Consultant Practice

in the

Dental Specialties

November 2005
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1. **Acknowledgements**

This document is a development of the 1997 British Dental Association publication entitled *Consultant Workload and Practice in the Dental Specialties*, which was prepared by David Barnard and John Lowry, both past Chairs of the Central Committee for Hospital Dental Services and subsequently Deans of the Faculty of Dental Surgery of the Royal College of Surgeons of England. That document was prepared following input from: the Dental Faculties of the Royal Colleges of Surgeons of England and Edinburgh, and the Royal College of Physicians and Surgeons of Glasgow; the Committee of Postgraduate Dental Deans and Directors; and various specialty groups and associations – including the British Association of Oral and Maxillofacial Surgeons; the Consultant Orthodontists Group; the Consultants in Restorative Dentistry Group; the Consultants in Paediatric Dentistry Group; the British Society for Oral Medicine; the British Society for Oral Pathology; the British Society of Dental and Maxillofacial Radiology; the Consultants in Dental Public Health Group; and the Negotiations Subcommittee of the British Medical Association’s Central Consultants and Specialists Committee.

Special thanks are due to a number of current members of the Central Committee for Hospital Dental Services who have contributed to this new publication. These include: Paul Allen; Ian Hollingum; Vinod Joshi; and Ray Reed,

In addition, we gratefully acknowledge contributions from: John Drummond, Past Chair of the Central Committee for Dental Academic Staff; Leslie Longman, Alex Milosevic and the Association of Consultants and Specialists in Restorative Dentistry; the Consultants in Paediatric Dentistry Group; John Rout, Consultant in Dental and Maxillofacial Radiology; and the Faculty of Dental Surgery at the Royal College of Surgeons of England – for permission to reproduce person specifications from their website.
2. **Foreword**

Since the first version of this document was published in 1997, important changes have occurred, of which the most significant is the new contract for consultants in the UK. This was negotiated between the Department of Health and the British Medical Association, with consultative involvement by the British Dental Association, and accepted following a ballot of consultants and Specialist Registrars in October 2003.

The move to reduce excessive hours of work for trainee doctors has been followed by similar measures in relation to consultants. These developments have been partly driven by the requirements of European legislation.

In the case of Oral and Maxillofacial Surgery, to take one example, this has led to some amalgamation of units to give a less onerous on-call commitment and to allow greater sub-specialisation among consultants. In addition to any on-call considerations, all colleagues in the dental specialties can now review their practice and weekly timetable in order that recognition can be given for all the various types of work that they may undertake. This review is repeated on an annual basis through the appraisal process, and that process contributes to revalidation – which will be required for continuing registration with regulatory bodies, such as the General Medical Council and the General Dental Council. This revised version reflects these changes.

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3. Consultant Practice – General Issues

This document is designed to provide information and advice on a range of items relating to the role, terms of service, appointment and work programme of consultants in the dentally-based specialties. Guidelines are provided to assist in the completion of job plans, but it must be emphasised that an individual consultant’s pattern of work is unique and the final programme agreed with clinical and managerial colleagues may show significant variation depending upon local circumstances. The references given refer largely to practice in England; colleagues based in Northern Ireland, Scotland and Wales are strongly advised to consult with colleagues in their countries, as well as BDA Headquarters, BMA local officers and surgical Royal Colleges regarding variations from the patterns described here.

i. Background

After a protracted phase of negotiations, the BMA and the Department of Health finally agreed on a new Consultant Contract during 2003. A ballot was held at which consultants and specialist registrars were asked to vote for or against the proposed new contract. The previous version had been rejected by the consultant body, but the second version was accepted: of the 20,184 consultants who voted, 60.7% were in favour; and of the 3,090 SpRs who voted, 55.4% were in favour. Devolution of government in the UK (through the creation of the Scottish Parliament, the Welsh Assembly and the Northern Ireland Assembly) means that there are slight differences with regard to the Consultant Contract in Scotland, Wales and Northern Ireland compared with England. After the ballot, the BMA produced guidance for consultants, which is designed to assist them in drawing up a job plan. Consultants were then advised to complete a weekly diary for several weeks so that they could produce an average job plan that reflected their practice. A job plan review with the service lead, the lead clinician or a manager allowed them to reach agreement about the job plan.

Enactment of the European Specialist Medical Qualifications Order (1995)\(^1\) and the European Primary and Specialist Dental Qualifications Regulations (1998)\(^2\) has introduced the requirement for all doctors seeking appointment to the consultant grade to be included in a General Medical Council and/or General Dental Council specialist register before they are permitted to take up a consultant appointment. Those practising in the field of oral and maxillofacial surgery are required to be on the General Medical Council specialist register for Maxillofacial Surgery and, with regard to teaching and supervision of dentally-qualified trainees, to be registered with the General Dental Council.

ii. Role of the consultant

Neither the terms and conditions of service of hospital medical and dental staff nor the Statutory Instrument relating to appointment describe an exact role for a consultant. Previous definitions have stated and reaffirmed that a consultant, being the most senior doctor or dentist in the hospital service, will usually have independent clinical responsibility for any patient entrusted to his or her care by the NHS Trust. The report of a working party of the Chief Medical Officer on the responsibilities of the consultant grade in 1969 stated:

'A consultant is a doctor, appointed in open competition by a statutory hospital authority to permanent staff status in the hospital service after completing training in a specialty and in future being included in the appropriate vocational register; by reason of his training and qualifications he undertakes full responsibility for the clinical care of his patients without supervision in professional matters by any other person; and his personal qualities and other abilities are pertinent to the particular post.'\(^3\)

This definition has not been superseded.

Consultants are appointed in open competition by a properly constituted Advisory Appointments Committee (AAC) to permanent staff status, to undertake independent specialist practice within the NHS. They are leaders of the clinical team and on the basis of their training and qualifications undertake full and independent responsibility for the clinical care of their patients, offer specialist opinion to general

\(^1\) Statutory Instrument 1995/3208.
practitioners and other colleagues and advise management on the efficient and smooth running of their specialist services. Each patient admitted or seen in an NHS hospital must be the responsibility of a named consultant and remains so until transferred to another consultant or discharged, normally to the care of a named general practitioner with a management plan. This is reiterated as the required guideline in the *Quality Framework and Guidelines for Hospital and Community Health Services Medical and Dental Staffing*. The majority of consultants in dental public health employed within the NHS will have contracts with Primary Care Organisations and will not normally function within the hospital environment. They will have equivalent responsibilities with regard to team leadership, and specialist advice and opinion, but this will be of a non-clinical nature. Many of the references within this document to clinical aspects of a consultant’s role will not be relevant for consultants in the specialty of dental public health.

iii. **Requirements of a consultant**

Consultants should have:

- sufficient knowledge to offer expert clinical opinion on a range of problems within the specific specialty;
- operative training and technical ability for the range of surgical procedures appropriate to that specialty;
- knowledge and ability for the full range of clinical problems within the specialty – although detailed knowledge and ability is often shared with other consultant colleagues working in the same or adjacent units;
- an enquiring, critical approach to work and a caring attitude to patients.

In addition, consultants are now required to have undergone a satisfactory annual appraisal. The General Medical Council and the General Dental Council have both issued guidance such that the maintenance of a consultant’s name on a specialist register will be subject to revalidation. Revalidation will depend upon a number of satisfactory annual appraisals, together with completion of sufficient (particularly external verifiable) Continuing Medical Education / Continuing Professional Development (CME/CPD).

iv. **General responsibilities**

The most onerous responsibility of a consultant in the acute specialties is the care of patients presenting with emergency conditions. These are unpredictable both in occurrence and requirement for time and skills. Some specialty services are largely consultant-provided, whilst others have greater trainee contribution to management and operative care. Some dentally-based specialties have a comparatively low emergency burden; however, the greater the number of emergencies and the more frequent the incidence of on-call responsibility, the greater is the need for flexibility in the consultant programme. Even in those specialties where a significant contribution to service care can be provided by trainees, there will be a need for extra flexibility in the consultant programme where the trainees are inexperienced. The patient, the public and the profession now expect increased personal consultant involvement in all aspects of emergency care.

Consultants need to be available when on emergency duty and contactable at other times to advise or assist in the management of all patients admitted under their care unless such management has been transferred to a named colleague.

