



**Role of Consultants & Specialists  
in  
Restorative Dentistry**

## Index

1. Executive summary .....	3
2. Restorative Dentistry.....	5
2.1: Definition	
2.2: Aims	
2.3: Remit	
3. Consultants and Specialists.....	6
3.1: Consultants	
3.2: Specialists	
4. Training & competency.....	8
4.1: Specialists in practice	
4.2: Consultants in Restorative Dentistry	
5. Role of the Consultant.....	10
5.1: Patient Care	
5.2: Education	
5.3: Research	
5.4: Support & Advice to Primary Care Trusts	
5.5: Management	
5.6: Quality Assurance	
5.7: Working with Other Professionals	
5.8: Political	
5.9: Others	
6. Workload.....	14
6.1: Average Working Week	
6.2: Workload – New Patients	
6.3: Workload - Treatment	
7. Casemix.....	16
7.1: Referral Pathway	
8. Workforce.....	18
8.1: Current	
8.2: Estimates	
8.3: Future supply	
9. Bibliography.....	20
10. Appendices.....	21
Appendix 1: Categories of Patients normally accepted for Treatment with the Restorative Service	
Appendix 2: Referral Pathway	

## **1.0 Executive summary**

Restorative Dentistry evolved as a recognized dental specialty in 1973 and comprises a broad-based area of expertise on the restoration of teeth and oral tissues. Over the past 35 years the specialty has seen significant changes as a result of changing population demographics including increasing life expectancy and greater patient awareness and maintenance of oral and dental health with a desire to retain natural teeth for longer. The next five years will see significant changes within health care and restorative dentistry needs to adapt to these changing circumstances. All consultants in Restorative Dentistry, as in other specialties, see patients referred for specialist/secondary care either within Dental Hospitals or District General Hospitals and as such are an important component of the support needed for NHS Dentistry.

Patient's expectations and the high cost of restorative treatment needs, often of a multidisciplinary nature, have made the Consultant's role today more demanding and challenging. The National Health Service, since its inception in 1946, has gone through a number of initiatives aimed at improving access to dental care with the biggest change being the introduction of financial scrutiny. These changes have improved the quality of patient care balanced with financial accountability and awareness. Unfortunately despite being established as a recognized specialty the breadth and scope of Restorative Dentistry remains poorly understood by many leaders and managers within the Health Services of the United Kingdom, often equating the discipline to being the same as "high street" dentistry. To this end the role of the consultant in Restorative Dentistry remains poorly understood and appreciated.

Restorative Consultants are employed either within the NHS or by Universities, the latter being employed with an honorary status. The bulk of consultants are employed directly or indirectly by Dental Hospitals and Schools, however, over the past 10 years there has been a growth in Consultants being appointed to District General Hospitals. All Restorative consultants see patients needing secondary or specialist levels of care but have an ever increasing focus on multidisciplinary treatment with different medical or dental teams. The key role of the consultant has been to provide support and advice predominantly for patients referred by Dentists within primary care and other secondary providers and where appropriate patient treatment. All consultants have a commitment to education, research and training with Honorary consultants committed to education and training of undergraduate and postgraduate dental students thus

helping maintain the workforce in dentistry. Honorary consultants are actively involved with research, normally patient centred, and achieve a high impact on restorative dental research.

The on-going changes within the health services are likely to see a shift of oral health care, potentially including restorative dentistry, into the primary care setting thus taking services closer to the patient. The Consultant in Restorative Dentistry will assume an ever increasing importance if changes are to be accommodated effectively while maintaining a high standard of patient care. Restorative Consultants can act as primary advocates to continue effective dialogue between the commissioners and purchasers and dental practitioners.

The purpose of this document is to provide an update and overview on the changing and expanding Role of the Consultant in Restorative Dentistry and Specialists in the Health Service today. It also provides guidelines on the function of and workload within the specialty.

## **2. Restorative Dentistry**

### *2.1: Definition*

Restorative Dentistry includes clinical practice, teaching and research into comprehensive and therapeutic oral health care for patients of all age groups including those who demonstrate medical, physical, intellectual, psychological and/or emotional problems. It involves the restoration and rehabilitation of the oral and dental tissues lost as a result of disease, inheritance and trauma to meet the aesthetic, psychological and functional needs of the patient, often requiring the co-ordination of multi-professional teams within and outwith dentistry.

