

**A HISTORY OF THE
EVENTS WHICH LEAD TO THE ESTABLISHMENT
ORTHODONTIC THERAPISTS IN THE UK**

The establishment of the first training course for Orthodontic Therapists in Leeds in July 2007 was the culmination of over forty years of campaigning by orthodontists. This is a summary of the events which lead to this significant advance for the Society and British orthodontics .

C J R Kettler and C D Stephens July 2011

Glossary of Acronyms Page 52

October 1967

Gordon Dickson, Chairman of COG wrote to COG members:

Orthodontic Department,
Royal Portsmouth Hospital,
Commercial Road,
Portsmouth.

11th October, 1967.

Dear

At the last meeting of the Consultant Orthodontists' Group it was suggested that the Committee investigate the question of the use of ancillary workers in orthodontics.

At the request of the Committee I have prepared the attached questionnaire and I would be very grateful if you would complete it and return it to me at the above address as soon as possible.

I will try to collate the replies and communicate them to the Group at the earliest opportunity.

Yours sincerely

G.C.DICKSON.

CDS - copy

CONSULTANT ORTHODONTISTS' GROUP

To you approve, in principle, of the creation of a type of ancillary worker in orthodontics? ... YES / NO

If so should they be

(1) trained solely for this purpose? ... YES / NO

(2) carry out specialist work as well? ... YES / NO

Should they carry out the following operations:

(1) Take impressions? ... YES / NO

(2) Take models? ... YES / NO

(3) Fit removable appliances? ... YES / NO

(4) Adjust removable appliances? ... YES / NO

(5) Fit-in arches adjusted by the orthodontist? ... YES / NO

(6) Tie and adjust arches? ... YES / NO

(7) Instruct patients in wearing and cleaning appliances? ... YES / NO

(8) Urtic arches? ... YES / NO

(9) Cement bands? ... YES / NO

(10) Any other operations? ... YES / NO

PLEASE SIGN HERE

Should they be trained at

(1) New Cross Ancillary School? ... YES / NO

(2) A Training Hospital? ... YES / NO

(3) A special centre? ... YES / NO

(4) By individual orthodontists? ... YES / NO

Should they be trained

(1) in limited numbers as an experiment? ... YES / NO

(2) as a continuous permanent process? ... YES / NO

Should the Group take immediate steps to inform those bodies of their views:

(1) General Dental Council? ... YES / NO

(2) Ministry of Health? ... YES / NO

(3) Royal College of Surgeons? ... YES / NO

(4) D.S.S.O.? ... YES / NO

Any other comment

Can you suggest a suitable title for these workers?
ORTHODONTIC HYGIENIST

1968

In the light of overwhelming support from the survey a letter was sent by Gordon Dickson, as Chairman of Consultant Orthodontists Group to the GDC urging them to consider the availability of auxiliaries for hospital consultants. No reply was ever received.

1973

BSSO Council set up a sub-committee of Charlie Parker, Peter Burke, Peter Cousins, Jim Moss and June Ritchie. It published a report "The Extended Role of Dental Ancillaries" which was submitted to the GDC on 8th October 1973. The report suggested the integration of three classes of ancillary dental worker: the dental hygienist, the orthodontic auxiliary, and the dental auxiliary. Detailed recommendations are made about the training of each class.

No action was taken by the GDC.

1989

Professor Norman Robertson persuaded the Standing Dental Advisory Committee of the Department of Health, of which he was a member, to set up a working group to look at all aspects of the provision of orthodontics in the UK.

January 1991

The SDAC Expert Orthodontic Working Group was established. Its membership was David Birnie, David Di Biase, David Lawton, Norman Robertson, Margaret Seward, Chris Stephens, R Heesterman, D Lester plus Mrs A Smith of the National Consumer Council. It was chaired by Ralph Followell of the BDA

September 1991

BAO Committee was advised by Mike Coleman, a BAO member and a member of the BDA Auxiliary Personnel Committee that the Nuffield Foundation were about to undertake an Inquiry into Ancillary Dental Personnel. He advised BAO to initiate a response. Kathy Postlethwaite and David Barnett were appointed to draft a document.

November 1991

A draft document was reviewed by the BAO Committee.

January 1992

BAO wrote to Nuffield indicating that there would be a joint response from the Orthodontic Societies. A joint response committee was set up comprising:

Martin Anderssohn, COS, David Barnett, BAO, Steve Jones, BSSO, Kathy Postlethwaite, BAO, and Chris Stephens, COG.

This Committee was fairly dominated by BAO, since COS were part of BAO at that time, and Chris Stephens was a member of the BAO Committee and had had a large input into the BAO draft document. Steve Jones undoubtedly made a significant contribution on the part of BSSO. Indeed Steve continued his interest in this subject without a break since this date and has also been involved in all the BOS responses.

June 1992

The SDAC Working Group Report on Orthodontics included the recommendation that orthodontic auxiliaries be established and Appendix E of the report contained a suggested way that this could be piloted. The Report was received but not endorsed by SDAC. Prof Roger Anderson led an attack and publication thought to be inadvisable by the Chairman Prof Murray. (See Appendix 2)

June 1992

"The Joint Response of the British Orthodontic Societies to the Nuffield Inquiry into Personnel Auxiliary to Dentistry" was sent to Nuffield before the closing date at the end of June. Needless to say there was much common ground between this and the relevant section of the SDAC Report

December 1992

Chris Stephens, Steve Jones and Kathy Postlethwaite gave a verbal presentation to the Nuffield Foundation at a meeting on 7th December.

September 1993

"Education and Training of Personnel Auxiliary to Dentistry" published by Nuffield Foundation. Steve Jones (BSSO) and Kathy Postlethwaite (BAO) attended the launch.

Nuffield said "There seems to be general support for the introduction of an auxiliary to assist in the provision of orthodontic treatment".

February 1994

Meeting at the Eastman with a panel of members from Nuffield, the GDC and the Orthodontic Societies.

The original Working Party members plus the Chairman and Secretary of the five orthodontic groups plus Prof W Shaw, Dr K O'Brien, together with representatives of the ancillary groups were invited to attend.

The meeting was chaired by Steve Jones. The earliest time for change was thought to be 1996/1997 because of the need for a change in either primary or secondary legislation. The meeting ranged over the whole broad area of training. There was concern that the global sum available for orthodontic treatment will not be increased. More patients could be treated if there are orthodontic auxiliaries but this could only be funded by reducing fees. Ken Lumsden said that auxiliaries may not be acceptable to general dental practitioners. Kathy Postlethwaite reported a recent phone call from John Galloway suggesting that changes could be in place by 1995 "via the Privy Council route". Steve Jones has written to Bill Collins, Chairman of the Auxiliary Committee of the GDC, requesting a meeting. The GDC will make its response to Nuffield in May.

The GDSC representative said that it appears the Speciality is trying to feather its own nest. Our concern is to provide orthodontic treatment to more patients and we need to say this to the GDSC. John Williams said that BSSO will agree.

Professor Moss outlined a possible training route starting with a core of health training at 16 years leading to DSA or Dental Technician training and finally to Clinical Dental Therapist or Clinical Dental Technician. He thinks there might be three classes of Oral Health Therapist: Orthodontic, Hygienist, and Therapist.

Jean Gorham of the Secretariat of the GDC outlined current legislation in the Dentists Act and the various ways of altering the Act to permit new classes of Clinical Auxiliaries either through primary or secondary legislation. The message was that it will inevitably take two or three years.

John Galloway, Secretary to the Nuffield Committee, discussed the content and funding of a training programme. It is possible that some funding might be forthcoming from the Department of Employment. Training could be by a core course at a Dental School, by distance learning and by training in accredited practices.

The effect of orthodontic auxiliaries on orthodontic fees was discussed and it was generally agreed that there would inevitably be some fee reductions. It was agreed that the ball is now in the court of the GDC.

The Joint Orthodontic Response Committee have approached the GDC and have been advised to wait until the GDC response to Nuffield is published in June.

May 1994

The Joint Response Committee of the British Orthodontic Societies sent a document entitled “The Training and Deployment of Orthodontic Auxiliaries” to the GDC.

The contents of this document were very similar to the Final Report of the GDC Orthodontic Therapists Curriculum Working Party which was approved by the full GDC in November 2001. How slow we progressed.

June 1994

The GDC published their response to the Nuffield Inquiry report.

BOS was established on 1st July.

July 1994

Workshop at Didcot. Anglia and Oxford Region. “Employment and Training of Orthodontic Auxiliaries” (See Appendix 3).

Present were: Dr Paul Witt from Vancouver, Steve Jones, Kathy Postlethwaite, and Chris Stephens.

John Galloway, Jean Gorham, and Roslyn Walters from the Nuffield Inquiry.

From the Anglia and Oxford Region: Richard Ward, Alan Lawrence, John Rayne, Shirley Scola, Julian Pedley, Linda Kennedy, Jane Norman, Jane Jones, Joy Bennett, Fiona Nixon, and Steve Kneebone.

From the British Orthodontic Society: David Di Biase, Chris Kettler, Alan Thom, Lesley Laxton, Chris Wright, Ray Reed and Nigel Taylor.

Other Representatives were: Lawrence Jacobs from the BDA, Alan Lawrence BASCD, Jay Daniels, Dental Therapist, Mabel Slater and Shelagh Lockyer, Dental Hygienists, Alison Chant and Wendy Soar, Dental Surgery Assistants, Chris Bridle, Orthodontic Technicians, Bill Collins, Chairman, Auxiliary Personnel Committee of GDC, Ken Eaton, Dept. of Health and Bill Reay, Armed Forces.

October 1994

Steve Jones was appointed Chairman of the BOS Auxiliaries Working Party which had the same membership as the committee which wrote the evidence to Nuffield, with the addition of Jeremy Moore. The Working Party produced a document “Comments of the British Orthodontic Society to the General Dental Council to the “Response of the General Dental Council to the Report of the Nuffield Inquiry into the Education and Training of Personnel Auxiliary to Dentistry” ”

This was one of the first acts of the BOS.

November 1994

Letter from GDC asking if the BOS approves the Joint Response document written in May 1994.

February 1995

Reply made to GDC

April 1995

Margaret Seward CBE who by this time was President of the GDC was also keen to progress matters. For several years she had been enhancing the training of enrolled dental nurses though the “Teamwork “ programme launched in 1991 when she was Editor of the British Dental Journal. In her GDC role she was aware there were those on the Council who felt expanded duties nurses such as those in orthodontic auxiliaries were inappropriate for NHS dentistry and would not be convinced of their effectiveness without the evidence of a trial. The Chief Dental Officer, Brian Mouatt, was keen to see the introduction of Orthodontic Auxiliaries to help reduce the long waiting lists of orthodontic treatment which at this time was the cause of more complaints than any other aspects of NHS dentistry. Professor Stephens, of Bristol Dental School, was thus asked by the CDO, Brian Mouatt, and the President of the GDC, Margaret Seward, to run a pilot trial to determine the training needs of orthodontic auxiliaries in the UK.

Bristol already had close links to the Dental School of the University of British Columbia which had been running a highly successful course for Canadian “orthodontic chairsides” for more than 10 years and was seen to be the world leaders in this training. Funding was to be provided by the CDO under “ Paper 10” allowing Paul Witt and his staff to come over from Canada. This trial was to be called a “pre pilot” in an effort to avoid the illegality of what was being done. It was hoped that the necessary legislation to allow the establishment of orthodontic auxiliaries would be passed in time for the results to be published as a legal trial.

July 1995

The GDC agrees amendments to the 1984 Dentists Act to enable Nuffield Recommendation to be implemented, in particular Section 37(1) and 37(2). Each study of this kind would require prior approval of the Council.

September 1995

Bristol Dental School conducts a 2 week “Pilot” training course using dental nurses who had been accepted to train as hygienists. It was programmed so that it started just before they commenced their Bristol dental hygiene course. It was thought that it might be argued that as such trainees could be permitted to work intraorally as they could be viewed starting their course a few days early. The course ran very successfully on phantom heads and following discussion with Margaret Seward just before the Bournemouth BOC it was agreed that the last two weeks of the course could include supervised work on patients. It had been agreed out the outset that the publication of the report of the trial would remain unpublished until the President of the GDC and the Chief Dental Officer decided that the time was right. Under their influence it would then be fast tracked to appear in the British Dental Journal.

The paper finally appeared in 1998 but not before Professor Stephens had been threatened with erasure from the Dentists Register by the then GDC Registrar, Norman Davies, much to the embarrassment of its President and the CDO. Reports were published in the BDJ (1998) and Dental Update (1999).

October 1995

Letter from GDC inviting BOS to comment on the analysis of the replies of the Directors of Schools of Dental Auxiliaries and from the Director’s and Tutor’s Groups to the British Orthodontic Society proposals for the education and training of orthodontic auxiliaries.

December 1995

Reply to GDC with “Response of the British Orthodontic Society to the analysis of replies from the Directors of Schools of Dental Auxiliaries and from the Directors’ and Tutors’ Groups”.

The reply enclosed, at the request of Professor C D Stephens, a “Preliminary Report of a Training Module to Provide Clinical Orthodontic Skills to Dental Nurses Entering a Two Year Dental Hygiene Course”. This report had not been seen or received by the British Orthodontic Society.

April 1996

Professor Stephens was asked by the Registrar of the GDC to explain the circumstances of the illegal trial and threatened with disciplinary proceedings. CDO and Margaret Seward advises – play for time as fortunately the Registrar was due to retire 2 months later.

May 1996

David Di Biase, then Chairman of BOS, was elected on to the GDC by a huge majority. Margaret Seward had suggested in her address to the BOC in September 1995 that if we wanted to have an orthodontic voice on the GDC we should get ourselves organised and this lead to a single orthodontic name appearing on the voting papers and the highest number of votes of any candidate.

July 1996

Chris Stephens writes an Editorial on Orthodontic Auxiliaries for the BJO (Br J Orthod 1996; 23: 367-36). Delay in publication of the illegal Orthodontic Auxiliaries trial paper was requested by Margaret Seward, President of the GDC, as she felt it would be “undiplomatic” to do so only a few weeks after the Registrar’s retirement.

November 1996

GDC “Dental Auxiliaries Review Group” (DARG) holds first meeting.

May 1997

It had been hoped that the necessary legislation to establish orthodontic auxiliaries would be put through in the dying days of the old Parliament but this was not realised.

June 1997

David Barnett attends a meeting with the Orthodontic Auxiliaries Task Group of the Dental Auxiliaries Review Group.

Support for the introduction of “Professions Complimentary to Dentistry” was not strong within the dental profession at this time. At the 1997 annual conference of Local Dental Committees held in June 1997 a motion was put “That this conference believes that the Dentist Act must not be amended to expand the role of auxiliaries without the agreement of the profession”.

March 1998

(i) Margaret Seward President of the GDC and the new CDO Robin Wild ask for the paper on the pilot training of orthodontic auxiliaries at Bristol to be published as soon as possible as “ the time was right”. This appeared as Stephens CD, Keith O, Witt P, Sorflett M, Edwards J, Sandy J, Orthodontic Auxiliaries - A Pilot Project. Br Dent J 185: 181-187.

(ii) David Birnie succeeds Dorothy Geddes as the Edinburgh Royal College’s Dental Council member on the GDC adding a second orthodontic voice

May 1998

GDC publishes “Professionals Complementary to Dentistry”. The term “PCD” is coined. Extension of orthodontic duties to Hygienists and Therapists advised.

September 1998

BOC Torquay 1998. Political Session on Orthodontic Auxiliaries with Margaret Seward, President of GDC and Gordon Watkins, Chairman of BDS Auxiliary Personnel Committee. In debate members made it clear that they want dental nurses to be the main source of orthodontic auxiliaries and that they should only be employed by specialists.

BOS Council agrees that Dental Nurses should be the main areas for recruiting Orthodontic Auxiliaries.

