THE HOSPITAL CONSULTANT ORTHODONTIST SERVICE GUIDE
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THE HOSPITAL CONSULTANT ORTHODONTIST SERVICE GUIDE

SECTION 1  INTRODUCTION

Once appointed, consultant orthodontists find themselves facing a heavy stream of directives, targets and guidelines. These emanate from a variety of sources, including the Trust, PCT, FHA, Royal College, the Department of Health and the European Union. This overload of information could easily result in early disillusionment, but fortunately, there are two compensating factors. The first is the nature of the job itself – none are perfect, especially at the start, but the variety of the clinical case mix makes the job highly stimulating. Together with the satisfaction of training juniors, as well as the clinical research possibilities, the work itself can be uniquely satisfying.

Secondly, there is the genuine fellowship offered by orthodontic consultants, both near and far. They are universally keen to share experiences and give help and advice, not least through the Consultant Orthodontists Group. Indeed, several members of our Group have contributed to this Guide. It has recently been revised at yet another period of change in the Health Service, when consultant contracts are being renegotiated, new commissioning arrangements are imminent and the introduction of G.D.P.s' with an 'interest' is planned. All these issues will have some effect on the hospital service.

We are indebted to those who have contributed to this Guide and especially grateful to Jay Kindelan, Consultant Orthodontist at York, who has been co-author and editor. Aimed at the newly appointed, it contains a great deal of useful information for consultant orthodontists at all stages of their careers.

Raymond Edler
Chairman, Consultant Orthodontists Group
SECTION 2 DEMOGRAPHICS RELATING TO THE CONSULTANT SERVICE

The Consultant Service was first established in 1950 and the population in most parts of the Country have access to Consultant Orthodontist care. The Consultant Orthodontist Group has carried out surveys of their work in 1971, 1985, 1996 and most recently in 2003. The 2003 survey results were circulated on CD by Joe Noar to members of COG. In addition the results are available in full elsewhere on the BOS website. Some data is reproduced here with kind permission. This guide is applicable to NHS consultants and the NHS sessions that are part of the academic consultant contract.

Orthodontic Consultant Survey 2003

Introduction

As you will all be aware the new consultant contract has been accepted. This brings with it the necessity to negotiate job plans. Job planning will be based on a partnership approach. The clinical manager will prepare a draft job plan, which will then be discussed and agreed by the consultant. Job plans will list all the NHS duties of the consultant, the number of Programmed Activities for which the consultant is contracted and paid, the consultants’ objectives and agreed supporting resources.

The Job Plan will set out all the consultants NHS duties and responsibilities and the service to be provided for which the consultant is accountable. The duties and responsibilities set out in a Job Plan will include, as appropriate:

- Direct Clinical Care duties including on-call work
- Supporting Professional Activities
- Additional NHS responsibilities
- External duties

The clinical manager will draw up the schedule after full discussion with the consultant, taking account of the consultants’ views on resources and priorities and making every effort to reach agreement.

The employer has the responsibility for ensuring that a consultant has the facilities, training development and support necessary to deliver the commitments in the job plan and should make reasonable endeavours to ensure that this support conforms with the standards set out in ‘Improving Working Lives’.

Summary of the Contract

The current contract refers only to minimum commitments; no maximum is defined, however, the new contract is based on a full-time commitment of 10 programmed activities (PAs) per week, each of 4 hours (3 hours in premium time). In contrast to the current contract the new contract does have a clear maximum commitment and this includes work carried out while on-call. Any additional work above the 10 PAs will be by agreement and paid at the full appropriate rate.

Job planning

Key features of the new system of job planning:

- Work done whilst on-call will be included in the job alongside all other clinical commitments;
• The job plan will be by mutual agreement between the clinical manager and the consultant;
• Non-emergency work in the evening and weekends will be entirely voluntary;
• There is an appeals process if there is no agreement on the job plan;
• Job plans will list all NHS duties as well as the consultant’s objectives and agreed supporting resources;
• New “good practice” guidance sets out in detail how the process will work and the CCSC will be developing separate step-by-step practical advice for consultants on how to job plan;
• These new arrangements are meant to make clear the consultants’ commitment to the NHS and the Department of Health has said that they ‘are emphatically not intended to diminish professionalism or override clinical judgement’;
• Adequate recognition must be given for supporting professional activities. This will normally be an average of 2.5 per week, but if more time is required to be devoted to this type of activity, the consultants’ allocation of direct clinical care activities should be reduced to take account of this.

The Working Week

This will consist of 10 programmed activities (PAs), separated into:

1. **Direct Clinical Care**: work directly related to the prevention, diagnosis or treatment of illness. This includes emergency work (for those consultants who have on-call commitment that can be recorded over a period of time in a log then an average can be taken out of direct patient care sessions), operating sessions including pre-and post-operative care, ward rounds, outpatient activities, clinical diagnostic work, other patient treatment, public health duties, multi-disciplinary meetings about direct patient care and administration directly related to the above (e.g. clinic letters, phone calls etc).

2. **Supporting Professional Activities**: activities that underpin direct clinical care. This may include participating in training, medical education, continuing professional development, formal teaching, job planning, appraisal, research, clinical management and local clinical governance activities.

3. **Additional NHS Responsibilities**: special responsibilities – e.g. being a Medical Director, Director of Public Health, Clinical Director or lead clinician, or acting as a Caldicott guardian, clinical audit lead, clinical governance lead, undergraduate dean, postgraduate dean, clinical tutor or regional education adviser. These need to be specifically agreed with the employer.

4. **External Duties**: duties not included in any of the above and not separate fee paying services or private practice. These are things undertaken as part of the job plan by agreement. These may include trade union duties, acting as an external member of an Advisory Appointments Committee, work for the Royal Colleges or work for the General Medical Council.

On average 7.5 PAs will normally be for direct clinical care as defined above, for example if 1.5 PAs are taken for administration then this leaves a maximum of 6 PAs for clinics or alternatively if 2 PAs are taken for administration this leaves a maximum of 5.5 PAs for clinics, however, it is negotiable in the job plan. Where work falling into the other categories is significantly above or below 2.5 PAs, consultants may agree a different balance of PAs with the employer. This is likely to be the case for consultants with large teaching commitments.
However, PAs can be split and activities i.e. committee work should be averaged over the year.

The balance of PAs differs for part-time consultants where it is recognised that they need to devote more of their time to supporting professional activities and in these cases the balance should be 2 direct clinical care PAs to 1 supporting activity. Again the balance is negotiable and should be agreed at the job plan.

**Consultant Job Profile Data**

The purpose of the questionnaire is to produce detailed data which can be viewed on a national and regional basis. In addition to these criteria the data will be available to be broken down by part-time, maximum part-time and full-time employment, years as a consultant and hospital type i.e. district general hospital, teaching hospital or combination.

By allowing this each individual consultant will be able to base their job planning on hard data with a national reference and also comparing themselves to other individuals in like employment.

**About the Questionnaire**

The idea of carrying out this survey was that of the COG and was headed by Joe Noar and carried out by Charlotte Eckhardt. Following the design of the questionnaire a pilot was carried out by the COG committee. The aim was to produce a questionnaire which was very detailed and would generate enough information to be of use for both job planning and appraisal.

The key areas covered by the questionnaire were:

- Present consultant contract
- Clinical duties
- Clinical administration
- Emergency/on-call duties
- Audit
- Teaching activities
- Appraisal
- Research
- Continuing professional development
- Examining
- Journal activity
- Administrative duties
- Committee work

These areas correlate very closely with ‘Preparation for Job Planning – Consultant Workload and Commitments’ diary sheets circulated by the British Medical Association’s Central Consultants’ and Specialists Committee.

The questionnaire was circulated in April 2003.

