

Advice for General Dental
Practitioners, PCTs and LHBs

Guidelines for Referrals for Orthodontic Treatment

This document has been produced by the British Orthodontic Society

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Introduction

The provision of orthodontics varies considerably across the UK. In some areas the majority of orthodontics is provided by specialists while, in other areas, general dental practitioners provide a large part of the service, often in close collaboration with the local hospital service. Historically, this is a reflection of how the service has developed and where orthodontists trained. There has also been an increasing demand placed on the service as the population's awareness of dental health has increased and more people have sought treatment. This increase in demand has not however been met by a relative increase in the number of specialist orthodontists being trained and therefore large waiting lists for treatment have developed in certain parts of the country.

To help provide a service in parts of the country where there was a lack of specialist orthodontic provision, a large percentage of the treatment was being provided by general dental practitioners. Since the introduction of the new dental contract, in April 2006, this service has reduced, placing greater pressure on the specialist providers. There is also the introduction of the 18 week wait for consultant led services in secondary care which will be a national target by December 2008. Combined, these place greater onus on the referring practitioner to refer, in the first instance, to the most appropriate provider. This, for some, will be a cultural shift as they may have referred preferentially to one provider for a variety of reasons.

However, considering the reported high levels of inappropriate referrals¹ which have in part contributed to the long historic waits for orthodontic assessment and treatment, it is important that all parties work together to manage referral pathways. This is dependent on good communication between all parties.

By working closely with user groups, providers in primary and secondary care can develop a managed clinical network with robust and transparent care pathways improving access to specialist orthodontic care. This includes the use of referral guidelines to ensure patients are referred to the most appropriate provider with minimal delay. This will negate the need for intermediate triaging of referrals and all the unnecessary cost and delay this would incur.

Introduction of Guidelines

Malocclusion is not a disease state but a variation from what is considered the ideal. Therefore there can be confusion among non-specialists as to what warrants referral for a specialist opinion. There is further confusion in orthodontics as specialist care is provided in a variety of settings. One possible solution is the introduction of guidelines on referral. To be acceptable and effective, guidelines need to be developed locally with input from the general dental practitioners who will be using them^{2,3}. Guidelines produced nationally by societies or colleges can be used as a basis and they should be based on scientific evidence as much as possible. They should not be prescriptive or take away referring practitioners' or patients' choice where they access a specialist opinion. They should also not be used to limit or prevent referral for a specialist opinion, which remains a fundamental patient right.

Therefore written guidelines should be accompanied by education and support for referring practitioners including lectures and courses, outreach education in the form of practice visits and regular reminders particularly for those practices which find it difficult to change their referral practice. The introduction of guidelines should be followed by regular audit to monitor their use and effectiveness and revision as necessary.

The Index of Orthodontic Treatment Need

The provision of orthodontics under the new contract is based on the Index of Treatment Need (IOTN); this has been shown to be both reliable and reproducible. It is therefore important that referring practitioners are aware of under what criteria, treatment will be offered to their patients and by what provider. At present however, the majority of practitioners are unfamiliar with IOTN and are unable and unhappy to apply it to their patients. It is therefore unrealistic to expect general dental practitioners to be able to accurately provide an IOTN score for the patients they refer. Referral guidelines should therefore be based on IOTN but not just replicate it. An effective alternative is to use a pictorial guide showing various malocclusal traits that correspond to categories of the dental health component of IOTN (Appendix 1).

When to make an orthodontic referral

The majority of orthodontic treatment can commence in the late mixed and early permanent dentition. Earlier referral is needed in certain circumstances as outlined in Appendix 2 when interceptive treatment is needed⁴. However, for the majority of patients, this is the appropriate time to refer for an orthodontic assessment. If patients are referred too early for treatment they should be referred back to the referring practitioner to monitor the dental development and then re-referred at the appropriate time. Patients should not be referred early in an attempt to circumvent long waiting lists as this is unfair on the patients, already on a waiting list, who were referred at the appropriate time.