January 1999

BOS sends Response to “Professionals Complementary to Dentistry” to GDC. This supports the concept of a “new class” to be recruited mainly from Dental Nurses

May 1999

The GDC formally agrees to establish orthodontic PCDs.

August 1999

Margaret Seward was about to leave Office as President of the GDC. She called a meeting at the GDC on 12th August 1999 to discuss orthodontic auxiliaries and orthodontic nurses. It was attended by Robin Basker, Colin Smith, Chairman of the Dental Auxiliaries Committee, Douglas Pike, the Vice-Chairman and David Birnie, who is an orthodontic consultant and a member of the Dental Auxiliaries Committee on Council, together with Ros Hepplewhite, Registrar of the GDC, and a number of GDC Officers. Also present were Steve Jones, Janet Robins, Alex Moss and Ann Jones and Chris Kettler. It was clear that Margaret Seward was seeking to promote the progress of this as best she could.

The permitted tasks for the orthodontic PCD were discussed. It was agreed that all tasks should be reversible and of low risk. The Auxiliaries Review Group have endorsed the list of tasks proposed by the British Orthodontic Society. It was also agreed that the problem with a prescriptive list was that new techniques and methods may arise in the future which are entirely appropriate for PCDs but from which they are excluded by the absence from the list. Means should be found to avoid this problem if possible.

There was total agreement that all training for orthodontic PCDs and certified orthodontic nurses should be exclusively by specialists. The question as to who should supervise them was discussed. The orthodontic nurses said they would not want to work with non-specialists. David Birnie spoke strongly in favour of limiting supervision to specialists. Douglas Pike said he was beginning to understand the rationality of restricting supervision to specialists. Ros Hepplewhite doubted the legality of imposing such a limitation.

Margaret Seward said that although the syllabus for the Certificate of Orthodontic Nursing was well developed nothing seems to have been done to develop a training programme for orthodontic PCDs. David Birnie and Chris Kettler protested that the Vancouver programme has been adopted as entirely suitable and as the GDC President well knows it has already been piloted in Bristol. Margaret Seward admitted that she knew of an illegal document in the GDC basement. She said she thought the recent report of the pilot in Dental Update was better than the earlier report in the BDJ.

The title of the Orthodontic PDC was discussed. “Orthodontic Clinical Assistant” and “Orthodontic Therapist” were mentioned.

November 1999

GDC approves “Orthodontic PCDs” to be recruited from Dental Nurses as well as Hygienists and Therapists. BOS list of permitted tasks is approved too.

December 1999

When Nairn Wilson took over from Margaret Seward as President of the GDC, he called a meeting at the GDC on 10th December 1999 to discuss implementation of Orthodontic PCDs. The meeting was attended by Nairn Wilson, President of the GDC, Colin Smith, Chairman of the Dental Auxiliaries Committee, Janet Robins and Ann Jones of the Orthodontic National Group, Stephen Lambert Humble, Chairman of the NEBDN, David Birnie, Member of the Dental Auxiliaries Committee, and Chris Kettler.

Nairn Wilson suggested the title of “Orthodontic Therapists”. The meeting agreed that Orthodontic PCDs will be called “Orthodontic Therapists”.

The GDC asked the BOS to set up a working group to consider the curriculum for orthodontic therapists. The BOS members will be Chris Stephens, Stephen Jones and Chris Kettler as Secretary. The Orthodontic National Group will be represented by Alex Moss, from the Eastman and Ann Jones from Manchester. David Birnie and Professor P Sutcliffe have been appointed to represent the GDC. Max Todd, Senior Administrator, of the Legal Services Department of the GDC will also be a member.

March 2000

GDC formally invites BOS and ONG to form an “Orthodontic Therapists Curriculum Working Group” together with two nominations from the GDC.

The Members of the Working Group appointed by the British Orthodontic Society were Mr C J R Kettler, Secretary of the British Orthodontic Society, Mr S P Jones of the Eastman Dental Hospital and Professor C D Stephens of Bristol University. The Orthodontic National Group (ONG) appointed Mrs A Moss of the Eastman Dental Hospital and Mrs A Jones of Manchester Dental School. The General Dental Council appointed Mr D J Birnie of the Royal College of Surgeons of Edinburgh and Professor P Sutcliffe of the Edinburgh Dental Institute. Mr M Todd, Senior Administrator, General Dental Council served as Secretary to the Working Group. Mrs M L Thomas, a specialist orthodontic practitioner, was invited to join the Working Group after its second meeting. The Working Group appointed Mr C J R Kettler as Chairman.

The three appointees of the BOS had all been associated with this subject for many years. In particular, Chris Stephens was involved in the successful pilot of orthodontic auxiliary training at Bristol Dental School. Steve Jones was a member of the original Group set up by the Joint Response Committee of the founding societies to report to the Nuffield Enquiry. The two members of the ONG were chiefly responsible for writing the curriculum for the Certificate in Orthodontic Nursing. The two GDC appointees are both members of the Dental Auxiliaries Committee of the GDC (DAC) and David Birnie has previously drawn up a curriculum for a Diploma in Orthodontic Therapy for the Royal College of Surgeons of Edinburgh.

The first meeting of the working group was held on 22nd March 2000. The Group held four meetings.

The remit of the Working Group was to draw up a curriculum for the training of Orthodontic Therapists and to report to the Dental Auxiliaries Committee of the GDC. The Working Group was not required to give advice on the appropriate way they will be employed. However the Working Group was aware of the need to make responsible comment on this and stated that their work should “*be carried out under the direct personal supervision, and to the written prescription at every patient visit, of a registered dentist with appropriate experience and training*”. The Working Group also said that their training must “*be supervised by a dentist on the specialist list in orthodontics*”.

November 2000

The GDC approved the Final Report of the Orthodontic Therapists Curriculum Working Group submitted by the BOS. This sets out a training programme of six weeks in a dental school and eleven months in an approved practice, hospital orthodontic department or Community clinic.

The document approved by the GDC is very similar in content to the original document drafted by Kathy Postlethwaite and David Barnett for the BAO Committee between September 1991 and January 1992.

June 2001

The consultation on the Report of Orthodontic Therapists Curriculum Working Group gave rise to 36 comments. The Working Group re-convened in June 2001. Paul Mallett of the Orthodontic Technicians Association (OTA) joined. An amended report was produced.

February 2002

GDC appoint a new Orthodontic Therapists Curriculum Working Group with a remit to align the most recent report with the GDC "Generic curriculum for PCDs". Almost the same membership as before. The main amendments were to clarify that orthodontic therapist' duties would not overlap those of other PCDs, such as Dental Hygienists.

May 2002

New Working Group approved the revised Curriculum. The Working Group stated:

"CLINICAL PRACTISE"

"The clinical activities of Orthodontic Therapists should:"

- * "be carried out under the direct personal supervision, and to the written prescription at every patient visit, of a registered dentist with appropriate experience and training;"
- * "be relevant to their sphere of work;"
- * "be of low risk to both PCD and patient;"
- * "not require decisions as to the long-term management of the patient's condition."

"At its meeting in May 2000 the General Dental Council decided that there should be common working arrangements for all groups of PCD and that no group should be treated fundamentally differently from others. Specifically, the Council decided that clinical groups of PCD should:"

- * "work in all sectors of dentistry;"
- * "work to the written prescription of a dentist;"
- * "be permitted to practise in premises separate from a dentist;"
- * "not be permitted to accept payment from patients."

"These principles are broadly consistent with those recommended by the Curriculum Working Group for Orthodontic Therapists. The Working Group is concerned, however, about the consequences of Orthodontic Therapists being permitted to work remotely from dentists. Since orthodontic treatment requires frequent monitoring and judgement by a dentist, it is necessary for the protection of the patient for Orthodontic Therapists to work under the direct personal supervision of a dentist. Such supervision would not be possible if Orthodontic Therapists were working in premises separate from the dentist. The Working Group also considers that practical considerations would make it difficult, if not impossible, for Orthodontic Therapists to work remotely. The Working Group recommends that ethical guidance should discourage dentists from working remotely with Orthodontic Therapists by advising that such an arrangement would not be in the best interests of patient care." (see Appendix 4)

BOS sent a questionnaire to all members, 56% of Specialists replied. 62% have the necessary space, 71% intend to employ OTs eventually, 62% intend to enrol an existing nurse, 80% of these would cover the costs of training, 71% would provide training facilities, 60% would do this on an ongoing basis. It was clear that orthodontic therapists would be in demand, many specialists want to help train them and they have the facilities and the finance for the training.

September 2002

The curricula for all seven classes of PDC have been brought together and approved by the GDC. Comments must be received by 31st December.

The original report from the Orthodontic Therapists Curriculum Working Group included many recommendations on the requirements for admission to training, on how the training should be conducted and on the circumstances under which orthodontic therapists should be employed. In particular the Working Group advised that Orthodontic Therapists should only be employed by specialists in orthodontics and that they should not work unsupervised, "on the written prescription of a dentist at every patient visit". The GDC has insisted that these recommendations be omitted from the latest report.

May 2006

Laura Mitchell sets out a Proposal for a joint FDS/FGDP course for Orthodontic Therapists which should be sited outside London. She states:

“It is envisaged that the majority of interest in this development will come from orthodontic nurses who see orthodontic therapy as a natural career progression. Indeed, many orthodontic nurses have already taken additional training in the form of the recognised Certificate in Orthodontic Nursing. It is unlikely that this group will be able to fund themselves on a longitudinal course. It is more likely that they will be funded by an Orthodontist (either in primary or secondary care) who will see the advantages, especially in terms of increased patient throughput, to fund their nurse to train as an Orthodontic Therapist. Furthermore, if the course is designed so that training is done on a day release basis, the trainee can achieve their orthodontic competencies whilst also continuing to work as an Orthodontic nurse.”

“Therefore it would appear that there is an opportunity to develop a course culminating in the College examination. To reduce the costs it has been suggested that the course should be sited outside London. There is the opportunity to build on administrative arrangements that have been put in place for another College development to be staged at Leeds Dental Institute and in addition, there is also local enthusiasm to run an Orthodontic Therapy course (the individuals concerned already run a successful Orthodontic Nursing course). It is proposed that this course will be self-funding. A business case is currently being developed to establish this aspect.”

Agreement in principle is being sought at this stage from the respective Boards of the Faculty of Dental Surgery and the Faculty of General Dental Practice to take forward the work to establish the feasibility of running a joint Faculty-badged course in Orthodontic Therapy.

July 2007

First Orthodontic Therapist course opens at Leeds Dental School. Simon Littlewood and Trevor Hodge are the Tutors.

Autumn 2008

The first Orthodontic Therapists qualify Diploma in Orthodontic Therapy RCS(Eng)

APPENDICES

APPENDIX 1

Relevant extracts from the BAO and BOS files.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting
held in the Neville Room, Pembroke Hotel, Blackpool
on Friday 27th September 1991

91/185 d) Nuffield Enquiry into Ancillary Dental Personnel

Chris Kettler reported that Mike Coleman has advised him that the orthodontic societies should formulate a joint response to the forthcoming Nuffield Enquiry. He believes that the BDA Auxiliary Personnel Committee will be sympathetic to extended duties orthodontic DSAs. It was agreed that Kathy Postlethwaite will produce a draft response to be sent to the Secretary for the November meeting. David Barnett will be asked to join with her in producing the response. The Chairman will alert the Chairman of the other Orthodontic societies. The Committee believes that a joint working party should be set up.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at the
Eastman Dental Hospital
on Sunday 24th November 1991.

91/220 Ancillary Dental Personnel

Kathy Postlethwaite presented her draft response to the Nuffield Enquiry on ancillary dental personnel. She has consulted with David Barnett, Robert Mordecai and Chris Stephens. Chris Stephens believes the first meeting of Nuffield will be in June and it will be March before we receive a request for evidence. Robert Kirschen is concerned about the recommendations on supervision and believes these are too similar to those of hygienists. Ken Lumsden asked what was meant by "redressing the balance of distribution of orthodontic services" on page 5. Kathy Postlethwaite said that ancillary workers could increase productivity. Chris Kettler thinks the proposed period of one years full-time training is much too long. Robert Kirschen thinks that any institution running a course of training for intra-oral skills must have students in place for at least six months to be able make use of their services in a practical way. There was some uncertainty as to whether we should be making recommendations for extended duties DSAs or for orthodontic training for Hygienists and Therapists. The Committee did not resolve this question. It was agreed that a pilot study should be based on Bristol and Manchester Dental Schools. The Chairman asked members to write to Kathy Postlethwaite with comments and the draft to be considered again at the next meeting.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at the
Eastman Dental Hospital
on Sunday 19th January 1992.

92/22 Ancillary Dental Personnel

Ken Lumsden introduced this item by stressing that the completed document needs very good presentation because it was crucial for orthodontics. He invited Kathy Postlethwaite to go through the letter from Robert Kirschen which commented on a few of the sections in the original document. Mr Kirschen felt it would better to omit 'bonding brackets' in Section 5, because this equated with the "practice of dentistry" and it was important not to imply a challenge to basic dentistry. He is not in favour of orthodontic auxiliaries fitting power chains either. There was some discussion on whether debonding and bonding should be allowed. Robert Mordecai thought bonding could be agreed but debonding could not. Paul Demuth said it was important not to advocate any course of action which might harm patients, and the overall treatment time for debonding was very small in proportion. Ken Lumsden felt that with training, dental auxiliaries would probably take more care than orthodontists.

No agreement was reached on whether orthodontic auxiliaries should be allowed to bond or debond brackets or place power chain; however it was agreed that auxiliaries should not activate looped archwires.

Section 6.1 Recruitment Robert Kirschen and the other committee members were in favour of permitting recruitment from qualified DSAs.

Section 6.2.2. Duration of Course David Williams said that a year was too long for training experienced DSAs. However, Ken Lumsden felt the committee should stick to the original recommendations of three months training for qualified hygienists and therapists and one year for qualified dental surgery assistants. David Williams would like to see a course on taking X rays included in the one year course.

Section 8 - Place of Employment. It was agreed that orthodontic auxiliaries should be employed in all branches of the NHS and in GDS and private specialist practice but not in general practice.

Kathy Postlethwaite said she would welcome guidance on whether the scope of the BAO evidence should be widened to include a description of the present roles of DSAs, hygienists, therapists and possibly technicians in the provision of orthodontic treatment and how the profession may wish to influence change and expansion of the existing roles. She will modify the document on the basis of the committee discussion and circulate it in time for the next meeting. Ken Lumsden thanked both Kathy and David Barnett for their hard work and asked for any further comments to be sent to her.

24 January, 1992

Dr John Galloway
Nuffield Foundation
28 Bedford Square
LONDON
WC1B 3EG

Dear Dr Galloway

Inquiry into the Education of Personnel Auxiliary to Dentistry

I have noted your letter in the British Dental Journal of 25 January and I am writing to inform you that the British Association of Orthodontists will be submitting evidence to the Inquiry into the Education of Personnel Auxiliary to Dentistry and we hope to tender a joint document with other national orthodontic societies.

I note that you wish to receive evidence before the end of June 1992. This does not give us all the time we would wish to arrive at a jointly agreed document but we will ensure that our evidence is submitted in time.

Yours sincerely

C J R Kettler
Hon Secretary

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at the
Eastman Dental Hospital on
Sunday 29th March 1992

92/64 Ancillary Dental Personnel

Ken Lumsden said that all five societies have agreed to give joint evidence. It was agreed to keep to the original submission date of June which will mean having a Joint Meeting of Chairmen of the Societies to agree the Report, rather than bringing it back to individual Society committees for discussion. This was agreed. Chris Stephens hopes that a pilot study could be set up within existing regulations. He wondered if individual members should be encouraged, via the Newsletter, to write to the Enquiry with their views. John Williams felt this could be a two-edged sword and not necessarily helpful.