**Response rate:** 187 returned questionnaires out of 234 (80%)

**Of the remaining 20%:**
- 2 consultants are on long term sick leave
- 2 consultants have just retired

**Adjusted response rate:** 81%
# Questionnaire Data National Figures

## Gender

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<tr>
<td>Male</td>
<td>73%</td>
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<tr>
<td>Female</td>
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## Present consultant contract

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<tr>
<td>Part-time</td>
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<td>Maximum part-time</td>
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## Academic posts

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<tr>
<td>Non-academic post</td>
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<tr>
<td>National Data</td>
<td>Number of useful respondents</td>
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<td><strong>Consultant Contract</strong></td>
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<tr>
<td>Average number of hours spent on NHS business in addition to your contracted sessions per week</td>
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<td>Average number of fixed sessions per week</td>
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<td><strong>Clinical Duties</strong></td>
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<td>Average number of new patient only clinic sessions per month</td>
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<tr>
<td>Average number of new and review clinic sessions per month</td>
<td>186</td>
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<tr>
<td>Average number of personal treatment sessions per month</td>
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<tr>
<td>Average number of joint orthodontic / paedodontic clinic sessions per month</td>
<td>186</td>
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<tr>
<td>Average number of joint orthodontic and restorative clinic sessions per month</td>
<td>186</td>
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<tr>
<td>Average number of orthognathic sessions per month</td>
<td>184</td>
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<tr>
<td>Average number of cleft clinic sessions per month</td>
<td>186</td>
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<tr>
<td>Average number of other clinical sessions spent in unspecified clinics per month</td>
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<td>Average number of hours spent in clinical meetings per month</td>
<td>177</td>
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<tr>
<td><strong>Clinical Administration</strong></td>
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<tr>
<td>Average number of hours spent on correspondence relating to patients per month</td>
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<tr>
<td>Average number of hours spent on dictation / writing up notes per month</td>
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<tr>
<td>Average number of hours spent on other administration relating to patient care per month</td>
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<td><strong>Audit</strong></td>
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<td>Average number of hours spent carrying out audit per month</td>
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<td>Average number of hours spent supervising audit per month</td>
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<td>Average number of hours spent at audit meetings per month</td>
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<td><strong>Teaching Duties</strong></td>
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<td>Average number of hours spent writing lectures per month</td>
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<td>Average number of hours spent planning seminars per month</td>
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<tr>
<td>Average number of hours spent preparing for other aspects of teaching</td>
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<td>Average number of hours spent giving lectures per month</td>
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<tr>
<td>Average number of hours spent giving seminars per month</td>
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<td>Average number of hours spent in teaching clinics per month</td>
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<td>Research</td>
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<td>Average number of hours spent marking written papers per year</td>
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<td>Journal Activity</td>
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<td>Average number of hours spent on journal business per month</td>
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<td>Administrative Duties</td>
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<td>Average number of hours spent on staffing issues per month</td>
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<td>Average number of hours spent on budgets per month</td>
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<td>Committee Work</td>
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<td>Average number of hours spent on local / hospital committee work per month</td>
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<td>1.26</td>
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<td>Average number of hours spent on regional / deanery committee work per month</td>
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<td>Average number of hours spent on national committee work per month</td>
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<td>Average number of hours spent on international committee work per month</td>
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The Consultant Orthodontist Survey – 2003; Noar, J, Eckhardt, C. BOS Website and can be linked to directly via:

www.bos.org.uk/members/special_interest/consultants/ContractSurvey/Survey_via_site.html
SECTION 3 JOB PLAN OF THE CONSULTANT ORTHODONTIST

Trusts should provide and agree job plans for consultants in all specialties. This should cover:

- Job content: A description of clinical duties including out of hours commitments, teaching duties, management duties, research and development duties, clinical governance and audit responsibilities. It should also include any supervision or agreed internal duties, e.g. ethics committees, IT roles and any other agreed external duties, eg, Royal College or BDA roles.

- Service objectives: A series of headings under which objectives will be agreed at the annual job plan review. These will vary according to specialty that might include waiting times and waiting list management, throughput and outcomes.

- Time and service commitments: A time table setting out how the job content and service objectives will be delivered. The Consultant Orthodontist Group drew up a job description for the Consultant Orthodontist 5 years ago and this was used as a basis for the job summary of a Consultant Orthodontist produced below with kind permission of the B.D.A. and minor modification. This was initially published in the document "consultant practice and workload in the dentally based specialities" produced by the British Dental Association in 1997.

- The most recent Consultant Group Survey is referred to in section 2 of the guide and published in full on the BOS website. The Survey makes additional references to job planning.

Job Summary for the Hospital-based Consultant Orthodontist

1. Consultant Advice

   The provision of orthodontic opinions to general dental practitioners, community dental officers and to medical practitioners. To liaise with specialist orthodontic practitioners and community orthodontists working within primary care and with hospital clinicians including consultants in oral and maxillofacial surgery, restorative dentistry, paediatric dentistry, paediatrics, plastic and ENT surgery.

   The consultant will be competent to provide advice on complex clinical patient management problems and interdisciplinary planning and treatment.

   The provision of second opinions at the request of a dental or medical practitioner or consultant colleague.

2. Treatment within hospital departments

   2.1 Severe and complex high need treatment

   Case loads should be restricted to malocclusions of greatest severity and technical treatment complexity.

   At present this is probably most appropriately achieved by selecting cases using the Index of Orthodontic Treatment Need (IOTN) of Manchester University as a guideline only.

   Primarily these will be chosen from grades 5/4. However some grade 3 cases should be included if these are technically complex, have a high aesthetic need rating and where dental health and psychological health gain is anticipated.
When there is a training commitment for either junior staff or general practitioners working as clinical assistants there will be a need to maintain a suitable range of patients of varying complexity including some patients of the type usually treated in primary care. Further selection will follow the assessment of malocclusion by severity and management difficulties.

2.2 Inter-disciplinary treatments

Consultant orthodontists will normally be involved in treatments requiring an interdisciplinary team approach and can therefore be expected to:

.. treat in conjunction with consultant oral and maxillofacial surgeons problems of unerupted, displaced (ectopic) and malformed teeth and the effects of trauma and pathology in the dento-alveolar structures of the child and young adult.

.. treat in conjunction with consultant oral and maxillofacial surgeons, plastic surgeons or paediatric surgeons severe skeletal malrelationships by means of combined orthodontic and surgical treatment approaches.

.. treat in conjunction with consultants in restorative dentistry and general dental practitioners those problems requiring a combined approach.

.. treatment in conjunction with consultant paediatricians and consultants in paediatric dentistry those children with special needs, growth related problems and disease who also have a malocclusion.

.. in conjunction with the other key specialities provide co-ordinated care for patients with cleft lip and palate and other craniofacial anomalies.

.. work with other consultant disciplines in areas of common interest including speech and feeding disorders resulting from sensory and motor nerve loss.

3. Treatment in the primary care sector

To provide the necessary advice, follow up and support to general dental practitioners or community dental officers carrying out orthodontics within primary care by regular review of patients to completion of treatment as necessary.

To advise or redirect those referred cases which may be treated within the general dental services through onward referral to specialist and community orthodontists.

To advise practitioners and counsel patients that no treatment is required for many minor malocclusions.

4. Access to treatment in primary care

To advise or assist referring general dental practitioners who do not carry out orthodontic treatment to refer selected patients to other providers of orthodontic treatment working within primary care where other providers exist.

5. Education and training

To provide clinical training for career junior staff, future specialists and trainee academics. Not all hospital orthodontic departments will train career junior staff and the variable teaching and training role will be reflected in the job plan.

To liaise with postgraduate deans in the provision of continuing professional education for general dental practitioners and community dental officers thereby helping to increase the quality of orthodontic treatment within primary care.
To participate in continuing professional education programmes for all trained providers of orthodontic care.

To undertake the education and training of undergraduates within or outside teaching hospitals as determined by the job plan.

6. **Public health role**

To work with consultants in dental public health in determining the needs and demands of the resident population with respect to orthodontic care and to ensure equity of access to orthodontic treatment by planning developments and strategies to meet demand.

This demands full discussion with representatives from all orthodontic providers or local orthodontic committees where these are established. Short term contracts or rapid cessation of contracts can have an adverse effect on training rotations and continuing patient care with potential medico-legal consequences.

