMC lacks robust protocols and has acted as a barrier to certain urgent non-cancer referrals. In addition, the dispersal of referrals is currently determined by available capacity so the opportunity to offer patient choice does not exist. Secondary care consultants and specialists feel that if RMCs are set up without professional input, robust criteria and clear guidance, there will be misunderstandings amongst patients and clinicians that can adversely affect patient care and experience.

- Consultants and specialists in secondary care have to spend a considerable time dealing with inappropriate referrals. Inappropriate referrals are usually returned to practitioners with an explanatory letter. Sometimes the referrer is contacted by telephone to clarify certain points or occasionally primary care advisors are contacted to highlight consistent poor referral performance of some practitioners. OMFS consultants have noted high numbers of inappropriate referrals from non-UK qualified GDPs with insufficient training and competency in oral surgery. Advisory letters to their employers have had little impact.

- The use of referral proforma across the secondary care specialities is variable. Consultants and specialists recognise that there is inconsistency in availability and quality of information concerning secondary care services and pathways for referral. They feel that this needs to be reviewed and a robust implementation and monitoring plan needs to be developed. A lack of robust monitoring of compliance with the referral system will result in GDPs 'ticking boxes' on the form to get their patient seen in secondary care. Without a monitoring and enforcement system in place, the effectiveness of a proforma-based referral system may be limited. Referrals also need to accurately identify patient need and their level of urgency.

- Consultants and specialists feel that additional resources will be required to meet the demand for intermediate care. Some of the resources for these intermediate services could be sourced from improved contracting. Many advanced dental services could be delivered by specialists and Dentists with Enhanced Skills (DES) based in primary care. However, the system should monitor clinical outcomes to ensure that safe and quality treatment is being delivered.

3.3 Perspective of Health Boards' Primary Care managers

- Primary care managers report that they are aware of anecdotal evidence of inappropriate referrals from consultants in secondary care. They feel that guidelines and referral templates are issued on an "ad hoc" basis and there seems to be confusion within the GDS providers about the availability and location of specialist treatment services. Some LHBs plan to distribute packs of guidelines for all dental specialties to practices during January 2014.
- Primary care managers feel that secondary care specialists and consultants need to improve their enforcement on the use of referral proformas and 'bounce back' all referrals that do not contain a minimum standard of information.
- Primary care managers are aware of many patient cases where GDPs feel that their management is outside the scope of the GDS services but consultants do not think the same cases are sufficiently complex for referral into secondary care specialist services.
- Primary care managers feel that intermediate services will need to be developed in primary care. The availability of resources for secondary care or specialist dental services varies between health boards and is based on historical service provision rather than need or equity. Within Health Boards, there is disagreement between the GDS providers/Local Dental Committees and secondary care about the source of funding for these services. A lack of integrated dental planning seems to be a barrier for the development of intermediate services within Health Boards and specialist services at a regional level.
- Primary care managers feel that all Health Boards should have a "single dental team" to deal with all issues in relation to dentistry. Currently there is a risk of patients being lost in the system and GDPs being disenchanted with the specialist care waiting time for their patients.
- A full cost benefit analysis should be carried out before setting up specialist services in rural/remote areas where there may not be economy of scale for provision of sustainable specialist services.

- The RMC in Hywel Dda was established to ensure that referrals into specialist services were being recorded; audit trails created and activity reporting enabled to aid future service planning. At present, it undertakes its simplistic role of collating and recording information very well. From the management perspective, the RMC provides a single point of contact which is of great benefit to all stakeholders. It also provides some sort of continuity for access to specialist services when there is change in provider or the service is being relocated. The lack of clear patient pathways in the wider dental services will hopefully be resolved when the RMC collects sufficient data to inform future service planning.
- Primary care managers feel that RMCs provide valuable information for service planning and the implementation of new care pathways. They suggested that RMCs could be replaced with appropriately commissioned services if these were provided with a robust data collection system and employed agreed criteria for managing referrals.

4 Patient perspective on referrals and involvement in the system

When considering the various approaches to referral management, it is essential to consider the patient perspective on the process to ensure any initiatives introduced have a positive impact on their experience and outcomes.

The Robert Powell Investigation (Jones 2012) concluded that the ultimate objective of an effective referral system must be to ensure that "patients receive the appropriate treatment at the appropriate time". In addition, both the Robert Powell Investigation and the Francis Report recommended improvements in communication and sharing of information during the referral process to ensure that patients are kept fully informed and involved with their care. Implementing changes to achieve these recommendations should therefore improve the quality of the patient experience and minimise the risk of past failures reoccurring within the health service (Jones 2012 and Francis 2013).