### *2.2: Aims*

The specialty of Restorative Dentistry aims to:

- Deliver advice, support and treatment to patients referred from primary care
- Improve the oral health of patients of all age groups through appropriate preventive, educational and treatment services.
- Deliver high quality patient centred research
- Ensure that individuals and agencies, both government and private, are given the relevant information in order to include the provision of specialist restorative care in their decision making processes to meet the oral health needs of the local population.

### *2.3: Remit*

Restorative Dentistry forms one of the 13 different dental specialties. It evolved as a distinct specialty in 1973 and comprises the following and particularly their integration:

- *Periodontology* which is the prevention, diagnosis and management of disorders of the tissues supporting the teeth (gums) and their associated structures;
- *Endodontics* which is the diagnosis and management of disorders of the tooth pulp and the tissues surrounding the root of a tooth
- *Prosthodontics* which is the diagnosis and management of the replacement by removable and fixed prostheses (including implants) of teeth and associated structures lost as a result of disease, inheritance or trauma. This also includes operative dentistry which involves the restoration of teeth damaged by caries or tooth wear;

### **3.0. Consultants and Specialists in Restorative Dentistry**

In recent years the importance of Restorative Dentistry has been recognized by an increase in the demand for consultant-led restorative services. Whilst the concept of specialism in Dentistry has been recognised by many (Mouatt Report 1994), Restorative Dentistry remains one of the more poorly recognized Consultant-led hospital-based dental specialties despite it being one of the most cost effective ways of delivering specialist treatment to targeted patient groups.

#### *3.1: Consultants*

A consultant today has an all encompassing role where he/she is a leader of service delivery and patient care allied to the educational and research demands which form the cornerstone of today's healthcare. They are predominantly based within the Hospital Services and interface with a wide range of providers including those based within the General Dental Services (dental practices) as well as those within the Salaried Primary Care Dental Services. They will also contribute to undergraduate and postgraduate education. Consultants will usually lead a team and be at the forefront of rehabilitation of patients with complex and multidisciplinary treatment needs particularly cancer care and those suffering from hypodontia and clefts. In regional and dental hospitals consultants are integral to undergraduate and postgraduate education. They have similar responsibilities to all other consultants including re-accreditation and professional development. All consultants will have an annual job plan agreed and are expected to undergo annual appraisal to ensure that their personal development needs are met. The same rules apply to Clinical Academics with an Honorary Consultant Contract who have a larger commitment to research. Consultants may also be required to take on the role of Training Programme Director within a Region, with a responsibility both to the Postgraduate Deanery and to the Royal Colleges. They are appointed by appropriately constituted and recognised appointment panels.

(For further details of consultant job planning and appraisal refer to BMA Consultants Handbook). Further details of the role are covered later.

#### *3.2: Specialists*

Specialists have expert knowledge and experience in the diagnosis and management of problems related to that specialty. They were introduced to improve the access to specialist level restorative care in a primary care setting (Mouatt Report 1994). They predominantly work within the primary care setting in independent practice and are able to accept referrals of, and provide care for, patients with problems in the specific discipline. However with the increasing treatment and training needs there are positions being established, mainly within University Teaching

Hospitals and Schools, where specialists play a role in the provision of education to those training to become specialists and also other dental care professionals and professionals allied to medicine. Positions are also being created for specialists within the salaried health services, either as community based specialists, specialist practitioners or as part of a hospital based consultant-led team to help cope with the increasing demand in each of these disciplines. They may also contribute to the service development within their locality.