The greatest number of complaints received by hospitals relate to failures in communication. The time and opportunity for proper communication with patients, their relatives and other healthcare professionals must be allocated in a consultant’s programme and allowed for when the workload appropriate for outpatient clinics is being determined.

v. **Specific responsibilities of a consultant**

vi. **Clinical (specialty-dependent)**

- Out-patient consultation/investigation/diagnosis
- Treatment/Operating elective/emergency as ambulatory/day-care/in-patient

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4 NHS Executive, April 1997.
• In-patient (where appropriate) continuing clinical management

v.ii Communication with:
• Patient
• Relatives
• General dental/medical practitioner
• Nurses/Dental nurses
• Technician
• Other agencies, including Professionals Complementary to Dentistry / Professions Allied to Medicine

v.iii Administration
• Organisation of out-patient priorities
• Clinical management of waiting lists
• Organisation of clinical work schedules/operation lists

v.iv Management
• Clinical ‘firm’ within:
  • Specialist unit
  • Surgical/specialist surgical/dental surgical directorate
  • Clinical/Medical directorship

v.v Training/Education
• General Professional Trainee supervisor PLUS
• Basic Specialist Trainee teacher of clinical in-training
• Higher Specialist Trainee and operating skills assessment and
• Undergraduate and postgraduate students basic clinical skills counselling
• General dental/medical practitioners
• Other consultants
• Nurses
• Professionals Complementary to Dentistry / Professions Allied to Medicine

v.vi Audit and Clinical Governance
• Unit
• Inter-disciplinary
• Regional
• College
• National (e.g. Clinical Standards Advisory Group, National Institute for Health and Clinical Excellence)

v.vii Continuing Medical Education / Continuing Professional Development/
• Personal study: journals/audio and video tapes/computer assisted learning/literature search/Internet
• Journal clubs
• Courses craft/sub-specialty
• Conferences regional/national/international

v.viii Research
• Research and development funding at local level
• Clinical trials: local and national
• Evaluation of new interventional techniques

v.ix Additional professional responsibilities
• Examinations
• Advisory Appointments Committees
• Local and regional training committees
• College advisory/standards and educational committees/college council/board
• General professional (e.g. BDA) and specialty association committees/councils
• Regional and national professional bodies
4. Continuing Medical Education (CME)/ Continuing Professional Development (CPD)

The quality of clinical service in any unit depends on the quality of the consultants appointed and their continued energy and initiative. To maintain enthusiasm and commitment, encouragement should be given and time provided for training in new techniques and methods of clinical management. Such encouragement is stimulated by the process of CME/CPD for consultants in post and has now been implemented by the Royal Surgical Colleges, who, with the specialist associations, have agreed a basic common framework of at least 50 hours per year.

It should be apparent that the career of a consultant passes through several phases. Initially after appointment it will generally be devoted to development of clinical practice with progressive responsibilities within the clinical directorate. Subsequently, as clinical practice consolidates, leadership roles may develop with involvement in regional and national professional bodies. Later, for appropriate individuals, further advance may include appointment to senior clinical management posts at the local level and responsibilities within the Royal Colleges, and/or national and international professional associations. Such breadth of experience will also enhance teaching/training potential at the local level.
5. **Appraisal**

Appraisal is a structured process that takes place in two phases. The first phase involves completion of an appraisal document that records information about the range of work undertaken by the consultant, the weekly timetable and commitments, and information provided by the consultant after reflection on matters such as how the consultant relates to colleagues and patients. The document allows the consultant to record other activities such as research, management duties and external duties (for example, national committee work or work for a Royal College).

The second phase of the appraisal process involves a meeting with the lead clinician/service lead and / or a manager. The aim of this meeting is to discuss the contents of the appraisal document with a view to formulating a plan or plans for the forthcoming year for the professional development of the consultant. For example, a consultant may wish to change his or her practice in some way, or develop a practice in a new direction and this may require additional training. The appraisal process gives the consultant the opportunity of informing his or her employing NHS Trust about any requirements to achieve personal professional goals. Attention can be drawn to the need for any resources for that purpose. Similarly, attention can be drawn, in a non-threatening way, to any weaknesses and an action plan developed to deal with those. The lead clinician/service lead and / or manager will have undertaken training to become an appraiser. The appraisee will also have received training. The appraisal process is repeated on an annual basis.
6. **Revalidation**

Hitherto, registration with regulatory bodies (the General Medical Council and the General Dental Council) has been renewed on an annual basis, subject only to the requirement that the consultant pay the appropriate registration fee and not be subject to any disciplinary action leading to a recommendation of erasure of the consultant's name from the register. The assumption was that, once qualified, a professional could be assumed to be fit for registration indefinitely, unless evidence suggesting otherwise came to light.

This model of registration, registration for life save in exceptional circumstances, dates from an era when clinicians' judgement was rarely openly questioned, and when the scientific evidence base, technology and treatment options available to clinical practitioners changed very slowly. Significant cultural changes, which have significantly altered the nature of the clinician–patient relationship, and the continuing substantial and rapid development of scientific knowledge, medical technology and new treatment options, all mean that a new model of registration is now needed.

It is now planned to base registration on the principle of regular revalidation – whereby the registrant is required to produce evidence of his/her continuing fitness for registration (i.e. safety for practice). In future, the consultant will have to demonstrate at regular intervals that he or she is fit to retain his/her name on the register. It has been proposed that this should be done on a five-yearly basis. The requirements will be five satisfactory annual appraisals and demonstration of adequate CME/CPD during those five years. With regard to this latter requirement, consultants will submit evidence of attendance at external verifiable CME/CPD, such as courses and scientific meetings, together with information about non-verifiable educational activities, such as local meetings, reading journals, and preparing and giving lectures.
7. Indemnity

It is a fact of life that problems and mishaps occur during consultant practice. Previously, these have been indemnified against by the defence organisations to which consultants subscribe as members. Such organisations include Dental Protection (a branch of the Medical Protection Society) and the Dental Defence Union (a branch of the Medical Defence Union). Nowadays, consultant practice in the National Health Service is indemnified by the NHS and this is known as Trust Indemnity. However, work undertaken outside the NHS, such as private practice and medico-legal reporting, is not covered by NHS indemnity. Consultants are advised to subscribe as members to one of the defence organisations for indemnity for any non-NHS work that they undertake. Private hospitals now require evidence of membership of one of the defence organisations, and evidence of completion of a satisfactory annual appraisal, prior to granting admitting rights. NHS and private hospitals require evidence of registration with the appropriate regulatory council and evidence of immunity to viral infections such as Hepatitis B.
8. Fitness to practise and disciplinary procedures

The regulatory bodies of the health professions, such as the GDC and GMC, have as their primary responsibility the protection of the public. As such, they have processes to identify practitioners who, for reasons of conduct or due to mental or physical ill health, may not be appropriate to practise at all or only with conditions.

A dentist may be reported to the GDC by appropriate health authorities or by individuals, either colleagues or members of the public, or, in the case of criminal proceedings, by the police and courts. These initial referrals are dealt with by a Preliminary Screener and, if thought to be sufficiently serious to warrant further investigation, the documentation is passed to the Preliminary Proceedings Committee. This Committee will decide whether the evidence justifies an investigation for serious professional misconduct, by the Professional Conduct Committee, or whether the dentist’s health may be such that she/he should be referred to the Health Committee.

The Professional Conduct Committee goes through a two-stage process. First, it determines matters of fact by deciding which of the allegations it finds proved. A case can stop at that point if the alleged facts are not found proved, or if those found proved would be insufficient to amount to serious professional misconduct. If the case proceeds to the second stage, the committee has a range of options:

- It can conclude the case with or without a finding of serious professional misconduct; and with or without an expression of displeasure or a formal reprimand (a ‘homily’).
- It can postpone judgement, which entails at least a second appearance before the case is finally determined.
- It can suspend registration for up to 12 months, after which the dentist is automatically restored to the register.

An erased dentist must wait at least 11 months (one month for the appeal, plus a further 10 months) before making an application for restoration to the register, which requires a further hearing by the Professional Conduct Committee.

Where it appears that the dentist’s fitness to practise may be seriously impaired through a physical or mental condition, the Health Committee will consider the case with the assistance of a Consultant Psychiatrist sitting as a Medical Assessor. The Health Committee has the power to impose conditions on a dentist’s registration, or to suspend registration; but not to erase.

The GDC are planning far-reaching changes to the Fitness to Practise arrangements. A Fitness to Practise Panel has been appointed, separating the judicial function from the functions of standards-setting, complaints-handling and prosecution, which remain with the General Dental Council itself. In future, the disciplinary regime will apply to all dental professionals, as all members of the dental team come under the regulatory aegis of the Council. Under the new disciplinary regime, the charge of ‘serious professional misconduct’ will be replaced by an inquiry into whether a registrant’s fitness to practise is impaired by reason of misconduct. There are also plans to introduce a third avenue of investigation, dealing with poor performance – where the emphasis will be on education and retraining to bring performance up to acceptable standards, rather than on culpability. It is likely that a longer period (probably five years) will be required after erasure before an application for restoration may be submitted. Further primary legislation is required before all of these new arrangements can be put into place, but it is hoped to phase them in from 2006 onwards.
9. Consultant Support

Senior House Officer and Specialist Registrar posts must meet the requirements laid down by the relevant Faculty of Dental Surgery and the regional Postgraduate Dental Dean. Hours of work must comply with the European Working Time Directive. These posts are subject to five-yearly inspection by the relevant dental faculty, in the case of Senior House Officer posts, and by the Specialist Advisory Committee (SAC), with regard to Specialist Registrar posts. There is an increasing shift in emphasis towards training for these grades, moving away from routine service provision. Whilst these posts provide important support to consultant practice, Consultants must ensure that appropriate training is provided in order to avoid losing these training posts. These constraints have led to the development of an increased number of Staff Grade and Associate Specialist (SAS Grades) posts, which are designed to contribute to the delivery of service workload.