7. **Management advice**

To provide advice to employing trusts on the specification and contracts for orthodontic services drawn up by purchasers.

To provide advice to trusts for subsequent negotiation with the purchasers on the availability of appropriate case mix for clinical training and continuing education programmes which the consultant organises and runs.
SECTION 4  THE TRAINING PATHWAY TO BECOME A CONSULTANT ORTHODONTIST.

GUIDELINES FOR THE UK TWO YEARS FIXED TERM TRAINING APPOINTMENTS FOR NHS CONSULTANT AND ACADEMIC PRACTICE IN ORTHODONTICS
OCTOBER 2004

1. INTRODUCTION

This guidance is intended to be used as a guide for universities and hospitals seeking approval for the two year Fixed Term Training Appointment (FTTA) programmes in orthodontics leading to eligibility to be appointed to a consultant appointment (NHS or honorary/academic) in orthodontics in the National Health Service. These two year programmes comprise of an additional two years of training following the UK 3 year specialist training programmes. They are normally available to holders of a CCST in Orthodontics awarded by the General Dental Council (or EU equivalent) and are specially designed to equip trainees to meet the regulations for the Intercollegiate Speciality Board Examination in Orthodontics (FDS(Orth)) of the Royal Surgical Colleges. This guidance should therefore be read in conjunction with the appropriate regulations of the Royal Surgical Colleges of Great Britain and Ireland.

This particular version of the guidance and the training pathways involved have been arranged at the request of the General Dental Council which is sole UK competent authority for dental specialist training.

This guidance is not framed with an exactitude designed to suit every occasion or circumstance. Compliance with its spirit is more important than rigid adherence to its letter. Programme directors, trainers and trainees are encouraged to show initiative in developing high quality training programmes that undergo continuous improvement and evolution. However, where programmes have significant deficiencies, they will not be approved even though excellent training may be offered in other fields.

This guidance should be read in conjunction with the “Guidelines for the UK Three Year Training Programmes in Orthodontics for Specialist Registrars and other Postgraduate Trainees” which is available from the SAC in Orthodontics.

During the two years of fixed term hospital training those orthodontists undertaking such programmes must have access to supervision and be working in clinical programmes approved by the SAC in Orthodontics designed to acquire new knowledge and broaden experience and maturity of clinical practice. The trainee should develop a consultant approach, an interest in continuing education, an interest in teaching and teaching skills, a continued interest in research methods and techniques, a responsible attitude and commitment to the training of hospital staff and an interest in professional activity. Experience and training in a special clinical interest is to be encouraged during these years.

2. THE PURPOSE OF ADDITIONAL TRAINING IN ORTHODONTICS

It builds on the initial 3 year training programme, and adds value. Trainees will be selected and appointed competitively as Specialist Registrars by a formal interview process. They will be appointed to Fixed Term Training (FTTA) and will be issued with a fixed term training number (FTN) by the Postgraduate Dental Dean. They must already hold (or fulfilled requirements for) a CCST in Orthodontics issued by the General Dental Council. Manpower numbers of these posts will be controlled as the numbers of training posts available are limited and the numbers are planned in order to supply the expected need for consultant orthodontist and senior academic posts in the UK. The NHS Executive, with help from the SACs and Royal Colleges, advises WNAB (Workforce National Advisory Board) which decides upon, and controls the numbers of Specialist Registrars both pre- and post-CCST - NTN or FTN - who may undergo orthodontic training.
2.1 The Completion of Additional Hospital Orthodontic Training

The Postgraduate Dental Deans will certify such training only when the full period of training has been completed. The exit examination will be the Intercollegiate Speciality Fellowship Examination.

2.2 Appointment to Specialist Registrar (Additional Hospital Orthodontic Training) and Academic Posts

Entry will be competitive. All posts must be advertised in the British Dental Journal.

Entrants to Fixed Term Training programmes will require to demonstrate successful completion of a 3 year SAC approved programme and possession of MOrth, or equivalent, together with RITAS ‘G’ and also the award of a CCST in Orthodontics by the General Dental Council. They will continue in the Specialist Registrar grade and hold an FTN (Fixed Term Training Number).

For academic training there will be several possible training pathways which will allow both flexibility between hospital and academic posts and also for individual trainees.

1. Additional University training
   The potential Academic trainee will have completed a speciality training programme and have been awarded MOrth/MDO and a University Masters degree. They will then apply for a lecturer’s post, which may be HEFCE funded. This will be a three year minimum programme although contracts may be extended. The trainee should complete a research based higher degree during the period of additional training. The Intercollegiate Speciality Examination will be taken towards the end of the programme.

2. Clinical training Fellowship
   This programme has the advantages of allowing the potential academic to have a period of protected research time leading to a research based higher degree. The potential postholder will have already completed a speciality training programme and have been awarded MOrth/MDO and a University Masters degree. The Clinical training Fellowship is awarded by various funding bodies for periods of up to three years. While 8 sessions are spent carrying out research the trainee may spend two sessions in a clinical setting where they will receive additional training. At the end of this period the trainee will have completed their research based higher degree. They can then enter a reduced additional training programme as either an academic trainee or an NHS trainee. Credit for the three year training Fellowship should be up to one year resulting in most trainees requiring to undertake a minimum of one year of further approved additional training before taking their Intercollegiate Speciality Examination.

   The satisfactory end of speciality training integrated with the two year’s academic and hospital orthodontic training will be marked by the successful completion of the Intercollegiate Speciality Examination plus a RITA ‘C’.

3. THE STRUCTURE OF ADDITIONAL ORTHODONTIC TRAINING PROGRAMMES

3.1 Objectives

The orthodontist at the end of the training programme will:

1. Be competent to treat malocclusions requiring an interdisciplinary or multiple disciplinary approach and involving other hospital based medical and dental specialities.
2. To be able to provide advice to general and specialist dental and medical practitioners and hospital consultants in all aspects of orthodontic care and craniofacial abnormality.

3. Be competent to provide and supervise treatment plans for dental practitioners who carry out orthodontics in primary care.

4. Be eligible to become a trainer for those who are engaged in specialist registrar training in orthodontics and play a full role in postgraduate orthodontic training.

5. Be able to treat the most severe types of malocclusion.

6. Be able to contribute to the care of Cleft Lip and Palate patients.

7. To become competent in hospital management and administration.

8. Have appropriate skills in teaching, appraisal, counselling and interviewing.

3.2 Training Rotations

The SAC wishes trainees to be exposed as much as possible to a longitudinal combined and integrated training between a dental teaching hospital and district general hospitals. Exposure should be gained in a range of district hospital environments. Because the 5 years (3+2) training will, for many trainees, be in different institutions the SAC wishes programmes to emphasise the long term nature of orthodontic treatment and as far as possible enable trainees to treat and observe patients and techniques over the long term. It might be difficult for single training centres to deliver the entire curriculum. Therefore, more than one centre should consider combining to provide a joint teaching programme.

3.3 Length of Training Programmes

Total training time will normally be full-time (or equivalent) for two years.

3.3.1 Full Time training

A period of additional full-time training of two continuous years in a clinical training programme in hospital orthodontics following a 3 year specialist programme approved by the SAC in Orthodontics. Locum experience will not normally be accepted.

3.3.2 Part Time Training

Flexible (Part-Time) training is permitted for Specialist Registrars under EC Directive EC 93/16/EEC. The arrangements for such training are given in the “Guide to Specialist Registrar Training” - ‘the Orange book’. To be eligible for such training trainees will have to show that “training on a full time basis would not be practicable for well founded individual reasons”. Full-time trainees can apply to become flexible trainees and flexible trainees can apply to revert to full-time training at any time.

Flexible training programmes must be for a minimum of six sessions per week and the training period will be a minimum of 3.5 and a maximum of 4 years (the exact time to be determined by the SAC at the time of approval of the application of the trainee.) Personal appointments may be extended for a further year with the agreement of the Deanery.
3.4 Distribution of time within the two years (or equivalent) of the FTTA Programme

In full-time posts, the trainee should spend at least 8 sessions per week involved in patient contact with at least 5 of these sessions devoted to personal treatment sessions.