Before making a referral the patient should be advised what orthodontic treatment may involve and their

commitment to treatment assessed. Ideally written information should be given to the patient and their parents/guardians prior to referral to help them make a decision. Patient information leaflets are available from the British Orthodontic Society. If the patient is unsure, a cooling off period is appropriate prior to referral for the patient to reflect on whether they want to proceed. If a referral is made, the patient should be advised why they are being referred and to whom.

If there is any doubt especially in relation to the need for orthodontic treatment, it is appropriate to seek a specialist opinion. Similarly, it is the view of the British Orthodontic Society that a patient has the right to seek a specialist opinion even if they present with a mild malocclusion that may not be eligible for NHS treatment.

Where to make an orthodontic referral

There are four main providers of orthodontics:

1. Specialist orthodontic practitioners working from practice
2. Hospital consultant service
3. Community orthodontic service
4. General dental practitioners with a special interest in orthodontics

Although there is crossover in the service they provide, each group provides a different service. Specialist practitioners can provide the majority of specialist orthodontic treatment for children and adolescents. The hospital consultant service provides treatment for those cases that require multidisciplinary care including patients with impacted teeth, severe skeletal problems that require a combination of orthodontics and surgery to correct and patients with complex medical histories. Many hospital departments also provide training and

teaching for specialist registrars and general dental practitioners and as such will accept a limited number of routine orthodontic cases. The community orthodontic service, similarly to the hospital service, will provide treatment for patients with complex medical and social problems. The provision of orthodontic services provided by general dental practitioners with a special interest in orthodontics will vary in different parts of the country depending on the number of specialist orthodontists. Generally however, general dental practitioners with a special interest in orthodontics can provide routine orthodontic treatment for children and adolescents.

The referring practitioner should refer the patient to the appropriate provider. Guidelines for this are provided in Appendix 3. The patient should not be referred to multiple providers as this will result in inappropriate referrals, creation of artificial waiting lists and confusion for the patient

Referral letters

All referral letters should include the following information:

1. Patient demographics
2. Reason for referral i.e. treatment, advice
3. Salient features of patient's malocclusion
4. History of previous treatment
5. Recent relevant radiographs where available

If the above information is not provided the referral should not be accepted, but returned to the referrer to provide the appropriate information. This information can be provided in the form of a referral pro-forma or standardised referral form. The advantage of a pro-forma is that it will help standardise referrals and encourage referral to the appropriate

provider. To be effective however it will need to be understandable by a non-specialist, be easy and quick to fill out and not require any specialist tools or equipment to assess the patient. The use of a pro-forma will also not work when a practice accepts referral by telephone. If it is apparent, from the information given with the referral, that the patient has been referred to an inappropriate provider, the referrer should be informed and advised to redirect the referral.

It is important that patients are advised, on referral, that treatment may not be offered and they may be referred to another provider, or that treatment is not available under the new NHS guidelines.





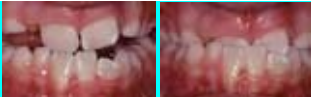











Patients will not be accepted onto the treatment waiting lists if oral hygiene is poor or there is evidence of active dental disease.

Patients' responsibilities during treatment

Orthodontic treatment depends on good compliance to achieve a successful outcome; therefore it is important that the referring practitioner informs patients before they are referred that:

1. All appointments should be kept
2. Appliances must be worn as instructed
3. Dietary advice and oral hygiene instruction must be adhered to
4. Treatment generally takes between 18 to 30 months followed by a period of retention
5. Appliances will be removed and treatment discontinued if there is persistent poor oral hygiene, broken appliances, poor compliance with instructions or failed appointments