Consultants are entitled to expect appropriate secretarial support and office space, together with access to computer facilities. Retirement/replacement and new posts may fail to achieve Royal College recognition and approval if secretarial and office support is lacking.
10. Management and external duties

Certain external duties, including work for other NHS organisations, may be specified as part of the Job Plan by agreement between the consultant and the employer (clinical manager, medical director or CEO). Other colleagues in the same specialty might also be advised of any such agreement. Such duties might include: reasonable quantities of work for the Royal Colleges in the interests of the wider NHS; reasonable quantities of work for a government department; acting as an external member of an Advisory Appointments Committee; undertaking assessments for the National Clinical Assessment Authority; undertaking inspections for the Commission for Health Improvement (or its successor body); specified work for the GMC or GDC; or trade-union (BMA/BDA) duties. The DoH and the CMO have stated that such external duties should be supported by Trusts. At the discretion of the employer, paid professional leave or unpaid leave may be available for other professional activities not covered in the Job Plan. Under the 2003 Consultant Contract, Study Leave and Professional Leave are summated to a normal maximum of 30 days in three years. Leave in these categories in excess of this should normally be agreed with the employer.

A consultant may also undertake additional responsibilities for her/his main employer – i.e. special additional responsibilities that are not undertaken by most consultants in the employing organization. They could include the responsibilities of medical directors, directors of public health clinical directors and lead clinicians. They could also include activities as, or on behalf of, undergraduate and postgraduate deans, clinical tutors, regional education advisors, clinical audit leads, clinical governance leads or Caldicott guardians.
11. Appointment to a consultant post

i. Job description for a consultant post

The job description for a consultant post should include:

- The hospital/s and clinic/s where services are to be provided
- The work of the department, including: the number of consultants; the range of out-patient, ambulatory, day-care and in-patient facilities; the number and grade of trainees; the diagnostic support and other specialties available; and the facilities for the consultant, including secretarial assistance
- The post itself, including: details of sub-specialty interest, qualifications and experience required; and the teaching, research and administrative duties involved
- Weekly work programme and emergency commitment
- Opportunities for CME/CPD locally and availability of appropriate study leave/expenses

The appropriate Regional Adviser of the Royal College/Faculty (or a National Panelist in Scotland) should be invited to comment on the document, in order to ensure that the post contains a satisfactory balance of clinical, academic, research and managerial activities and that there are adequate facilities to allow the performance of them.

ii. Person Specifications

Person specifications are prepared to support job descriptions for new appointments and are used by members of Advisory Appointments Committees to assess the suitability of applicants for the post:

"The person specification should be drawn from the job description and outline the minimum qualifications, skills and experience required to perform the job. It should distinguish between what is essential and what is desirable" 5

Examples of person specifications for the dental specialties are given in the appendix.

iii. Advisory Appointments Committees

Advisory Appointments Committees for consultants are required to be constituted in accordance with the The National Health Service (Appointment of Consultants) Regulations (1996). 6 This guidance states that an AAC must include:

- a lay member
- a professional member who practices in the relevant specialty outside the NHS Trust making the appointment; or
  - in the case of a Special Health Authority, a practitioner not employed by the Special Health Authority, who shall be appointed after consultation with the relevant Royal College
- the Chief Executive of the NHS Trust
- the person who is-
  - (when the appointment is to a consultant post in a hospital) the medical director or dental Director of that hospital, or a person who acts in a similar capacity at that hospital OR
  - (where the appointment is to a consultant post in dental public health) the director of public health in the Primary Care Organisation in which the duties of the post will mainly be carried out AND
- a professional member who shall be-
  - a person employed by the NHS Trust as a consultant in the relevant specialty OR
  - where no such person is available for the purpose, a person employed by the NHS Trust as a consultant in some other specialty

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5 The National Health Service (Appointment of Consultants Regulations): Good Practice Guidance (Department of Health, January 2005).
• where the appointment is to a post which involves substantial teaching or research commitments a further professional member shall be appointed after consultation with the relevant university

In addition to these core members, the Trust may appoint such additional members to the committee as it considers appropriate. A committee shall have a majority of professional members and a majority of members who are persons employed by the NHS Trust making the appointment. Two or more NHS Trusts may in the appointment of a committee act together as if they were a single Trust.

The Good Practice Guidance document suggests that “Trusts should seek to secure a balanced Committee”.

The professional member appointed after consultation with the relevant Royal College is likely to be the only external member and, therefore, has an important role to play in ensuring that the consultant appointed is likely to play an active role in the maintenance of standards of clinical care, teaching and training.
12. Consultant contracts and job plans: general issues

i. Introduction

An applicant for a consultant appointment is normally given a job description and a programme of duties for the post to which they have applied. This can be reviewed annually at the consultant appraisal meeting or sooner with the department’s lead clinician/service lead if necessary. The job plan includes a work programme, which shows the time and place of weekly fixed commitments.

ii. Terminology

A consultant’s contract is based on four-hour units known as “Programmed Activities” (PAs). A weekly programme, under the 2003 Contract, would normally show 7.5 PAs involved with direct patient care and 2.5 PAs for supporting activities.

Since 2004, all appointees to consultant posts have been offered the new contract.

The Central Consultants and Specialists Committee of the BMA has produced guidance on the 2003 Consultant Contract. This has been adapted below as a basic model for consultants in the dental specialties. Notes relating to each individual specialty, together with model person specifications and job plans, follow in the Appendices.

iii. Description of 2003 Contract

The 2003 contract is designed to provide a much more effective system of planning and timetabling consultants’ duties and activities for the NHS. For consultants, it will mean greater transparency about the commitments expected of them by the NHS and greater clarity over the support that they need from employers to make the maximum effective contribution to improving patient services. The framework for the 2003 contract includes the following:

- Job planning

All consultants should have a job plan, agreed with their lead clinician and manager on behalf of their lead employing NHS Trust. It incorporates a work programme showing the nature, location and timing of the consultant’s fixed commitments. The Terms and Conditions of Service of Hospital Medical and Dental Staff (“Ts &Cs”) state that, when drawing up job plans, ‘the employing Trust shall take the following duties into account: out-patient clinics, ward rounds, operating procedures, investigative work, administration, teaching, participation in medical audit and clinical governance, management commitments (for example as a clinical director or lead clinician), emergency visits, on-call rota commitments and so on’. Time devoted to private patients and Category 2 work should be identified in the job plan – but that time will not count towards the 10 PAs that make up the weekly timetable. Model job plans are included as appendices to this document.

Under the 2003 contract, a system of mandatory job planning applies to all consultants, including dental clinical academics. The job plan is reviewed on an annual basis, but this is separate from the annual appraisal. The consultant and the employer agree about the duties and responsibilities in the job plan, as far as possible, taking into account the consultant’s views on resources and priorities. The job plan sets out a consultant’s duties, responsibilities, time commitments and accountability arrangements, including all direct clinical care, supporting professional activities and other NHS responsibilities (under which latter heading are included managerial responsibilities). The process allows the consultant to set out agreed service and related personal objectives. Where consultants work for more than one NHS employer, a lead employer is normally designated and an integrated single job plan agreed. Where a consultant disagrees with a job-planning decision, there is an initial referral to the medical director, with provision for a subsequent local appeal, if required. The appeals process is governed by a national framework.

- Working week
The working week for a full-time consultant consists of ten Programmed Activities, each of four hours. These are separated into:

- direct clinical care;
- supporting professional activities;
- additional NHS responsibilities that may be substituted for other work or remunerated separately;
- other duties – external work that can be included in the working week with the employer’s agreement.

Additional work may include acting as clinical governance lead, Caldicott Guardian or Clinical Audit lead and other managerial roles for the employing Trust. External duties may include inspections for the Commission for Health Improvement, trade-union duties, Royal College work, examining and serving on specialist associations.

Consultants are generally expected to be on-site for all Programmed Activities, but there is flexibility for employers to agree off-site working where appropriate.

- **Pay progression**

  A series of pay thresholds allows for the recognition of seniority both for existing consultants and new consultants, where appropriate. Subsequent progress through thresholds is not automatic, although the majority of consultants are expected to progress. Progression depends on:

  - meeting the commitments in the job plan;
  - satisfactory annual appraisal, job planning and objective-setting;
  - achieving personal objectives in the job plan;
  - appropriate support for the overall objectives of the organisation/employing Trust;
  - meeting required standards of conduct governing the relationship between private practice and NHS commitments.

  Where a consultant does not meet the necessary requirements as agreed in the job plan, pay progression may be deferred for that year. Employers have the flexibility to pay a recruitment premium to consultants where there is demonstrated evidence of recruitment difficulties.

- **On-call duties**

  Emergency work that takes place at regular and predictable times will be programmed into the working week. On-call emergency work will be treated as counting towards the total number of Programmed Activities in a consultant’s working week, up to a maximum of two PAs per week. Consultants who need to be on an on-call rota are paid a supplement on top of their basic salary, in addition to the arrangements described above for recognising emergency work arising from on-call duties. The supplement is related to the frequency of the on-call rota (high frequency 1:1 to 1:4; medium frequency 1:5 to 1:8; low frequency 1:9 or less). On-call duties are also banded as A or B. Band A reflects a need to be able to return to the hospital immediately. Band B recognises a need to be available for telephone advice and perhaps for return to the hospital later on a less immediate basis.

- **Out-of-hours work**

  The 2003 contract recognises, by one of three methods, the unsocial nature of work done outside normal hours:

  - by treating a three-hour, instead of a four-hour, period as a Programmed Activity; or
  - by reducing a consultant’s timetabled weekly work; or
  - by a premium payment depending on the number of Programmed Activities (of three hours each) agreed for out-of-hours on-call work. Employers have a responsibility to ensure that, where consultants work through the out-of-hours period, adequate rest is provided before and after the period of duty.