Kathy Postlethwaite reported a letter from Dr. Dowker of the London Hospital requesting information on the role of dental therapists in orthodontics. Chris Stephens said the information asked for could be obtained from Professor Moss who is also a member of the Nuffield Inquiry.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at the
Eastman Dental Hospital
on Sunday 28th June 1992

92/93 h) Auxiliaries

The Report for the Nuffield Inquiry into Personnel Auxiliary to Dentistry has been sent to the Nuffield Foundation with a covering letter on Joint Response Committee paper. The Chairman congratulated the team who produced the Report. It is a fine piece of work and a valuable source of reference. A copy has been sent to the BJO Editor,

Ray Edler, with a view to publication in the November BJO. The Appendices will not be included but they will be available on request. A notice will be placed at the BOC inviting orders for the Report.

BAO NEWSLETTER

July 1992

NUFFIELD INQUIRY INTO DENTAL AUXILIARIES

The Nuffield Foundation has established a Committee to inquire into the education of personnel auxiliary to dentistry and amongst the terms of reference is their role in dentistry. The BAO appointed Kathy Postlethwaite and David Barnett to write the BAO evidence to the Nuffield Inquiry. This has been well received by the other orthodontic societies and after joint discussion it has been agreed that it will be sent to Nuffield as evidence from all five national orthodontic societies.

The principal recommendation is that a class of Orthodontic Auxiliary shall be established after additional training of a year for Certificated DSAs and after a shorter period for Hygienists. Their role would be the traditional functions of a DSA and expanded functions into simple clinical tasks such as record taking, instruction in the care of appliances and simple attention to fixed appliances. It is recommended that a pilot study be set up.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at
UMIST, Manchester. at 2.00 pm on
Monday 21st September 1992

92/136 h) Auxiliaries

Kathy Postlethwaite reported that the joint response to the Nuffield Inquiry into Personnel Auxiliary to Dentistry was sent to the Nuffield Foundation before the deadline. The Nuffield Foundation have invited Kathy Postlethwaite, Steve Jones and Chris Stephens to meet them on 7th December.

BRITISH ASSOCIATION OF ORTHODONTISTS

Hon Secretary's Report to AGM 1992

Kathy Postlethwaite and David Barnett drew up a very comprehensive document of evidence to the Nuffield Enquiry. This was subsequently approved by all the national orthodontic societies and has been submitted as a joint document.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at the
Eastman Dental Hospital
on Sunday 22nd November 1992

92/205 h) Auxiliaries

Chris Stephens, Steve Jones and Kathy Postlethwaite have been invited to a meeting on 7th December with the Nuffield Foundation. They will give a half hour presentation, followed by half hour of questions. The Nuffield Report should be available in Spring 1993.

BAO NEWSLETTER

January 1993

NUFFIELD INQUIRY INTO DENTAL AUXILIARIES

The joint evidence from all five national orthodontic societies was sent to the Nuffield Inquiry in June. Kathy Postlethwaite, Chris Stephens and Steve Jones were invited to give verbal evidence to the Inquiry early on December. They have a very satisfactory meeting and believe that the Inquiry accept the need for some sort of Orthodontic Auxiliary. The date of publication is not known but is expected to be in the middle of the year.

EVIDENCE TO HOUSE OF COMMONS HEALTH SELECT COMMITTEE

20th January 1993

In its verbal evidence BAO advocated the introduction of orthodontic auxiliaries.

MEMORANDUM TO HOUSE OF COMMONS HEALTH SELECT COMMITTEE

29th January 1993

9) A new class of ancillary worker, the orthodontic auxiliary, should be created as this would provide a low cost means of redressing some of the problems of manpower shortages. Standards of care would also be likely to rise. Even with the introduction of this new group of ancillary workers, there is a long-term need to double the number of orthodontic specialists to achieve a population ratio similar to other western countries. Without trained orthodontic auxiliaries, a three to four fold increase in specialists would be needed.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at
Eastman Dental Hospital at 10.00 am
on Sunday 21st March 1993

93/63 h) Auxiliaries

Kathy Postlethwaite reported that a resume of the Joint Response of the British Orthodontic Societies to Nuffield was published in the BDJ on 6 March. Tony Kravitz has reported that the BDA support orthodontic auxiliaries. It was noted that the BDA do not want hygienists to be trained in this role and David Lawton thinks this should be contested. Kathy Postlethwaite thinks it would be politically unwise to argue over this at present. The Chairman agreed and congratulated her on her growing political perception.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at
Eastman Dental Hospital at 10.00 am
on Sunday 6th June 1993

93/123 h) Auxiliaries

Kathy Postlethwaite reported that she expects the Nuffield Foundation to publish their report in September. She hopes to receive some advance information from them in time for her presentation to the DSA Programme at the BOC in Glasgow. There was some discussion about the legal measures required to implement the creation of orthodontic auxiliaries. Chris Stephens said that if the GDC want to go ahead they will find the means.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at
Hospitality Inn, Glasgow. at 11,00 am on
Sunday 19th September 1993

93/168 g) Auxiliaries

The Report. Nuffield are proposing a framework which will not be prescriptive and they want the profession to work out the details. The term "Oral health therapist" is proposed. There will be training modules for different dental activities. Oral health therapists will be permitted to do what the dentists wishes them to do and they will be able to work in any branch of dentistry. The Nuffield Enquiry office will remain open for nine months "aftercare" following publication of the Report for discussions on implementation. Press releases have already been sent out.

Steve Jones has been invited to the launch of the Report. The Committee think that it would be appropriate that Kathy Postlethwaite shall attend too. It was agreed that the DSAs must join any Group which responds to the Report and arrangements for DSA representation must be made during our time in Glasgow.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at the
Royal Air Force Club, London
on Sunday 21st November 1993

g) Auxiliaries

93/343 Kathy Postlethwaite spoke to the Orthodontic DSAs at the BOC in Glasgow and was able to give them some prior information after her briefing by John Galloway. She sent a joint letter from herself, David Barnett, Steve Jones and Chris Stephens to the Chairmen of all the societies advocating the formation of a new Group,

including representatives of the ancillaries, to rapidly develop an effective plan of action for a unified response to Nuffield. The Chairmen have given the Group authority.

93/344 The Group have agreed that an immediate written response is not the most appropriate. They will write to Nuffield with delight at the Report. They will request that orthodontic auxiliaries shall not be delayed by discussions about auxiliaries for Generalists and that it be clear that orthodontic auxiliaries may only be supervised by qualified orthodontists. Otherwise, the best plan is to organise a meeting of orthodontic representatives with Nuffield. She will arrange the meeting jointly with Steve Jones. They have agreed that a small meeting will be most suitable. It will involve members of the Nuffield Group with the Chairmen and Secretaries of the Orthodontic Societies, Professor Shaw and Kevin O'Brien, and representatives of the Hygienists, Therapists, Technicians and DSAs. The meeting has been provisionally arranged for Friday 18 February at the Eastman Dental Hospital. Letters of invitation on Joint Response Committee notepaper will be sent out soon. Questions to Nuffield will be submitted at least three weeks before the meeting. Nuffield will arrange for a barrister with knowledge of the Dentists Act to be present. Eric Tonge expressed an interest in attending the meeting and it was agreed that he will be invited too.

93/345 Kathy Postlethwaite was the only orthodontist to attend the Workshop on the Training and Education of Personnel Auxiliary to Dentistry at the Faculty of General Dental Practitioners on 30 October. She has sent her report of the meeting to all the Chairmen of the orthodontic societies. Some alarming views were presented by John Taylor and Aubrey Sheiham.

93/346 Kathy Postlethwaite said that Mike Coleman has encouraged her to write to him urgently as a member of the Auxiliary Personnel Committee of the BDA endorsing orthodontic auxiliaries. The APC may recommend that orthodontic auxiliaries are the subject of the first pilot study. Richard Swift said that there was some opposition at the GDSC meeting to auxiliaries but he thinks they are not opposed to orthodontic auxiliaries. It was agreed that the Group will write to Tony Kravitz, Chairman of the Auxiliary Personnel Committee.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at the
Eastman Dental Hospital
on Sunday 23rd January 1994

Nuffield

94/23 A Meeting with the Nuffield Committee will take place at the Eastman on 18th February. The original Working Party members plus the Chairman and Secretary of the five orthodontic groups plus Prof W Shaw, Dr K O'Brien, together with representatives of the ancillary groups have been invited to attend. Questions for the Nuffield Committee should reach Steve Jones by 24th January although other questions can be put on the day. Norman Davies, Registrar to the GDC, is expected to attend. Support for a pilot study is being sought but this could pose legal problems. Ken Lumsden said he wholly supports the idea of orthodontic auxiliaries but it raises a whole series of questions which need addressing, particularly the fee scale. Richard Swift said that with more through put of patients and more treatment undertaken, a reduction in the fee scale would appear to be the only way of funding.

BRITISH ASSOCIATION OF ORTHODONTISTS

Minutes of the Committee Meeting held at the
Eastman Dental Hospital
on Sunday 20th March 1994

94/66 Nuffield

Kathy Postlethwaite reported that a meeting with the Nuffield Committee and other representatives took place on 18 February at the Eastman. It was chaired by Steve Jones and minutes of the meeting have been sent to Jane Gordon for verification. The earliest time for change was thought to be 1996/1997 because of the need for a change in either primary or secondary legislation. The meeting ranged over the whole broad area of training. There was concern that the global sum available for orthodontic treatment will not be increased. More patients could be treated if there are orthodontic auxiliaries but this could only be funded by reducing fees. Ken Lumsden said that auxiliaries may not be acceptable to general dental practitioners. Kathy Postlethwaite reported a recent phone call from John Galloway suggesting that changes could be in place by 1995 "via the Privy Council route". She has not discussed this with Prof Stephens or Steve Jones yet. Steve Jones has written to Bill Collins, Chairman of the Auxiliary Committee of the GDC, requesting a meeting. The GDC will make its response to Nuffield in May.

Chris Kettler said that the GDSC representative said that it appears the Speciality is trying to feather its own nest. Our concern is to provide orthodontic treatment to more patients and we need to say this to the GDSC. The

Committee agreed that the present team shall continue to pursue auxiliaries. John Williams said that BSSO will agree. Ken Lumsden thanked Kathy Postlethwaite for the tremendous amount of work she has undertaken and asked her to pass on thanks to the other members of the Working Party.

BAO NEWSLETTER

April 1994

NUFFIELD INQUIRY INTO DENTAL AUXILIARIES

The Nuffield Report into the "Education and Training of Personnel Auxiliary to Dentistry" was published on 30 September. The contents have been widely publicised in the dental press.

Nuffield believe that the most effective way of improving oral health is through teams led by dentists. Dentistry should become more like , and more a part of, the rest of medicine. Auxiliaries must be allowed by law to carry out any procedures for which they have been fully trained. Training of auxiliaries should be acknowledged by statutory enrolment and qualification by statutory registration.

The Report contains a whole Chapter on Orthodontic Auxiliaries for which they say there seems to general support.

The Joint Orthodontic Response Committee for Nuffield arranged a meeting with members of the Nuffield Committee at the Eastman Dental Hospital on 18 February. The meeting was attended by representatives of the following:

- Association of British Dental Surgery Assistants
- Association of University Teachers in Orthodontics
- British Association of Dental Therapists
- British Dental Association
- British Dental Hygienists Association
- British Society for the Study of Orthodontics
- Community Orthodontists Section
- Consultant Orthodontists Group
- General Dental Services Committee
- National Dental Auxiliaries Liaison Committee
- Orthodontic Dental Surgery Assistants
- Orthodontic Technicians Association.

At this meeting, Professor Moss outlined a possible training route starting with a core of health training at 16 years leading to DSA or Dental Technician training and finally to Clinical Dental Therapist or Clinical Dental Technician. He thinks there might be three classes of Oral Health Therapist: Orthodontic, Hygienist, and Therapist. He thinks the Clinical Dental Technician will mainly be concerned with Prosthetics and he sees little role for this class of Auxiliary in Orthodontics.

Jean Gorham of the Secretariat of the GDC outlined current legislation in the Dentists Act and the various ways of altering the Act to permit new classes of Clinical Auxiliaries either through primary or secondary legislation. The message was that it will inevitably take two or three years.

John Galloway, Secretary to the Nuffield Committee, discussed the content and funding of a training programme. It is possible that some funding might be forthcoming from the Department of Employment. Training could be by a core course at a Dental School, by distance learning and by training in accredited practices.

The effect of orthodontic auxiliaries on orthodontic fees was discussed and it was generally agreed that there would inevitably be some fee reductions.

It was agreed that the ball is now in the court of the GDC. A full report of the meeting is in preparation. The Joint Orthodontic Response Committee have approached the GDC and have been advised to wait until the GDC response to Nuffield is published in June.

BRITISH ORTHODONTIC SOCIETY Founded 1st July 1994.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society
held at the Moat House International Hotel, Harrogate
on 5th October 1994 commencing at 1.30 pm

94/55 Nuffield and Orthodontic Auxiliaries

Reports of the Oxford Region meeting at Didcot by the Secretary and from the Kings Fund were circulated with the Agenda. Jeremy Moore, although basically in favour of the principle, voiced the concern of Specialist Practitioners that the use of orthodontic auxiliaries could result in a reduction of fees and also a reduction in funding for orthodontic training. The introduction of auxiliaries should be linked with the introduction of Specialist Registration. Bill Collins has indicated that the Dentists Act will be re-opened only once. Changes will be made on Specialist Registration, the title "Doctor", Dental Auxiliaries and any changes proposed in the Green Paper. David Di Biase is anxious that too many changes should not be made and said the points we needed to get across are that auxiliaries should not be used to the detriment of the profession and that we must be involved in the consultation process. There was some discussion on where training should take place and a difference of opinion as to whether we should recommend that training courses could be away from dental schools. David Birnie said there is no reason why only dental schools should be used and he believes that excellent training could be provided at technical colleges. Chris Kettler asked Council members to write to him with amendments. He will ask Steve Jones to incorporate the changes and will circulate to the Council for approval before the response is sent to the GDC.