A balanced programme will, for all trainees, allow personal treatment sessions, diagnostic sessions, review clinics, formal and informal teaching, research and reading time.

Flexible trainees should be given a timetable for a minimum of six sessions per week which should include a minimum of 5 patient contact sessions, 3 of which are personal treatment sessions.

**SESSIONAL DISTRIBUTION FOR THE 2 YEARS (OR EQUIVALENT) OF THE FIXED TERM TRAINING PROGRAMMES IN ORTHODONTICS**

**TABLE 1**

The table below gives details of Training times and Clinical Sessional distribution:

<table>
<thead>
<tr>
<th>GRADE</th>
<th>Training Time (yrs) Maximum</th>
<th>Training Time (yrs) Minimum</th>
<th>Weekly Sessions</th>
<th>Total Clinical Sessions</th>
<th>Personal Treatment</th>
<th>Other - New patient Teaching, Joint Clinics &amp; Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>F/T NHS Hospital Trainee</td>
<td>2</td>
<td>2</td>
<td>10</td>
<td>8</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>P/T NHS Hospital Trainee</td>
<td>4</td>
<td>3.5</td>
<td>6-8</td>
<td>5-6</td>
<td>3-4</td>
<td>2</td>
</tr>
<tr>
<td>F/T Honorary Academic Hospital Trainee</td>
<td>4</td>
<td>2</td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>1 (plus 2 clinical teaching)</td>
</tr>
<tr>
<td>Clinical Training Fellowship</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1-2</td>
<td>Depends on stage</td>
</tr>
</tbody>
</table>

**TABLE 2**

The table below gives details of Sessional Distribution between Non Clinical Sessions:

<table>
<thead>
<tr>
<th>GRADE</th>
<th>Total Sessions</th>
<th>Total Clinical Sessions</th>
<th>Non Clinical Sessions</th>
<th>Non Clinical Being taught</th>
<th>Non Clinical Research, Study, Audit</th>
<th>Non Clinical Management, Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>F/T NHS Hospital Orthodontic Trainee</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>1.5</td>
<td>0.5</td>
</tr>
<tr>
<td>F/T Honorary Academic Hospital Trainee</td>
<td>10</td>
<td>6</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>P/T NHS Hospital Orthodontic Trainee</td>
<td>6-8</td>
<td>5-6</td>
<td>1-2</td>
<td>0</td>
<td>1</td>
<td>0.5</td>
</tr>
</tbody>
</table>
3.5 Timetabling

1. The extended nature of orthodontic treatment and treatment review requires the trainee to attend continuously in each unit for a period of at least 2 years.

2. A period of attachment in other units at home or overseas will be approved by the SAC provided that the period does not exceed 3 months. The Secretary of the SAC should be notified in advance.

3. The academic aspect of orthodontics together with its interface with other dental specialities normally requires the trainee to spend a proportion of each week in a (Dental) Teaching Hospital.

4. The training programme should equip the FTTA for a consultant post in the National Health Service. Substantial experience of work in a District General Hospital is essential.

5. An effective training rotation for the FTTA is for the training week to be divided into 3 days and 2 days, so that the pattern of training is Teaching Hospital: District General Hospital 3:2 or 2:3. Either split of the training week can work well.

6. The District General Hospital facilities should be of an adequate size and quality with fully available consultant cover to permit the allocation of 2 or 3 days of a Trainee week. (Honorary academic FTTA are expected to attend a District General Hospital ideally for a minimum of 1 day per week throughout the programme).

7. Whilst visits to a number of hospitals are valuable for occasional clinics, in general the more satisfactory programmes limit the major part of the training to two principle hospitals. The FTTA should have sufficient time to make a significant administrative, clinical and teaching impact in each unit.

8. Absence of a Dental Teaching Hospital in a Deanery will require a flexible approach to be taken and the SAC will closely examine individual proposals. Visits by the FTTA may be arranged to a Dental Teaching Hospital outside the Deanery.

9. Honorary (Academic) FTTA must include personal treatment sessions under the guidance of several consultants and hospital administrative experience must be obtained.

10. The trainee should spend full days at each hospital and avoid changing units at midday.

3.6 Facilities

At each training unit there should be:

a. fully equipped surgery accommodation at each centre with an appropriate range of appliance systems and instruments

b. trained dental nurse support with reasonable continuity of personnel.

c. adequate secretarial support within the department

d. adequate access to a full range of relevant diagnostic facilities including radiography and photography

e. access to a full range of high quality laboratory services associated with orthodontics.

f. desk space for personal study by the trainee during the time they spend in the unit
g. ready access to a range of relevant journals and text books or on-line access

h. computerised facilities for the storage, analysis and retrieval of cephalometric data, the collection and analysis of audit data

In at least one unit, there should be:

a. advanced teaching facilities (e.g. teaching laboratory with typodont facilities, video replay facilities, etc.)

b. a fully equipped post-graduate centre with an active dental programme

c. full library facilities including the facility for borrowing from other libraries and computerised literature searches

d. facilities for medical illustration such as the production of diagrams, poster material and slides

e. Access to a full range of high quality laboratory services associated with orthodontics

The combined training units (Dental Teaching Hospital and District General Hospital) should be linked with a department of Oral and Maxillofacial Surgery. There should be adequate clinical association with other disciplines including Oral Medicine, Paediatrics, Cleft Lip and Palate Surgery, Restorative Dentistry and Paediatric Dentistry.

An active oral and maxillofacial surgery service and ready access to consultant oral and maxillofacial surgery opinions is normally required within the District General Hospital. Ideally this would also involve access to consultant restorative advice.

3.7 Caseload

The caseload for a trainee on a FTTA programme should normally be 175±25 cases in active treatment. Caseloads outside of this range will require explanation. Caseloads should be modified pro rata for part time trainees.

It is expected that all cases should be in IOTN Dental Health Component grades 4 and 5. Any that are not should require some explanation on why treatment is being provided.

3.8 Case mix

Training centres should attempt to provide the following case mix
- At least 25% orthognathic
- 15% joint restorative
- 10% joint paediatric/special needs
- 10% dento-alveolar surgery
- The remainder should be relatively complex cases

3.9 Transfer cases

It is inevitable with such a short training programme that the FTTA will receive some transfer cases. This situation should not be regarded as a problem because transfer cases will give the trainee an opportunity to finish cases. However, it is imperative that the quality of the cases that are transferred is high. If the training and supervision are good, then the transfers should be good, and this is the responsibility of the trainers. As a result, at the commencement of FTTA training, no more than one-third of the caseload should be transfer cases.
3.10 Cleft lip and palate

At this stage the SAC assumes that CLP services will evolve as a “hub and spoke” model, so that the trainee should have a few “spoke” type cases. They should also gain exposure to the workings of the cleft centre and have attachment once per month to an interdisciplinary cleft clinic.

3.11 Supervision

There are four levels of training supervision:

1. Trainer in the surgery directly supervising or demonstrating techniques.
2. Trainer present in the clinic available to assist or advise.
3. Trainer available within the hospital.
4. Trainer available from outside the hospital as for emergency on-call.

The trainer allocated to a particular clinic duty is responsible for decisions relating to the nature of supervision. If the trainer is not in the clinic, the trainee must know where to contact help. Trainers should be away from the clinic only in exceptional circumstances and not routinely.

Close supervision of the training programme is essential.

The Training Programme Director will be elected by the Specialty Training Committee which is responsible for the organisation of the programme. The Training Programme Director should be a consultant involved in the training scheme with close links to the Dental Teaching Hospital.

1. ensure access by the trainees to clinicians who have academic training or proven academic ability
2. appoint for each trainee a tutor responsible for monitoring the trainee’s progress and ensuring that any difficulties are identified and resolved as rapidly as possible. The tutor should be a person who works frequently with the trainee and is closely involved in their training.
3. formal meetings between trainers and individual trainees, arranged by the tutor, should take place to monitor and advise on a trainee’s progress and training needs. A record should be kept of these meetings which should occur at least once per year.

