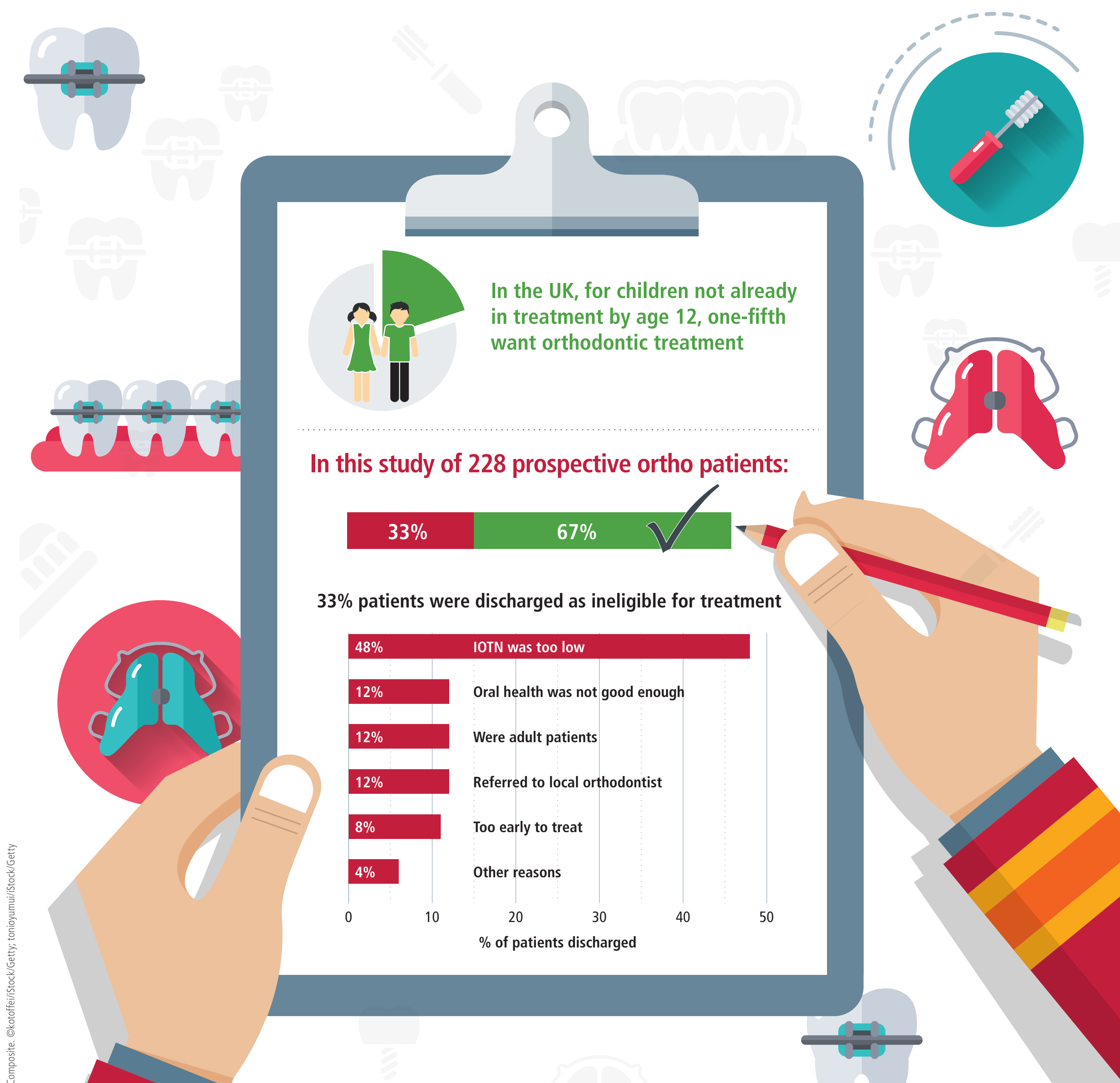
Getting referrals right

Orthodontic referrals: why do GDPs get it wrong?
Br Dent J 2016; **221:** 583-587; DOI: http://dx.doi.org/10.1038/sj.bdj.2016.826

The matter of referrals is always a tricky one. Who to refer, when to refer and to whom to refer? Each decision point comes with a range of considerations which include clinical judgment, personal competence and skill, appropriate care pathways, economics, social circumstances and personal choice. Weaving one's way through such a maze of options can be aided by guidelines and protocols.

In this paper the authors wanted to investigate, through the method of an audit, how appropriate patient referrals were for orthodontic treatment from general dental practitioners (GDPs) to a teaching hospital. The audit found several causes of inappropriate referrals; incorrect Index of Orthodontic Treatment Need (IOTN) for treatment, patient referred with poor oral hygiene and/or caries, timing of referral incorrect or adult patients, and referred to incorrect service provider.

