The role of the consultant in restorative dentistry

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In brief

Raises awareness of the role of a consultant in restorative dentistry and how the role has changed in the past decade.

Provides an overview for general dental practitioners about what consultants do and how they can support them.

Highlights the pressures a consultant faces in today's NHS.

The role of a hospital consultant has changed extensively over the past decade as the National Health Service has progressed through a series of challenges including an ageing population and rising costs of clinical care. The traditional concept of a consultant has changed with different and increased expectations of the role as the pressures to deliver high quality patient care, education and advice continue to rise in a difficult financial climate. In addition, consultants in restorative dentistry are faced with the challenge of a poor general awareness of the scope of their speciality and their role. This paper provides an update on how the role of the consultant in restorative dentistry has evolved in the last decade and how it differs from that of other dental specialists and general dental practice.

Introduction

The title 'consultant' is unique to the United Kingdom, Republic of Ireland and parts of the commonwealth. A 'consultant' is the most senior grade of doctor working in a hospital, although some consultants work outside hospitals. They are highly trained and skilled, with vast expertise gained through a lengthy and extensive (usually publicly funded) training programme[1] and are normally on the specialist register for their appropriate speciality. Historically, the main focus of the role was to be ultimately responsible for patients under their care by leading groups of clinicians or multidisciplinary teams, including nurses and other health professionals in the delivery of that care. As a result consultants have always been expected to be strong leaders. This leadership role has changed in recent times to include strategic service development while retaining the ultimate responsibility for patient care.

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In restorative dentistry, where there is lack of clarity about the scope of the service, the consultant plays an essential role in ensuring the delivery of the service across the different sectors (hospital and general dental practice) is undertaken with the best outcome for patients while at the same time raising awareness of the breadth of restorative services in today's National Health Service. Although the General Dental Council recognises restorative dentistry as a separate speciality, its scope remains poorly understood[2,3] with many equating it to care being delivered by a general dentist in the high street. This further adds to the challenges that the consultant in restorative dentistry faces in service delivery in times of financial constraint when trying to establish a strategic direction for the speciality.

The role of a consultant in restorative dentistry

A document outlining the role of the consultant in restorative dentistry was first published in 1983[4] and their status was noted to be equivalent to that of other consultants, both medical and dental. Since the original publication, however, the demands of the new National Health Service, which is becoming increasingly risk assessed and patient focused, have changed substantially. The Darzi report[5] highlighted the need for renewed clinical leadership and engagement in shaping the future delivery of high quality patient care but also stressed the importance of having the right balance of workforce in delivering this care. In restorative dentistry, the ageing population with increasing life spans has led to varying complexity of treatment need resulting in a commensurate rise for integrating services across different sectors within a constrained financial envelope. The role of the consultant in restorative dentistry thus encompasses the responsibility related to patient care, but also has the expectation of delivering a leading role in the development of services for patients, supervision and training of other dentists and professionals allied to dentistry as well as overseeing the running of clinical services and undertaking research and audit to improve patient outcomes. These integrated roles have resulted in very high workloads which are often complex, demanding and occasionally conflicting. These roles can be grouped into the following categories.

Patient care

The consultant in restorative dentistry plays a key role in the provision and delivery of their service which involves advice and second opinions, directly delivered specialist treatment, treatment by staff in training or in staff grade (SAS) posts, dental care professionals (DCPs), or in conjunction with the referring practitioner.

They provide:

- Leadership in service delivery by defining referral criteria and managing and prioritising referrals. They assist in developing information leaflets and documents for service provision and development
- Treatment by way of advanced interventions for patients usually requiring multidisciplinary care and also direct their teams in delivering advanced treatment of the highest standards for patients. In addition to this they lead multidisciplinary teams to ensure the best outcome of care for patients with conditions requiring integrated and multidisciplinary care for example, hypodontia, cleft palate, aggressive periodontitis, head and neck oncology to name a few and also develop and provide outcome based information ensuring that the service delivery expectations from commissioners are realistic and achievable
- They may also advise primary care and specialist colleagues on patient management issues, emphasising the role on the integration of care for patients with joint treatment needs eg oncology (head and neck) patients, developmental anomalies such as hypodontia, cleft lip and palate and acquired injuries due to dental trauma.
- Interaction with other providers of care and provision of treatment plans which may be deliverable in primary care to optimise service delivery and where possible provide shared patient care with general dental practitioners as well as advice to medical practitioners, specialist medical and surgical colleagues and DCPs, as well as other healthcare providers.
- Guidance on how to shape delivery of patient care locally without compromising quality within the constraints of funding. This can be done via the Local Dental Networks or the Managed clinical networks
- Leadership to managed clinical networks[6] (a focus of the modern National Health Service) to ensure equitable and fair delivery of restorative care maintaining the quality of care patients receive. Although managed clinical networks are not fully set up in restorative dentistry, the national focus is to establish these in all areas to optimise patient care and outcomes with equitable access. This is critical in restorative dentistry where increasing complexity and cost of treatment often pose challenges in prioritisation of individual cases and how, where and by whom their treatment should be delivered.

The consultant in restorative dentistry, as the lead clinician, will be expected to chair these networks to drive local changes needed for delivering restorative services using the available evidence and outcome based measures. This role thus involves drive and energy but also necessitates building relationships with a range of stakeholders which include service users, providers (both hospital and general practice based) as well as commissioners and others for the benefit of the local population. This forum enables the consultant in restorative dentistry to collaboratively develop care pathways to optimise quality and patient outcomes thus improving the patient experience by providing a more consistent approach to delivering care across the country. The essential role of the consultant in assessing patient care using care pathways (more commonly referred to as the patient journey) is reported in the Introductory guide to commissioning specialist dental services[7] where the consultant drives the referral management process by determining the level of treatment required by the patient and by whom and where this will be provided thus ensuring that the treatment is delivered in the correct setting by the appropriately trained dentist or specialist. This care pathway model is, in recent times, being extended beyond the referral management process, in restorative dentistry, to those conditions requiring multidisciplinary engagement where costs of treatment are high. Consultants as core members of these teams are often at the helm of these pathways ensuring that the care delivered is risk managed from a quality, outcome and financial perspective.

Education

The consultant plays an essential role in the training of all dental professionals and other teams. In particular the consultant has a crucial role in training as:

- Clinical and educational supervisors for hospital and university based trainees. In these roles they will provide supervision of clinical cases and ongoing pastoral support in the clinical environment as well as providing guidance and support for junior staff, undertaking appraisals and assessments and ensuring that the curriculum requirements for training are met
- Training programme directors ensuring that the standards of training are met and fulfilled and the trainees have the required support
- Trainers for professional colleagues in general practice and salaried services through the delivery of Section 63 courses, distance learning courses and provision of clinical reports. They also train DCPs, for example, dental therapists, hygienists and nurses and overseas teams as well as peers and specialists in restorative dentistry
- Educators to external bodies, commissioners and other purchasers of healthcare to raise understanding of restorative dentistry and its remit
- Quality assessors of education in their different roles to ensure that there is compliance with the quality standards in education ensuring delivery of clinical training that is safe and patient focused
- Mentors and coaches for trainees, professional colleagues and others.

Support and advice to general dental services

Consultants provide professional leadership to the local area teams and commissioners as well as dental advisors in delivery of restorative services. They also lead by chairing the managed clinical networks to develop clinical care models aimed at improving effectiveness, outcomes and delivery of restorative care.

Research

Consultants are expected to drive the research agenda by leading on research activities that focus on disease prevalence with service demands versus need, cost effectiveness of services provided, evaluating clinical outcomes of treatment undertaken, developing new strategies for improving and managing restorative problems (bringing science to the clinic) and patient-reported experience and outcome measures. The consultant may also be involved in participating in research ethics committees, as well as training research students and presenting research findings at meetings or via publication. Thus they play a key role often with other partners in disseminating knowledge about interventions and outcomes that are used within the National Health Services thus providing valuable information about service delivery and effectiveness.

Management

There is an increasing expectation that consultants will work with healthcare managers to develop efficient pathways for patient care and finance teams/managers to develop and deliver cost effective strategies for the provision of

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restorative care. They are also expected to work with senior managers and key players to improve awareness and understanding of the scope of restorative dentistry in line with the treatment needs of patient population and to promote the awareness of restorative dentistry in the wider arena nationally and its importance in the context of quality led patient care and managing and developing professional teams.