Trainees should be exposed to the views of more than one consultant and this will normally happen through the linked appointments between teaching hospital and district general hospital. Most direct supervision should be provided by a consultant, however some guidance by an experienced senior specialist practitioner in orthodontics is also welcomed.

Dental teaching hospitals require at least two WTE consultants (including the course director), preferably at a senior academic level, with a significant teaching input to run effective programmes. These posts should not be split between more than three people. Where the training programme has more than four trainees at any one time, additional staff will be required.
3.12 Trainee Documentation

Trainees should keep records of the patients they have under treatment. This should ideally be done through the SAC approved computerised patient database programme, or other computerised spreadsheet or database. The records should include all patients who are under or have completed treatment. Each patient record should contain relevant data about:

- demographic information about the patient
- diagnosis
- indices
- treatment
- adjunctive treatment from other disciplines
- outcome, including complications
- retention
- Consultant responsible

While most of the record entries will relate to cases requiring active orthodontic treatment, it should also represent the full range of the trainee's clinical activity.

It should be possible in a graphical or statistical manner to demonstrate:

- the distribution of data
- the relationships between or associations between sets of data (e.g.: cross-referencing diagnosis and treatment method)
- the significance of these findings

3.13 Programme Content

1. The programme should enable the FTFA, in association with supervising consultants, to complete the diagnosis, treatment planning and treatment of the widest possible range of cases, using the full range of orthodontic techniques, with graded and progressive responsibility. At least half of the trainees time should be allocated to the personal operative treatment of his or her patients.

2. The experience should specifically include review clinics, including those for whom only opinion and advice has been given.

3. The programme should include attendance at combined clinics which consider the treatment of patients with cleft lip and palate and other developmental facial anomalies, the treatment of patients who require combined orthodontic and maxillofacial surgical treatment, combined orthodontic and restorative treatment, and the orthodontic treatment of patients with special needs.

4. Training and experience should be gained in the management of an orthodontic department in a National Health Service hospital and in the broader aspects of the organisation of health services.

5. The programme should include experience in orthodontic teaching of hospital staff, general dental practitioners, postgraduate and undergraduate students, nurses and technicians.

6. Each trainee should prepare and submit for publication articles in refereed journals as a result of their FTFA programme. Facilities and specific guided sessions should be made available for this. Wherever possible experienced academic guidance should be given and trainers should be involved in the projects chosen.
7. Arrangements should be made to enable FTTAs to gain some experience in the relevant medical and surgical disciplines, i.e. paediatrics, growth and development clinics.

3.14 Curriculum

The curriculum is based on the Learning Outcomes Document and the grid on what a Consultant is expected to be able to undertake. Training should enable the Fixed Term Trainee to meet the requirements of the Intercollegiate Fellowship Examination in Orthodontics which is available in the “Regulations and Guidance to Candidates Relating to the Intercollegiate Specialty Fellowship Examination in Orthodontics”.

**FIXED TERM TRAINING PROGRAMME MODULES IN HOSPITAL ORTHODONTICS (FOR CONSULTANT PRACTICE)**

During additional training the FTTA will acquire new knowledge and skills and also greater depth of training and experience of certain modules in the 3 year speciality training programme.

**Section K. Clinical**

M45 The treatment of extreme malocclusions
M46 Advice for referring medical and dental practitioners and prescriptive treatment planning for dental practitioners

**Section L. Interdisciplinary with Hospital based Specialities**

M47 Interdisciplinary planning and treatment
M48 Malocclusion and medical problems
M49 Interface with Oral and Maxillofacial Surgery
M50 Interface with Restorative Dentistry including Implantology
M51 Interface with Paediatric Dentistry
M52 Adult Orthodontics

**Section M. Multidisciplinary with Hospital based Medical and Surgical Specialities**

M53 The role of the Multidisciplinary Team
M54 Management of Congenital Cranio-facial Anomalies
M55 Multidisciplinary Management by Surgery and Orthodontics of Dento Facial Anomalies
M56 Care and Treatment of Cleft Lip and Palate patients

**Section N. Teaching and Training the Trainers**

M57 Acquiring skills essential to Train Dental Specialist Registrars
M58 Teaching and Training General Dental Practitioners, Undergraduates and Medical SpRs

**Section O. Management, Co-ordination and Communication**

M59 Structure of Purchasing Authorities and the management of Hospital Trusts
M60 Hospital Audit
M61 Communication Skills
M62 Advisory Committees and Interface with Dental Public Health and Health Purchasing
M63 Health Service Structures

**Section P. Research and Self Assessment**

M64 Hospital based Research
M65 Self Assessment during Additional Training
4 VISITATION AND APPROVAL

Every orthodontic department providing a training programme will be visited by at least two members of the Specialist Advisory Committee, before approval is granted, to ensure that the guidance is met and to discuss with the trainers the training programme and difficulties in implementing these requirements.

At visitations, the visitors will wish to see items of Course Documentation. At the trainee interview, each trainee should bring an up to date curriculum vitae, a copy of their personal timetable and their clinical logbook with a summary of caseload cross-referenced by diagnosis and treatment method. Trainees will normally be interviewed at least once during their training period.

The departments will be revisited at least once every 5 years or at the SAC’s discretion.

Applications for approval should be made to the Secretary, the Specialist Advisory Committee in Orthodontics, the Royal College of Surgeons of England, 35-43 Lincoln’s Inn Fields, London WC2A 3PN.
SECTION 5  CLEFT LIP AND PALATE CARE

Hospital Consultant Orthodontist: Management Of Cleft Lip & Palate

Following the publication of the Clinical Standards Advisory Group (CSAG) report into cleft lip and palate care, and the government’s acceptance of these proposals, the role of the Consultant Orthodontist has changed considerably in recent times. The advent of regional centres for the management of cleft lip and palate has not only profound effects for surgery, speech and language therapy, and psychology but also, the delivery of orthodontic treatment. In the new setting there will be 2 distinct roles for the orthodontist. The first will be that of the Lead Clinician in Orthodontics, in addition, locally based Consultants will provide treatment to their patients under the direction of the Lead Orthodontist.

Lead Orthodontist

This individual would act as the Lead Clinician for orthodontic treatment within the regional cleft lip and palate team. They will contribute to the strategic development of the multi-disciplinary cleft lip and palate team, and represent primarily, the interests of orthodontics. In addition, appropriate referral to Paediatric and Restorative dentistry is crucial. The Lead Orthodontist would be involved in a review of orthodontic services throughout the region for the planning, co-ordination, and implementation of orthodontic services. Clinical services will need to be provided to a high level of expertise in diagnosis, treatment planning, and the treatment of orthodontic and dental needs of children born with a cleft lip and palate. In addition, other responsibilities will involve the collection and co-ordination of appropriate audit records, and the development and implementation of research teaching, audit and clinical governance activities. The Lead Orthodontist will act as a pivot for the region providing advice, and where appropriate, further opinion for treatment. They will act to co-ordinate the role of Orthodontists throughout the region and to ensure maximum communication and continuity of treatment through a treatment network (hub and spoke mechanism). In addition, the Lead Orthodontist will take responsibility for the organisation and training of orthodontic trainees, and act within the guidance for national frameworks for training.

The clinical imperative for the Lead Orthodontist, would be to plan, lead, and deliver a high quality, best practice, orthodontic service for the regional cleft lip and palate team. The objective of orthodontic treatment would be to achieve the best possible dental function and dental facial aesthetics by the age of 20 years for each individual. They will also ensure that treatment would include, where appropriate, pre-surgical orthopaedics, interceptive orthodontics, pre-alveolar bone graft orthodontics, routine orthodontic treatment, and if necessary, pre and post-surgical orthodontic care. Treatment and treatment planning for these children will need to conform to a concept of the co-ordinated multi-disciplinary team, which includes all networked Orthodontists. The Lead Consultant Orthodontist would be responsible for developing standardised protocols for clinical records at appropriate stages.