The study highlights that there is a problem of inappropriate orthodontic referrals which is not only a frustration for the three parties involved, the patient, referrer and specialist service receiver, but also a waste of time and resources. The conclusion is that there



Composite. ©Kotoffei/iStock/Getty; toniyoumui/iStock/Getty

© 2016 British Dental Association. All rights reserved.

is significant scope in improving the quality of orthodontic referrals by GDPs. As shown by the data, in order to reach the set standard there is need for improvement in several key areas regarding GDPs' knowledge and understanding notably; IOTN, importance of good oral hygiene, absence of caries, referral timing, adult patients and referral pathway. Dissemination of guidelines has been shown to be ineffective and thus the authors recommend the need for widespread orthodontic education of GDPs and use of proformas/pathways to reduce inappropriate referrals.

Quite how this might come about in a system already under strain and with seemingly little chance of seeing the tensions relived is another matter. Perhaps it is another of the subject areas that requires careful thought and planning in postgraduate education and possibly even CPD. But then, where have you read that before? Valuable research in pointing to the source of problems nonetheless.

By Stephen Hancocks

Author Q&A

with Sharan Reddy

Guys and St Thomas' Trust

What prompted you study orthodontic referrals?

As an undergraduate I was amazed to see a large number of orthodontic referrals that could not be accepted, usually along with a disappointed parent and child being sent home. It often struck me as a waste of clinic time, patient time and resources. This of course was not the first study of orthodontic referrals, highlighting that inappropriate referrals were an issue in many departments. I did, however, feel that more depth of insight into why these referrals were presenting was needed, which lead to the development of this study.

Did anything in the results surprise you?

Several results surprised me, firstly the extensive number of referrals failing to meet our standards (62.8% cycle one and 66.6% cycle two) leading to the number of patients we had discharged in both cycles being extremely high (32.8% and 40.7% respectively). The variety of reasons why referrals might be rejected and the difficulties in trying to intervene to improve the quality of referrals also surprised me.

How would you advise GDPs to improve the quality of referrals?

As a former Associate I appreciate the time pressures involved in general practice, in addition to the competition of further learning in other areas of CPD away from orthodontics. Referrals should be treated as a skill which requires practice and development. This article aimed to give a starting point for further reading and learning, to develop this skill. A practitioner with a good understanding of IOTN, orthodontic assessment and treatment will be able to develop fast, effective assessments and referrals as a GDP. I was once told: 'Practice does not make prefect, practice makes permanent!' Unfortunately, habits tend to stay with us and this is the challenge this article aims to instigate. ■

Expert view

By Guy Deeming

Chair Orthodontic Specialist Group British Orthodontic Society and Specialist Orthodontist

There has been significant discussion between commissioners and providers about the need to reduce 'inappropriate' referrals.[1] It is worth highlighting that any referral system, process or protocol has a primary objective to ensure patients receive the right treatment at the right time in the right place. A useful analogy being to 'just in time' manufacturing.[2]

The preponderance of human factors has presented a significant and seemingly insurmountable challenge to this goal. This paper effectively demonstrates that the distribution of written guidance has no (or in this paper negative) impact on referral quality. Despite numerous attempts to deliver such programmes, there is scant evidence that training GDPs in IOTN is effective.

Whilst the scale of the problem (and any possible cost efficiencies) is a moot point amongst the orthodontic community, perhaps the time has come for innovation? The use of e-referral systems is suggested, certainly the use of such technology to enforce mandatory fields and utilise clinical feature algorithms to assess IOTN may have potential. In addition the BOS has recently launched an 'Easy IOTN' smartphone app for use by the dental team to aid IOTN diagnosis.[3]

One area this paper does not develop is the concept of what 'inappropriate' referrals are. There is a strong argument that not all referrals with poor oral hygiene or seen 'too early' are inappropriate by definition – for example, there is an essential role for an assessment for a proportion of cases that can be cost-effectively managed with interceptive extractions alone. Therefore, the use of the 100% standard in this paper should perhaps be called into question. The value of such assessments for patients that may never have or need appliances should be upheld as a core element of delivering a comprehensive orthodontic service.

Whatever the future may hold it is imperative that time and resources spent managing inappropriate referrals are focussed and not disproportionate. In addition, referral processes should be standardised across settings and regions. This paper (essentially a two-cycle audit) demonstrates the challenge managing referrals in a secondary care setting and, in many ways, poses more questions than solutions. ■

1. NHS England. Guides for commissioning dental specialties - Orthodontics. London: NHS England, 2015. Available online at https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/guid-comms-orthodontics.pdf (accessed 2016).
2. Womack J P, Jones D T, Roos D. *The Machine That Changed the World: The Story of Lean Production* (1991). HarperBusiness, 2003.
3. Easy IOTN app. Available online at https://appsto.re/gb/6Xjoeb.i (accessed October 2016).

© 2016 British Dental Association. All rights reserved.