Consultants are required to interact with commissioners and purchasers of service outside of the hospital settings and also work with the Royal Colleges and other regulatory bodies to help drive and deliver strategy in both service delivery and training.

Quality assurance

Consultants in restorative dentistry are expected to establish and lead on quality assurance (clinical governance) in their speciality locally and nationally. They are leaders of clinical effectiveness and audit both of which aim to improve service delivery and outcomes of care. They also participate in networks to ensure that restorative dentistry has a voice that is heard. In addition to the local roles, they will work towards ensuring that nationally agreed guidelines are endorsed and implemented maintaining standards and protocols. They may also get involved with external agencies such as Royal Colleges and others to foster guideline development.

Working with other professionals

Consultants may offer advice and support to health professionals in other disciplines across dentistry and medicine including general medical practitioners, health visitors and other health professionals. They work with Local Areas Teams (and their future successors) as well as dental public health consultants to ensure that the restorative services locally map to the local population needs.

Political

Consultants in restorative dentistry play a key role in the development of oral healthcare strategies with a focus on the delivery of restorative dentistry at local, regional and national level. They are able to influence decision making to improve restorative dentistry services and also act as patient advocates to ensure that their restorative needs are adequately met. There is scope for the consultant to work with other leaders of healthcare delivery to ensure that the remit of restorative dentistry is known at local and national levels.

Others

In addition to the above roles, a consultant has a role in undertaking appraisals and leads on revalidation for their teams and peer reviews. They are also involved in becoming members and examiners for the Royal Colleges and assessors for the General Dental Council and may chair and become involved in national and local committees. They are expected to maintain their clinical standards by annual appraisal and also keep an up to date record of professional development and CPD to demonstrate good clinical practice. They may also undertake medicolegal work which includes the health services ombudsman and may also be peer reviewers for journals.

How does the consultant role differ to that of specialists?

Specialists have expert knowledge and experience in the diagnosis and clinical management of problems related to that speciality. Within restorative dentistry these specialties are periodontology, endodontics and prosthodontics. The consultant in restorative dentistry has a multifaceted role which, to some extent has moved away from the original focus of adopting ultimate responsibility for the care of all patients referred to them. It still carries a significant personal clinical responsibility alongside the responsibility for their teams and enables a broader overview of the specialties especially where integration of the subspecialties and other specialities, both dental and medical, is required.

The pathway to becoming a consultant differs to that from becoming a specialist with a longer training time needed for a consultant. The specialist role in restorative dentistry was first identified by the Mouatt Report in 1994[8] to enable broader access for specialist level clinical care (aimed at high street dentistry). The focus of a three-year full time speciality training programme is to ensure that the individual has the highest level specialist clinical skills within their speciality. The culmination of the three-year programme is defined by the satisfactory completion of the Annual Review of Competence Progression (ARCP) process and attainment of the Masters in Restorative Dentistry (MRD) (soon to be replaced with Masters in Periodontology, Masters in Endodontics and Masters in Prosthodontics) within the speciality which enables the individual to register onto the General Dental Council's specialist list relevant to their training. In contrast, the consultant training pathway in restorative dentistry lasts five years and the training includes significant multidisciplinary clinical training, in addition to exposure to management and leadership attributes that are essential within the NHS today. The end point of the two training programmes accordingly are quite different, with one aimed at producing leaders with expertise across a breadth of skills and competence whereas the other aims at producing clinicians who are highly skilled clinically in one of the single specialities of restorative dentistry. Specialists do not carry the ultimate responsibility of patient care as often they are part of the team overseen by a consultant within the hospital setting.

Conclusion

The role of a consultant today, including that in restorative dentistry, is assuming an increasingly important role as the NHS goes through a turbulent change. It needs strong leadership and support from clinicians capable of driving strategic change and direction, raising awareness and understanding of what constitutes restorative dentistry and provision of appropriate service delivery. Consultants in restorative dentistry with their extensive training and experience are best placed to achieve this. As the impact of carefully planned and provided restorative care on people's well-being is better recognised, the role of the consultant in restorative dentistry is increasingly being recognised as a cost effective option of clinical dental leadership that will help shape the future for clinical service delivery, education, research and clinical management.

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