## **4.0. Training & Competency**

Local training programmes for those aspiring to be either Consultants or Specialists have been determined and fully accredited by the Regional Deaneries, based on a nationally agreed curriculum. The Specialist Advisory Committee (SAC) and the JCPTD - Joint Committee for Postgraduate training in Dentistry - of the Royal Colleges play a key role in defining the curriculum which is competency based. The implementation of the curriculum is quality assured by the Regional Deaneries. Those wishing to enrol in a programme must have completed 2 years of General Professional Training (GPT) and successful acquisition of a training place is via competitive entry. Due to the lack of clinical academics, there is currently a drive to increase the number of academic training places via the development of academic training posts which are part funded by the Department of Health. The posts, pre PhD or post PhD, are funded by the NHS through the NIH IAT (integrated academic trainees) and aimed to provide supplementary funding to Universities to improve succession planning. These posts however still need to fulfil the training requirements for either a Specialist or Consultant. The training standards are quality-assured through formal assessment - ARCP (Annual Review of Competence Progression, previously known as the Record-In-Training Assessment – RITA) as agreed by the deanery. All programmes fulfil the General Dental Council (GDC) requirements for enrolling on one of the specialist lists. There are distinct differences between the training of a consultant compared to that of a specialist.

### *4.1: Training of Specialists*

Specialists in each of the disciplines of Endodontics, Periodontology and Prosthodontics enrol into recognised training programmes currently offered predominantly within a University setting. The majority are self funded, although there are some situations where the funding is provided by the NHS. Acceptance onto a programme is by competitive entry. The end point of training is demonstrated by the achievement of the ‘Membership in Restorative Dentistry (MRD)’ examination within the specific discipline. This, in conjunction with satisfactory progress through the ARCP process, will result in the award of a ‘Certificate of Completion of Specialist Training (CCST)’ which enables entry onto the Specialist Register held by the General Dental Council. The current requirement for entry into this list is a minimum of 3 years of specialist level training, or evidence of equivalence. Specialists may work in a number of spheres as previously indicated.

#### *4.2: Consultants in Restorative Dentistry*

The training for a Consultant in Restorative Dentistry takes place over 5 years and culminates in the successful completion of the Intercollegiate Specialty Fellowship Examination (ISFE). The 5 year training programme is competency based and covers a range of domains which include knowledge, clinical, management, communication, teaching and research with an emphasis on 60% of the training time to be dedicated to clinical outputs.

The additional training time for a restorative consultant allows for close integration with other specialties and additionally focuses on management training with a particular emphasis on governance, quality assurance and Health Service delivery including leadership and management skills and integrated team working.

## 5.0 Role of the Consultant in Restorative Dentistry

The Role of the Consultant in Restorative Dentistry is similar to that of consultants in the other medical and dental disciplines in the National Health Service. Accordingly, they are responsible for managing the care of patients, assisted by a team of junior staff, trainees and other dental care professionals (DCPs). They integrate and liaise with other consultants within dentistry and medicine as part of a team in the overall care of the patient. The role is multifaceted and the list provided below gives an overview whilst not being exhaustive. Dentistry in primary care has an increasingly mixed economy with delivery of care from the NHS and private sources producing unique pressures for the NHS. As such Restorative consultants provide valuable and independent advice to all patients. Within primary care Dentistry there are no other comparable groups with the necessary levels of training and expertise to provide advice and treatment to those patients needing secondary levels of care.

### 5.1: Patient Care

The consultant plays a key role in the provision and delivery of service which involves advice, treatment, treatment in conjunction with the referring practitioner and second opinions.

Restorative consultants provide:

- Service Delivery: Acceptance of referrals for advice and management
- Treatment: Usually this will be via their teams and will usually be aimed at patients needing secondary or tertiary care.
- Integrated and multidisciplinary care: For patients requiring multidisciplinary team management to optimize the clinical outcome.
- Interaction with other providers of care to optimize service delivery and patient care eg General Dental and Medical Practitioners, Dental Care Professionals, other health care providers

### 5.2: Education

The consultant plays an essential role in the education and training of all dental professionals. In particular the consultant will play a key role in the education/training and clinical supervision of the following groups of hospital junior colleagues:

- General Professional Trainees – consultants may be the hospital-based educational supervisor for newly qualified colleagues undertaking a two year programme of training in primary and secondary care; also delivering education, training and clinical supervision for them.

- Senior house officers (SHOs) or equivalent grade as DF2: The consultant may be the educational supervisor and takes the overall responsibility of ensuring that the training curriculum fulfils the Deanery requirements and the needs of the trainee are met.
- Specialist / Specialty Registrars: Consultants act as clinical or educational supervisors working together with the Training Programme Directors (TPD) to ensure that the training programme fulfils the training requirements as established by the Deanery and Colleges. The consultant will play a key role in ensuring that the trainee meets the competency based curriculum requirements by ensuring that appropriate appraisals and assessments are undertaken in a timely manner. A consultant may also hold the position of the TPD.

