Kent Surrey Sussex Advanced Restorative Pathway 2023

Referral criteria

Clinical requirements

The Advanced Restorative pathway is for patients registered with a General Medical Practitioner in Kent, Surrey and Sussex

The Advanced Restorative pathway is concerned with Periodontal, Endodontic and Prosthodontic treatments in line with the Commissioning guide levels 2 and 3.

The services are provided by consultants, specialists or dentists accredited by NHS England for each of the specialties falling within the remit of Restorative treatment.

The pathway refers to the NHS Commissioning standard for Restorative Dentistry, version 2, October 2022. The Commissioning standard also details the nature of treatment to be provided in primary care, mandatory services setting.

Contents

After reading the referral criteria below, for any further queries please contact either your dental adviser or the dental contracts team by email at England.southeastdental@nhs.net

Patient identifiable data such as names, dob etc should only be sent from one nhs.net email address to another nhs.net email address.

For technical issues with the DERS Rego software, please contact the system provider at rego.support@necsws.com

Patient identifiable data should not be sent to this email address, but use the referral URN (unique reference number, located at the top right of the referral form).

Kent Surrey Sussex Advanced Restorative Pathway 2023

Referral criteria

Kent, Surrey and Sussex referral criteria to Specialist led Restorative service

Periodontics

NHS England Commissioning standard levels for Periodontal treatment	Kent, Surrey and Sussex criteria for acceptance of referrals for specialist led Periodontal service
General referral criteria for Periodontics	1. Patients referred should be regular attenders of the practice and able to demonstrate the ability to maintain an excellent level of oral hygiene. 2. Patients should have engaged in their primary dental care experience by evidencing a favourable response to self-care advice and sufficient improvement in oral hygiene as indicated by a 50% or greater improvement in plaque and marginal bleeding scores, **OR:** 1. Indicative Plaque Levels <20%, 2. Indicative Bleeding Levels <30% 3. AND a stated preference to achieving periodontal health
Level 1 (*Provided in Primary Care*) Classification, diagnosis and management of patients with uncomplicated periodontal diseases including but not limited to: • Evaluation of periodontal risk, diagnosis of periodontal condition & design of initial care plan within the context of overall oral health needs. • Measurement/recording of periodontal indices • Communication of nature of condition, clinical findings, risks & outcomes. • Designing personalised care plans.	Level 1 care is not provided by the Kent, Surrey and Sussex specialist restorative service *Update January 2022 re phased treatments in primary care:* https://www.england.nhs.uk/publication/avoidance-of-doubt-provision-of-phased-treatments

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• Providing treatment including behaviour modification. • Assessment of patient understanding, willingness & capacity to adhere to advice & care plan. • Evaluation of outcome of periodontal care and provision of supportive periodontal care programme. • On-going motivation & risk factor management including plaque biofilm control. • Avoidance of antibiotics except in specific conditions (necrotising periodontal diseases or acute abscess with systemic complications) unless recommended by specialist as part of comprehensive care plan. • Preventive & supportive care for patients with implants. • Palliative periodontal care and periodontal maintenance. **Any other treatment not covered by level 2 or 3 complexity**	
Level 2 Management of patients: • With stage II or III periodontitis who following primary care periodontal therapy have	Subject to the general referral criteria above and other criteria below, the Kent, Surrey and Sussex restorative referral service will accept level 2 referrals where: **Following primary care periodontal therapy patients have** • Grade C Periodontitis and Stage II, III or IV periodontitis (>30% bone loss) periodontitis and residual true pocketing of 6mm and above.