4.1 Copying the referral letter to the patient

One option to improve patient involvement in the referral process would be to give the patient a copy of their referral so that they are fully aware of:

- the reasons for the referral
- which provider they have been referred to
- whether it is for second advice, treatment planning or treatment.
- the intended outcome of the referral.

Clinicians should also explain to patients what they need to do if they do not hear from secondary/specialist services within an expected timeframe.

Copying the referral letter to the patient would minimise risks of failure that were evident in the Robert Powell Investigation; it would act as a safeguard should there be any breaks in the continuation of patient care or if the referral was lost from the system. This should also facilitate improved communication between the clinician and patient. The patient's copy would provide some sort of evidence that decision to refer was discussed, the patient consented for the referral and would help the patient recall points about their condition that were discussed at the point of referral. As such, copying the referral letter to the patient is recommended in good practice guidelines issued by the Department of Health (DoH 2003).

Providing a patient with a copy of their referral letter may also have some potential disadvantages. Firstly, there may be issues relating to the patient's reaction to information included in the referral letter. For example a referral for a suspicious lesion (suspected cancer) or the inclusion of sensitive medical history details, may arouse unnecessary concern or anxiety in patients while they wait to see a consultant/specialist. There is also a risk of confidentiality being compromised should the patient lose the copy of their referral letter or it is accidentally seen by a third party outside of the clinical environment. The DoH guidelines (2003) state that giving bad news to a patient is not in itself a reason to justify not copying a letter and there should be no new information in a letter that might surprise or distress the patient. In addition, they state that it should be up to the patient to decide whether they would like to receive a copy of the letter. Therefore, it must be ensured that there is an effective discussion with the patient before a referral is made and a copy of the letter should be offered to the patient.

4.2 Patient involvement at the point of referral

One initiative to encourage greater patient involvement in the referral process is to involve them at the point of referral by having them complete a section of the referral form. Coulthard et al. (2011) undertook development of a referral form for sedation that included a section for the patient to complete themselves. This involves the service user in the decision to refer and facilitates an opportunity for expressed need to be recorded and communicated to the secondary care provider rather than solely professionally-induced demand for the referral. Pretty (2012) reported that there is a need to expand this approach into an integrated referral management system.

One further approach would be to include a section where the patient could express their desired outcome from the referral. This would ensure patient expressed demand for the referral rather than just professionally-induced demand and it may exclude those that are not motivated to attend for further treatment. Perhaps this selection approach may lead to better attendance rates at secondary care clinics and improved compliance with treatment in the future. This approach should help to reduce pressure on long waiting lists and improve the efficiency of secondary care. However, such a system should ensure that vulnerable patients are not disadvantaged by their lack of capacity to fully understand the information and complete the patient section of the referral proforma.

4.3 Patient expectations

At the point of referral, a patient may expect that a certain treatment will be provided by a specialist. If this expectation is not met by the

secondary care service, the patient will be confused, dissatisfied and frustrated. This may adversely affect their relationship with their GDP.

The current NHS dental system lacks clarity and tranparency. From the patient perspective, it is unclear and confusing what dental treatments they can get from NHS dentistry. The concept of providing "all treatment that is clinically necessary" (NHS choices 2014) is not always realistic due to limited resources. Providers are not transparent about the care they can offer. Currently there are geographical variations in the availability of specialist and secondary care services: for example access to specialist restorative dentistry, conscious sedation and adult orthodontic services. These barriers to care adversely affect the relationship of trust between patient and the profession and the wider NHS.

It is, therefore, important that there is national agreement on what dental services are available in the NHS. This should be followed by the development of local/regional/national patient care pathways for the provision of specialist services, including tertiary dental care, to reduce service inequity. Referral systems developed to implement agreed care pathways are more transparent and robust and are likely to meet patients' and professional expectations.

4.4 Waiting times

Waiting times for advanced care are usually held within the professional domain and patients are often unaware of the waiting times for specialist advice and/or treatment. Even referring GDPs are often unaware of waiting times for various specialist treatments. The Managed Clinical Network in Orthodontics in South Wales has started providing waiting time information to referring practitioners. Provision of live waiting time information to both patients and referring primary care practitioners could be made available via various media such as the Health Board's website.