BRITISH ORTHODONTIC SOCIETY

Minutes of the first Annual General Meeting of the British Orthodontic Society
held at the Harrogate International Centre, Harrogate
on Tuesday 4 October 1994 at 5.15 pm

2. Chairman's Report

Shortly after its first Council meeting, representatives of the British Orthodontic Society attended a post-Nuffield Day on orthodontic auxiliaries organised jointly by the Oxford Region and Kings Fund with speakers addressing regional, national and international issues. The meeting proved to be very worthwhile, and there was an impressive presentation by Dr Paul Witt from Vancouver who showed their methods of training and the success they have achieved over the last two decades. The Chairman of the GDC's Ancillary Personnel Committee outlined the General Dental Council's response. There was further need for support from the various Societies and Associations, particularly the British Orthodontic Society, if the GDC are to give their approval. With this in mind, your Council has been considering its response. We still need some clarification as to whether the introduction of auxiliaries will require primary legislation.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society
held at the Eastman Dental Hospital on 4th December 1994 at 10 am

94/91 Nuffield and Orthodontic Auxiliaries

Chris Kettler reported a letter for the Norman Davies to Steve Jones asking if the British Orthodontic Society supports the document on orthodontic auxiliaries produced by the Joint Response Committee of the founding societies and sent to the GDC in May 1994 and additionally requested the view of the Society on the training of qualified dental surgery assistants to become orthodontic auxiliaries. It was agreed to reconvene the original Working Party which produced the Nuffield Response, with the addition of Jeremy Moore, to revise the May document as appropriate. The revised document will be sent to Council members for approval as soon as possible and sent to the GDC as a BOS document.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society
held at the Eastman Dental Hospital on 11 March 1995 at 10 am

95/29 Nuffield and Orthodontic Auxiliaries

The Secretary will write to the Working Party thanking them, and particularly Steve Jones, for their efforts in preparing the response to the letter from Norman Davies of 22 November. The General Practitioners Group do not agree that clinical work must be supervised only by an orthodontist with a registerable orthodontic qualification. The Secretary reported this in the letter to Norman Davies.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society
held at the Highcliff Hotel, Bournemouth on Sunday 17 September 1995 at 9.00 am

95/99 Matters arising

95/93 Orthodontic Auxiliaries The Secretary has written to the Registrar of the GDC asking the current state of progress towards orthodontic auxiliaries. In reply Norman Davies states that the Council has received comments from, the Directors of Schools of Dental Auxiliaries and from the Directors' and Tutors' Groups and a paper is to be submitted to the Dental Auxiliaries Committee for consideration at their meeting on 26 September. The Committee will report to the Council in November 1995.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society
held at the Eastman Dental Hospital, London on Tuesday 5th December 1995 at 10.00 am

95/162 Orthodontic Auxiliaries

The Secretary reported that the BOS Working Party on Auxiliaries is composing the response to the GDC paper which analysed the replies from Directors of Schools of Dental Auxiliaries and Directors' and Tutors' Groups on the Education and Training of orthodontic auxiliaries. The BOS is asked to respond by 31 December. The proposed response will be circulated to Council members as soon as it is available. Chris Stephens said that at the request of Margaret Seward and the CDO, the Dental School at Bristol has run a pre-pilot training course for orthodontic DSAs for dental nurses entering a two year dental hygiene course, based on the Vancouver course. A report on the course is in preparation and Chris Stephens hopes that it may be sent to the GDC with the response from the Society. The students have achieved a very high standard. The proposal is for four weeks training as on the pre-pilot followed by 6-9 months supervised training in recognised specialist units and practices possibly followed by an examination prior to certification. The Chairman is concerned that the Society was unaware of the pre-pilot scheme and asked that in future the Society should be kept informed. Jeremy Moore and David Birnie expressed concern about which dentists would be allowed to work with orthodontic auxiliaries. The trainers will require training too.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society
held at the Royal Hotel, Scarborough, on Sunday 22nd September 1996 at 9.00 am

96/81 Auxiliaries

David Birnie, Chris Stephens and Ian Crossman attended the GDC "Seminar on the Dental Team" on 5 September. The Secretary will write to Margaret Seward for a report of the meeting. Chris Stephens said that there is a general assumption that orthodontic auxiliaries will happen. Most of the discussion was about other auxiliaries. He is concerned that there seemed to be a slowing down of the process towards allowing orthodontic auxiliaries. Margaret Seward said the GDC would be unhappy to go ahead without pilot studies and provision for these will be made in forthcoming legislation. This could mean that auxiliaries will not be in place until about 2002.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society held at Heythrop Park on 16th May 1997 commencing at 10 a.m.

97/47 Secretary's Report

c) GDC Auxiliaries Task Group

The GDC after some delay are addressing the question of Auxiliaries in Dentistry. A report is expected to be presented to the full Council in May 1998. A Task Group looking into the development of Orthodontic Auxiliaries have invited the Society to send a representative. It had been hoped to ask Steve Jones, but he is unable to attend the meeting of the Dental Auxiliaries Task Group on 2 June. David Barnett will stand in for him at this one meeting, and Steve Jones will be available for any subsequent meetings to be held.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society held at Eastman Dental Hospital on 7 July 1997 commencing at 10 a.m.

97/64 A Report on a meeting between the GDC Dental Auxiliaries Review Task Group on Orthodontic Auxiliaries and a representative from the BOS.

Notes on this meeting held on 2 June 1997 were circulated with the Agenda. David Barnett attended as Steve Jones was on holiday. David Barnett said that the GDC were not entirely happy with the notion that orthodontic auxiliaries should only be employed by recognised orthodontic specialists. They wanted to know why GDPs should not be able to employ them. Barry Cockroft said the problem, as the GDSC sees it, is that GDPs doing a few orthodontic sessions a week would not be able to use auxiliaries. David Bowden said this is the crux of the matter - if GDPs are able to employ auxiliaries, this would open up the real possibility of the "super generalist". The GDC will report on auxiliaries next May.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society held at the Eastman Dental Hospital on 9 July 1998 commencing at 10.00 a.m.

98/53 The GDC report on Auxiliaries in Dentistry

Response to this document is required by January 1999. The Chairman said it was not his intention to discuss the Report to-day but merely to draw it to members' attention with a view to setting aside Council time in Torquay for an informed debate. Council members will also be sent a copy of the BOS response from last year. He said it was a very important document opening up huge opportunities hand in hand with potentially huge problems. The Political Session at the Conference will be devoted to Auxiliaries with Margaret Seward, Steve Jones, Jeremy Moore and Gordon Watkins as the suggested speakers. David Barnett will co-ordinate the Society's response with help from Steve Jones, Laura Mitchell and Chris Kettler. SPG Chairman said that his Group was putting together a policy document on auxiliaries and he will pass a copy to David Barnett when finalised. It was agreed that a document from each Group setting out their views would be required. The BDA commissioned an independent report from JM Consulting whose brief was to prepare a commentary on the regulation of dental auxiliaries, looking at the issues from first principles. A copy of this had also been circulated to Council members. Allan Thom was a little sceptical about the independence of the Report indicating that JM Consulting advise the Government.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society held at the Grand Hotel, Torquay, on 27 September 1998 commencing at 9.00 a.m.

98/74 Professionals Complementary to Dentistry (Auxiliaries)

The response from the BOS to the GDC Dental Auxiliaries Review Group submitted in April 1997 had been circulated for members to read in conjunction with the consultation paper from the GDC entitled "Professionals Complementary to Dentistry" A Consultation Paper. A response from the Society is required by Friday 15 January 1999. David Lawton reminded members that the Political Session during the Conference will be devoted to Auxiliaries with Margaret Seward on the platform. Council members discussed the issue at length.

1. Leslie Joffe said that the issue which needed to be resolved first is whether we, as a Society, are prepared to go along with auxiliaries if dental nurses are not included with hygienists and therapists in those who can train as orthodontic PCDs. David Lawton pointed out that the document is not just about orthodontic auxiliaries but about regulating all types of auxiliaries. The difficulty with including dental nurses is that legislation would be required but if DSAs are registered with the GDC, there could be a way out using "Orders in Council". Hygienists and therapists are in short supply and only allowing them to train would deplete the pool even further with a possible knock on effect with their disappearance from some dental surgeries and the consequences of that for oral health. David Di Biase said there was a lot of support at the GDC for training dental nurses and Council members should remember that this is a consultation paper only and open to change. Council members agreed to respond to the GDC insisting that qualified dental nurses as well as hygienists and therapists must be allowed to train as orthodontic PCDs.

2. Council members discussed where orthodontic PCDs should be allowed to work and who should be allowed to employ them. This was underlined because some clinical dental technicians are now working away from dentists and some hygienists have also started to do that. David Di Biase said this had recently been discussed at the GDC. The GDC President would certainly like to stop hygienists setting up on their own. Chris Kettler said that it was vital that orthodontists maintain responsibility for their support staff. This was supported by Garry Lewis who said that the dentist must be seen to have clinical control. Allan Thom commented that the document gave as one of its general principles that "The needs of the patient and the protection of the public are of paramount importance." Council members agreed that orthodontic PCDs should only be allowed to work with the orthodontist on the premises and available and that only orthodontically qualified dentists should be able to employ them.

3. Nigel Harradine said the Society must decide on supervision and what procedures the auxiliaries can undertake. He regarded this as fundamentally important. Allan Thom commented that supervisors need to be trained to train and supervise and there should be a limit on how many PCDs can be employed in a practice by any one orthodontist. Council members agreed to produce a list of procedures which PCDs cannot do rather than a list of permitted duties (bearing in mind the comment from David Di Biase that there must be a principle behind the "do's" or "don'ts"). They also agreed the need to limit the number of PCDs employed in a practice and that orthodontists need to be "trained" before they can employ them. David Barnett and Nigel Harradine will discuss the points made at the meeting and produce an outline document for discussion at the Wednesday Council meeting.

BRITISH ORTHODONTIC SOCIETY

BOC Torquay 1998. Political Session on Orthodontic Auxiliaries with Margaret Seward, President of GDC and Gordon Watkins, Chairman of BDS Auxiliary Personnel Committee. In debate members made it clear that they want dental nurses to be the main source of orthodontic auxiliaries and that they should only be employed by specialists.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Elected Members of the Council of the British Orthodontic Society held at the Grand Hotel, Torquay, on 30 September 1998 commencing at 1.30 p.m.

98/92 Professionals Complementary to Dentistry (Auxiliaries)

A document prepared by David Barnett outlining points to be made in response to the GDC consultation paper was circulated. This followed the discussion at the last Council meeting and took into account the views expressed there. Council members were in agreement with the points listed and added another with regard to approved sites of training and the requirement for the Society to recommend a satisfactory outline training. David Lawton said that Margaret Seward, GDC President, spent twenty minutes or so during her presentation at the Conference explaining about orders in Council. If the dental nurses are registered by the GDC, the GDC could use orders in Council to permit the training of dental nurses. The Chairman said that the GMC use orders in Council on a regular basis to control auxiliaries. Some members of Council, however, could see the disadvantages in dental nurses having to register with the GDC and expressed their concerns. David Di Biase suggested the BOS replied positively not dismissing the hygienist pathway but proposing that orthodontic nurses become auxiliaries in orthodontics creating a parallel group. Taking impressions would need to be added to the list of duties they could undertake. Dr Seward has indicated that a four week course to train orthodontic auxiliaries would be needed. The overwhelming view of Council members was that if dental nurses are not included in the GDC plans for auxiliaries, the BOS should not go along with it. However, it was agreed that this must be put across positively. David Barnett will produce a

first draft of the response and circulate this amongst the members of the Working Group for their comments. A further draft will then be produced for the Council meeting in December.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society held at the Eastman Dental Hospital on 4 December 1998 commencing at 10.00 a.m.

98/102 The Society's response to DARG Report

The GDC require a response to the Dental Auxiliaries Review Group Report by 15 January. Draft 3 of the Society response was tabled. David Barnett acknowledged the work carried out by the Working Party and asked for his thanks to Chris Kettler, Steve Jones and Laura Mitchell to be recorded. This draft included the changes which had been suggested by the Groups. A request from Ray Reed that dental technicians be included in the list of those able to train as PCDs was accepted. It was agreed to enclose a copy of the "Proposals to the GDC Auxiliaries Review Group" originally sent in April 1997, in support, as an Appendix. This would then confirm to the GDC, the British Orthodontic Society view as to what procedures the Society recommends that an orthodontic PCD could perform. The response also supports the registration of dental nurses. Dr Pabhary pointed out that the BDA does not support statutory registration. Chris Kettler queried the alteration from dentists to orthodontists in the response. David Birnie agreed that it would be better to use the word dentist, qualifying it with "on the specialist list" of "with appropriate specialist training", rather than use "orthodontist". David Barnett will finalise the Society response and forward it to the GDC by 15 January. It will be released on our website.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society CLG held at Heythrop Park, Oxfordshire, on 7 May 1999 commencing at 10.00 a.m.

99/59 Report from the GDSC

The DARG response report will be available on 11 May and is confidential until then. There had been 233 responses. Dr Di Biase said there were some things in the Report the Society would approve and some they would not.

It is believed that there will be a new class of PCD for orthodontics with entry accepted from dental nurses. Training and permitted duties have not been decided as yet. Restricting orthodontic PCDs to working for specialists on the Specialist List and no other dentists, which the Society wanted to see, would raise legal problems. However, Dr Di Biase will pursue this for the Society. But he said one of the problems is that at GDC visitations Dental Schools report that their undergraduates receive adequate training in orthodontics.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society held at the SECC, Glasgow, on 25 September 1999 commencing at 9.30 a.m.

99/96 Professional Complementary to Dentistry

Chris Kettler attended a meeting on 15 September on Post-Qualification Certificate in Orthodontic Nursing chaired by John Galloway. The report was circulated with the meeting papers. The National Certificate is going ahead and the examination is being set up now. Three members at the meeting had attended a GDC meeting on 12 August and this report was also circulated with the agenda. There was a favourable reaction to the introduction of the certificate and of orthodontic PCDs with dental nurses as the main area of recruitment. Dr Kettler believed that the Society should not pursue the issue of orthodontic PCDs working for specialists only. The Society had placed its views on record and now it should leave it at that.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society held at the British Library on 8 December 1999 commencing at 10.00 a.m.

99/131 PCDs in Orthodontics

David Di Biase reported on the decisions taken by the GDC with regard to PCDs. Three Boards would be established : Board A would be responsible for dental hygienists, dental therapists and orthodontic PCDs, Board B for dental technicians, clinical dental technicians and maxillofacial prosthetists and technologists and Board C for dental nurses. Each Board will be self regulating. There was some concern that

orthodontic PCDs will be marginalised by their comparatively small numbers on Board A but assurance from the GDC had been received that they will have proper representation. Two new legal classes of PCD would be created under the Dentists Act - the GDC had decided that the number should be kept to the minimum necessary. The Orthodontic PCD would therefore be an additional title rather than the separate class that the Society had preferred. This title would be available to members of the classes of dental nurse, dental hygienist, dental therapist or dental technician with the appropriate additional training. The Dentists Act will need to be amended through Orders in Council. No date has been set for this. The GDC accepted the recommendations made by the BOS in the consultation document concerning the procedures that orthodontic PCDs could carry out. These will form the basis for the development of a curriculum for orthodontic PCDs. PCDs will be registered with the GDC. The GDC confirmed that it would need to work with existing organisations to set standards of education and training. There was considerable discussion on length of training and where that training should take place. A pre-pilot study had already been carried out at Bristol Dental School based on the Vancouver model. In Germany, DSAs were trained "in house" with day release for two years to College. In the USA, there were two pathways - full time training, and "in house" with day release. It was agreed that whatever system was used, there must be a national exam and accreditation. The Chairman was concerned that there would not be enough specialist practices interested in training orthodontic PCDs. There was also the question of how to control and monitor those practices involved in training and how this was to be funded. Dr Cook commented that hospitals would not run these training courses either, unless they were properly funded. The Specialist Practitioner Group had held a meeting in November at which the main speaker was an American orthodontist who employed orthodontic auxiliaries. A member of their Committee was looking at the whole question of orthodontic PCDs and the Group would present a paper in time for the next Council meeting. Meanwhile, Dr Joffe would liaise with Chris Kettler and David Di Biase. Dr Di Biase will be attending a meeting of the GDC in January and said it would be helpful for him to have a document by then so that he could represent the Society's views. There was a general feeling that the GDC were not taking enough notice of how other countries managed the question of auxiliaries.

BRITISH ORTHODONTIC SOCIETY

Minutes of the Annual General Meeting of the British Orthodontic Society, held in the Brighton Centre, Brighton at 5.15 p.m.

Monday 11th September 2000

5 Secretary's Report.

The Council has been pleased to see considerable advances in the area of orthodontic PCDs. The National Examining Board for Dental Nurses has approved the Certificate of Orthodontic Nursing. The BOS were invited by the GDC to join with the ONG to form a Working Group to draw up a curriculum for the training of orthodontic therapists. The Group has completed its report and the Dental Auxiliaries Committee of the GDC will consider this later this month.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society held on Saturday 9 September 2000 at the Brighton Centre, Brighton, commencing at 10.00 a.m.

00/98 Secretary's Report

d) Orthodontic Therapists

The GDC Orthodontic Therapists Curriculum Working Group have completed their report which will go to the Dental Auxiliaries Committee of the GDC on 18 September.

BRITISH ORTHODONTIC SOCIETY

Minutes of the meeting of the Council of the British Orthodontic Society held on Monday 4 December 2000 at the BOS Offices, 291 Gray's Inn Road, London, commencing at 10.00 a.m.