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residual true pocketing of ≥5mm or 4mm + bleeding on probing.	Should be referred after initial preventive advice on risk factor management and oral hygiene instruction.
• With certain non-plaque-induced periodontal diseases e.g. virally induced diseases, auto-immune diseases, abnormal pigmentation, vesiculo-bullous disease, periodontal manifestations of gastrointestinal & other systemic diseases and syndromes, under specialist guidance.	• Certain non-plaque-induced periodontal diseases e.g. virally induced diseases, auto-immune diseases, abnormal pigmentation, vesiculo-bullous disease, periodontal manifestations of gastrointestinal & other systemic diseases and syndromes, under specialist guidance.
• With Grade C periodontitis as determined by a specialist at referral.	
• With furcation defects and other complex root morphologies when strategically important and, realistic and delegated by a specialist.	• Furcation defects and other complex root morphologies when strategically important teeth where delegated by a specialist.
• With gingival enlargement non-surgically, in collaboration with medical colleagues.	
• Who require pocket reduction surgery when delegated by a specialist.	• Require pocket reduction surgery when delegated by a specialist.
• With peri-implant mucositis where implants have been placed under NHS contract.	• With peri-implant mucositis where implants have been placed under NHS contract.
Level 3 Triage & Management of patients:	Subject to the general referral criteria above and other criteria below, the Kent, Surrey and Sussex restorative referral service will accept level 3 referrals for:

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• With Grade C or Stage IV periodontitis. • With stage II or III periodontitis who following periodontal therapy have residual true pocketing of 6mm or more.	• Grade C or Stage IV periodontitis (bone loss > 1/3 root length) & true pocketing of 6mm or more. Should be referred after initial preventive advice on risk factor management and oral hygiene instruction.
• Requiring periodontal surgery	• Periodontal surgery where not suitable for delegation as assessed by Specialist.
• Furcation defects and other complex root morphologies not suitable for delegation	• Furcation defects and other complex root morphologies not suitable for delegation.
• With non-plaque induced periodontal diseases not suitable for delegation to a practitioner with enhanced skills.	• With non-plaque induced periodontal diseases not suitable for delegation to a practitioner with enhanced skills.
• Peri-implantitis where it is the responsibility of the NHS to manage the disease when implants have been placed under an NHS Contract	• Peri-implantitis where it is the responsibility of the NHS to manage the disease when implants have been placed under an NHS Contract.
• Patients who require multi-disciplinary specialist care (Level 3).	• Patients who require multi-disciplinary specialist care (Level 3).
• Where patients of level 2 complexity do not respond to treatment	• Where patients of level 2 complexity do not respond to treatment.
• Non-plaque induced periodontal diseases including periodontal manifestations of systemic diseases, to establish a differential diagnosis, joint care pathways with relevant medical colleagues & where necessary, manage conditions collaboratively with practitioners with enhanced skills if appropriate & provide	• Non-plaque induced periodontal diseases including periodontal manifestations of systemic diseases, to establish a differential diagnosis, joint care pathways with relevant medical colleagues & where necessary, manage conditions collaboratively with practitioners with enhanced skills if appropriate & provide advice and care planning to colleagues.

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advice and care planning to colleagues.	
Clinical Need demonstrated	1. All referrals for tier 2 and tier 3 must include dated full six-point pocket charts and plaque scores, taken both before and after a course of initial periodontal treatment carried out in primary care. These must be legible, ideally a pdf. Photographs of computer monitor screens are usually illegible and not acceptable. The only exception might be for example a patient with BPE <4 with a localised recession defect recorded as RT1 where a photograph is supplied. 2. Referrals should include a diagnosis, using the 2017 Classification of Periodontal Diseases, based on the referring dentist's assessment of Grading, Staging and localised or generalised risk factors. 3. If the patient has a concurrent medical condition or if the patient is on drug therapy which is having a direct adverse impact on the periodontal tissues, may be appropriate for referral once the initial assessment and advice has been undertaken. 4. Patients with modifying factors may require movement to the next level of care, including those where behaviour change is challenging. Evidence for the latter will be required to accompany referrals.
First line treatment complete	All cases of periodontitis should have initial care (including treatment) in primary care and if unsuccessful, referral may then be indicated. The initial treatment should have taken place over 12 months and usually include assessment and 3/4 courses of treatment as advised in the NHS Guidance July 2021 Avoidance of Doubt: Provision of Phased Treatments: https://www.england.nhs.uk/primary-care/dentistry/clinical-policies/#avoidance