As well as delivering clinical advice and support, consultants will provide education for the following:

- Primary care dentists in general practice and the salaried services: This is usually via the delivery of section 63 courses and may also involve leading distance learning courses for dental practitioners
- Dental care professionals (DCPs), such as dental therapists, dental hygienists and dental nurses
- Other Consultants and Specialists in Restorative Dentistry
- Speciality training in Endodontics, Periodontics and Prosthodontics delivered both in university dental hospitals and other hospital units. The training programmes involve meeting the required standards of clinical, didactic and research training as specified by the Deanery.
- Dental undergraduate and postgraduate students dependent on the role of the individual in a dental teaching institution

### *5.3: Research*

Consultants, both substantive and honorary work to drive forward the research agenda within the NHS and Universities. Honorary Consultants in the UK encompass some of the best known Dental Researchers in our speciality throughout the world. The key areas of interest that a consultant will be expected to lead are:

- Disease prevalence and the demand on services
- Evaluating the clinical outcomes of treatment
- Developing new strategies for improving and managing restorative problems
- Linking basic science to the clinical environment
- Patient reported outcome measures

#### *5.4: Support and advice to primary care dental services*

- Professional leadership to the PCTs and dental advisors in delivery of restorative services
- Working towards developing clinical care networks to improve the effectiveness and delivery of restorative care

#### *5.5: Management*

- Working with health care managers to develop efficient pathways for patient care
- Working with managers and finance teams to develop and deliver cost effective strategies for the provision and delivery of restorative care
- Improve awareness and understanding of the scope of Restorative Dentistry alongside the treatment needs of patients
- Promote the awareness of Restorative Dentistry in the wider arena nationally and its importance in the context of quality led patient care
- Managing and developing professional and DCP staff

#### *5.6: Quality Assurance*

- Lead on quality assurance (clinical governance) locally and nationally
- Lead on Clinical Effectiveness and Audit to help drive service delivery and outcomes
- Ensure that clinical guidelines established by NICE are implemented and acted upon
- The consultant may also become involved in guideline development either through the Royal Colleges or National Institute of Clinical Excellence

#### *5.7: Working with other professionals*

- Offering advice and support to health professionals in other disciplines across dentistry and medicine including general medical practitioners, health visitors and other health professionals
- Working with purchasers of clinical services eg Primary Care Trusts (and their future successors) to deliver quality assured service in their local areas

#### *5.8: Political*

- Development of oral health care strategies with a focus on the delivery of Restorative Dentistry at local, regional and national level
- Influencing measures to improve restorative dentistry services
- Acting as advocates for patients to ensure that their restorative needs are adequately met

- Working with the leaders of health care delivery to ensure that remit of Restorative Dentistry is known at local and national levels

#### *5.9: Others*

- Play a role in leading revalidation for their teams
- Maintain an up to date record of professional development and CPD
- Provide evidence of standards of clinical practice by participating in annual appraisal and job planning
- Lead on external peer reviews and undertake appraisals
- Become members of advisory committees of the Royal Colleges
- Become examiners for the Colleges or assessors for the GDC
- Secure positions on committees locally and nationally

## 6.0. Workload

The document 'Consultant Practice & Workload in the Dentally Based Specialties' defines the workload for the Consultant in Restorative Dentistry.

### *6.1: Average working week*

The average working week for a full time (FT) consultant is made up of 10 sessions. For part time consultants the working week is agreed on a pro rata basis. The actual number of weeks dedicated to patient care are determined as follows:

$52 - 10 \text{ weeks} = 42 \text{ weeks}$  (6 weeks annual leave; 2 weeks bank holidays; 2 weeks study leave)

### *6.2: Workload – New Patient consultation clinics*

Consultant contracts are either substantive NHS contracts or Honorary contracts usually associated with Senior Clinical Academic posts. The workload of a consultant may vary and is determined by local agreement and agreed within the individual's job plan with the Clinical or Medical Director. The job plan is normally based on 10 Programmed Activities (PA) a week for a full time consultant with each programmed activity being equivalent to 4 hours' work. The workload is normally dependant on the service needs and for clinical academics is determined by the local educational and research needs. The PAs are usually split between direct patient care and supporting activities such as audit, governance, continuing professional development and teaching.