00/104 General Dental Council

b) PCDs

The Report from the Working Group set up to prepare a Curriculum for Orthodontic Therapists has been submitted to the Dental Auxiliaries Committee of the GDC. The Working Group changed its report to take into account all of the comments from the Dental Auxiliaries Committee except one. This was that orthodontists wanting to be trainers should be on the Orthodontic Specialist List. The GDC has

recommended that this should not be supported. The Report will be issued for consultation. The Orthodontic National Group supports the view that orthodontic therapists should only be trained by orthodontists on the Specialist List. Tim Pollard said he thought it was bizarre that the Specialist List has been created and was not to be used to select the trainers. He asked that this opinion be recorded in the BOS response to the GDC. BOS Council members were invited to send their comments on the Curriculum to the Secretary by the end of January in order that he could respond to the GDC by 7 February.

BRITISH ORTHODONTIC SOCIETY

Minutes of a meeting of the Council of the British Orthodontic Society held on Wednesday 4 July 2001 at the BOS Office, 291 Gray's Inn Road, London WC1X 8QF commencing at 10.00 a.m.

01/72 Secretary's Report

e) The Orthodontic Therapists Curriculum Working Party reconvened on 11 June at the request of the Dental Auxiliaries Committee of the GDC. The Working Party was asked to consider the 36 responses to the consultation with Deans of Dental Schools, Postgraduate Dental Deans, Directors of Schools of Hygiene and Therapy, members of the Committee, members of Council and PCD groups. Where the Group thought appropriate, the Report of the Curriculum Working Group was amended to incorporate the suggestions and to clarify the recommendations. The amended Report will be considered by the DAC on 17th September.

APPENDIX 2

Standing Dental Advisory Committee's Report

ORTHODONTICS IN THE NATIONAL HEALTH SERVICE - REPORT OF AN EXPERT WORKING PARTY - January 1992

Section 8. A PROPOSAL FOR THE EVALUATION OF ORTHODONTIC AUXILIARIES IN THE UK

8.1 INTRODUCTION

It is a basic premise of health care, that the availability of health services should match the needs of the community. A shortage of services results in a reduction in the care available to patients, and this is reflected in an increase in the length of waiting lists for treatment or a reduction in the quality of service provided. However, it is also the responsibility of health services to provide treatment with maximum cost-efficiency, in order that scarce resources may be utilised optimally. We believe that for these reasons, the orthodontic specialty in this country should consider the various methods that may be available to increase the quality and efficiency of the provision of NHS orthodontic treatment. One method of achieving this goal is to consider the team approach, utilising auxiliary personnel (Report into Dental Education published by the Nuffield Foundation 1980).

8.2 ORTHODONTIC AUXILIARIES IN EUROPE

Dental auxiliary personnel are defined as those persons who are involved to a greater or lesser extent in the practice of dentistry in its widest forms but who are not qualified with a degree or diploma in dentistry (Allred, 1977a).

There is relatively little published information on the role of orthodontic auxiliaries. However, a recent as yet unpublished study, by Moss (1992) indicates that at least 16 out of 23 European States (2 countries no reply received) permit the use of auxiliary orthodontic staff. In a report which compared the provision of orthodontic treatment in England and Wales, to that provided in the Netherlands, Denmark, Norway and Sweden, Shaw (1983) listed the orthodontic tasks that were routinely delegated to auxiliary staff in European countries. These are shown in the table below.

TASK	HYGIENIST	S.DSA
Separation	*	
Band selection/cementation	*	
Bonding	*	
Debonding/debanding	*	
Ligation of passive archwires	*	*
Archwire removal	*	*
Impressions	*	*

8.3 ORTHODONTIC AUXILIARIES IN THE USA

In the United States there appears to be a more extensive deployment of orthodontic auxiliary staff. In a recent survey of American Orthodontic specialist practices carried out by Gottlieb et al.(1987), it was found that there was extensive delegation of tasks. The delegation of such procedures as the insertion of bands, adjustment of archwires and removable appliances and removal of bonds had more than doubled since 1981. It appears that the United Kingdom is unusual in that it is one of only 5 European countries which do not employ orthodontic auxiliaries (Moss, 1992). Hence the advantages of their employment in the U.K. is worthy of consideration.

8.4 COMPETENCE AND COST-EFFECTIVENESS

There is considerable evidence to support the cost effectiveness of employing dental auxiliaries in such procedures as rubber dam placement and the restoration of prepared cavities (Baird et al., 1963;Hammons et al., 1971; Lotzkar et al., 1971; Rosenblau 1971; Allred, 1977a; Overstreet et al., 1978). There is also evidence that the deployment of orthodontic auxiliaries results in a increase in both the productivity and cost effectiveness of a dental team. For example, When the figures obtained by Overstreet (1978) are substituted into treatment data obtained from an Orthodontic Department of a typical UK District General Hospital (Reed, 1988) the following improvements are obtained.

The likely change produced by employing one full time orthodontic auxiliary to work with a single orthodontic consultant in a UK District General Hospital. (After O'Brien and Shaw 1988)

Change in Expenditure including salaries but excluding additional initial capital costs

(excluding clinical materials)	+10.2%
Attendances	+66.2%
Cost per case	-22.6% (adding cost of clinical materials, & assuming 24 attendances per course of treatment)

It can be seen that the employment of an orthodontic auxiliary could result in a saving of as 22% of the total per case. Although the figures given above can only be said to be approximations, they provide a best estimate until such time as a pilot study of orthodontic auxiliaries has been carried out.

Certainly there is evidence that an increase in the treatment capacity of the Consultant Orthodontic Services would be welcome (Banks et al. 1988) and would go some way towards reducing present hospital waiting lists. In the survey of the work of the Consultant Orthodontist in the U.K. 83 per cent of the respondents felt that the efficiency of their unit would be increased, if auxiliaries were permitted to carry out intra-oral tasks (Banks et al. 1988) and a recent study has confirmed that 88% of orthodontic consultants are now in favour of such a move (Postlethwaite and Stephens (1989).

An alternative method of illustrating the effect of employment of an orthodontic auxiliary on the cost-effectiveness of treatment provided at a General Hospital. An estimate of the salary costs incurred in placing a bonded upper and lower fixed appliance is listed in the table below.

Relative salary costs per operating session
(after O'Brien and Shaw 1988)

AUXILIARY/ THERAPIST	1
CLINICAL ASSISTANT	2.25
DENTIST	2.75
CONSULTANT	4.5 (10)

(It has recently been shown that only 45% of a consultant's time is spent in active treatment of patients hence the alternative figure in parenthesis may be said to more closely represent the true cost ratio).

*In cash terms, O'Brien and Shaw calculated in 1988 that if an orthodontic auxiliary placed upper and lower fixed appliances instead of the Consultant Orthodontist a substantial saving of £29 per patient would result for that procedure alone.

8.5 TRAINING COSTS

In addition to the above, there are potential benefits to be gained when the costs of training orthodontic personnel are considered. The table below indicates the major differences in the training costs of personnel who are involved in orthodontic procedures.

The estimated comparative total training costs of Dental personnel
in 1991 excluding pension and NI costs

TRAINING COSTS (£k)

DSA	17
HYGIENIST	24
DENTIST	98
ORTHODONTIST	176
CONSULTANT	266

The cost of Dental Surgery Assistant training is based upon two years salary for in-training, the hygienist figure upon the fee for overseas candidates entering courses in 1990 but includes the cost of DSA training which is now a prerequisite at all UK Schools of Dental Hygiene. The figure for dentist training include Universities Funding Council (UFC) and SIFTR allocations (Service Increment For Teaching) for a 4 1/3 year course, plus an allowance paid for each student to cover additional costs incurred by the N.H.S. in providing teaching) but not local authority grants. The additional costs for orthodontists includes the current fees payable by U.K. students for a full time three year postgraduate course and salary at the Registrar grade but does not include the costs of academic staff which cannot be separated from their other duties of undergraduate teaching and research. For consultants the further cost

of 3 years in-service salary at Senior Registrar level leading to accreditation. Therefore, not only might the employment of auxiliary personnel increase the cost-effectiveness of orthodontic treatment provision through the hospital services, but would in addition reduce the substantial costs incurred for the training of additional orthodontic personnel.

8.6 MANPOWER

At present, estimated hygienist, dentist and orthodontic personnel manpower in the UK is as follows :-

	Number	FTE
HYGIENISTS (GDC 1991a)	2,917	
Working as Hygienists	2,313	
THERAPISTS (GDC 1991a)	413	
Working as Therapists	300	
Working as Hygienists	30	
DENTISTS (GDC 1991b)	26,320	
Practicing	22,467	
Working in GDS UK	18,589	
* ORTHODONTIC SPECIALISTS (BAO 1990)	280	
COMMUNITY ORTHODONTICS (wte)(O'Brien 1990)		71
ORTHODONTIC CONSULTANTS (Consultant Orthodontists Group Directory, 1990)	175	134

(FTE = Fulltime equivalent)

* with and without orthodontic qualifications

The major concern that has been voiced by the profession in considering the employment of auxiliary staff to carry out some of the procedures that are normally considered to be in the domain of the dentist has been the effect that this might have on dental manpower. In this connection we welcome the Departments recently announced a review of Dental Manpower which we understand will include a consideration of dental auxiliaries. However, using the information available to us at the present time, it appears that those members of the dental profession who limit their practice to orthodontic treatment, either within the GDS or the salaried services, total only 3 percent of persons on the Dentists Register. Furthermore, if the use of orthodontic auxiliaries was restricted to the hospital service and an auxiliary was employed for every Consultant Orthodontist, resulting in the employment of around 180 auxiliaries, this would involve 0.74 percent of those on the register. The introduction of orthodontic auxiliary staff would thus have a negligible effect upon the overall needs for dental manpower provided that their use was restricted to the secondary care services.

8.7 CONCLUSION

We believe that in view of the widespread and successful of orthodontic auxiliaries in other countries similar staff could be trained to perform intra-oral duties to a satisfactory standard in the UK. It is highly likely that their employment would result in an improved cost-effectiveness of orthodontic care. The details of training and employing such staff in the UK require evaluation:

- * to determine the training needs of orthodontic auxiliaries.
- * to determine the training costs.
- * to confirm the likely benefits in terms of the unit cost savings and overall improvement and efficiency of service delivery which would be likely to accrue from such an initiative.

We believe the answers to these questions could be achieved along the same lines as the Experimental Dental Care Project (Allred1977b). Such a study would need to be based at more than one centre to take account of the differences which exist in treatment techniques within the specialty. The objectives of a training course for orthodontic auxiliaries are set out in appendix 7. A proposal to run a pilot trial is set out in appendix 8. Costings for such a trial are given in 11.3.

8.8 RECOMMENDATION

We recommend the establishment of an experimental training project to evaluate the training needs and use of orthodontic auxiliaries on similar lines to the 1971 Experimental Dental Care Project (Allred 1977b). This project should be publicly funded.

APPENDIX 3

British Orthodontic Society

(incorporating the BSSO)
Registered Charity No: 801814

"EMPLOYMENT AND TRAINING OF ORTHODONTIC AUXILIARIES"

Joint Workshop

ANGLIA AND OXFORD REGION

AND

THE NUFFIELD INQUIRY INTO THE EDUCATION AND TRAINING OF PERSONNEL AUXILIARY TO DENTISTRY

Tuesday 26 July 1994 Didcot, Oxfordshire

Present:

Dr Paul Witt, Vancouver
Steve Jones
Kathy Postlethwaite
Chris Stephens

Nuffield Inquiry:

John Galloway
Jean Gorham
Roslyn Walters

Anglia and Oxford Region:

Richard Ward	Regional Dental Adviser (Anglia)
Alan Lawrence	Regional Dental Adviser (Oxford)
John Rayne	Postgraduate Dental Education
Shirley Scola	SDO CDS (Berkshire)
Julian Pedley	Local Purchaser, Bucks Health Authority
Linda Kennedy	Clinical Centre Manager, John Radcliffe Hospital
Jane Norman	Dental Administration, Berkshire FHSA
Jane Jones	Locality Purchaser, Northants FHSA
Joy Bennett	Chief Officer, CHC (Wycombe)
Fiona Nixon	Consultant Orthodontist
Steve Kneebone	Specialist Orthodontic Practitioner

British Orthodontic Society:

David Di Biase	Chairman
Chris Kettler	Secretary and SPG
Alan Thom	Treasurer
Lesley Laxton	GPG
Ray Reed	COG
Chris Wright	CG
Nigel Taylor	TGG

Other Representatives:

Lawrence Jacobs	BDA
Alan Lawrence	BASCD
Jay Daniels	Dental Therapists
Mabel Slater	Dental Hygienists
Shelagh Lockyer	
Alison Chant	Dental Surgery Assistants
Wendy Soar	

Chris Bridle
Bill Collins
Ken Eaton
Bill Reay

Orthodontic Technicians
Chairman, Auxiliary Personnel Committee of GDC
Dept of Health
Armed Forces

Welcome and Introduction

by Alan Lawrence.

Alan Lawrence thanked the Nuffield Inquiry, the Anglia & Oxford Region, the Cordent Trust and the British Orthodontic Society for sponsorship of the meeting.

Alan Lawrence referred to the difficulty of making adequate provision for orthodontic care. The Oxfordshire FHSA and the local Members of Parliament receive more complaints about the lack of provision of orthodontics than any other dental subject.

The aims of the meeting will be to consider what is required to change the law to allow the use of orthodontic auxiliaries and the kind of package we want for both the local needs of Oxfordshire and Nationally through the UK.

The Oxford Perspective

Fiona Nixon **Consultant Orthodontist,**
John Radcliffe and Royal Berkshire Hospitals

Fiona Nixon defined the role of the Consultant Orthodontist as

- Advice to practitioners
- Provision of complex treatment
- Postgraduate training of
 - General Practitioners
 - Senior Registrars and Registrars
- Administration within the department
- Clinical research

Her clinical work is mostly confined to severe and complex malocclusions, joint surgical cases, cleft lip and palate and patients with associated medical problems. The severe cases would benefit most from the use of orthodontic auxiliaries. Her current waiting times are 30 weeks for a consultation and another 96 weeks before treatment, a total of 2½ years. Treatment is limited to IOTN grades 4&5. She believes the quality of treatment is reduced by the long waiting times and the failure always to treat patients at their optimum stage in development.

She believes that the use of orthodontic auxiliaries would bring the following benefits:

- Increase in patient throughput
- Easier to maintain clinical standards
- Cost effective and efficient and more productive than a Clinical Assistant
- A good use of skill mix
- Optimum care and value

Orthodontic auxiliaries will complete the team approach, using the orthodontist, orthodontic auxiliary, hygienist, DSA and health educator.

Steve Kneebone **Specialist Orthodontic Practitioner**
Wokingham

Steve Kneebone has approximately 45 regularly referring general dental practitioners. There are 1,600 patients on his waiting list who will wait approximately 2 years to be seen. There is no subsequent waiting time for treatment. There are approximately 2,400 patients currently being seen. About 1,400 of these are under active treatment and 1,000 are under review or retention. In the four weeks of June 1994 he saw 400 patients with fixed appliances, nearly 200 with removable appliances, 92 new patients and 151 patients on recall. He works 55 hours a week of which 40 hours are at the chairside and 15 hours are for administration. He has consulted 10 other orthodontic practitioners in the Southeast of England who reported similar, if slightly lower figures to his own for treatment

volumes and waiting lists. Combining the figures of 11 orthodontists gives figures of 10,000 under treatment and 8,000 on waiting lists.

He believes that orthodontic auxiliaries are needed to help with the long waiting lists and to allow the orthodontist to spend more time on diagnosis and treatment planning. There will be considerable financial investment needed to provide the facilities for their work. He estimates that £700,000 capital is required to start an orthodontic practice with all the necessary facilities to allow efficient work by a full time orthodontist and full time orthodontic auxiliary.

