

Role of the Consultant in Restorative Dentistry

This document has been produced by the ACSRDR to inform PCTs, SHAs, WDCs and other interested parties including patients' representatives

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1.0 Introduction

Since the inception of the NHS in 1946, dental disease patterns have changed and emergent disorders have presented new challenges to dentists. In response to this, the provision of hospital dental services has expanded and developed, in part to satisfy increased public expectations. In 1973, the then Joint Committee for Higher Training in Dentistry formally requested the Department for Health and Social Security to recognise Restorative dentistry as the third dental specialty. A statement on the role of the "consultant restorative dentist" by the Consultants in Restorative Dentistry Group (predecessor of the ACSRDR) was published in 1983 but since then the role has evolved and expanded. The purpose of this document is to re-define the role of the Consultant in Restorative Dentistry and provide guidelines on the function and workload within the specialty.

2.0 Definition of the specialty

Restorative Dentistry is the study, diagnosis and integrated effective management of patients with diseases of the oral cavity, the teeth and supporting structures including the care of those who have additional needs associated with disability. Treatment provision involves the rehabilitation of the teeth and the oral cavity to functional, psychological and aesthetic requirements of the individual patient including the co-ordination of multi-professional working to achieve these objectives. Its scope includes all the activities associated with Endodontics, Periodontics and Prosthodontics. (Quality Assurance for the Dental Specialties, 2000).

3.0 Role of the consultant

3.1 Clinical

The Consultant in Restorative Dentistry aims to improve and maintain the oral health of adults and some children in conjunction with Consultants in Orthodontics and Paediatric Dentistry through appropriate preventive, educational, diagnostic and treatment services. This includes assessment and

advice for GPs and other consultant colleagues in all specialties. The Consultant will be particularly involved in the management of patients falling within group 3 of the Complexity Index.

3.2 Clinical Governance

Consultants lead clinical governance including clinical effectiveness, clinical audit and service evaluation. National clinical guidelines have been developed through the Clinical Effectiveness Committee of the Faculty of Dental Surgery of the RCS (Eng) and this work will continue to be developed through the NICE agenda.

3.3 Research

NHS consultants and senior academic staff holding honorary consultant contracts will be actively engaged in research leading to peer reviewed publications and a greater body of knowledge which will increase understanding of disease processes and their management.

3.4 Education and training

Consultants make a significant contribution to education and training.

- a. This commitment is primarily concerned with SHOs and Specialist Registrars whereby consultants will have formal responsibilities as either Educational Supervisors and/or Training Programme Directors.
- b. Consultants in restorative dentistry have always been actively involved in the provision of postgraduate training such as teaching of General Dental Practitioners (eg Section 63 courses), and university programmes eg taught Masters' programmes.
- c. Further involvement with the education of undergraduate dental students and Professions Complementary to Dentistry (nurses, hygienists, therapists) will add to this activity.

3.5 Revalidation & Personal Development

To ensure that all specialists maintain the knowledge, skills and attributes for effective clinical practice, the GDC has introduced its scheme "Lifelong learning: Recertification for the dental profession". All members of the Dental Faculties of the Surgical Royal Colleges have been required to register for CPD since 1996. All specialists are therefore required to "Keep up to Date" by attending appropriate courses and scientific conferences. The consultant must provide evidence about standards of clinical practice by taking part in Annual Appraisal, external peer review and Personal Development Plans (PDP). Annual appraisal is undertaken with their immediate line manager, normally the clinical director, who will also be a consultant but not necessarily in restorative dentistry. Appraisal is a positive process to provide feedback on performance, chart continuing progress and to identify development needs (GMC, May 2000). The Follett Report recommended that honorary consultants have a joint appraisal with a senior academic, normally the head of department or dean, representing the university. Appraisal includes personal development planning and revalidation. External peer review by regular visits

of the Hospital Recognition Committees and Specialist Advisory committees ensure that trainers conform to good practice and are up to date with CPD (Quality Assurance for the Dental Specialties, RCS, England, 2000).

4.0 The nature and scope of the specialty

4.1 The specialty provides a comprehensive diagnostic and treatment planning service for a wide range of congenital and acquired diseases/disorders affecting the mouth, face and jaws. Furthermore, the consultant will provide treatment for patients under his or her care.