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	These conditions will only be waived if other significant periodontal pathology is the reason for referral or **young patients** with rapid breakdown of tissues. The referring practitioner should continue the provision of periodontal care prior to a referred patient waiting to be seen for consultation and should continue to provide routine examination and any other care required or advised if the patient is accepted for periodontal treatment on referral.
Treatment	• The referring practitioner will manage all other treatment required. • Patients cannot be accepted simply because they cannot pay NHS charges in the GDS, private charges if applicable or • in cases where the patient requests they are seen by a specialist and the dentist does not consider this clinically necessary. It is important that your patient understands that an initial assessment, where indicated and approved by NHS England, will be undertaken by a consultant or GDC registered Specialist in Periodontics, normally at a London teaching hospital. This may lead to the issue of a treatment plan for the practitioner or if treatment is offered, then this may involve several visits. Referring practitioners must ensure patients agree to the commitment for completing the course of treatment, which involves travelling for lengthy appointments for complex treatment, possibly under local anaesthesia. The referring practitioner is responsible for ongoing care after the initial series of appointments. The referring practitioner is responsible for implementing any treatment plan advised, or if treatment is offered any ongoing care: 1. prior to any treatment offered commencing and 2. after the initial series of specialist appointments **or**

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	3. as an interim measure when specialist visits are delayed for any reason and long-term maintenance following specialist treatment.
Adequate information provided	• Referrals should include evidence that patients who smoke have signed up to and attended smoking cessation services. The outcome of this should be included. • It is essential to include high quality recent radiographs. These must be attached to the DERS/REGO system and correctly dated. These should include bite wing radiographs/OPGs and periapicals where specific problems are identified. Digital versions must be of diagnostic quality. Photographs are helpful for e.g. recession, unusual features or after disclosing to show plaque levels. All referrals should be made via the Dental Electronic Referral Service – using the Rego software. Clearly legible and dated radiographs, photographs, dental and periodontal charting (as pdfs) and relevant documents can be uploaded. Please ensure reasons for referral are clear. The referral should contain an indication of the history of the problem and of the treatment carried out to date and details of the treatment provided between the pre-treatment and post-treatment 6-point periodontal charts with a reasonable follow-up period.
Appeals	If the referring practitioner does not accept the outcome of the triage they can ask to appeal. Before a referral is passed to an appeal, it is expected that all information requested by the triager will be supplied or reasons given as to why it is not available. Appeals will be decided by a Consultant in Restorative Dentistry

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Endodontics

NHS England Commissioning standard levels for Endodontic treatment	Kent, Surrey and East Sussex criteria for acceptance for specialist led Endodontic service
Level 1 (*Provided in primary care*) Diagnosis and management of patients with uncomplicated endodontic treatment need including but not limited to: • Root canals with a curvature <30 degree to root axis and considered negotiable, from radiographic evidence, through their entire length • No root canal obstruction or damaged access, e.g. perforation • Previously treated teeth with a poorly condensed root filling short of ideal working length where there is evidence of likely canal patency beyond the existing root filling • Routine dismantling of plastic restorations, crowns and bridges to assess restorability • Pulp extirpation as an emergency treatment • Incision and drainage as an emergency treatment • Straightforward retreatment • Coronal trauma severity limited to enamel and dentine. **This also includes any endodontic treatment not covered in level 2 or 3 procedural complexity**	Level 1 care is not provided by the Kent, Surrey and Sussex restorative referral service