- **Extra Programmed Activities**
The 2003 contract allows employing NHS Trusts to offer the consultant the opportunity to carry out additional Programmed Activities, contracted for separately under the same terms and conditions of service, as their main contract.

- **Private practice**

The 2003 contract includes a framework designed to minimise the potential for conflicts of interest – or perceived conflicts of interest – which might arise between private and NHS commitments. The key principles are:

- There should be no, real or perceived, conflict of interest between independent work and NHS work.
- Provision of services for private patients should not prejudice the interest of non-paying patients.
- Consultants should not allow private practice to disrupt the provision of NHS services or have any adverse impact on NHS performance or delivery of NHS commitments.
- Work outside NHS employment should not adversely affect NHS employment nor in any way hinder or conflict with the interests of the NHS employer, other NHS employers or NHS employees.
- Agreed NHS commitment should take precedence over private work.
- NHS facilities, staff and services are provided for the benefit of NHS patients and may only be used for private practice with the agreement of the NHS employer.

Where consultants undertake private practice, the time that they devote to their private practice is excluded from the European Working Time Directive.

- **Flexibility of the 2003 contract**

The 2003 contact allows for part-time and flexible ways of working, in order to improve recruitment and retention of consultants in the NHS. Part-time work regulations ensure that part-timers are not treated less favourably than comparable full-timers in their terms and conditions. Trusts can offer part-time consultant contracts of between one and nine Programmed Activities. Where the request to work part-time is in order that the consultant can undertake private practice, part-time contracts should not normally be for more than six Programmed Activities. Where a consultant wishes to work part-time mainly for reasons other than private practice, but still wishes to undertake some private work, they can be appointed on a contract for more than six Programmed Activities. The division between direct clinical care and other activities for part-time consultants are broadly the same as those for full-time consultants, on a pro-rata basis – although it is recognised that part-timers will need to devote proportionately more of their time to supporting professional activities.

- **The ‘old’ consultant contract**

Those who were already in post prior to the introduction of the new contract had the option to retain their original contract, which would have been one of three types:

- Whole-time (WT)
- Maximum part-time (MPT)
- Part-time, i.e. nine sessions or fewer (PT)

Holders of WT and MPT contracts are expected to devote substantially the whole of their professional time (normally not fewer than 10 sessions) to the NHS. However, in interpreting this obligation, the Department of Health (DH) has accepted that it can only operate in the light of the consultant’s ethical obligation to all patients when emergencies arise and that those with a MPT contract must be permitted sufficient flexibility to make arrangements to carry out private practice: ‘The arrangement of consultants’ work has of necessity to be flexible and consultants need to be free to take clinical decisions within the boundaries of accepted professional standards.’ This right is recognised in those contracts – and, in return, a percentage of the aggregate whole-time salary is forfeited.

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Thus, for the MPT contract-holder, the programme is regarded as a basic commitment of not fewer than 10 sessions per week, computed in a flexible way. Traveling time between home (or private consulting rooms/hospital) and NHS place of work should be included in the computation. Subject to the requirement to give the NHS priority, there is no limit on private-practice earnings. There is a right for the MPT contract-holder to change to a WT contract and vice versa. This option does not apply as of right to nine-session PT contract holders.

Currently, WT practitioners are permitted to engage in private practice, provided that their gross income from this source (excluding any payments made for the use of NHS facilities) does not exceed 10% of their gross NHS salary (including any distinction award) for that financial year. Earnings from work performed on NHS patients by separate agreement outside the practitioner’s principal contract of employment (e.g. work under a contract between the practitioner and a NHS Trust that is not subject to the terms and conditions of service) will not be added to the income from any private practice for the purposes of the 10% limit.

Nine (or fewer)-session contracts are not subject to the requirement to give the NHS priority. They permit unlimited private-practice earnings, provided the NHS commitment is honoured. Traveling time to and from NHS duties may be included in the computation of the programme.

When the workload changes substantially subsequent to the commencement of employment, it is open to consultants to seek reassessment of their contract with their employing authority by taking on a further session. This arrangement is deemed to be temporary and the extra salary is not generally superannuable. Calculation of retirement pension is based on the highest earnings over the final three years of employment.

iv. Work Programme

A consultant’s duties will encompass the following:

- **Fixed Commitments**
  Fixed commitments are defined as those that substantially affect the use of other NHS resources such as other staff or facilities. Examples include treatment sessions/operating and out-patient clinics. Some work may or may not be a fixed commitment, depending on whether it is a regular scheduled activity or not.

- **Out-patients**
  Adequate time should be given to practice the professional discipline to a satisfactory standard; and time to dictate correspondence should be included in the work programme.

- **Ward work**
  A ward round is an essential component of the work of a consultant with responsibility for in-patients, and is used to assess and determine the clinical management of patients, as well as to implement the doctrine of informed consent with regard to any intervention or operative treatment. Time is required to discuss a forthcoming treatment procedure or the clinical progress of a patient with trainees, students, nursing staff and relatives. It is not acceptable that all ward rounds take place on an ad-hoc basis at odd times of the day or evening when it may be impossible for all members of the clinical team or appropriate nursing staff to be available. Ideally, two formal ward rounds should take place each week during normal working hours of the day, with additional informal rounds as necessary. The time required will depend on many factors and may include informal teaching. Formal teaching ward rounds might better be included under the section on teaching.

- **Operating lists**
  An operating list may be more than two PAs. This will need to be taken into account when drafting a work programme.

- **Training/examining/accreditation of postgraduate dental and medical staff**
  It may be appropriate to list any College or Faculty work under this heading.

- **Teaching undergraduate students**

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8 *The Patient’s Charter* (HPC1), Department of Health, October 1991
This should be identified separately in the work-programme. The teaching commitment of a PT consultant will usually be in proportion to the total number of PAs. It is suggested that such consultants take a special interest in part-time training.

It is pertinent to note the different balance of the hospital dental staff: general dental practitioner ratio, as compared to that of medical consultants: general medical practitioners. This would suggest a proportionately greater teaching and advice workload, requiring preparation as well as clinical time. Supervision, even of delegated care, is essential to maintain a satisfactory standard of patient care, as well as to ensure that trainees advance in their careers. For those consultants who have trainees, it is part of their duty to teach them on a formal basis and to train in the clinical environment. It is a requirement that there be teaching elements within each trainee training programme to which all consultants in the relevant unit contribute. Time should be allowed in the consultant’s weekly programme for this work. There should also be time allowed for training within every session where trainees are present. This should include out-patient clinics, for both new and follow-up patients, and also operative procedures on ambulatory out-patients, day-case patients and in-patients.

- **Research**
  Clinical research record-keeping (including departmental case-recordings) is one of the elements of research that should be included in the work programme. Other research activities should be identified.

- **Laboratory/imaging services/special interest**
  It is important, where appropriate, to consider the allocation of time for responsibility in respect of the continuing education and supervision of technicians, as well as overall management of the laboratory. Time also may be taken up in planning with technicians.

  Special interest/interdisciplinary clinical meetings will vary according to the specialty and the need for extra flexible sessions to accommodate emergency responsibilities. This time may be used for an extra treatment/operating session, special out-patient clinic session, research or teaching. The session could also be designated as ‘administration’ by consultants with extensive medical advisory or management commitments at Trust, regional, Royal College or national level. In most dental specialties, interdisciplinary clinical meetings are an essential component of clinical management.

  When NHS clinical contracts are made with departments rather than individual consultants, allowance should be made for absences where the clinical work relates to a specific subspecialty interest. This may be especially relevant in university departments when an academic consultant has heavy teaching/research responsibilities in addition to clinical commitments.

  - **Medical audit**
    Formal meetings to discuss outcomes and to review departmental data should be included in the work programme and may be taken in conjunction with teaching and training. Protected time should be allowed for audit as part of the contract. Wherever possible, audit meetings within departments should be arranged to accommodate part-time staff.

  The 1989 White Paper, *Working for Patients*, 9 required that all consultants be involved in the formal audit of their work from April 1991. Auditing is regarded as an integral part of the postgraduate education programme of every clinical department, together with joint clinico-pathological, radiological and interdisciplinary meetings as appropriate to the specialty, journal clubs and formal teaching sessions. This may comprise regular weekly, fortnightly or monthly audit sessions, with other commitments flexibly rostered into the weekly work programme. The programme for all trainees, as well as consultants, must include dedicated time for postgraduate medical education, including audit, with an appropriate balance between service and training commitments.

  - **Management**
    Management duties should be included in the work programme, as should advisory committee and departmental meeting commitments at the local level. However, managers and clinical directors will have specific management contracts. Advice on this has been prepared by the Clinical and Medical Directors’ Subcommittee of CCSC 10. Part-time consultants should be able to participate in the running of a unit, attend departmental meetings and be involved in decisions that affect the running

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10 CCSC. Guidance for Developing the Role of Clinical Directors. BMA, 1996.
of the department. Where the additional time involves chairmanship of a specific committee, consideration of an additional session on a temporary basis may be negotiated. Equally, should a colleague be significantly involved in this way, an additional sessional allowance may be available to help cover extra clinical work.

- **Committees (local or national)**
  It might be more appropriate to reserve time under this separate heading for regional and national committees if local committees are included under management.