A Full time (10 sessions) NHS funded consultant would usually be expected to undertake 2 new patient consultation sessions per week with an average of 6-8 new patients (the lower end if this is a teaching clinic). There is normally some allowance made for DNA (did not attend) occurrences which would be agreed within a job plan.

$42 \text{ weeks} \times 2 \text{ clinics} \times 6 - 8 = 504 - 672 \text{ patients per year}$

For part time NHS funded consultants, this figure is calculated on a pro-rata basis. Consultants with 6 sessions or less may on average undertake 1-1.5 consultation clinics. The distribution of new to follow up clinics is normally determined locally during the consultant's job planning which should take place annually. In terms of patient volume and time per patient it should be noted that most new patients will need radiographs and associated investigations which are

normally interpreted at the same visit so that a full diagnosis and treatment plan is given at that appointment, unlike other disciplines where tests are requested and the final diagnosis and treatment plan is made at a follow up visit.

The nature of the Clinical Academic's job derives from its 2 major components – academic and clinical both of which make up the integrated workload. Full time Clinical Academics with Honorary Consultant Contracts would normally be expected to spend 50% of their time to clinical activity, either patient treatment or undergraduate teaching. The role and responsibility of an Honorary Consultant falls in line with substantive NHS Consultants; however, the remit for these University positions is balanced between research, education and clinical care. The distribution of the work load is determined at a local level and agreed within the job plan by the University and NHS organisation, however it is suggested that within the 50% of the clinical time, time is allowed for patient care. The direct clinical care duties for Clinical Academics would include (but are not limited to) a dental teaching clinic where patients are treated under the direct supervision of the Clinical Academic, personal treatment sessions and an outpatient clinic (eg new patient clinic) where patients are seen with trainees in attendance. The contractual obligation of Honorary Consultants falls in line with the NHS guidance (further details can be found in the BMA consultant Handbook).

### *6.3: Workload – Treatment Clinics*

The number of patients seen will be determined by the complexity of the case seen. However on average for routine recall and follow ups an estimated number of patients can range from 4-6 depending on the case mix.

## 7.0 Casemix

The Consultant in Restorative Dentistry normally works on a shared care basis with the referring dental practitioners who have the responsibility for the patient's continuing care which includes maintenance. The service aims to provide:

- Multidisciplinary care for patients liaising with other disciplines within dentistry eg orthodontics, oral surgery
- An advisory, diagnostic and treatment planning service to support medical and dental practitioners.
- Patient treatment in conjunction with the referring dental practitioner, providing if necessary guidance in the planning and execution of treatment as necessary
- Recall clinics where treatment outcomes for patients are evaluated

The needs of referred patients that are accepted for treatment within the hospital based restorative services will usually depend on the local NHS priorities. The acceptance criteria will normally be discussed and agreed with the local Primary Care Trust who commission the service from the Trust and pay for the delivery of the service. Most Primary Care Trusts have a Dental Advisor who represents the local dentists and has an important role in the discussion and agreement about the acceptance criteria. A number of Units particularly Dental Hospitals will also include additional factors in their acceptance criteria particularly for their Educational and Research needs. However it is important that patients and their experience of care continues to remain at the core of any educational and research objectives in line with the National Health Service of today. The focus of modern day commissioning is based on Quality with the patient at the core of the service delivery, education and research.

The patient who is accepted for treatment is normally discharged back to the care of the referring practitioner on completion of the active course of treatment, thus ensuring that the dental practitioner maintains the overall and ongoing responsibility for the patient's dental needs. The list in appendix 1 gives a guide to the types of patients normally accepted for treatment.

Treatment within a hospital department is often undertaken by the Consultant or their team with the Consultant retaining the overall responsibility of the patient.

### *7.1: Referral Pathway*

The referral pathway for patients (also called the patient journey, patient pathway or care pathway) is developed locally in conjunction with the Primary Care Trusts to meet the demands on the service in line with the national targets. Appendix 2 shows an example of such a pathway. Each Trust will have their local guidelines for the time frames within which patients referred to the service are seen for consultation with many focussing on keeping this within 9 weeks of receiving the referral.