Appendix 1

Types of occlusal problem eligible for NHS orthodontic treatment	Occlusal problems <i>not eligible</i> for NHS orthodontic treatment (unless there is another occlusal feature which falls into the eligible category or a significant aesthetic impairment)	Inappropriate referral
 <p>Teeth protrude (overjet) more than 6mm</p>	 <p>Teeth protrude (overjet) less than 6mm</p>	<p>Patient does not want orthodontic treatment or would not wear a brace</p>
 <p>Reverse overjet greater than 1mm</p>	 <p>Reverse overjet less than 1mm and no anterior displacement</p>	<p>Patients over 18 will only be accepted for orthodontics if they have a complex occlusal and skeletal problem requiring multidisciplinary care (see overleaf)</p>
 <p>(Initial contact) (Intercuspation position) Anterior or posterior crossbite with mandibular displacement on closure</p>	 <p>Anterior or posterior crossbite without mandibular displacement</p>	<p>Active thumb/finger sucking (please encourage your patient to stop their sucking habit as orthodontic treatment will not be started until the habit has ceased)</p>
 <p>Impacted teeth Submerged teeth</p>	 <p>Spacing between teeth</p>	<p>Poor oral hygiene or caries/periodontal disease (unless advice is needed for extractions only)</p>
 <p>Severe crowding with at least one contact point displacement > 4mm</p>	 <p>Mild crowding with no significant contact point displacements</p>	
 <p>Hypodontia (missing teeth)</p>	 <p>Mild crowding</p>	
 <p>Anterior or lateral open bites > 4mm</p>	 <p>Mild anterior or lateral open bites</p>	
 <p>Increased overbite with clinical evidence of gingival or palatal trauma</p>	 <p>Increased overbite but without gingival or palatal trauma</p>	

Appendix 2

Early referrals

When to refer in the deciduous dentition:

- Individuals with cleft lip and/or palate, or other craniofacial anomalies
- Severe maxillary/mandibular disproportion (only if parents concerned otherwise wait until mixed dentition stage)

When to refer in the mixed dentition:

- Anterior or posterior crossbites with associated mandibular displacement
- Class III malocclusion in the mixed dentition
- Class II/I malocclusion where there is an underlying skeletal II pattern. Most functional appliances are easiest to wear when upper 4|4 are fully erupted. Such a patient entering his or her pubertal growth spurt should be seen without delay
- Asymmetry in the pattern of tooth eruption (especially upper central incisors)
- Severely hypoplastic/carious first molars of poor long-term prognosis
- Lack of palpable canine bulges buccally at 10-12 years indicating palatal impaction of canines
- Hypodontia (missing teeth); supernumerary teeth
- Submerged deciduous molars; impacted first permanent molars
- Periodontal problems caused by severely ectopic tooth position
- Severe crowding of incisors

Appendix 3

Where to make an orthodontic referral

Specialist Orthodontic Practice:

- Patients that present with malocclusions that require routine orthodontic treatment including crowding, increased overjet, increased overbite especially with evidence of gingival trauma, posterior and anterior crossbites with displacements and mild hypodontia (missing no more than one tooth per quadrant)

Dentist with Special Interest in Orthodontics:

- Patients that require routine orthodontic treatment, as above, but often in conjunction with a consultant's treatment plan

Hospital Orthodontic Service:

- Malocclusions which require interdisciplinary orthodontics and orthognathic (jaw surgery) treatment i.e. those with skeletal anomalies and/or asymmetries
- Malocclusions which require interdisciplinary restorative treatment, such as hypodontia, ankylosed teeth, previously traumatised anterior teeth, developmental anomalies affecting tooth structure (amelogenesis/dentinogenesis imperfecta), severe tooth surface loss
- Malocclusions which require interdisciplinary orthodontics and surgical treatment, such as impacted/ectopic teeth, ankylosed teeth
- Children with physical or mental handicap, growth-related problems and disease who also have a malocclusion which fulfils the eligibility criteria in Appendix 1
- Individuals with cleft lip and/or palate or other craniofacial anomalies
- Non-multidisciplinary cases which fulfil the eligibility criteria in Appendix 1 (a number of such cases are required for teaching purposes but if no cases are needed for training at the time of your referral it may be forwarded to a local specialist practice or Dentist with Special Interest in Orthodontics)

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4. Hassan T, Nute SJ. An audit of referral practice for patients with impacted canines and the impact of referral guidelines. *Br Dent J* 2006;200:493-496.

FURTHER READING

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