Julian Pedley Chief Executive
Buckinghamshire Health Authority

Julian Pedley is a purchaser for Buckinghamshire. He finds that the provision of orthodontic treatment has become worse and is now out of control. There are now no problems in the Health Service, only challenges. The challenge is that waiting times are getting worse. The lack of provision of orthodontic care causes the most complaints and the inequity of provision across his area is becoming worse and there are wide variations within Buckinghamshire. The retirement of orthodontic practitioners without replacement and the rising expectation of the patients is contributing to the worsening situation. A retiring practitioner recently dumped 600 patients from his waiting list on the hospital. It is proving impossible to manage the demand. The Patients' Charter expects a new patient appointment within twelve weeks. Patients are waiting in Buckinghamshire for 12 months for a new patient appointment and 2 to 3 years for treatment. About a third of the child population are requesting and requiring treatment.

His main problem in meeting the demand for treatment is not resources, but staffing. He cannot get the orthodontists he needs. He thinks the remuneration of orthodontists in practice is pathetic. Auxiliaries are unobtainable and illegal but he thinks they would be a way out of the problem. As a resident of Bedford he is reminded of John Bunyan's "Slough of Despond" when he contemplates his challenges with the provision of orthodontic care.

He believes the way forward is for a high quality of training of orthodontists and auxiliaries. There must be good supervision of auxiliaries and team work. He has ample resources to devolve to practitioners and he can pay orthodontists whatever they want in Buckinghamshire, if he can get them. At present they are paid a pittance, even purchasers can see that. Unfortunately auxiliaries are illegal. Resources should be devolved to practitioners. He wants to see improved orthodontic courses for GDPs as well. At present practitioners are paid a pittance, even purchasers can see that. He believes that it appears to be Government policy to push dentistry into the private sector.

Ken Eaton said that there is no question of children paying for treatment

Joy Bennett Chief Officer
Wycombe Community Health Council

There are wide socio-economic extremes in South Buckinghamshire. The problems of orthodontic treatment provision have been exacerbated by the recent retirement of three practitioners.

Parents express many concerns. They want earlier treatment than is allowed by long waiting lists. When finally seen, they are denied NHS treatment. They do not know or understand the criteria for acceptance for NHS treatment and become very frustrated. She believes patients suffer long term psychological damage by being denied orthodontic treatment.

Joy Bennett listed the following points:

1. Parents expect orthodontic treatment for their children
2. They need to know what treatment can be done on the NHS
3. They do not want to return to a time when teeth are "not perfect"
4. They want "quality" treatment
5. They would readily accept orthodontic auxiliaries
6. If orthodontic treatment is not available on the NHS to those in need this area will become a socio-economic division.

The National Perspective

Chris Stephens **Professor of Orthodontics**
Bristol Dental School

Chris Stephens said he wishes to address five topics:

Who do we treat

About 35% of children in England & Wales receive orthodontic treatment, almost all in the NHS. This figure has been stable for 10 years.

Who provides the treatment

75% in the GDS, 12% in the CDS and 8% in the HDS
40% of GDPs do no orthodontic treatment

How do we treat

Since the 1960 the proportion of fixed appliance has increased from less than 5% and is now 30%. Gravelly has shown that 30% of patients treated with removable appliances are greatly dissatisfied with the results; less than 5% of treatment with fixed appliances results in patient dissatisfaction. The child population declined between 1985 and 1990, and this allowed time for an increase in treatment standards. Unfortunately the child population has now increased. A poor quality treatment results in poor health gain.

Treatment in the Future

At present 30% of treatment is with removable and 70% is with fixed appliances. It should be 75% fixed and 25% removable. Unfortunately such a change would require much more chairside time. He estimates a removable appliance course requires about two hours chairside time and a fixed appliance treatment takes 9-13 hours; but with assistance by orthodontic auxiliaries, fixed appliance chairside time could be reduced to 2-4 hours.

Causes of the present problems

1. The number of GDPs providing orthodontic treatment is declining, because they recognise the need to use the skills acquired by postgraduate training and because the cuts in university orthodontic staff has reduced the level of undergraduate orthodontic training.
2. Most GDPs do no orthodontic treatment until they have been qualified for 10 years, are in established practice and can take time to attend postgraduate training as a clinical assistant or on Regional Training Schemes.
3. Improving professional standards and patient's expectations are rightly causing the number of fixed appliance courses of treatment to increase which reduces the number of treatments undertaken.
4. Most serious in the long term is the fact that we are training insufficient specialists to replace those retiring. The increase in the length of training programmes from 1 to 3 years has not been matched by a corresponding increase in resources at the dental schools. Academic orthodontic staff has reduced by nearly 40%.
5. An increasing number of specialists are withdrawing from the NHS, mainly for reasons of a conflict of quality and cost.

Conclusion

Chris Stephens concluded by saying that, although the introduction of orthodontic auxiliaries will not solve all problems, they would give us a chance to provide orthodontic care for all patients with a serious malocclusion within a cash limited health service and to provide this to a standard, acceptable to patients and the profession.

Alison Chant **Principal DSA Tutor**
Eastman Dental Hospital

Alison Chant said that orthodontic auxiliaries have been a dream of hers for many years.

Who should we train? Hygienists have learnt manual skills and oral health education. Therapists also have manual skills and are used to working with children. Technicians have manual skills but no experience of working with patients. DSAs, particularly if they have worked with an orthodontist, have a knowledge of orthodontics but do they have the manual skills? When considering who to train, it should be remembered that young people tend to change job frequently.

Training. Allison Chant believes this should be in more than one centre and not just in one place like the New Cross School. This has the disadvantage of isolating the students from the rest of dentistry and results in an unequal distribution of qualified girls afterwards.

What work should they do? They should only do reversible procedures. They should not work on their own and should have defined tasks at the start of each treatment session.

Where should they work? She believes they should only work with specialists. She welcomes a Specialist Register as defining who these specialists are.

Pay. There should be an agreed rate of pay.

Paul Witt **Orthodontic Tutor**
Vancouver Scheme for Orthodontic Auxiliaries,
University of British Columbia

The scheme was set up at the impetus of the Dental Societies with approval from the Dental College.

Participants are Certified Hygienists and Certified Dental Assistants. Many already work in Specialist practices but DSAs from General practices are accepted too. Dental Assistants already have some manual skills. They are permitted to take impressions, apply sealants and topical fluoride and do prophylaxis, but not scaling. Most of the participants are Dental Assistants. Hygienists generally perform less well as they are not used to working in a team. After qualification, they find the pay unacceptable.

Before attending the course, students will have undertaken a 6-8 month study programme at home and at college.

Duties and Procedures

1. Provision of instruction in placement and care of removable appliances
2. Tying in of archwires that have been fitted by an orthodontist
3. Removal of archwires
4. Removal of excess cement after bonding/ banding and debonding/debanding. They may use hand and ultra-sonic instruments but not rotary instruments.
5. Fitting of bands for assessment by the orthodontist. Cementing is not permitted. Placement of brackets to be checked by the orthodontist prior to light curing by the auxiliary
6. Impressions for appliances
7. Fitting of space maintainers
8. Removal of bands and attachments with hand instruments
9. Preparation of teeth for direct bonding
10. Application of wax
11. Placing of separators
12. Fitting of headgear prior to assessment by orthodontist

Procedures

Manual. Participants are required to be familiar with the manual before the course.

Course. Seven day course. All the teaching is by DSAs or Hygienists. The course take 40 students at a ratio of student: instructor of 10:1.

1. Two days lectures based on the manual covering aetiology of malocclusion, categories of treatment, biomechanics, types of appliances.
2. Four days in the clinic, laboratory and of lectures covering:
Tracing, impressions, bonding and banding, separators, debonding and debanding, clean up including ultra-sonics, arch wire trying with steel ligatures. The students work on each other for banding and bonding.
3. Sixth day: the Exam of a two hour paper. There is continuous assessment throughout the previous four days. Pass mark is 70%.
One or two students fail each course.

Costs. The course is expensive. The main cost is for the instructors, particularly the orthodontists. However the role of the orthodontist is crucial. The students pay \$500 each.

There are two courses each year and therefore 80 are trained per year.

Discussion

In questions and discussion the following points were made:

After passing the orthodontic auxiliary may undertake all the listed procedures.

There is no "upgrade course". In future continuing education will become mandatory.

Orthodontic practices in Canada use between 3 and 6 orthodontic auxiliaries per orthodontist.

Hygienist training in Canada takes 2 years.

Training of a certified Dental Assistant involves a six or twelve month part-time programme in college.

Paul Witt recommended that the course should be administered by DSAs and not by orthodontists.

A professional educator is needed.

Orthodontic auxiliaries are not paid much more than certified Dental Assistants.

Practices with orthodontic auxiliaries will see up to 100 patients a day. Practices without orthodontic auxiliaries see 50-60 patients a day.

Coming Up With The Answers

Alan Lawrence chaired the discussion.

Who should train as an orthodontic auxiliary?

Chris Stephens said that the exclusive role of the orthodontist will remain, the clinical examination, the collation of clinical records, treatment planning, prescription of each treatment procedure and those treatment procedures not permitted to the orthodontic auxiliaries. He estimates that out of 11 hours chairside time for a treatment, 90 minutes will be orthodontist's time. In other words the orthodontic auxiliary will bring the treatment time down to the equivalent of a removable course of treatment. If he assumes the additional time is used to treat more patients and there is the money available for treatment he estimates that orthodontic auxiliaries could result in a saving of 30% of the cost of treatment.

Lawrence Jacobs said that more orthodontic treatment could and should be undertaken by GDPs. The use of orthodontic auxiliaries should be permitted to GDPs as well.

Steve Jones said that we could retrain hygienists and therapists as orthodontic auxiliaries. However there is already a dearth of Hygienists and it would be much better to train DSAs.

John Rayne said that the UK DSAs do not have training in manual skills, as in Canada. Therefore if we are to follow the Canadian model of training DSAs will need a preliminary course in manual skills.

Richard Ward pointed out that there are quite a large number of unemployed Dental Therapists who might be glad to retrain as orthodontic auxiliaries.

Ken Eaton said that there are 368 Dental Therapists on the GDC role and this number would be quite insufficient. However there are 29,000 DSAs with a National Certificate.

Ray Reed said it would be very useful if technicians were legally permitted to take impressions for study models and appliances.

John Galloway said that although Dental Therapists may be in low numbers they do offer the advantage of requiring less training and could be put in post sooner.

Bill Collins said that training for DSAs would require Primary legislation through Parliament. Training for Hygienists would require Secondary legislation, also through Parliament.

Ken Eaton said there is a big backlog of legislation in Parliament and the earliest possibility to re-open the Dentists Act will be the session of November 1995.

Paul Witt said the Vancouver course will be glad to give advice on training.

Summary. In summary Alan Lawrence said that there should be a proper course of training with DSAs are the main group of trainees. Therapists, hygienists and technicians should not be excluded. The Vancouver experience shows that hygienists should not be put on fast track.

How long should training take?

It was agreed there should be a core course and training "on the job". Certified DSAs would need a preliminary course to learn "in the mouth" manual skills. It was suggested that the preliminary course might last one month, the core course, one month and the "on the job" training for eight months.

Where should training take place?

The Core course should be at Dental Schools. The course should be modular. The course should be the same for all entrants, whether DSA, Hygienist, Therapist, or Technician. Additional training “on the job” should take place in approved Teaching Hospitals, DGHs, Practices and the CDS Clinics.

Cost. Trainees could be employees or students. It was agreed that they should be employees.

Paul Witt said that in Canada, the orthodontic auxiliaries training is usually paid by the orthodontic practice with a requirement that the auxiliary stay with the practice for two years afterwards.

What work should they do?

It was agreed that this should be defined in a pilot study.

Where should they work?

Nigel Taylor said it was essential they should only work in Specialist Practices, Orthodontic Departments in the Hospital Service and with qualified orthodontists in the Community Dental Service.

John Galloway said they should only work where they can be properly monitored.

Bill Collins said the GDC will dissent from this view. The GDC will wish all registered dentists to have equal rights and to be allowed to work in any area of dentistry. However the GDC would not object if a purchaser decided not to purchase work from a generalist who used orthodontic auxiliaries.

How many are needed

The meeting did not attempt to answer this question.

The General Dental Council Position

**Bill Collins Chairman, Dental Auxiliaries Committee
General Dental Council**

Bill Collins said that the GDC have made their response to the Nuffield Report. In general they welcome it. They are disappointed that Nuffield give no evidence that auxiliaries would improve the quality and cost of delivery of dental care. Training courses should be in dental schools and must be validated and monitored by the GDC. Significant changes in the Dentists Act would be needed. The need for orthodontic auxiliaries should be assessed by pilot studies. The GDC are concerned at the proposed loss of the title of “Dental Hygienist”. There is more likelihood of successful legislation if there are separate categories of auxiliary. The GDC has changed its view on Clinical Dental Technicians. He said that once you are registered as a dentist, you may do anything in dentistry; but you have an ethical duty to make sure that you are properly trained for what you are doing; and this would include the employment of orthodontic auxiliaries.

There is much support for orthodontic auxiliaries and they are less problematic than other areas. The Dental Auxiliaries Committee are meeting in September. He said the GDC must receive a response from the British Orthodontic Society by 1 September. They will prepare a report for the meeting of the General Dental Council in November.

Producing a position paper.

Alan Lawrence said we are not ready to produce a position paper. However we can make an action list for the British Orthodontic Society to respond to the GDC before 1 September.

On behalf of the British Orthodontic Society, David Di Biase thanked Alan Lawrence and the Anglia and Oxford Region for arranging the meeting.

APPENDIX 4

GDC ORTHODONTIC THERAPIST CURRICULUM WORKING PARTY

ORTHODONTIC THERAPIST CURRICULUM

22.05.02

CURRICULUM GOALS

THE GOALS OF EDUCATION FOR ORTHODONTIC THERAPISTS LEADING TO A REGISTRABLE QUALIFICATION

The aim of the Orthodontic Therapist curriculum and subsequent training pathway is to produce a caring, knowledgeable, competent and skilful PCD who will contribute to the safe and effective care of orthodontic patients. Orthodontic Therapists will be able to accept professional responsibility within the framework of their area of knowledge and competence. Orthodontic Therapists will understand the role of the patient in decision making, appreciate the need for continuing professional development and will be able to utilise advances in relevant knowledge and techniques.

The Orthodontic Therapist curriculum will:

- enable students to acquire the necessary clinical understanding and competence within the framework of their prospective particular areas of work, and to be aware of their limitations;
- promote acquisition of the skills and professional attitudes and behaviour that facilitate effective and appropriate interaction with patients and colleagues;
- encourage recognition and acceptance of the obligation to practise in the best interests of patients at all times, as outlined in the Council's guidance on professional and personal conduct in *Maintaining Standards*;
- foster the knowledge and understanding, skills and attitudes that will promote effective lifelong learning and support professional development.

KNOWLEDGE OBJECTIVES

The newly qualified Orthodontic Therapist should understand those aspects of the following topics that relate to their framework of professional responsibilities:

- the scientific basis of dentistry, including basic oral and dental anatomy, physiology and pathology as it relates to orthodontics;
- mechanisms of knowledge acquisition, scientific method and evaluation of evidence;
- behavioural science and communication;
- the body of clinical experience necessary to inform the Orthodontic Therapist's clinical orthodontic practice;
- the provision and care of orthodontic appliances and devices;
- the processes of disease and how these affect the appearance and function of normal tissues;
- principles of health promotion and disease prevention;
- organisation and provision of health care in the community and in hospital;
- broader issues of orthodontic practice, including ethics, medico-legal considerations, health and safety legislation and the maintenance of a safe working environment;
- the relevance of business and management skills.

SKILLS OBJECTIVES

The newly qualified Orthodontic Therapist should be able to demonstrate the ability to undertake the following activities that relate to their framework of professional responsibilities:

- a range of clinical orthodontic procedures that are within their area of knowledge and competence;
- effective communication with patients, their families and associates, members of the dental team and other health professionals involved in patient care, including the provision of advice on oral health and orthodontic appliance care;
- the obtaining and recording a of a relevant history, performing an appropriate physical examination, interpreting a care plan or prescription and making secure and timely arrangements for the further management of patients whose treatment is beyond their level of competence;
- evaluation and application of evidence - based treatment and techniques;
- use of a wide range of transferable skills, including investigative, analytical, problem solving, planning, communication, presentation and team skills.