Referral letters are usually triaged by the Consultant in Restorative Dentistry who will determine the urgency from the information provided in the letter. A number of hospitals have designed referral proformas making the referral process much easier for the referring dentist. Referrals usually would be made by dental practitioners although some units may also accept referrals from General Medical Practitioners.

## 8.0 Workforce

### 8.1: Current

Supply and demand within the specialty at present is reasonably balanced. Approximately half of all consultants are honorary consultants. There are 290 hospital/ university and “high street” specialists on the Restorative Dentistry Specialist list. The following table shows the most recent data available on distribution of the current NHS workforce in England\*

Category of Staff	No	FTE
NHS Funded Consultants	67	49
Specialist Registrars **	48	40 (35NTN; 5 VTN)
SHOs **	28	28
NCCGs**	25	13

\*Data from Information Centre census 2007; DH monitoring March 2006

\*\* May also include some but not all trust doctors.

### 8.2: Estimates

Demographic changes will result in increased demand for the provision and maintenance of increasingly complex restorative dentistry. The specialty reports an increased number of referrals to the hospital service from both general dental practitioners and high street specialists, because of patients’ increased expectations and the retention of teeth with existing complex restorations into old age. These referrals have led to increased waiting times.

- Based on a target of one consultant per 200,000 population, the specialty estimates that 170 consultants in England will be needed by 2012 (assuming a population of approximately 51 million people).
- The specialty believes the service requires one FTE consultant per ‘district’ Head and Neck Cancer MDT.

As a high proportion of the dental undergraduate programme is delivered by restorative dentists, there is a need to expand capacity in the existing and new dental schools.

### 8.3: *Future Supply*

The supply of restorative dentistry consultants should ideally increase slightly over the next 15 years based on the following observations:

- 20% of the consultants currently in post in England will retire in the next 5 years, the majority of which will be academic consultant posts.
- The increased trend towards part time private practice is likely to impact on NHS capacity
- ~ 60% of all the National Training Numbers (NTN) are NHS posts and 40% are university-based.
- An additional five NTN's per year would enable the estimated requirement for consultant/specialists to be met.
- There will be a pressure on current and future academic staff due to the low numbers being trained and the high number due to retire. Although deaneries have secured a number of Walport funded academic training programmes in the specialty, the funding constraints to support these posts remain a challenge for universities and trusts alike.
- Expansion of current training opportunities is required to balance the demands from patients; however, consideration must be given to who can provide this training.

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- b. Academic and Careers Sub-Committee of Modernizing Medical Careers and the UK Clinical Research Collaboration. (2005) *Medically and dentally-qualified academic staff: Recommendations for training the researchers and educators of the future.*
- c. Fitzpatrick, S. (2008). Clinical Academic Staffing Levels in UK Dental Schools. Dental Schools Council.
- d. General Dental Council. (2005). *Standards for dental professionals.*
- e. Association of Consultants and Specialists in Restorative Dentistry (ACSRD) website: [www.acsrd.org](http://www.acsrd.org) carries a host of information about the Specialty and other aspects of Restorative Dentistry and provides links to the other Societies and include the following:
  - British Society of Restorative Dentistry (BSRD)
  - British Society of Periodontology (BSP)
  - British Society for the Study of Prosthetic Dentistry (BSSPD)
  - British Endodontic Society
- f. [NHS.employers.org](http://NHS.employers.org) website carries wide range of information on consultant appraisals, job planning and other matters relating to pensions etc.

## **11. Appendices**

### **Appendix 1:** *Categories of Patients normally accepted for Treatment within the Restorative Service*

- Head and neck cancer requiring rehabilitation
- Medical disorders deemed unsuitable to be managed within the primary care setting
- Other types of cancers that require oral and restorative input
- Congenital conditions eg: cleft lip and palate, severe hypodontia
- Multidisciplinary treatment needs eg Developmental anomalies eg amelogenesis, dentinogenesis imperfecta cases
- Traumatic injuries resulting in tooth &/or soft tissue loss eg road traffic accidents
- Genetically inherited diseases of the oral tissues
- Clinical cases requiring restorative dentistry treatment deemed to be beyond the scope of primary care generalist or specialist practice

## Appendix 2: Referral Pathway