4.5 Choice of care provider

There is evidence in the literature that the majority of patients wish to have a choice of their secondary care provider even within local areas. Although patients feel quality is an important factor to inform choice, few consult official performance reports. Most rely on their own past experience or advice from their general practitioners to guide their decisions. In addition, low levels of discontent were observed when patients were not offered choice (Robertson and Dixon 2009).

These findings suggest that for a patient choice system to work, patients need to be health literate. They need to be given sufficient information to improve their understanding of healthcare standards, ratings and be encouraged to use available resources to inform their decisions. "Choose

and book" and practice-based commissioning are still under development in England and it is envisaged that if patients switch to higher quality providers, this will drive improvements in the overall quality of care (Department of Health 2004). However, these market interventions do not exist in Wales and the ability to offer patients a choice of provider is currently limited.

5 Conclusions

There are general feelings of dissatisfaction with current dental referral systems in Wales. At one end, the traditional method of using referral letters, with or without clinical guidelines, to make a referral to specialist or secondary care services seems to be a prevalent mechanism. Such a referral system is ineffective and there seems to be consensus that this should not continue. At the other end, Referral Management Centres (RMCs) have been introduced in Wales and local clinicians have reservations about this system. There is only limited published evidence concerning the benefits of RMCs. Anecdotal reports from England show RMCs that have been introduced in conjunction with a whole system redesign and consultant-led triage can achieve some benefits in terms of a single point of access for all referrals, an initial reduction in the number of inappropriate referrals and the ability to obtain valuable data to aid future service planning. However, it is clear that RMCs established on an "ad hoc" basis are not effective and require additional resources.

Structured referral proformas and guidelines, in conjunction with active feedback, have the strongest evidence base and are proven to be effective at reducing inappropriate referrals. Anecdotal evidence suggests that this approach has the greatest satisfaction amongst all professional stakeholders and seems to be working the best in Wales.

Wider issues within NHS dentistry are causing an increasing number of inappropriate referrals to secondary care services. Many factors contributing towards inefficient referral systems were mentioned by stakeholders such as the nature of the current GDS contracts, a lack of intermediate services, the competency framework of new graduates and non-UK dentists, a lack of systematic monitoring and feedback on inappropriate referrals, a lack of good quality information available to referring practitioners and a lack of meaningful patient involvement in referrals.

At a national level, there is lack of clarity on the availability of types of dental treatments in the NHS. The distribution of specialist services in Wales is not equitable and seems to be based on historical service provision. At a local and regional level, there seems to be lack of agreed care pathways in place for the provision of many specialist

dental treatments. Referral systems that are set up without agreed local and regional care pathways are unlikely to benefit patients.

6 Recommendations

- Health Boards should work locally with professionals and patient advocates to agree local and regional dental care pathways prior to setting up a referral management system. The development of intermediate dental services seems vital to ensure patients are provided the right care in the right place by the most appropriate clinicians. Regional Management Clinical Networks could be established and supported to facilitate development of regional care pathways for specialist services.
- Reduction in inequity in provision and utilisation of specialist services between and within health boards should be considered in establishing care pathways and specialist service developments.
- A system utilising structured referral proformas, criteria and guidelines, in conjunction with active systematic feedback to referring GDPs, is likely to be the most effective way to improve the quality of referrals in Wales. There needs to be monitoring and stricter enforcement of existing referral protocols for this system to become more effective and referral behaviour to change.
- Referral Management Centres (RMCs) should not be established without a cost benefit analysis, a communication plan and local stakeholder engagement. They should be closely monitored and evaluated to ensure patients are not disadvantaged because of the RMC.
- General Dental Practices should set up a system within their practice so that they can monitor and review the patients who are or were in the 'Referral System'. This system should be robust to monitor the patients who have been referred for suspected malignancies and urgent specialist advice/care.
- Information about intermediate, specialist, secondary and tertiary care services should be readily available to patients and referring practitioners.
- Patients and/or their carers should be involved and well informed about their referrals, waiting time involved and who to contact to receive updates on their referrals.

- The Welsh Government should consider clarifying the types of specialist or complex dental treatments that are available within NHS. The proposed introduction of a new dental contract provides an opportunity for greater clarity and transparency within the NHS dental system. This will reduce confusion amongst the public and professionals. This will also help Health Boards and its stakeholders to establish care pathways at regional and local level.

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