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Level 2 The management of patients with teeth requiring endodontic treatment or retreatment where: Root canal curvature >30° but <45° • Locating and negotiating canals NOT considered negotiable in the coronal 1/3 but patent thereafter, based on radiographic and clinical evidence • Difficulties with local analgesia that cannot be resolved by routine measures • Locating and negotiating where the referring GDP has attempted but experienced problems with location, instrumentation or obturation of the root canals • Teeth > 25mm in length • Incomplete root development • Limitation of mouth opening (between 25mm and 35mm inter-incisal opening). • Removal of fractured posts, less than 8mm in length. • Well condensed root fillings short of ideal working length with evidence of likely patency beyond existing root filling where previous treatment did not involve complicating factors • Coronal trauma severity extends beyond enamel and dentine, involving the pulp.	The Kent, Surrey and East Sussex specialist restorative service will accept referrals where: 1. The patient has a stable oral environment including periodontal tissues should have been achieved and all caries managed (there should be no active caries present). This includes carrying out any other restorative care prior to referral. 2. Teeth must be able to be restored by the referring practitioner and made functional after removal of disease with sound coronal tooth tissue above the alveolar crest, 2mm high and 1 mm width (the referrer will be responsible for the provision and maintenance of the final restoration). The Kent, Surrey and Sussex restorative referral service will accept level 2 & 3 referrals for: **Incisors, canines and premolars** For endodontic complications of trauma. 1. Single/multiple root canals with curvature greater than 40 degrees 2. Single/multiple root canals that are NOT considered negotiable from radiographic and clinical evidence through their entire length including fractured posts that cannot be removed by the referrer. Includes retreatment involving removing well condensed root fillings. 3. Periradicular surgery 4. Teeth with iatrogenic damage 5. Pathological resorption 6. Teeth with difficult root morphology or developmental abnormalities e.g. recurved (S shaped) root canals,

Level 3 The management of patients with teeth requiring endodontic treatment or retreatment where: • Root canals curvature >45° • Recurved (S-shaped) root canals • Canals are NOT considered negotiable through their entire length based on radiographic and clinical evidence • Developmental tooth anomalies present, e.g. bifid apex, complex branching of root canal(s), dens in dente, gemination, and C-shaped canals). • Coronal trauma severity extends beyond enamel & dentine-pulp complex, involving the root/multiple teeth • The management of teeth with iatrogenic damage or pathological resorption.	complex branching of root canals, bifid apex and C-Shaped canals 7. Endodontic treatment should not be precluded by either patient cooperation or medical history. 8. Incomplete root development **Molars** Molars will only be accepted if they are necessary to maintain a shortened dental arch, which means premolar to premolar and does not include molar teeth, except where a molar is strategically placed so its loss would mean the patient no longer had a functioning dentition or there are other exceptional reasons. For molars, if this criterion is fulfilled, then molars will be subject to the same acceptance criteria as anterior teeth above

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• Severe limitation of mouth opening (inter-incisal opening less than 25mm) • Complicated retreatments are required (e.g. well-fitting posts longer than 8mm; posts thought to be associated with a perforation; carrier-based obturations; silver points; fractured instruments; well condensed root fillings to length; overfilled roots with apical lesions). • Major iatrogenic errors e.g. large ledges, blocked canals, perforations where these can be rectified • Periradicular surgery	
Clinical Need demonstrated	Refer **only** when the tooth/teeth: 1. Is/are of strategic importance Endodontic treatment will not be carried out on teeth which are not considered to be of strategic importance. 2. For the referral of molar teeth for treatment it is important that in addition to the reasons given as to why the molar tooth cannot be treated in practice, a case is made for the **strategic importance of the tooth**. 3. Failure to justify why a molar is strategically important is the most frequent cause of referrals being rejected. 4. For all teeth, a referral will be accepted where exceptional medical or anatomical reasons for the retention of the tooth are given and therefore why an attempt to maintain the tooth is important. 5. **Radiographs** – a recent dated periapical radiograph of diagnostic quality must accompany all referrals. It must show all relevant details such as the apex of the tooth, the

	diagnostic working lengths with the instruments in place. In the case of iatrogenic damage, separated instruments and root canals that cannot be located, intra-operative radiographs are desirable. For non-healing apical pathology, a clearly dated sequence of radiographs demonstrating this are desirable. Any available bitewing radiographs should also be uploaded to show the patient's overall dental status.
Adequate information provided	All referrals should be made via the Dental Electronic Referral Service – using the Rego software. A dental charting and bitewing radiographs and/or a panoramic radiograph should be included if available. Radiographs, dental charting (as pdfs) and relevant documents can be uploaded. Please remember to make the reason for your referral clear. The referral should contain an indication of the history of the problem and of the treatment carried out to date.
Treatment	It is important that patients understand that if approved by NHS England South-East, an initial assessment, where indicated and any later treatment will be funded by the NHS, will normally take place at one of the London dental hospitals and that it may involve a number of visits. They must agree to the commitment for completing the course of treatment, which involves travelling for lengthy appointments. The referring practitioner is responsible for providing and maintaining the final restoration.