They will also need to ensure that all other necessary services for a child are recruited at appropriate stages, and this will include guidance from Speech & Language Therapists, Psychologists, and Surgical members of the cleft team. Rolling audits will be a pivotal part of the delivery of this service, as the regional centres would need to demonstrate positive health outcomes in all facets, and in this context, the Lead Orthodontist would play a major role. Audit will need to be led at a regional level, and contribute to national and international projects.

The Lead Consultant will need to work within Trusts, in order to monitor the service level agreements, modify service specifications as appropriate, and ensure that audit outcomes are independently assessed on a regular basis with agreed and standardised assessment techniques. They will need to ensure that appropriate resources are made available to enable these services to function and to provide advice to the Trusts for their subsequent negotiations with the purchasers on the availability of orthodontic services. Further work will be needed with Consultants in Public Health Medicine and Dentistry, to determine the needs and demands of the resident populations, with respect to cleft lip and palate care. In addition,
they should provide advice to the employing Trusts on the specification and contracts for orthodontic services drawn up by Health Authorities or Primary Care Purchasing Groups.

The Lead Orthodontist will need to liaise with other members of the multi-disciplinary team, families and other professionals, including hospital and community personnel, regarding the management of individual patients. They will need to liaise with the network of Orthodontists throughout the region, with respect to the organisation of caseload management, and service delivery as a whole. Links will need to be developed with normal statutory organisations, such as professional bodies, national bodies, relevant to the clinical specialties of the post, and to network with similar specialist services, in addition to liaising with family report groups, such as CLAPA. Communication will be the most important component of the development of an efficient, high quality network relationship. The Lead Orthodontist will need to play a role in the development of protocols and care pathways for the effective delivery of care. Any deviations from these agreed protocols will need to be agreed by the team, as a result of evidence based research and/or audit. They will need to maximise the use of multi-media communication strategies throughout the region, to minimise the travel requirements of both patients and healthcare professionals. It is essential that adequate arrangements of birth notifications are made, and that these are validated. It may be that the Lead Orthodontist would be responsible for the collection and maintenance of appropriate records at both the hub and spoke, with an effective archiving system to enable the use of completed clinical records for audit and research.

**Local Orthodontic Consultants**

The Local or Spoke Orthodontist should be designated by the Lead Orthodontist. This means that although several Orthodontists may practice within a particular Trust, not all of them will undertake cleft care. It is well recognised that low-volume surgery produces poor quality treatment outcomes, and it is likely that the same is true for orthodontics. Therefore, not every locally based Consultant Orthodontist can expect to be involved in the management of cleft lip and palate patients.

The treatment protocols should be agreed with the Lead Orthodontist, and be designed to produce the highest possible quality treatment outcome with the minimum burden on patients and their carers. Treatment intervals should be restricted to clearly defined periods, with care being undertaken in positive bursts of activity, rather than extending over prolonged periods of time. In general, treatment should be confined to the following phases:-

- Pre-surgical orthopaedics (if required).
- Correction of anterior crossbites, only if these are traumatic.
- Orthodontic expansion in preparation for an alveolar bone graft.
- Definitive orthodontics in the teenage years.
- Orthognathic treatment, if necessary.

Ideally, treatment should be avoided in the deciduous dentition, and should only be undertaken in the mixed dentition, in preparation for bone grafting. The only exception to this should be if a traumatic anterior crossbite exists, with evidence of damage to the incisors or gingival tissue. The correction of buccal or anterior crossbites with or without a displacement should be delayed until the time of orthodontic treatment in conjunction with alveolar bone grafting.

Treatment in the teenage years should only be undertaken if there is a strong likelihood that growth will be favorable. If there is concern about adverse facial growth, then the treatment should be delayed until a decision about the need for orthognathic surgery can be undertaken.

All treatment should be undertaken in a standardised way throughout the region, and in discussion with the Lead Clinician and other Orthodontists at other locations. Participation in local combined clinics with the core team should be undertaken, and participation in national and regional audit is required.
Treatment should be undertaken in a comprehensive way, as part of an organised network of care, and in conjunction with other healthcare professionals, such as locally based Speech & Language Therapists, Specialist Nurses, Paediatricians, Psychologists, Family Support Groups, as well as the central core team. The Local Consultant Orthodontist should assist the Lead Orthodontist with notifications and to ensure patients are not lost from the system. Collection and maintenance of appropriate records at the Spoke with an effective archiving system is essential to allow appropriate treatment, audit and research to be undertaken.

All Orthodontists in the cleft team should have their training needs identified and met, and this will involve ensuring attendance at courses, professional meetings, team meetings, in order to maintain an up-to-date knowledge of the literature, and development in the fields of orthodontics in relation to cleft lip and palate.

The teaching of Specialist Registrars and FT TA’s will be carried out under the direction of the Lead Orthodontist, and may be confined to treatment at the centres.
SECTION 6  PRIVATE PRACTICE

In the majority of orthodontic units in the UK all grade 5 Index of Orthodontic treatment need (IOTN) cases are accepted for treatment and in many centres grade 4 cases are also accepted. Within the General Dental Services, there has previously been no restriction on which cases can and cannot be treated on the Health Service. However, in the future it is likely that the Government will limit payment for cases with IOTN grade 3 dental health component (DHC) and grade 6 aesthetic component (AC) or greater than that. Therefore, a proportion of cases may not qualify for health service treatment and may wish to pursue private orthodontic care.

In addition to this, due to limited orthodontic manpower provision waiting times for Health Service treatment can sometimes be frustrating both for the patient and the orthodontic practitioner. In these cases it is obviously possible to offer the orthodontic treatment on a private basis. There is usually very little waiting time before private orthodontic treatment commences.

For those consultants who chose to transfer across to the 2003 Consultant Contract, the ceiling of private practice earnings was abolished over a three year transitional arrangement for whole time practitioners. For those consultants remaining on the old terms and conditions, the limitations on private practice income remain in place.

Consultants undertaking private practice must ensure that in the provision of private practice, or indeed any fee paying services, that it is not to the detriment of NHS patients or services and does not diminish the public resources that are available for the NHS.

A consultant must inform his or her clinical manager of any regular commitments in respect of private practice or fee paying services and this should include the planned location, timing and broad type of the work involved. This information should be disclosed at least annually as part of the Job Plan review or where there are any significant changes to this information.

NHS commitments must take precedence over private work and the Consultant is responsible for ensuring that private commitments to not conflict with his NHS programmed activities. Regular private commitments must be noted in the Job Plan.

The employing NHS organisation can propose a change to a consultant’s NHS work pattern and it will allow the consultant six months to allow external private practice commitments to be rearranged. Consultants may not use NHS facilities or NHS staff for the provision of private practice, unless they have the employing NHS organisation’s prior agreement.

Where a consultant undertakes NHS on-call duties which require immediate return to the hospital, they should ensure that no private practice commitments are undertaken during scheduled on-call duties unless the consultants on-call commitment frequency is 1 in 4 or more frequent. However, in the case of a private patient requiring emergency treatment this requirement is waived. Should the consultant find that they are required to regularly provide emergency care to private patients and this impacts upon NHS duties, the consultant must make alternative arrangements for emergency cover for private patients.
SECTION 7 APPRAISAL OF CONSULTANTS (CONTINUING PROFESSIONAL DEVELOPMENT – CPD)

The development of clinical governance in the NHS and the future requirement of the General Medical Council for revalidation of Doctors have underlined the need for a comprehensive annual appraisal scheme for medical and dental staff. Appraisal for consultants is the professional process of constructive dialogue in which the Doctor being appraised has a formal structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved. Appraisal is already a contractual requirement for NHS consultants.