  It is important to recognise that some consultants bear heavy responsibilities at the national and international level. In 1995, the Director of Human Resources of the NHS Executive stated:

  ‘I would like to encourage employers as part of their obligations as part of the NHS to release consultants for a range of duties such as advising the Department of Health participating in College duties or examining. These are all examples of work necessary for the broader benefit of the NHS but which involve consultants being away from their employment base.’

  In January 2004, the following statement was released as part of a bulletin on the consultant contract by the Modernisation Agency’s Consultant Contract Implementation Team:

  ‘The new contract is designed to recognise a range of possible circumstances where it is in the wider interests of the NHS for consultants to be allowed time – as part of their NHS programmed activities – for work done outside the employing organisation. This includes reasonable quantities of work for the Royal Colleges in the interests of the NHS and reasonable quantities of work for a Government Department – other examples are listed in definitions of “external duties” in the Terms and Conditions of Service. The inclusion of such activities in job plans is a matter for agreement between employers and consultants. It remains, however, the policy of the Department of Health to encourage NHS organisations to release consultants for work that is necessary for the broader benefit of the NHS.’

  This principle has also been endorsed by the Chief Medical Officer and is incorporated into the Quality Framework and Guidelines for Hospital and Community Health Services Medical and Dental Staffing.

- **Administration**
  This will include correspondence, waiting-list management, record keeping and other tasks normally undertaken in conjunction with a secretary.

- **Travelling-time**
  Travelling time between a consultant’s main place of work and home or private practice premises will not be regarded as part of Programmed Activities. Travelling from main base to other NHS sites, travel to and from work for NHS emergencies, and ‘excess travel’ will count as working time. ‘Excess travel’ is defined as time spent travelling between home and a working site other than the consultant’s main place of work, after deducting the time normally spent travelling between home and main place of work. Employers and consultants may need to agree arrangements for dealing with more complex working days.

- **In-patient referrals**
  This may be included in ward work, but if it is a major element of the work pattern it should be identified separately.

- **Continuing clinical commitment**
  For most consultants, it is necessary to provide an element of recognition for the ongoing commitment to patients that is not covered by the on-call rota. For some consultants, this may be a substantial element of the contract if there is no formal on-call commitment.

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11 NHS Executive Letter EL(95)93.
- **Complaints and litigation**
  In recent years, the incidence of complaints and litigation has grown at an alarming rate; and the time taken to deal with them has also increased. It is felt that this should be reflected in the work programme if it forms a significant amount of work.

- **Other**
  To be agreed as appropriate.

- **On-call for emergencies**
  The assessment will be in PAs and should relate to time on-call as well as actual call-out, which will depend on the level of other clinical cover. It should also include any travelling time involved. It is desirable for part-time consultants to participate in the emergency rota; their on-call commitment should be proportional to the number of PAs for which they are contracted.

- **Continuing Medical Education / Continuing Professional Development**
  The educational requirement for a part-time consultant is considered to be the same as that for a whole-time consultant (50 CME/CPD points per year) and, therefore, part-timers should be entitled to the full allocation of study-leave (rather than on a pro-rata basis).

- **Flexible sessions**
  These accommodate emergency work and activities such as clinical administration, travel and continuity of care. The number reflects the immediacy of involvement required for high-quality patient care. Some specialties with a major consultant-provided emergency component require more than those where the immediate responsibility for the management of an emergency is shared with trainees. As a guide, two PAs are the norm for specialties with a heavy emergency workload, on a rota of 1:4 to 1:6. For consultants in larger units with good Specialist Registrar support, one of these may be regarded as obligatory for teaching, research and other clinical work.

- **Part-time Consultants in the Dentally-Based Specialties**
  Under the previous contractual arrangement, consultants employed on a part-time basis were entitled to fair job descriptions that reflected the contracted time commitment whilst enabling the practitioner to fulfill the range of duties as a consultant. Job descriptions that only allocate time for service commitments and fail to recognise that all consultants have educational and administrative obligations are unsatisfactory. The introduction of consultant appraisal has allowed these additional obligations to be recognised and reviewed on an annual basis. The 2003 contract recognizes that some consultants will wish to undertake private practice; there is no longer any distinction between full-time and maximum part-time job plans. The previous maximum part-time contract involved consultants dropping one eleventh of their salary when their private practice income was greater than 10% of their NHS salary for two successive years. This forfeit does not exist in the 2003 contract. Despite this, existing consultants with a maximum part-time contract are free to choose to stay on that contract and to not move to the 2003 consultant contract.
Clinical Excellence Awards are given to recognise and reward contributions to the NHS that are 'over and above' that normally expected. They aim to ensure recognition of exceptional personal contributions made by individual consultants or equivalent grade that show a commitment to achieving the delivery of high quality care to patients and to the continuous improvement of the National Health Service. They must work to the standards of professional and personal conduct required by the General Medical Council or the General Dental Council.

In particular, the objectives are:

- To reward individuals who perform over and above the standard expected of a consultant in their post, and who locally, nationally or internationally:
  - demonstrate sustained commitment to patient care and wellbeing or improving public health;
  - sustain high standards in the technical and clinical aspects of service whilst providing patient-centred care;
  - in their day-to-day practice, demonstrate a clear commitment to the values and goals of the NHS by participating actively in annual job planning and observing the private practice code of conduct such that they:
    - show a commitment to achieving agreed service objectives;
    - through active participation in clinical governance, contribute to continuous improvement in service organisation and delivery;
    - embrace the principles of evidence-based practice;
    - contribute to the knowledge base through research;
    - are recognised as exceptional teachers and/or trainers and/or managers;
    - contribute to policy making and planning in health care.

Lower value awards are made by local committees. Higher value awards are recommended by the Advisory Committee on Clinical Excellence Awards (ACCEA), and its sub-committees. Awards are determined according to a common rationale and set of objectives.

There are 12 levels of award. Awards at Levels 1–8 and Local Level 9 (Local Bronze) are recommended by local committees. Awards at National Level 9 (National Bronze) and Levels 10–12 are recommended by ACCEA.

Consultants already in receipt of a distinction award or discretionary points from the previous awards system keep these, subject to existing review provisions, and are eligible to apply for awards under the current scheme in the normal way. A Clinical Excellence Award will subsume the value of any discretionary points or distinction awards held by the consultant concerned.

Further details about the scheme are given on the NHS web site http://www.advisorybodies.doh.gov.uk/accea/index.htm
14. **Dental clinical academics**

Dental clinical academic consultants have both a substantive contract of employment with a university and an honorary contract with the NHS. The number of PAs they undertake in the university and in NHS practice can vary. In England, the dental clinical academic consultant contract stipulates that they have five NHS PAs and five university PAs. The university PAs can be any combination of teaching and research. The NHS PAs will include work similar to that of NHS Consultants – for example, direct clinical care as well as supporting activities.

Although dental clinical academic consultants are covered by the generality of the provisions in the arrangements for NHS consultants, there are some important differences in terms of job-mix and joint job-planning. These are determined in England by the dental clinical academic contract, the guidance notes to the contract and the model clauses inserted into the substantive university contract for dental clinical academic consultants.

Job plans are agreed on an individual basis and involve integration between the work for the University and for the NHS employer. Generally, a job-planning meeting should involve both employers. These new arrangements should allow dental clinical academic consultants to control the commitment they have both to the university and to the NHS employer. Considerable flexibility exists in agreeing a job plan, and this may depart from the norm of five academic PAs and five NHS PAs, if all parties agree. Student teaching clinics count as direct patient-care activities where patients are treated as part of on-going care. Extra PAs may also be agreed or a reduction in working hours may be agreed. In Scotland, all dental clinical academic consultants, with few exceptions, will be offered an additional academic PA (Part 13 of the consultant contract).
15. Summary

The 2003 consultant contract recognises that the nature of a consultant’s work demands considerable flexibility. Although it is desirable that the job plan/weekly timetable should not exceed 10 PAs, it is recognized that some consultants will have a timetable with 11 or more PAs.

‘A consultant job plan should be a prospective agreement that sets out a consultant’s duties, responsibilities and objectives for the coming year. In most cases, it will build upon the consultant’s existing NHS commitments.’ ¹⁴

‘Job planning should be based on a partnership approach between the consultant and their clinical manager. Job planning undertaken in this spirit of partnership should balance the needs of the Trust and the wider NHS with those of individual consultants. Within this context it is expected that all parties will participate openly in the process, and actively consider alternative ways of working to enable service improvements within the job planning context.’ ¹⁵

¹⁵ NHS Modernisation Agency website, 2005.
16. References and web links

A Code of Conduct for Private Practice: Guidance for NHS Medical Staff
(Department of Health, 2003)
http://www.dh.gov.uk/assetRoot/04/03/46/10/04034610.pdf

Advisory Committee on Clinical Excellence Awards Scheme (Department of Health)
http://www.advisorybodies.doh.gov.uk/accea/index.htm

“Appraisal: a guide for medical practitioners” (BMA, October 2003)
http://www.bma.org.uk/ap.nsf/Content/Appraisal

“Consultant Contract Negotiations” – BMA website (The Consultant Handbook, BMA 2000, can be accessed from here)
http://www.bma.org.uk/ap.nsf/Content/CCSCAnnRep03~negs

“Consultant Job Planning: Standards of Best Practice” (Department of Health, September 2003)