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Appeals	If the referring practitioner does not accept the outcome of the triage they can ask to appeal. Before a referral is passed to an appeal, it is expected that all information requested by the triager will be supplied or reasons given as to why it is not available. Appeals will be decided by a Consultant in Restorative Dentistry.

Referral criteria

Prosthodontics

NHS England Commissioning standard levels for Prosthodontic treatment	Kent, Surrey and Sussex criteria for acceptance for specialist led Prosthodontic service
General referral criteria for Prosthodontics	• Patients should be regular attenders, have excellent oral hygiene and be well motivated. Patients cannot be accepted simply because they cannot pay NHS charges in the GDS, or private charges if applicable. • Patients must have a stable oral environment that is suitable for advanced care and all caries and periodontal issues must be managed (there should be no active caries or periodontal issues present). This includes carrying out any other routine restorative care prior to referral. • Referrals will not be accepted where the reason for referral is relating to treatment carried out with the NHS. This includes treatment provided overseas as well as treatment carried out by a private contract. However, referral for advice may be appropriate.
Level 1 *(Provided in primary care)*	Level 1 care is not provided by the Kent, Surrey and Sussex restorative referral service **All practitioners are expected to provide the full range of NHS treatment at Tier 1 (as below) and will be assumed to be competent to do so.** Lack of training in a recognised technique to deliver tier 1 treatment is not a reason for referral.
Diagnosis and management of patients with uncomplicated prosthodontic treatment needs including but not limited to:	Diagnosis and management of patients with uncomplicated prosthodontic treatment needs including but not limited to:

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Straightforward patient factors: • Patient factors and medical history represent commonly encountered conditions and a wide range of less common conditions that have no significant implications for routine dentistry AND **Technical treatment delivery at routine level of complexity** • All routine plastic fixed and partial removable restorations where conforming to existing occlusion. • Fixed restorations where aesthetic, functional and occlusal stability and control can be maintained • All removable restorations where the hard and soft tissue anatomy is healthy and reasonably well formed **Any prosthodontics care not covered in level 2 or 3 complexity**	**Straightforward patient factors:** • Patient factors and medical history represent commonly encountered conditions and a wide range of less common conditions that have no significant implications for routine dentistry. **AND** **Technical treatment delivery at routine level of complexity** • All routine plastic fixed and partial removable restorations where conforming to existing occlusion. This includes many tooth wear cases where dentine is exposed and requires protection • Fixed restorations where aesthetic, functional and occlusal stability and control can be maintained. This includes the provision of Resin Bonded Bridges. • All removable restorations where the hard and soft tissue anatomy is healthy and reasonably well formed. • Treatment of the typical stress related TMD patient.
Level 2 The management of patients with prosthodontic needs: **Patient with moderately difficult complicating factors where:** • Technical excellence essential to minimise risk of re-intervention, extraction or loss of vitality (e.g. for patients undergoing bisphosphonate	**Most primary care practitioners will be able to provide some or all of Tier 2 for their own patients** The management of patients with prosthodontic needs: **Patient with moderately difficult complicating factors where:** • Technical excellence essential to minimise risk of re-intervention, extraction or loss of vitality (eg for patients undergoing bisphosphonate