The following list is not exhaustive but reflects the broad scope of restorative dentistry:

- Management of pain and anxiety
- TMD
- Prosthetic rehabilitation of cancer/trauma
- Implantology
- Endodontics including periradicular surgery
- Management of diseases affecting the periodontal tissues
- Management of dental caries
- Tooth wear including attrition, abrasion and erosion
- Aesthetic/Cosmetic dentistry
- Replacement of missing teeth other than by implants
- Care of medically compromised patients
- Care of patients with special needs
- Interdisciplinary co-operation with other specialties

4.2 The relationship to the monospecialties of Restorative Dentistry
Restorative Dentistry is the parent discipline or umbrella specialty for the monospecialties of Fixed & Removable Prosthodontics, Endodontics and Periodontics. The Mouatt Report (1996) advised that the monospecialties would essentially provide a service outwith the hospital service in the community with the Consultant in Restorative Dentistry acting in an advisory capacity if need be. Consultants in Restorative Dentistry can provide services in all monospecialties.

4.3 The relationship to the General Dental Council
Curricula and training requirements were agreed by the GDC as the competent authority with ultimate responsibility for standards of specialist training, working closely with the partners of *The Accord* (Quality Assurance for the Dental Specialties, 2000). The specialist lists are held by the GDC.

5.0 Training

The basic entry requirements for RD training include a recognised dental degree, two years or equivalent general professional training, an MFDS and a competitive interview process as agreed with the SAC in Restorative Dentistry. There is heavy demand for training places and candidates may possess a higher degree. The training programme is of five years duration and the curriculum has been established by the SAC and the JCSTD. The standard of training is monitored regularly by the SAC through the RITA process. A competency based curriculum

has been developed with assessments in several domains: Knowledge, Clinical, Management, Communication, Teaching and Research. It is recommended that the proportion of time in the programme should be 60% clinical, 25% academic and 15% research. The Fellowship examination of a surgical college, FDS (Rest Dent), is taken towards the end of training. Success at the FDS (Rest Dent) examination and satisfactory progress through the RITA process results in a recommendation to the GDC for the award of the Certificate of Completion of Specialist Training (CCST).

Entry to a training programme for those appointed to a university post must meet the same entrance criteria.

6.0 Manpower and service delivery

6.1 General

There does not seem to be a recommended ratio of consultants or specialists in Restorative Dentistry to population nor with respect to areas of patient need. The Platt norms recommended consultant to population ratios of 1:250,000 and for orthodontics 1:500,000. The demands on the consultant service will be greater as the proportion of elderly in the population increases and patients on long term medication survive longer eg HIV. Furthermore, public expectations have increased with improvements in medical science. One specialist Paediatric Dentist was advocated for 20,000 children. The recommended "team structure" for an Oral & Maxillofacial surgical unit for a population of 10^6 is: 7 consultants, 4 SpRs, 4 non-consultant grade surgeons and 10 SHOs.

6.2 Consultants

The stated aim of the government in the NHS Plan of July 2000 is for a service delivered by fully trained doctors. Implementation of the preferred option of a consultant delivered service is highly dependent on recruitment to achieve adequate consultant expansion. The government's projections for 2009 demonstrate significant shortfalls in consultant numbers and careful planning is needed.

6.3 Non Consultant Career Grade

There are very few NCCGs in Restorative Dentistry.

6.4 Specialist Registrars

The Lead Dean in Restorative Dentistry holds all the National Training Numbers (NTNs) in the UK. Manpower planning for this grade should reflect the number of available posts in the country.

6.5 Senior House Officers

A period of General Professional Training (GPT), followed by an MFDS qualification, is mandatory prior to entry on a specialist training programme. Most SHO posts are, therefore, in general duties and few are in Restorative Dentistry.

6.6 Support staff

In general, there are no recommendations for this very important group. Although the expansion of the consultant grade is welcome, Strategic Health Authorities and Departments of Dental Public Health must include provision for support staff lest service provision is disadvantaged. Support staff includes technicians, hygienists, therapists, nurses, secretaries (0.5 WTE/consultant across the NHS) and others (radiographers/clinical governance staff/microbiologists).

7 Workload

The workload of the consultant in Restorative Dentistry has been published in Consultant Practice & Workload in the Dentally Based Specialties (CCHDS, 1997). There appear to be miscalculations regarding the average referral rate. Based on a working year of 40 weeks (NB 6wks annual leave, 2 weeks bank holidays, 2 weeks study leave), 2 consultation sessions per week and an average of 6 new patients per session, the calculation

$40 \times 2 \times 6 = 480$ A maximum of 500 new patients per year is reasonable

Most new patients require radiographs which are interpreted by the clinician at consultation resulting in a diagnosis and treatment plan at that appointment. This can differ with other disciplines when tests are requested and diagnoses made at follow-up visits.

The number of patients per clinic:

New patient clinic	Typically 8
Treatment	numbers dependant on complexity

It must be recognised that the number of patients seen on any one clinic depends upon several variables such as the presence or absence of other staff (SpRs, SHOs), need to teach u/g & p/g students or complexity of case load.

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