“Consultant job planning tool kit” (NHS Modernisation Agency, January 2005)
http://www.content.modern.nhs.uk/cjpt/

CPD requirements (GDC)
http://www.gdc-uk.org/Current+registrant/CPD+requirements/

Guidance on Person Specifications for NHS or Honorary Consultants in the Dentally-Based Specialties
http://www.rcseng.ac.uk/fds/committees/sac/aac.html

Good Practice in the Dental Specialties (The Senate of Dental Specialties 2004)
http://www.rcseng.ac.uk/rcseng/content/publications/docs/dental_specialities.html

“Overview of the Consultant Contract” (Department of Health)

The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England
(National Audit Office, 2003)
http://www.nao.org.uk/publications/nao_reports/02-03/02031143.pdf

The National Health Service (Appointment of Consultants Regulations): Good Practice Guidance
(Department of Health, January 2005)
http://www.dh.gov.uk/assetRoot/04/10/27/50/04102750.pdf

“The 2003 Contract” – BMA website
APPENDIX 1
Consultants in Oral and Maxillofacial Surgery

During the 1990s, a typical Oral and Maxillofacial Unit in a district general hospital had two consultants covering perhaps two NHS Trust hospitals with a total catchment population of approximately 400,000 on a 1:2 rota, where each consultant covered the other for annual leave. It was often difficult to find locums. As consideration of working hours began to be applied to consultants, it became apparent that such working practices were generally unacceptable. This led to the amalgamation of some units ("federation") and a move to "hub-and-spoke" arrangements, with a main in-patient base and peripheral units where out-patient consultation, review, and ambulatory and day-care surgery is carried out. The consultant/population ratio is now a minimum of 3 per 500,000, but many units in the UK have gone further along this path and there are now units with between five and 10 consultants serving populations in excess of one million.

SAS grade support

The Staff and Associate Specialist (SAS) grades in oral and maxillofacial surgery can form an invaluable part of the maxillofacial team. Both these are career grades that are appointed on the basis of qualifications and experience. All Staff Grades and Associate Specialists are responsible to a named consultant, but as both these grades encompass a wide variation in experience, ability and competence, the level and amount of clinical freedom will vary widely. Most SAS grades will be involved with routine oral surgery and procedures, although some will undertake more complex treatment. It is important that all SAS grades are valued and encouraged to undertake further postgraduate training and courses, and to become actively involved with their own career development. There are major plans to restructure the SAS grades into one single grade, although the details of this are yet to be published.

Fixed Commitments

- Operating lists (which the consultant attends on a regular basis)
- Out-patient clinics (which the consultant attends on a regular basis)
- Regular ward rounds (which the consultant attends on a regular basis)
- Regular on-call commitments for emergencies
- Multi-disciplinary joint clinics
- Special interest sessions

These fixed commitments involve direct patient care, and the time taken to undertake them counts as direct care PAs.

Supporting Care Commitments

- Training/examining/accredation of postgraduate dental/medical staff
- Teaching undergraduate students
- Research
- Laboratory/imaging services/special interest
- Medical audit
- Management
- Committees (local or national)
- Administration
- Continuing Medical Education / Continuing Professional Development

Flexible Commitments

- Emergency surgery
- Laboratory/imaging services

Operative Workload (Elective, Emergency and Day Cases)

Caseload alone can be misleading, as it does not take into account the complexity of the operative procedure. It is possible to assess this to some extent by weighting each operation for complexity, for
example, using the BUPA schedule of procedures. But such calculations exclude other factors, such as the need to supervise Specialist Registrars in training – they may require a greater time-allocation in theatre, and this may reduce the number of patients who can be treated on an operating list.

Some reconstructive head-and-neck oncological surgical operations may extend over the equivalent of three PAs.

**Resources Required**

These suggested workload figures will only be achievable if appropriate hospital resources are made available to surgeons and their teams. This means:

- out-patient facilities to enable trainee surgeons to work in independent facilities adjacent to, and properly supervised by, the consultant;
- bed allocations sufficient to meet the needs for all emergency admissions and for elective surgical operating lists;
- fully-staffed operating facilities for emergency surgery to be carried out during the day (it is recommended that unrestricted access within 30 minutes be available at all times for surgical emergencies);
- a day-surgery unit of approximately 10 beds, with a dedicated operating theatre;
- access to a fully-staffed ITU and recovery ward;
- adequate secretarial support;
- laboratory support;
- a personal office and a computer with Internet access for each surgeon.

**Other Posts within the Specialty**

It should be noted that the Faculty of Dental Surgery website also contains person specifications for a Consultant In Cleft Lip and Palate Surgery, where that person has trained within Oral and Maxillofacial Surgery; and, secondly, for the post of Honorary Consultant in Oral Surgery for somebody who has completed the academic training pathway culminating in the Intercollegiate Fellowship examination in oral surgery and who intends to work principally within a dental teaching hospital.
## CONSULTANT IN ORAL & MAXILLOFACIAL SURGERY - PERSON SPECIFICATION

**Post:** Consultant in Oral & Maxillofacial Surgery  
**Hospital:** (Name of NHS Hospital Trust)

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<th>DESIRABLE</th>
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<td>Specialist listing</td>
<td>On the GMC Specialist Register in Oral &amp; Maxillofacial Surgery or within three months of eligibility for inclusion</td>
<td>Possession of a Certificate of Accreditation or eligibility for a CCST in Oral &amp; Maxillofacial Surgery</td>
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<td>Professional Qualifications</td>
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<td>Fellowship in Dental Surgery or Membership of the Faculty of Dental Surgery, or equivalent</td>
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<td><em>Intercollegiate Fellowship Examination in Oral &amp; Maxillofacial Surgery or equivalent</em></td>
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<td>TRAINING</td>
<td>Successful completion of an SAC-approved five-year minimum training programme in Oral &amp; Maxillofacial Surgery, or within six months of completion</td>
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<td>Team Skills</td>
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<td>Satisfactory preemployment health screening</td>
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Footnotes:
Model job plan for Mr. Max Hiller, Consultant Oral and Maxillofacial Surgeon

1. Job content

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<tr>
<th>Day</th>
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<th>Work</th>
<th>Categorisation</th>
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<td>1.00pm-2.00pm</td>
<td>St. Muddles</td>
<td>Patient Admin.</td>
<td>Direct care</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>2.00pm-2.00pm</td>
<td>St. Muddles</td>
<td>Teaching</td>
<td>Supporting</td>
<td>1</td>
</tr>
<tr>
<td>Friday</td>
<td>8.30am-6.30pm</td>
<td>St. Muddles</td>
<td>Major Operating List</td>
<td>Direct care</td>
<td>2.5</td>
</tr>
<tr>
<td>Saturday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional agreed activity to be worked flexibly</td>
<td>Variable</td>
<td>St. Muddles</td>
<td>Audit, Teaching Management Meetings, RCS work, BAOMS work, AACs, CPD, Appraisal Reports, References, Research, Paper Writing, Lectures etc. etc.</td>
<td>Supporting, Additional NHS External Duty</td>
<td>1.5</td>
</tr>
<tr>
<td>Predictable emergency on-call work</td>
<td>Nil</td>
<td>St. Muddles</td>
<td>1:4 on call. Average work when on call is 8 hours</td>
<td>Direct clinical care</td>
<td>0.5</td>
</tr>
<tr>
<td>Unpredictable emergency on-call work</td>
<td>Variable</td>
<td>St. Muddles</td>
<td>On-site, at home on the telephone and travelling to and from site</td>
<td>Direct clinical care</td>
<td></td>
</tr>
<tr>
<td>TOTAL Pas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Programmed activity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct clinical care (including unpredictable on-call)</td>
<td>9.0</td>
</tr>
</tbody>
</table>
Supporting professional activities | 2.5  
---|---
Other NHS responsibilities | 0.5  
External duties | 0.0  
TOTAL PROGRAMMED ACTIVITIES | 12

Notes
(a) There are four time blocks set out for each day. Not all blocks need to be filled in. It is feasible that consultants will have 1, 2, 3 or even more PAs on any one day.
(b) Under ‘additional agreed activity’ the consultant might agree, for example, with the employer that they will undertake a certain proportion of regular patient administration equating to x PAs, at an unspecified time and location during the week. This section might also be used to set out the number of PAs for any unpredictable external duties.
(c) Predictable on-call work: where this work follows a regular pattern each week, consultants should identify within the weekly schedule when and where this takes place. Where such work does not follow a regular pattern, for example due to the variability of the on-call rota, consultants should assess an average level of activity per week and identify it in the predictable activity box at the bottom of the form.
(d) The location and timing of unpredictable emergency work cannot be completed, therefore only the categorisation and number of PAs should be completed.
(e) Location can be the principal place of work or any other agreed location e.g. the consultant’s home for some duties.
(f) In the ‘work’ column, a description of the duty should be completed, e.g. outpatient clinic, ward round, operating list.
(g) The ‘categorisation’ column should define whether the work is direct clinical care, supporting professional activity, additional NHS responsibility or external duty.
(h) The number of PAs should specify the number of PAs allocated to the duty. This can be a full PA or broken down into smaller units. If the work is in premium time after 1 April 2004, 3 hours of work is one programmed activity.
(i) Regular private practice commitments should be identified broadly in terms of timing, location and type of work.
(j) In addition to regular duties and commitments, the consultant might have certain ad-hoc responsibilities. These would normally but not exclusively fall into the ‘additional NHS responsibilities’ or ‘external duties’ categories of work, for example member of an Advisory Appointments Committee or work for a Royal College. Such duties could be scheduled or agreement could be reached to deal with such work flexibly (see section 5 below).