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therapy, radiotherapy, haemophilia management).	therapy, radiotherapy, haemophilia management).
• Factor or factors that increase complexity (e.g. previous poor management, analgesia concerns or in some cases a complex medical history)	• Factor or factors that increase complexity (eg previous poor management, analgesia concerns or in some cases a complex medical history)
• A motivated patient in whom behaviour change or risk factor management is challenging.	• A motivated patient in whom behaviour change or risk factor management is challenging.
Moderately difficult technical treatment needs and/or environment:	**Moderately difficult technical treatment needs and/or environment:**
• Pre-prosthetic procedures or optimisation (optimisation of abutments, occlusal adjustments, and minor surgical procedures) required	• Pre-prosthetic procedures or optimisation (optimisation of abutments, occlusal adjustments, and minor surgical procedures) required
• Occlusal reorganisation is needed and medium-term stability can be achieved with plastic restorations, a removable appliance or both.	• Occlusal reorganisation is needed and medium term stability can be achieved with plastic restorations, a removable appliance or both. This includes the majority of moderate tooth wear cases.
• Aspects of occlusion need careful management to avoid premature failure of restorations (e.g. guidance where multiple restorations)	• Aspects of occlusion need careful management to avoid premature failure of restorations (e.g. guidance where multiple restorations)
• Replacement and temporisation of multiple fixed restorations is required and the stability or control of the oral condition may be at risk	• Replacement and temporisation of multiple fixed restorations is required and the stability or control of the oral condition may be at risk
• There are anatomical difficulties related to soft tissues	• There are anatomical difficulties related to soft tissues
• There is compromised health of denture-bearing soft tissue	• There is compromised health of denture-bearing soft tissue
• Manageable access difficulties, including minor gagging problems	• Manageable access difficulties, including minor gagging problems
• Raised or critical aesthetic or functional expectations/needs	• Raised or critical aesthetic or functional expectations/needs

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• Some cases following minor orthodontic treatment • The provision and maintenance of simple implant retained prostheses (single tooth, simple overdenture) that meet NHS criteria.	• Some cases following minor orthodontic treatment • The provision and maintenance of simple implant retained prostheses (single tooth, simple overdenture) that meet NHS criteria.
Level 3 Triage and management of patients where: **Patients with complex patient complicating factors:** • Decision making associated with treatment planning is required • Complex patient complicating factors (e.g. facial pain,) • A motivated patient with systemic risk factors or behaviour change challenges **Patients with complex diagnostic or planning needs (advice only) where treatment can be provided by others:** • Undiagnosed pain or temporomandibular disorders • Long term treatment strategy development where many teeth are affected, or multiple stages are involved. • Care involving the management of failed restorations that involve several teeth.	**Most patients will require Tier 3 (Specialist/Consultant) referral for the following reasons, but the other general referral criteria must be considered first.** Triage and management of patients where: **Patients with complex patient complicating factors:** • Decision making associated with treatment planning is required • Complex patient complicating factors (e.g. facial pain • A motivated patient with systemic risk factors or behaviour change challenges **Patients with complex diagnostic or planning needs (advice only) where treatment can be provided by others** • Undiagnosed pain or temporomandibular disorders (excluding patients with typically stress-related TMD) • Long term treatment strategy development where many teeth are affected or multiple stages are involved. • Care involving the management of failed restorations that involve many teeth.

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Complex technical treatment needs or intraoral environment (not with Multi-Disciplinary Team):	Complex technical treatment needs or intraoral environment (not with Multi-Disciplinary Team)
• Major occlusal reorganisation is required, and stability cannot be achieved easily without multiple fixed restorations or where there are problematic patient factors (e.g. parafunction)	• Major occlusal reorganisation is required and stability cannot be achieved easily without multiple fixed restorations or where there are problematic patient factors (e.g. parafunction)
• Complex local oral circumstances e.g. severe gagging reflex, profound dry mouth, limited access etc.	• Complex local oral circumstances e.g. severe gagging reflex, profound dry mouth, limited access etc.
• Extensive anatomical resorption of edentulous sites in patients requiring complete dentures	• Extensive anatomical resorption of edentulous sites in patients requiring complete dentures
• Need for pre-prosthodontic surgery, periodontal surgery, endodontic surgery, other complex periodontal or endodontic management or implants	• Need for pre-prosthodontic surgery, periodontal surgery, endodontic surgery, other complex periodontal or endodontic management or implants
• Significant TMJ/TMD concerns	• Significant TMJ/TMD concerns
• Need for assessment for benefits of dental implants and implant planning to agreed NHS criteria	• Need for assessment for benefits of dental implants and implant planning provided this maps to agreed NHS criteria Dental implants are only funded by the NHS in a limited number of circumstances. Referrers should consult the guidance available in the documents – Guidance on the standards of care for NHS-funded implant treatment 2019 – Restorative Dentistry-UK (RD_UK) and Faculty of Dental Surgery, Royal College of Surgeons. There may be circumstances where patients will be eligible to receive dental implant treatment in line with this guidance. The provider will be expected to provide