ATTITUDINAL OBJECTIVES

The newly qualified Orthodontic Therapist should have:

- approaches to teaching and learning that are based on curiosity and exploration of knowledge rather than its passive acquisition;
- a desire to seek and act on evidence, a capacity for self-audit and an appreciation of the need to participate in peer review;
- an awareness of personal limitations, a willingness to seek help as necessary, and an ability to work effectively as a member of the orthodontic team;
- respect for patients and colleagues that encompasses without prejudice diversity of background and opportunity, language and culture;
- an understanding of patients' rights, particularly with regard to confidentiality and informed consent;
- an awareness of moral and ethical responsibilities involved in the provision of care to individual patients and to populations;
- an appreciation of the importance of honesty and trustworthiness;
- an understanding of audit and clinical governance;
- an awareness that Orthodontic Therapists should strive to provide or support the highest quality of patient care at all times;
- an awareness of the importance of one's own health, and its impact on the ability to practise as an Orthodontic Therapist;
- an awareness of the need for continuing professional development allied to the process of their continuing education, in order to ensure that high levels of clinical competence and knowledge are maintained
- .

SUBJECTS AND TOPICS

THE TEETH AND SUPPORTING STRUCTURES IN HEALTH AND DISEASE

The oral and dental aspects of the biological sciences should include the theoretical and practical instruction necessary to provide a detailed knowledge of the structure and function of teeth and associated tissues.

Integrated with the instruction into normal dental and oral soft tissues, should be the development of an ability to recognise the presence of disease or developmental abnormalities. Whilst it is not expected that the Orthodontic Therapist will develop knowledge and skills to diagnose disorders, the ability to recognise departures from the normal and the recognition of the need to arrange appropriate referral are important aspects of skills development. In order to support the principles of disease processes, instruction should be provided on aspects of caries and periodontal disease including the role of dental plaque.

Theoretical and practical instruction should be given in tooth morphology and identification. The Orthodontic Therapist will be required to differentiate between deciduous and permanent teeth, and identify individual teeth for which specific orthodontic attachments are available.

BEHAVIOURAL SCIENCES

The key to the provision of good orthodontic care is the ability to communicate with patients from all backgrounds. The development of appropriate communication skills must be an important part of the curriculum. Behavioural sciences should be taught throughout the programme with careful integration so that the subject matter assumes its proper relevance to the care of the patient. The subjects concerned are principally psychology and sociology.

COMMUNICATION SKILLS

The teaching of communication skills is an essential aspect of the education of Orthodontic Therapists. It is important that students develop the ability to communicate clearly with patients, parents and other healthcare professionals. There should be emphasis on the need to communicate to patients the knowledge and understanding of treatment proposed or advice given. Of particular importance is the development of patient education and motivation skills. These skills should be taught as an integrated element of clinical orthodontics. Instruction should be given in providing advice to patients and parents on orthodontic appliance management, maintenance, safety and care. Students should be taught to provide advice on care of the mouth to maintain oral health, including dietary counselling and oral hygiene instruction. All students must achieve good communication skills before completing the programme.

HUMAN DISEASE

Sufficient instruction in human disease should be given to enable the student to understand its manifestations in so far as they may be relevant to the practice of orthodontics as a PCD. Students should acquire the skills necessary to elicit an appropriate medical history, with particular reference to cardio-respiratory diseases, haemorrhagic disorders, allergies and drug therapy.

INFECTION CONTROL

With the introduction to clinical orthodontics, the student takes responsibility for the safety of patients and other staff. Instruction should be provided in the nature of transmissible diseases and the importance of preventing cross infection in the clinic. Students should develop knowledge of the theory and practicalities of sterilisation, disinfection and antisepsis in the dental surgery. Instruction should be provided in carrying out infection control procedures.

TRANSMISSIBLE DISEASES

Students should be advised that if they may be infected with transmissible diseases that could be a biohazard to patients or colleagues they must obtain medical advice and, if found to be infected, must receive regular medical supervision. Students must act upon any medical advice they receive, which might include the necessity to cease carrying out invasive dental procedures. This rule conforms to Guidance on Professional and Personal Conduct issued by the GDC in Maintaining Standards. Any student who knows or has reason to believe that he or she is the carrier of a transmissible blood-borne virus has the responsibility to declare that fact to the programme director or equivalent person.

LAW, ETHICS AND PROFESSIONALISM

Orthodontic Therapists should understand the legal and ethical obligations of PCDs, the range and limits of their permitted activities and the regulatory functions of the GDC. Students should be aware of the principles and practices involved in dental audit, of the ethical responsibilities of the dental profession in clinical investigation and research and in the development of new therapeutic procedures including the concept of risk assessment and management. The ethical aspects of professional relationships should also be drawn to students' attention, and their reconciliation with personal and public morality. Students need to have some familiarity with the specific requirements of contemporary practice, including reference to relevant regulations, the need for professional indemnity and the valuable role played by the medical defence organisations. The GDC's publication *Maintaining Standards* should be studied. The Disability Discrimination Act and the Human Rights Act are examples of how this area is rapidly changing and influencing many facets of professional life. Issues of professionalism such as conduct and misconduct, including alcohol and the use of recreational drugs should be addressed.

The legal basis under which patients are treated should be discussed, and the ethical responsibilities the PCD assumes under these circumstances examined. No student should proceed to treat patients without a proper understanding of these matters, especially consent, assault, duty of care and confidentiality. The legal requirement to maintain full, accurate clinical records should also be appreciated by the student.

Students should understand the importance of communication between dentist, PCD and patient. This helps to develop attitudes of empathy and insight in the student and provides the opportunity for discussion of contemporary ethical issues. Students should also be encouraged to understand their own responses to work pressures and their management.

There should be guidance on the key ethical and legal dilemmas confronting the PCD. Students should learn how to:

- maintain accurate and clear medical records;
- handle patient complaints;
- ensure that patients' rights are protected;
- maintain confidentiality;
- manage gender and racial issues;
- take appropriate steps with colleagues failing their professional responsibilities;
- work only within the limits of permitted duties and respond to requests to work beyond these.

HEALTH AND SAFETY

Students should become familiar with aspects of health and safety relevant to orthodontic practice. A modern approach to health and safety in the workplace should be an essential component of the curriculum. Students must be able to adhere to health and safety legislation as it applies to orthodontic clinical and laboratory practice, to arrange and use the working environment in the most safe and efficient manner for all patients and staff.

CLINICAL ORTHODONTICS

The moment of introduction to clinical orthodontics may involve first contact with patients for many PCDs and is a highly significant event. It is important that the introduction is carefully planned. Key safety procedures and ethical considerations should be emphasised at the same time.

CLINICAL RECORDS

Practical teaching should be provided in the taking of a full range of records required for orthodontic patients. At all times, an ethos of quality assessment and critical self-evaluation should be fostered.

Teaching should be provided in dental photography using contemporary film-based or digital technology. The skills to take good quality intraoral and extraoral photographs, together with views of models or radiographs should be developed.

The student should be taught to take accurate dental impressions, using contemporary impression materials safely. Teaching should be provided in the taking of an accurate occlusal record, including the use of gnathological facebows where required. Students should become skilled in the laboratory techniques of model casting, basing and trimming, being mindful of laboratory health and safety issues.

The student should be taught the basics of cephalometrics. This should include the identification of common landmarks on a skull radiograph and from this the production of a cephalometric analysis by contemporary methods.

Progress in information technology will continue to accelerate and become an important and integral part of dental practice. These technologies provide access to clinical and educational information in a wide variety of formats. Ideally students should enter the programme equipped with sufficient skills to be able to use these from the start. During their training they should develop an understanding of the advantages and limitations of electronic sources of health information. They should have an opportunity to use information and communication technologies for research, healthcare provision and health promotion. They must become aware of the law as it relates to data protection and patient confidentiality.

THE PRINCIPLES OF ORTHODONTICS

Prior to embarking upon clinical orthodontic treatment, students should develop a sound basis of orthodontic theory. This will include:

- the concepts and features of normal and ideal occlusion;
- the features and classification of malocclusion;
- the principles of tooth movement under the influence of applied load, the application of forces and the concept of anchorage;
- the identification and mechanical principles of a range of contemporary orthodontic appliance systems;
- the aetiology of malocclusion, including skeletal, soft tissue and local factors;
- the scope and limitations of orthodontic treatment;
- the potential risks and benefits of orthodontic treatment, with particular emphasis on iatrogenic damage to teeth and supporting tissues.

ORTHODONTIC INSTRUMENTS AND BIOMATERIALS

Teaching should be provided to introduce students to a wide range of orthodontic instruments. From this should develop the skills to identify and select instruments for a range of orthodontic tasks. Crucial within this skill is the ability to use selected instruments safely and following use to maintain them to a clinically acceptable standard.

Students should be introduced to a wide range of orthodontic materials, including their clinical use and limitations. They should be aware of the contemporary health and safety issues relating to these materials.

REMOVABLE APPLIANCE PLACEMENT

Teaching should be provided in the clinical techniques of appliance insertion, and should be accompanied by the behavioural teaching of advice to patients on appliance management and care.

Students should be taught to insert passive removable appliances such as space maintainers or retainers, and active removable appliances which have been adjusted previously by a registered dentist. They should be taught to assess the quality of fit and the criteria by which to accept or reject the appliance.

Students should be taught to fit orthodontic headgear, including the insertion of facebows previously adjusted to fit by the registered dentist. Integral with this is the need to understand the risks of headgear and to give advice on headgear safety to patients.

FIXED APPLIANCE PLACEMENT

Preparatory teaching of technical fixed appliance skills relies upon the use of models, manikins or typodonts. Sufficient instruction should be given on technical exercises to develop the skills required to treat patients. Technical skills must be tested before students are allowed to treat patients. Such tests must show that students can work safely before they treat patients under supervision. A wide range of fixed appliance skills will be required.

Teaching will include the placement and removal of orthodontic separators in preparation for the fitting of orthodontic bands.

The student should be taught to select appropriately sized bands for the individual tooth and patient, weld attachments where required and then cement the band to the tooth to achieve an ideal fit.

The student should be taught to select attachments appropriate for individual teeth, clean and prepare the tooth surface for bonding, and place attachments onto the teeth in the correct position using orthodontic adhesives.

The student should be taught to prepare, insert and ligate archwires and archwire auxiliaries safely.

FIXED APPLIANCE REMOVAL

Integral to orthodontic fixed appliance treatment is the process of appliance reactivation by removing and replacing archwires. At the completion of active treatment, archwires, attachments and bands must be removed prior to cleaning residues from the teeth.

The student should be taught to release and remove ligatures, and to remove archwires and archwire auxiliaries. Students should become skilled at removing attachments and bands safely and non-traumatically from the teeth.

The student should be taught to differentiate between dental tissues, dental deposits, adhesives and cements. Using contemporary methods, they should be able to remove adhesive and cement residues from the teeth, before cleaning and polishing them.

ORTHODONTIC EMERGENCY CARE

Students should be taught to manage unanticipated orthodontic events presenting in the surgery, such as a patient presenting with appliance breakage, trauma or pain.

In line with other categories of PCD, the Orthodontic Therapist will work as a member of the orthodontic team, interpreting and fulfilling a care plan provided through a registered dentist. In circumstances where a patient presents as an orthodontic emergency, the Orthodontic Therapist may be required to carry out limited treatment in the absence of a dentist. Instruction should be provided to enable the student to identify damaged or distorted orthodontic appliances and to carry out limited treatment in order to relieve pain or make an appliance safe. It is important that the student is made aware of the limits of their own knowledge, skills and expertise and when to seek the help of a registered dentist when a problem is beyond these.

MEDICAL EMERGENCIES

Students should have knowledge of first aid measures, including the principles of cardiopulmonary resuscitation and its practice under realistic conditions. Students should understand the necessity for this practice to be repeated on an annual basis throughout the career to maintain skills. Students should know how to recognise and take appropriate action in situations such as: anaphylactic reaction, hypoglycaemia, upper respiratory obstruction, cardiac arrest, fits, vasovagal attack, inhalation or ingestion of foreign bodies and haemorrhage.

COMPREHENSIVE ORAL CARE

Students should have the opportunity to work with other members of the dental team. They should appreciate the benefit of working with a dental nurse and learn the principles and practice of assisted operating. They should also be in a position to refer to and interact with registered dentists and other PCDs.

Students should be taught to interpret and work to an orthodontic care plan or prescription, with due knowledge of the Orthodontic Therapist's role in the team. They should be aware of when to refer the patient to a registered dentist, where treatment is beyond their training or experience.

SPECIFIC LEARNING OUTCOMES

Specific learning outcomes have been identified from the subjects and topics previously listed. These relate to those tasks that Orthodontic Therapists must be able to carry out safely and competently upon completion of their training. The outcomes include some tasks that are performed by other groups of PCD. However, these tasks are included **only where they are relevant to orthodontic treatment.**

Learning outcomes are expressed in three levels:

- Be competent at: students should have a sound theoretical knowledge and understanding of the subject together with an adequate clinical experience to be able to resolve clinical problems encountered, independently, or without assistance.
- Have knowledge of: students should have a sound theoretical knowledge of the subject, but need have only a limited clinical/practical experience.
- Be familiar with: students should have a basic understanding of the subject, but need not have direct clinical experience or be expected to carry out procedures independently.

The Orthodontic Therapist should:

THE TEETH AND SUPPORTING STRUCTURES IN HEALTH AND DISEASE

- be competent at assessing tooth quality, including normal tooth tissue and the presence of disorders of tooth tissue;
- be competent at identifying deciduous and permanent teeth
- be competent at recognising the supporting structures of the teeth in health and disease, including the identification of normal intraoral soft tissues and the presence of disorders of the soft tissues;
- have knowledge of oral and dental anatomy, physiology and pathology relevant to orthodontics;
- have knowledge of the role of dental plaque in the development of caries and periodontal disease.

BEHAVIOURAL SCIENCES

- be competent at communication with patients, other members of the dental team and other healthcare professionals ;
- be competent at explaining and discussing orthodontic treatment with patients and their parents;
- be competent at instructing patients in the techniques and methods of maintaining and monitoring oral health;
- be competent at undertaking a dietary analysis and giving dietary advice to orthodontic patients;
- be competent at providing instructions for the care and maintenance of fixed and removable orthodontic appliances;
- be competent at issuing instructions to the patient on the risks and safety features of orthodontic headgear;
- have knowledge of the importance of patient education in orthodontics, including the principles of instruction and motivation;
- be familiar with the social and psychological issues relevant to the care of patients.

HUMAN DISEASE

- be competent at carrying out sterilisation, disinfection and antisepsis by appropriate methods;
- be competent at taking an accurate medical history;
- have knowledge of the scientific and clinical principles of sterilisation, disinfection and antisepsis;
- be familiar with the implications of a positive medical history and the main medical disorders that may affect the provision of orthodontic treatment.

LAW, ETHICS AND PROFESSIONALISM

- be competent at maintaining full, accurate clinical records;
- have knowledge of responsibilities of consent, duty of care and confidentiality;
- have knowledge of patients' rights;

- have knowledge of the permitted activities of PCDs;
- have knowledge of the regulatory functions of the General Dental Council;
- be familiar with the legal and ethical obligations of PCDs;
- be familiar with the standard of conduct expected of a PCD, and the kind of behaviour which might be regarded as misconduct;
- be familiar with the obligation to practice in the best interest of the patient at all times;
- be familiar with the importance of a contract of employment;
- be familiar with the requirement for professional indemnity;
- be familiar with the need for lifelong learning and professional development.