2. On-call availability supplement

Agreed on-call rota e.g. 1 in 5: 1:4

Agreed category (delete): A

On-call supplement e.g. 5%: 8%
3. Objectives

Objectives and how they will be met

1. Continue to provide a high quality emergency service for all emergencies.
2. Continue to provide a high quality day case and ambulatory service for dento-alveolar surgery whilst making all reasonable efforts to keep the waiting lists below six months.
3. Provide an oncology surgery service and develop it further in conjunction with cancer services.
4. Maintain the present teaching services and expand the teaching to Staff Grade and Associate Specialist doctors.
5. Maintain the present levels of local and Regional audit.

4. Supporting resources

<table>
<thead>
<tr>
<th>Facilities and resources required for delivery of duties and objectives</th>
<th>Sufficient ITU beds for post-operative care of cancer patients, sufficient ward beds, all pathology reports within seven days, rapid access to CT and MRI scanners for cancer patients. Expand radiotherapy access.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staffing support</td>
<td>Extra oncologists, ward nurses, ITU nurses, pathologists and radiologists.</td>
</tr>
<tr>
<td>2. Accommodation</td>
<td>Provide extra operating sessions</td>
</tr>
<tr>
<td>3. Equipment</td>
<td>Computers with the following minimum requirements, easy access, inter and intranet, attached printer, DVD/CD Rewriter</td>
</tr>
<tr>
<td>4. Any other required resources</td>
<td>Departmental digital camera</td>
</tr>
</tbody>
</table>

5. Additional NHS responsibilities and/or external duties

In view of excessive work of all types and increased additional activity the Trust is prepared to allow up to two days a month on a flexible basis for these activities.

Other agreements

Note: In addition to regular duties and commitments, the consultant might have certain ad-hoc responsibilities. These would normally but not exclusively fall into the ‘additional NHS responsibilities’ or ‘external duties’ categories of work, for example member of an Advisory Appointments Committee or work for a Royal College. Such duties could be scheduled or agreement could be reached to deal with such work flexibly. The method of dealing with such commitments should be set out in the box above.

6. Other comments or agreements
7. Additional programmed activities

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Are you undertaking private medical practice as defined in the terms of service?</td>
<td>Yes</td>
</tr>
<tr>
<td>b. If yes, are you already working an additional programmed activity above your main commitment?</td>
<td>Yes</td>
</tr>
<tr>
<td>c. If no, has the trust offered an additional programmed activity this year?</td>
<td>N/A</td>
</tr>
<tr>
<td>d. If yes, has this been taken up?</td>
<td>Yes</td>
</tr>
<tr>
<td>e. If no, have other acceptable arrangements been made (e.g. taken up by a colleague)?</td>
<td>No</td>
</tr>
</tbody>
</table>

If yes to (e) please describe:

…………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………

8. Signed off and agreed

<table>
<thead>
<tr>
<th>Field</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant name</td>
<td>………………………</td>
</tr>
<tr>
<td>Signed (consultant)</td>
<td>………………………</td>
</tr>
<tr>
<td>Date</td>
<td>………………………</td>
</tr>
<tr>
<td>Clinical manager</td>
<td>………………………</td>
</tr>
<tr>
<td>Signed (clinical manager)</td>
<td>………………………</td>
</tr>
<tr>
<td>Date</td>
<td>………………………</td>
</tr>
</tbody>
</table>
APPENDIX 2

Consultants in Orthodontics

The Consultant Orthodontists Group (COG) of the British Orthodontic Society have recently drawn up a job description for a consultant orthodontist and this has been widely circulated and this section draws heavily on the information provided in the document. In addition a detailed survey of the workload, case mix and pattern of work of all consultant orthodontists updating data collected 10 years ago is currently being carried out. This annex will therefore be amended when the results of this are available.

Job Summary

Consultant advice
The provision of orthodontic opinions to general dental practitioners, community officers and to medical practitioners.
To liaise with specialist orthodontic practitioners and community orthodontists working within primary care and with hospital clinicians including consultants in oral and maxillofacial surgery, restorative dentistry, paediatric dentistry, paediatrics, plastic and ENT surgery.
The consultant will be competent to provide advice on complex clinical patient management problems and interdisciplinary planning and treatment.
The provision of second opinions at the request of a dental or medical practitioner or consultant colleague.

Treatment within hospital departments
Severe and complex high need treatment
Case loads should be restricted to malocclusions of greatest severity and technical treatment complexity. At present this is probably most appropriately achieved by selecting cases using the Index of Orthodontic Treatment Need (IOTN) of Manchester University as a guideline only. Primarily these will be chosen from grades 5/4. However some grade 3 cases should be included if these are technically complex, have a high aesthetic need rating and where dental health and psychological health gain is anticipated. When there is a training commitment for either junior staff or general practitioners working as clinical assistants there will be a need to maintain a suitable range of patients of varying complexity including some patients of the type usually treated in primary care. Further selection will follow the assessment of malocclusion by severity and management difficulties.

Inter-disciplinary treatments
Consultant orthodontists will normally be involved in treatments requiring an inter-disciplinary team approach and can therefore be expected to:
..treat in conjunction with consultant oral and maxillofacial surgeons problems of unerupted, displaced (ectopic) and malformed teeth and the effects of trauma and pathology in the dentoalveolar structures of the child and young adult
..treat in conjunction with consultant oral and maxillofacial surgeons, plastic surgeons or paediatric surgeons severe skeletal malrelationships by means of combined orthodontic and surgical treatment approaches
..treat in conjunction with consultants in restorative dentistry and general dental practitioners those problems requiring a combined approach
..treat in conjunction with consultant paediatricians and consultants in paediatric dentistry those children with special needs, growth related problems and disease who also have a malocclusion
..in conjunction with the other key specialties provide co-ordinated care for patients with cleft lip and palate and other craniofacial anomalies
..work with other consultant disciplines in areas of common interest including speech and feeding disorders resulting from sensory and motor nerve loss
Some patients in this group may cross contract boundaries and joint treatment programmes between surgeon and orthodontist should be regarded as a continuing care contract with hopefully minimal delay in ECR processing.
Treatment in the primary care sector

To provide the necessary advice, follow up and support to general dental practitioners or community dental officers carrying out orthodontics within primary care by regular review of patients to completion of treatment as necessary.
To advise or redirect those referred cases which may be treated within the general dental services through onward referral to specialist and community orthodontists.
To advise practitioners and counsel patients that no treatment is required for many minor malocclusions.

Access to treatment in primary care

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

Education and training

To provide clinical training for career junior staff, future specialists and trainee academics. Not all hospital orthodontic departments will train career junior staff and the variable teaching and training role will be reflected in the job plan.
To liaise with postgraduate deans in the provision of continuing professional education for general dental practitioners and community dental officers thereby helping to increase the quality of orthodontic treatment within primary care.
To participate in continuing professional education programmes for all trained providers of orthodontic care.
To undertake the education and training of undergraduates within or outside teaching hospitals as determined by the job plan.

Public health role

To work with consultants in dental public health in determining the needs and demands of the resident population with respect to orthodontic care and to ensure equity of access to orthodontic treatment by planning developments and strategies to meet demand. This demands full discussion with representatives from all orthodontic providers or local orthodontic committees where these are established. Short term contracts or rapid cessation of contracts can have an adverse effect on training rotations and continuing patient care with potential medico-legal consequences.

Management advice

To provide advice to employing trusts on the specification and contracts for orthodontic services drawn up by purchasers.
To provide advice to trusts for subsequent negotiation with the purchasers on the availability of appropriate case mix for clinical training and continuing education programmes which the consultant organises and runs.

National NHS committee structures

Contribute to national and local NHS based committees and in such areas as education, research, audit, examinations and conferences.

Research, innovation and improvements in service including audit

To be involved in personal research and to work in national and international collaborative research programmes as necessary.
To lead and/or play an active part in sub-regional and departmental audit. To liaise with other providers of orthodontic care in audit projects.
The need for clinical audit should be recognised in job plans.
In-patient treatments
Some orthodontists carry out dento-alveolar surgery under local anaesthesia. Others have day case or in-patient/surgical lists and nominated beds. Paediatric cots or special care baby unit cots are used for the assessment and management of feeding and/or airway problems in babies with cleft lip and palate.

Special clinical interests
To be encouraged to develop special clinical interests which forward knowledge of the discipline or patient care.
A number of consultants have taken a special interest in helping to manage patients suffering from speech/feeding difficulties associated with motor or sensory nerve loss, including strokes and there is increasing collaboration with ENT consultants in the treatment of obstructive sleep apnoea.