It is a positive employer led process to give consultants feedback on their performance, to chart their continuing progress and to identify development needs. It is a forward looking process essential for the development and educational planning needs of an individual. It is not the primary aim of appraisal to scrutinise Doctors to see if they are performing poorly but rather to help them consolidate and improve on good performance aiming towards excellence. However, it can help to recognise at an early stage developing poor performance or ill health which may be effecting practice.

The aims and objectives of the appraisal scheme are to enable NHS employers and consultants to:

- Review regularly an individuals work and performance utilising relative and appropriate comparative performance data from local, regional and national sources.
- Optimise the use of skills and resources in seeking to achieve the delivery of service priorities.
- Consider the consultants contribution to the quality and improvement of services and priorities delivered locally.
- Set out personal and professional development needs and agree plans for these to be met.
- Identify the need for the working environment to be adequately resourced to enable any service objectives in the agreed job plan review to be met.
- Provide an opportunity for consultants to discuss and seek support for their participation in activities for the wider NHS.
- Utilise the annual appraisal process and associated documentation to meet the requirements for GMC/GDC revalidation.

Appraisal is a contractual requirement for all consultant staff. The Chief Executive is accountable for the appraisal process and must ensure that appraisers and appraisees are properly trained to carry out this role and are in a position to undertake appraisal of clinical performance, service delivery and management issues. In most cases this would be appropriate for the clinical director to carry out the appraisal.

The consultant being appraised should be prepared for the appraisal by identifying those issues he or she wishes to raise with the clinical director/appraiser and prepare an outlined personal development plan.

The appraiser should prepare a workload summary with the consultant being appraised. It will be necessary for early discussion to take place on what data is relevant and will be required. This will include data on patient workload, teaching, management and any pertinent internal and external comparative information. Appraisees should also submit any other data which is considered relevant to the appraisal. This must include sufficient relevant data relating to other work carried out externally to the Trust/Health Authority (e.g. in private practice and in commercial healthcare industries).
The primary purpose of the workload summary is to inform the appraisal and job plan review, and to facilitate departmental planning and development. It will highlight any significant changes which might have arisen over the previous 12 months and which require discussion.

Discussion should be based on accurate, relevant, up to date and available data. This should be supplemented by any information generated as part of the regular monitoring of organisational performance undertaken by the Trust.

In advance of the appraisal meeting, the appraiser should gather the relevant information as specified above and consult in confidence and where appropriate, the Medical Director, other Clinical Directors/lead consultants and members of the immediate care team. The information and paperwork to be used in the appraisal meeting should be shared between the appraiser and the appraisee at least two weeks in advance to allow for adequate preparation for the meeting and validation of supporting information.

The maximum benefit from the appraisal process can only be realised where there is openness between the appraisee and appraiser. The appraisal should identify individual needs which will be addressed through the personal development plan. The plan will also provide the basis for a review with specialty teams of their working practices, resource needs and clinical governance issues. All records will be held on a secure basis and access/use must comply fully with the requirements of the Data Protection Act.

Appraisal meetings will be conducted in private and the key points of the discussion and outcome must be fully documented and copies held by the appraiser and appraisee. Both parties must complete and sign the appraisal document and send a copy, in confidence to the Chief Executive, Medical Director and Clinical Director (if not the appraiser).

For the Chief Executive, this will also include information relating to service objectives which will inform the job plan review. Additionally, for clinical academics a copy will be sent, in confidence, to the nominated university representative. There will be occasions where a follow up meeting is required before the next annual appraisal and Clinical Directors should ensure that the opportunity to do this is available.

Where there is disagreement which cannot be resolved at the meeting, this should be recorded and a meeting will take place in the presence of the Medical Director to discuss the specific points of disagreement.

Where it becomes apparent during the appraisal process that there is a potentially serious performance issue which requires further discussion or examination, the matter must be referred by the appraiser immediately to the Medical Director and Chief Executive to take appropriate action. This may for example include referral to any support arrangements that may be in place.

The Chief Executive must also submit an annual report on the process and operation of the appraisal scheme to the Board. This information will be shared and discussed with the Medical Staff Committee or its equivalent and Local Negotiating Committee. The annual report must not refer, explicitly or implicitly, to any individuals who have been appraised. The report will highlight any Trust wide issues and action arising out of the appraisal process – e.g. educational developments.

Where consultants work in more than one Trust the employing Trust must agree on a lead Trust for the consultants appraisal. Agreement will also include appropriate discussion prior to the appraisal between Clinical Directors to ensure key issues are considered as well as systems for accessing and sharing data and arrangements for action arising out of the appraisal.
Continuing Professional Development (CPD)

It is recognised that any professional person has a duty to the public to give the best advice and service of which he or she is capable. In recent years there has been increasing public interest in how the Professions govern and regulate themselves and this interest has extended into the field of continuing education. There is wide spread acknowledgment of the need for continuing professional development for those who have completed formal training and entered into consultant or independent practice. The majority of orthodontic consultants already participate in CPD and welcome a structured and more formalised approach for the future. Self regulation of this type is likely to lead to enhancement of the image of the profession in the eyes of the public, government and fellow professionals.

Each consultant orthodontist should take responsibility for the way in which he or she seeks to fulfil the recommended CPD requirements. They will be responsible for choosing their CPD activities in accordance with their needs, learning methods and clinical settings.

The Chief Dental officer and General Dental Council (GDC) view the goal of CPD is to help consultants and career grade staff and specialists in independent practice to maintain and improve their professional competence. There is a professional responsibility to practice CPD and thereby provide patients with up to date quality healthcare. With the rapid advances in medical and dental science and the high demands of clinical practice it is a difficult task for clinicians to keep abreast of relevant developments.

1. **Mandatory Continuing Professional Development (CPD)**

   Lifelong Learning - the introduction of mandatory continuing professional development - is a major step forward for the dental profession and is supported by the leading dental organisations. All dentists are now required to undertake 250 hours of CPD over a five-year period as a condition of retention on the Dentists Register.

   By requiring all dentists to keep their knowledge and skills up-to-date throughout their careers, Lifelong Learning offers both greater protection for the public and increased professional satisfaction for dentists.

   **Key Facts**

   - All dentists must complete 250 hours of CPD over every five-year period to remain on the UK Dentists Register
   - All dentists must maintain their own CPD records
   - All dentists must submit an annual statement of the CPD hours they have completed each year
   - The GDC will monitor compliance with the requirements by random sampling of dentists' CPD records
   - Failure to comply with the requirements may lead to erasure from the Dentists Register
   - All dentists who take time off the Register must demonstrate compliance with CPD when they apply to restore

2. **Step-by-step Guide to CPD for Dentists**

   - **Step 1** - Make sure you know your mandatory CPD start-date
   - **Step 2** - Make sure you understand the hours requirement
   - **Step 3** - Plan and choose what CPD activities will meet the requirement
   - **Step 4** - Record your CPD
   - **Step 5** - Fill in an annual statement of your CPD hours each year
CPD Hours Required

You must do, and record, 250 hours of CPD over each five-year cycle, beginning on your start-date for mandatory CPD.

At least 75 of these 250 hours must be spent undertaking Verifiable CPD. The remainder can be general CPD.

Verifiable CPD

To count as verifiable CPD, an activity must have:

1. Concise educational aims and objectives;
2. Clear anticipated outcomes;
3. Quality controls (i.e. you should be given the opportunity to give feedback); and
4. You must obtain and keep documentary proof (e.g. a certificate) of your attendance/participation from an appropriate third party (e.g. the activity provider/organiser).

Whether or not the activity has quality controls and whether you'll be able to get documentary proof of your attendance/participation are both matters of fact; either there is an opportunity to give feedback and documentary proof is provided, or not. But the questions of whether the activity has concise educational aims and objectives and clear anticipated outcomes are matters on which you must satisfy yourself, using your own professional judgement.

General CPD

General CPD activities are those which contribute to your professional development as a dentist, but do not meet all four of the criteria (above) for verifiable CPD. Examples might include journal reading and private study.

CPD is defined as study, training, courses, seminars, reading and other activities undertaken by you, which could reasonably be expected to advance your professional development as a dentist. Non-clinical activity can count as CPD.