• Combined prosthodontic, periodontal and endodontic problems in association with strategic teeth (**Level 3**) • Any case involving an MDT (oncology, hypodontia, clefts etc) and where prosthodontic and/or other restorative treatment is involved, these will normally be Restorative consultant led.	dental implants in in line with this guidance when required. *Guidelines can be found in the link below* *Clinical Guidelines — Royal College of Surgeons (rcseng.ac.uk)* *In the section pre-2020 Current Guidelines; Publication year 2019 'Guidance on the standards of care for NHS funded dental implant treatment'* Combined prosthodontic, periodontal and endodontic problems in association with strategic teeth **(Level 3)** • Patients with hypodontia should be treatment planned by a multidisciplinary team (MDT) prior to the start of treatment. • Referrals for implant restorations at the conclusion of orthodontic treatment are not accepted unless this was agreed by a named NHS Restorative Consultant at the treatment planning stage. • Any case involving an MDT (oncology, hypodontia, clefts etc) and where prosthodontic and/or other restorative treatment is involved, these will normally be Restorative consultant led.
Clinical Need demonstrated	• Referral must include recent high quality dated panoramic or full mouth periapical radiographs where appropriate. Digital radiographs must be of diagnostic quality and include the date. Faxed and photocopied images will not be accepted. • Referral should include appropriate study models and/or photos, where they would add useful additional

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	information to support the referral. Photographs of study casts can be uploaded. • Photographs are particularly helpful to add details to the referral, especially in tooth wear cases. **Examples of currently recognised exceptions where the tooth/teeth are of strategic importance to maintain long term oral function** • Where there are orofacial defects requiring obturation/ restoration • Patients with unique requirements, for example special care patients or those aged 18 years and under, who require specialist management and treatment for a successful long-term outcome e.g., patients 18 years or under who have suffered trauma to their teeth • Patients with medical conditions which affect the oral environment and who need specialist management to increase the potential for a successful outcome or where anatomical configurations of the jaws make specialist intervention necessary e.g. Sjogren's syndrome, post head and neck cancer patients etc. • Where there are developmental abnormalities of dental tissues, such as amelogenesis imperfecta or dentinogenesis imperfecta.
Adequate information provided	All referrals should be made via the Dental Electronic Referral Service – using the Rego software. A dental charting and bitewing radiographs and/or a panoramic

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	radiograph should be included if available. Radiographs, photographs, clinical and periodontal charting (as pdfs) and other relevant documents e.g. previous referral letters, can be uploaded. Please remember to make the reason for your referral clear. The referral should contain an indication of: • the full history of the problem, and • the treatment carried out to date If the referral relates to a restoration or implant that was not provided under NHS regulations, then this needs to be made clear in the referral.
Treatment	• It is important that patients understand that if approved by NHS England South East, an initial assessment, will normally take place at one of the London dental hospitals and that it may involve a number of visits. They must agree to the commitment for completing the course of treatment, which involves travelling for lengthy appointments. • Where an assessment and treatment plan only is provided then the referring GDP will be responsible for undertaking some or all of the treatment but with the support of the Specialist/Consultant. • Ongoing maintenance is usually the responsibility of the referring practitioner.
Appeals	• If the referring practitioner does not accept the outcome of the triage they can ask to appeal. Before a referral is passed to an appeal, it is expected that all information requested by the triager will be supplied or reasons given as to why it is not available. Appeals will be decided by a consultant in restorative dentistry. JMUc