CLINICAL ORTHODONTICS

CLINICAL RECORDS

- be competent at taking intraoral and extraoral photographs of patients, and photographs of models and radiographs;
- be competent at taking dental impressions;
- be competent at taking and checking occlusal records, including gnathological facebow readings;
- be competent at casting, basing and trimming orthodontic models;
- be competent at producing a cephalometric analysis of a skull radiograph by contemporary methods;
- be competent at using information technology.

THE PRINCIPLES OF ORTHODONTICS

- have knowledge of the features of normal and ideal occlusion;
- have knowledge of the classification of malocclusion;
- have knowledge of the principles of tooth movement, force application and anchorage;
- have knowledge of common orthodontic appliance systems and their mechanical principles;
- be familiar with the aetiology of malocclusion;
- be familiar with the limitations of orthodontic treatment;
- be familiar with the potential risks and benefits of orthodontic treatment including iatrogenic damage.

ORTHODONTIC INSTRUMENTS AND BIOMATERIALS

- be competent at identifying and selecting appropriate instruments for the task to be carried out;
- be competent at using equipment and instruments safely;
- be competent at maintaining instruments;
- be competent at using a range of orthodontic biomaterials;
- have knowledge of the range of available orthodontic biomaterials;
- have knowledge of the limitations of materials;
- be familiar with those aspects of biomaterials safety that relate to orthodontics;
- be familiar with relevant health and safety regulations and procedures in the laboratory and clinic.

REMOVABLE APPLIANCE PLACEMENT

- be competent at inserting passive removable appliances;
- be competent at inserting active removable appliances previously adjusted by a registered dentist;
- be competent at fitting orthodontic headgear;
- be competent at fitting orthodontic facebows which have been previously adjusted by a registered dentist;
- be competent at measuring elastic headgear forces.

FIXED APPLIANCE PLACEMENT

- be competent at placing and removing orthodontic separators;
- be competent at identifying and selecting orthodontic bands appropriate for the patient;
- be competent at placing, adapting and cementing bands to achieve an ideal fit;
- be competent at identifying attachments appropriate for individual teeth;
- be competent at cleaning and preparing the tooth surface for orthodontic bonding;
- be competent at using orthodontic adhesives and cements;
- be competent at placing attachments, including bonded retainers, onto the teeth in the correct position;

- be competent at preparing archwires;
- be competent at inserting and ligating archwires and archwire auxiliaries;
- be competent at ligating groups of teeth together;
- be familiar with the technique of welding attachments to bands.

FIXED APPLIANCE REMOVAL

- be competent at releasing and removing ligatures;
- be competent at removing archwires and archwire auxiliaries;
- be competent at removing cemented and bonded attachments;
- be competent at differentiating between dental tissues, dental deposits, adhesive and cement;
- be competent at removing orthodontic adhesive and cement residues from the teeth;
- be competent at supragingival cleaning and polishing of the teeth using both powered and manual instrumentation, and in stain removal and prophylaxis where directly relevant to orthodontic treatment.

ORTHODONTIC EMERGENCY CARE

- be competent at identifying damaged and distorted orthodontic appliances;
- be competent at taking limited action to relieve pain or make an appliance safe in the absence of a registered dentist;
- be competent at identifying when a situation is beyond the Orthodontic Therapist's expertise, and requires the patient to be seen by a registered dentist;
- have knowledge of the need to arrange early attention by a registered dentist following the emergency treatment.

MEDICAL EMERGENCIES

- be competent at identifying the cause of sudden collapse in the dental surgery;
- be competent at carrying out resuscitation techniques and immediate management of cardiac arrest, anaphylactic reaction, upper respiratory obstruction, collapse, vasovagal attack, haemorrhage, inhalation or ingestion of foreign bodies, and diabetic coma.

COMPREHENSIVE ORAL CARE

- be competent at working with other members of the dental team;
- be competent at interpreting, and working to an orthodontic care plan or prescription;
- have knowledge of the role of the Orthodontic Therapist within the framework of the dental team;
- have knowledge of when to refer the patient to a registered dentist where treatment is beyond the training or experience of the Orthodontic Therapist;
- be familiar with the organisation of orthodontic services within the United Kingdom.

Annex 1:

ENTRY REQUIREMENTS FOR TRAINING

Before training as an Orthodontic Therapist, it is necessary to have basic knowledge, understanding and experience of clinical dental sciences, patient management and surgery protocols including cross infection control. This knowledge is integral within training programmes in Dental Nursing, Dental Hygiene and Dental Therapy. It is hoped that new foundation courses will be developed so that those without a background in Dental Nursing, Dental Hygiene or Dental Therapy will have greater opportunity to acquire the necessary knowledge and skills required prior to applying for Orthodontic Therapy.

The following minimum entry requirements are recommended for those seeking to train as Orthodontic Therapists:

Dental Nurses

- Membership of the statutory register of Dental Nurses **AND**
- At least one year of full-time, or equivalent, post-qualification experience.

Dental Hygienists and Dental Therapists

- Membership of the statutory register of Dental Hygienists or Dental Therapists **AND**
- At least one year of full-time, or equivalent, post-qualification experience.

Dental Technicians

- Membership of the statutory register of Dental Technicians **AND**
- At least one year of full-time, or equivalent, post-qualification experience **AND**
- Demonstrable accredited prior learning from a suitable foundation course at a level commensurate with the requirements for an understanding of clinical dental sciences, patient management and surgery protocols including cross infection control.

In the future, consideration should be given to direct entry to Orthodontic Therapy courses, in a manner similar to Dental Hygiene and Dental Therapy. This would necessitate the taking of a suitable foundation course or an extension to the curriculum.

Training providers would be responsible for selecting suitable students and they would need to exercise their discretion in cases where it was uncertain whether a candidate met the minimum requirements. For example, it would be for individual training providers to decide whether a person who had worked part-time had sufficient post-qualification experience. As a rule, however, part-time students would be expected to have the same experience as full-time students.

ANNEX 2:

STRUCTURE OF TRAINING

Training should comprise three parts:

- (a) an introductory and theoretical course;
- (b) an intensive clinical skills and theory course
- (c) supervised clinical training.

Each part of the training should be completed in the order shown above i.e. first, introductory and theoretical, then the intensive clinical skills course, followed by supervised clinical training.

THEORETICAL COMPONENT

The theoretical component should comprise theoretical elements of the curriculum. The introductory and theory part of the training should be made available by distance learning in order to achieve greater access and convenience. Once the new Certificate in Orthodontic Nursing, awarded by the National Examining Board for Dental Nurses has been approved by the General Dental Council, holders of this certificate could be exempt from this part of the training through accredited prior learning. Collaborative work should take place with the NEBDN to harmonise the curricula for the Certificate of Orthodontic Nursing and the theoretical component of Diploma in Orthodontic Therapy, and if possible produce a single distance-learning programme to cover both.

INTENSIVE CLINICAL SKILLS AND THEORY

The intensive clinical skills and theory course should comprise skills-based elements in the curriculum and should be delivered by dental schools, hospitals and institutes that run three-year full-time post-graduate courses in orthodontics. At present only such institutions are considered to have the necessary teaching skills and clinical environment. The overwhelming majority of dental schools, hospitals and institutes fall into this category and so this part of the training would be available in most regions of the country. Orthodontic therapists would benefit greatly from contact with orthodontic postgraduate students.

SUPERVISED CLINICAL TRAINING

Supervised clinical training should take place in a community dental clinic, a dental hospital, a hospital or a specialist orthodontic practice. It should be supervised by a dentist with appropriate training and experience in orthodontics, who has completed a "Training the Trainer" course or equivalent. Trainees should provide evidence of clinical practice through a portfolio validated by the supervisor, to confirm that the required clinical competences have been achieved.

The introductory and theoretical course, the intensive clinical skills and theory course and the supervised clinical training should form an integrated programme. The dental school, hospital or institute responsible for the introductory and theoretical course, the intensive clinical skills and theory course should have overall responsibility for the training programme and should liaise regularly with the provider of supervised clinical training, (if not provided by the hospital itself) to monitor the progress of individual students.

Theoretical training should continue after the completion of the introductory and theoretical course and the intensive clinical skills and theory course in order to reinforce underpinning knowledge and understanding. This supplementary theoretical training should last one or two days and take place at least once every three months after the intensive clinical skills course. These days should also serve as an opportunity for the training institution to assess the trainee's progress and to gain feedback on the supervised clinical training. In due course it is expected that suitably qualified Tutor Orthodontic Therapists will emerge and make a contribution to training similar to that of Tutor Dental Hygienists and Tutor Dental Therapists.

DURATION OF TRAINING

The overall training period (intensive clinical skills and theory course plus the supervised clinical training) would require a total of approximately 12 months full-time or a part-time equivalent of not less than three days a week. The intensive clinical skills and theory course would require a period of 4 - 6 weeks. The remainder of the training period should be spent undertaking supervised clinical training, either full-time or an equivalent period part-time. Part-time trainees would need to undertake at least six sessions a week.

ORGANISATION OF TRAINING

The curriculum should be delivered through a nationally approved course available in a small number of centres and assessed by a national examination. This objective could best be met through a partnership between training providers, the General Dental Council, dental authorities, the Royal Surgical Colleges and the British Orthodontic Society. The training centre should be responsible for organising the introductory course, for delivering the intensive clinical skills training, monitoring a trainee's progress and overseeing the training programme as a whole. Providers of supervised clinical training should deliver and co-ordinate workplace training and the development of portfolios of evidence. The General Dental Council should set standards of education and training and maintain these standards through visitations. The Royal Surgical Colleges, in partnership with the British Orthodontic Society, should inspect specialist practices and other units to determine their suitability to provide supervised clinical training.

ASSESSMENT

The assessment of training should be based on modules to avoid the need for trainees to retake the entire course if they fail one individual element. There should be summative assessments at the end of the introductory theoretical and intensive clinical skills and theory training and an examination at the end of the course as a whole. A portfolio of evidence would form an important part of this examination. Clinical trainers should validate the portfolio and hold regular appraisal meetings with the trainee and the training institution. Success in the examination should result in the award of a registrable qualification in Orthodontic Therapy by an appropriate dental authority.

ANNEX 3:

STANDARDS REQUIRED OF PROVIDERS OF SUPERVISED CLINICAL TRAINING

Providers of supervised clinical training should meet certain minimum standards of provision in terms of facilities and education. The tables below show both the essential and desirable levels of provision.

FACILITIES

	<u>Essential</u>	<u>Desirable</u>
1	Specialist orthodontic practice	
2	Critical mass of patients	At least 150 new orthodontic patients taken on each year.
3	Access to a wide range of orthodontic treatment modalities (removable, functional, fixed, headgear)	Range of fixed appliance techniques practised
4	Dedicated chair for orthodontic therapist	Two or more chairs within practice for orthodontic therapist and trainer to work closely together
5	Nursing support for orthodontic therapist, when clinically necessary	Full-time nursing support for orthodontic therapist with 4-handed facilities
6	Access to contemporary materials, instruments, equipment and systems	
7	Access to photographic equipment (conventional or digital)	Access to digital photography
8	Contemporary cross infection control procedures routinely practised	
9	Administrative support	
10	Facilities and education aids for the provision of patient education (OHI, appliance care etc)	
11	Access to laboratory facilities	On-site laboratory or opportunity to be seconded to local laboratory
12	Access to orthodontic radiography	On-site orthodontic radiography
13	Manual tracing facilities or computer aided digitisation facilities	Both available

EDUCATIONAL

<u>Essential</u>	<u>Desirable</u>
1 Educational contract signed with commitment to train by the trainer.	An agreed minimum post-training period of employment at the sponsoring training unit.
2 Trainer willing to fund training and remunerate	
3 Trainer with the necessary level of skill and experience.	Trainer on orthodontic specialist list
4 Trainer willing to devote time to maintaining logbook in conjunction with trainee	
5 Full-time, on-demand supervision	
6 A contingency plan to cover trainer absences	
7 Training of the trainer prior to commencing orthodontic therapist training	
8 Trainer in contact with training centre to maintain levels of teaching consistency.	
9 Work load sufficient for educational purposes but flexible enough to give time to discuss issues at the chair-side with trainer beside the patient or between patients	
10 Out of clinic teaching time for seminars, case discussions, quality assessment debriefing.	
11 Necessary opportunities for academic release in connection with training course including support	
12 Regular appraisal meetings during the year with training institution or local assessor.	
13 Computer with internet access and e-mail.	
14 Basic library of orthodontic texts and journals	Active local orthodontic study group which trainee and trainer are encouraged to attend

These standards should be enforced through the regular inspection of specialist practices and other units providing clinical training. These inspections could be carried out by the Royal Surgical Colleges through their network of specialist advisors in partnership with the British Orthodontic Society.

ANNEX 4:

CLINICAL PRACTISE

The clinical activities of Orthodontic Therapists should:

- * be carried out under the direct personal supervision, and to the written prescription at every patient visit, of a registered dentist with appropriate experience and training;
- * be relevant to their sphere of work;
- * be of low risk to both PCD and patient;
- * not require decisions as to the long-term management of the patient's condition.

At its meeting in May 2000 the General Dental Council decided that there should be common working arrangements for all groups of PCD and that no group should be treated fundamentally differently from others. Specifically, the Council decided that clinical groups of PCD should:

- work in all sectors of dentistry;
- work to the written prescription of a dentist;
- be permitted to practise in premises separate from a dentist;
- not be permitted to accept payment from patients.

These principles are broadly consistent with those recommended by the Curriculum Working Group for Orthodontic Therapists. The Working Group is concerned, however, about the consequences of Orthodontic Therapists being permitted to work remotely from dentists. Since orthodontic treatment requires frequent monitoring and judgement by a dentist, it is necessary for the protection of the patient for Orthodontic Therapists to work under the direct personal supervision of a dentist. Such supervision would not be possible if Orthodontic Therapists were working in premises separate from the dentist. The Working Group also considers that practical considerations would make it difficult, if not impossible, for Orthodontic Therapists to work remotely. The Working Group recommends that ethical guidance should discourage dentists from working remotely with Orthodontic Therapists by advising that such an arrangement would not be in the best interests of patient care.

APPENDIX 5

September 1995

Bristol Dental School 2 week "Pilot" training course.



Top right the Course Trainers

Back row Jonathan Sandy, Olly Keith, Chris Stephens

Front row (from the University of British Columbia) Marjory Sorfleet, Paul Witt

July 2007

First Orthodontic Therapist course opens at Leeds Dental School.



Top right: the Leeds Trainers : Simon Littlewood and Trevor Hodge

Bottom right: presentation of the first diplomas at the Royal College of Surgeons of England

Glossary of Acronyms

APC	Auxiliary Personnel Committee of the BDA
BASCD	British Association for the Study of Community Dentistry
BDA	British Dental Association
BDJ	British Dental Journal
BJO	British Journal of Orthodontics
BOC	British Orthodontic Conference
BOS	British Orthodontic Society
BSSO	British Society for the Study of Orthodontics
CDO	Chief Dental Officer
CDS	Community Dental Service
CG	Community Group of the BOS
CHC	Community Health Council
COG	Consultant Orthodontists Group
COS	Community Orthodontic Section
DAC	Dental Auxiliaries Committee of the GDC
DARG	Dental Auxiliaries Review Group of the GDC
DSA	Dental Surgery Assistant
FDS	Faculty of Dental Surgery, Royal College of Surgeons of England
FGDP	Faculty of General Dental Practitioners, Royal College of Surgeons of England
FHSA	Family Health Service Authority
GDC	General Dental Council
GDP	General Dental Practitioner
GDSC	General Dental Services Committee of the BDA
GPG	General Practitioner Group of the BOS
IOTN	Index of Orthodontic Treatment Need
NEBDN	National Examining Board for Dental Nurses
ONG	Orthodontic National Group
PCD	Professions Complementary to Dentistry
SDAC	Standing Dental Advisory Committee
SDO	Senior Dental Officer
SPG	Specialist Practitioners Group of the BOS
TGG	Training Grades Group of the BOS