When choosing activities to undertake to meet the requirements, you should always ask yourself "Does this activity contribute towards my continuing professional development as a dentist?"

Examples of potential CPD activities

The following are activities that you might consider counting towards your CPD. The list is not exhaustive. Remember: if the activity doesn't meet every one of the four criteria listed above, you will not be able to count it as verifiable CPD, but you can still count it towards your general CPD.

- Courses and lectures
- Vocational Training or General Professional Training study days
- Educational elements of professional and specialist society meetings
- Peer review and clinical audit
- Distance learning
- Multimedia learning
- Staff training
- Background research
• Private study
• Journal reading
• Attendance at conferences

You must keep a record of all the CPD you wish to count towards the 250 hour requirement, both verifiable CPD and general CPD. You can use the GDC recording form for this purpose.

You do not have to use the GDC form for your CPD records, but whatever method you use, you should ensure that you record:

Your name and GDC registration number
Date of course/activity
Title of course/activity
Venue (where appropriate)
The name of the organisation or individual running the course/activity
Indicate whether you are counting the activity as verifiable CPD or general CPD
The number of hours you spent doing the CPD activity (you should not include lunch breaks or travel time)

Remember: an additional requirement for verifiable CPD is that you obtain and keep a certificate as proof that you took part in the activity (see above). You might find it helpful to record your verifiable CPD and general CPD on separate sheets, so that activities for which you will need a certificate are readily identifiable.

At the end of every year in each five-year cycle, the GDC will write to you and ask you to fill in an annual statement of the CPD hours (both verifiable and general) that you have completed that year. The GDC will keep a tally of your yearly totals. Filling in an annual statement is a legal obligation.

You should ensure that your CPD records are up-to-date, so that, at the end of each year, you are in a position to fill in your annual statement of CPD hours. This will be even more important at the end of year 5 of each cycle, as the Registrar may ask you to submit your CPD records, and certificates for verifiable CPD, for audit.
SECTION 8  CLINICAL GOVERNANCE - AUDIT

Clinical governance is defined as a system through with NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence can flourish. (A first class service: Quality in the new NHS 1998).

In orthodontics this means we need to know are we doing the right forms of treatment, are we completing that treatment to a high standard and are we continually learning. Do we learn from our mistakes and those of others? Within the organisations that we work for, does the left hand know what the right hand is doing? We are fortunate in orthodontics that we can use our Peer Assessment Rating outcome measure as a way of monitoring the success of our treatment. In this way one would hope to see satisfactory standards of care and hopefully a continual improvement in those standards of care.

Individuals have developed clinical governance and tailored it to different organisations needs. Many hospital trusts work with the “seven pillars of clinical governance”.

PILLAR 1

Clinical Effectiveness (Evidence based practice, NICE, NSFs, NAO, Guidelines, Clinical Indicators, Information Framework, Clinical Audit)

Organisational Strategic Aims & Objectives
- To ensure that the organisation responds to all external and internal audit findings as appropriates.
- To ensure the implementation of national quality imperatives e.g. National Patient Safety Agency reporting guidance and alerts, NICE guidance and NSF standards which are appropriate to the services the organisation delivers
- To ensure that clinical services are developed and maintained to meet the needs of patients, are focussed on outcomes, and are clinically and cost effective.
- Implement systems to monitor care and evaluate the outcomes of care

PILLAR 2

Risk Management (AIRs, SUIs, complaints, risks, poor professional practice)

Organisational Strategic Aims & Objectives:
- Promote an open learning culture where staff identify, report and learn from adverse events and near misses
- To ensure a well-informed and functional health and safety management system within the Trust, which is working towards achieving the ‘National Revitalising Health and Safety’ targets.
- To implement a risk identification, assessment and treatment strategy that assists in the delivery of the organisation’s principal objectives.
- To improve the utilisation, efficiency and safety of operating theatres.

PILLAR 3

Patient Experience (Patient centred development, patient information, patient surveys, patient forums)

Organisational Strategic Aims & Objectives
- To ensure action arising from 'Strengthening accountability' is implemented through the further development of the Trust Patient and Public Involvement strategy and patient advice and liaison service by regular seeking our and acting on local feedback.
- To ensure the environment facilitates high standards of patient privacy and dignity.
• To ensure the organisation is developed and modernised with a focus on the patient experience
• To achieve and maintain the highest level in patient environmental action (PEAT) inspections
• To develop patient care facilities in line with present and predicted patient care needs

PILLAR 4

Communication Effectiveness (Organisational communication, clinical alliance and networks)

Organisational Strategic Aims & Objectives:
• To work with partners to improve the way Health Services and other services at work together to improve health and Health Service provision.
• To form clinical alliances and participate in clinical networks with other providers and partner organisations including the PCT, local authorities, neighbouring Trusts, Strategic Health Authority and HYMS to ensure best care for patients
• To ensure skills and competencies in partnership working are developed

PILLAR 5

Resource Management (people, time, equipment, IT, knowledge)

Organisational Strategic Aims & Objectives
• Delivery of the Joint Information Strategy and in particular Implementation of real time admissions, discharge and transfer, Implementation of the theatre system including electronic operation notes and discharge notification, Clinician coding in out-patients, Order communications (pathology and radiology requesting), Clinical imaging, Clinician reporting
• To ensure that the diversity agenda is progressed in relation to employment, services and access.
• Ensure all staff have access to e-mail, browsing and national applications.
• Meet national targets in relation to improving data quality
• Implement electronic booking by September 2005
• To ensure that the organisation recruits, retains and develops staff in order to provide high quality patient services.

PILLAR 6

Strategic Direction (organisational leadership, modernisation, asset management/ financial control, capacity and capabilities)

Organisational Strategic Aims & Objectives:
• To review clinical services and, where necessary, redesign services so that they meet the needs of patients.
• To ensure the environment within which care is delivered is safe and facilitates high quality patient care.
• To work with partners to manage demand for, and supply of, secondary care services where alternative models of care delivery are appropriate and in the patients best interests.
• To develop and implement a workforce development strategy in line with NHS expansion, modernisation and diversity targets
• Improve compliance on New Deal and EWTD targets for all staff
• Implement action plan on IWL aiming for practice plus accreditation in 2005.
• To identify how clinical capacity can be increased and agree specific action
• To develop and communicate a shared strategic direction which reflects the population served
• Reduce numbers of delayed discharges of care in line with agreed targets.

**PILLAR 7**

**Learning & Development** (Continued professional development, appraisal, best practice)

**Organisational Strategic Aims & Objectives:**

- To ensure that the organisation learns and implements ‘best practice’ from other organisations and literature.
- To develop high quality care within a reporting and learning culture
- To action and implement the Learning Strategy

A major driving force behind this framework aims to tackle wide variations in quality of care throughout the country. For patients Clinical Governance will mean greater confidence in the NHS. Each of the component parts detailed above will contribute to improving the quality of their care and tackling unacceptable variations in care. For health care staff it means taking responsibility and professional accountability for ensuring all components of Clinical Governance are fulfilled to the best of one’s ability. The process involves close multidisciplinary and user teamwork and the development of a new quality culture. Working within such a culture can prove to be mutually rewarding (DoH 1999).

**REFERENCES:**


SECTION 9  OTHER USEFUL LINKS

Following is a list of useful website addresses. The previous edition of the COG guide included reference to the new contract; as this has largely been implemented colleagues are now referred to the BMA site for updated information.

www.modern.nhs.uk/consultants - new consultant contract update
www.dh.gov.uk - Department of Health
www.bma.org.uk - British Medical Association
www.hcsa.com - Hospital Consultant and Specialist Association
www.bda-dentistry.org.uk - British Dental Association
www.nice.org.uk - National Institute of Clinical Excellence
www.rcseng.ac.uk - Royal College of Surgeons
www.rcsed.ac.uk/content - Royal College of Surgeons Edinburgh
www.rcpsglasg.ac.uk - Royal College of Physicians Surgeons Glasgow