Workload of a consultant orthodontist
Analysis of the components shows that some elements will be common to all but some may undertake a selection from a larger list. Programmes must be flexible to take account of emergencies, continuing care of patients and joint clinic arrangements with other disciplines. Clearly no two programmes will be identical in content and will depend upon such factors as:
- Type of hospital ..teaching/DGH and number of hospitals/trusts covered
- Teaching, research, audit, professional education and development
- Management, administration and committee activities
- Special interests/commitments

An effective clinical, management, special interest/care, educational/research role requires a suitable balanced distribution of time away from the chairside. In planning a work programme these activities should be clearly identified.
The following headings should be considered when calculating NHD allocation in detail:
Outpatient consultation (general)
Outpatient consultations (joint inter-disciplinary)
Outpatient orthodontic treatment
1985 survey of time expenditure suggested 28% in diagnosis and review with 45% in treatment. However flexibility should be incorporated into programmes to allow for variations in special clinics and waiting-lists. Time for new patient consultation should be preserved to allow for availability to provide paediatric dental advice when required.
Administration and correspondence
Advice to general practitioners who carry out treatment often requires lengthy correspondence
Case preparation including laboratory work and cephalometric analysis
Includes liaison with technicians in appliance design and possibly model surgery for joint clinics. In some units there may be a travelling component. Even if tracing and analysis are not carried out by the consultant time is still required for in-depth assessment
Travelling to and from work (part-time contracts only)
Travelling time between base hospital and outlying units
This should be taken out of the session when completing the work programme whether or not the consultant wishes to do so in practice.
Theatre and ward work
Allow for time required to visit theatre according to local practice to provide opinion on unerupted teeth, bonding of brackets and other assistance during orthognathic surgery. Also to visit orthognathic patients on the ward for checking/adjustment of bands and brackets pre and post-operatively. Additional theatre time will be required for those consultants undertaking dento-alveolar surgery in relation to orthodontics. For consultants visiting maternity wards and special care baby units as part of the care of patients with clefts of the lip and/or palate an NHD as a special requirement or interest may be appropriate. In addition an ‘on-call’ component should be considered for cleft palate commitment and general orthodontic emergencies.
Teaching and training junior staff, orthodontic postgraduate/undergraduate students and dental practitioners (if not remunerated separately)

Includes direct chairside and clinical instruction. Consider also formal orthodontic courses, lectures to BDA groups, radiographers, junior medical staff, dental nurses on local courses, medical and dental practitioner groups.
Administration (division, trust, region, national)
There may be an additional managerial role in relation to the laboratory including health and safety aspects, responsibility for the technicians to ensure that they are kept abreast of teaching.
development and, attend training programmes. The consultant orthodontist activity survey 1985 suggested 27% non-clinical activity. Includes budget holder responsibilities, financial planning, administration of staff training and rotation, organisation and planning with records and staff, data collection/retrieval

Continuous clinical responsibility
Clinical research and audit, including statistical recording (local/national)

The trainees’ contribution to clinical service
The following probably reflect the relative work contributions of the training grades:
Consultant 1.0
Senior Registrar 0.8)Terminology to be revised
Registrar year 1 M.Orth 0.5)to Specialist Registrar (SpR)
Registrar year 2 M.Orth 0.6)and relevant training levels
Registrar year 3 M.Orth 0.7)when details available
Clinical Assistant (untrained) 0.4
Clinical Assistant (experienced) 0.5
Clinical Assistant (trained) 0.7

It is important to note that where a consultant is committed to training on a clinical session there will be a reduction in the throughput of patients and research is continuing in order to assess the ‘cost’ of training v patient care. The figures for a clinical team workload are based on a working year of 44 weeks (excluding holidays and study leave)
CONSULTANT IN ORTHODONTICS – PERSON SPECIFICATION

<table>
<thead>
<tr>
<th>Post:</th>
<th>Consultant in Orthodontics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital:</td>
<td>(Name of NHS Hospital Trust)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ATTAINMENTS</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
<th>HOW ASSESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration</td>
<td>Full registration with the United Kingdom General Dental Council (GDC)</td>
<td></td>
<td>CV and Documentation</td>
</tr>
<tr>
<td>Specialist listing</td>
<td>On the GDC Specialist Register in Orthodontics</td>
<td>Possession of a Certificate of Accreditation or eligibility for a CCST in Orthodontics</td>
<td>CV/Interview</td>
</tr>
<tr>
<td>Professional Qualifications</td>
<td>Fellowship in Dental Surgery or Membership of the Faculty of Dental Surgery, or equivalent. Specialist Membership in Orthodontics or equivalent. Intercollegiate Fellowship Examination in Orthodontics or equivalent. Higher Degree by Thesis (Honorary Consultants for Academic Appointments only).</td>
<td>MSc or equivalent</td>
<td>CV and Documentation</td>
</tr>
</tbody>
</table>

| TRAINING | Successful completion of an SAC – approved minimum three year training programme in Orthodontics. *Successful completion of an SAC-approved minimum two year training in a Fixed Term Training Appointment (FTTA) which follows on from the pre-CCST training period of three years, or within six months of completion – or equivalent for other European Economic Area (EEA) Nationals. Current holders of an NHS or | | CV/Interview |
honorary NHS consultant contract in Orthodontics are eligible to be shortlisted.

Applicants who are Nationals from another European country or elsewhere overseas would have to show equivalence to the five years’ minimum training period in the NHS required for the Specialty.

<table>
<thead>
<tr>
<th><strong>TEACHING</strong></th>
<th>Experience of postgraduate and undergraduate teaching</th>
<th>CV/Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Training in teaching</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>AUDIT</strong></th>
<th>Effective participation in clinical audit</th>
<th>CV/Interview</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>RESEARCH</strong></th>
<th>Research relevant to the specialty</th>
<th>CV/Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Publications in refereed journals</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>MANAGEMENT</strong></th>
<th>Management of clinical service</th>
<th>CV/Interview</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>PERSONAL</strong></th>
<th>Work independently</th>
<th>CV/Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good communication skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Team skills</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>GENERAL</strong></th>
<th>Satisfactory pre-employment health screening</th>
<th>CV/Interview</th>
</tr>
</thead>
</table>

**Footnotes:**

These are the core requirements that need to be in any person specification. There will be additional requirements suited to local circumstances. It was agreed at the meeting of the Committee of Senior Officials for Public Health (CSOPH) in Brussels that ‘for some high level posts, or senior posts for which there are specific management and/or training functions, a two years’ additional training period will be requested for access to these posts’. This refers to post-CSST training. It was made clear that this additional training would not be mandatory for an individual who had trained in another Member State but that individual would have to show equivalence to the two years’ additional post-CCST training period.

Thus an individual who is on the Specialist List in Orthodontics is not eligible for a consultant post unless he or she has done additional training either as a Senior Registrar or in a Fixed Term Training Appointment (or equivalent for other EEA nationals) and **must not be shortlisted**. Human Resource Departments do not often appreciate this, as in medical specialties inclusion on the appropriate specialist list indicates potential eligibility for consultant appointments. All individuals who have been shortlisted are potentially appointable.
Model job plan for Mr W I R Bender, Consultant in Orthodontics
Mr Bender works on three sites - A District General Hospital (St Giles’s) – A Peripheral Hospital (St Jude’s) and his Private Practice

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Location</th>
<th>Work</th>
<th>Categorisation</th>
<th>No. of PAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>0830-0930</td>
<td>St Giles</td>
<td>Patient admin</td>
<td>DCC</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>0930-1230</td>
<td>St Giles</td>
<td>Operating</td>
<td>DCC</td>
<td>0.75</td>
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<tr>
<td></td>
<td>1300-1700</td>
<td>St Giles</td>
<td>NP Clinic</td>
<td>DCC</td>
<td>1</td>
</tr>
<tr>
<td>Tuesday</td>
<td>0900-1100</td>
<td>St Giles</td>
<td>Review clinic</td>
<td>DCC</td>
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</tr>
<tr>
<td></td>
<td>1100-1300</td>
<td>St Giles</td>
<td>Joint clinic</td>
<td>DCC</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>1300-1400</td>
<td>St Giles</td>
<td>Patient admin</td>
<td>DCC</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>1400-1700</td>
<td>St Giles</td>
<td>Operating</td>
<td>DCC</td>
<td>0.75</td>
</tr>
<tr>
<td></td>
<td>1700-1800</td>
<td>St Giles</td>
<td>Imaging</td>
<td>DCC</td>
<td>0.25</td>
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<td>Wednesday</td>
<td>0900-1300</td>
<td>St Elsewhere</td>
<td>Operating</td>
<td>Private</td>
<td>1</td>
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<tr>
<td></td>
<td>1330-1730</td>
<td>Variable</td>
<td>Patient admin</td>
<td>DCC</td>
<td>1</td>
</tr>
<tr>
<td>Thursday</td>
<td>0900-0930</td>
<td>Variable</td>
<td>Travel (StG to StJ and back)</td>
<td>DCC</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>0930-1230</td>
<td>St Judes</td>
<td>Operating</td>
<td>DCC</td>
<td>0.75</td>
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<tr>
<td></td>
<td>1230-1330</td>
<td>St Judes</td>
<td>Patient admin</td>
<td>DCC</td>
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<tr>
<td></td>
<td>1330-1630</td>
<td>St Judes</td>
<td>NPs / Reviews</td>
<td>DCC</td>
<td>0.75</td>
</tr>
<tr>
<td>Friday</td>
<td>0800-0900</td>
<td>St Giles</td>
<td>Planning</td>
<td>DCC</td>
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<tr>
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<td>St Giles</td>
<td>Teaching</td>
<td>SPA</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>1100-1300</td>
<td>St Giles</td>
<td>Operating</td>
<td>DCC</td>
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<td>1330-1530</td>
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<tr>
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<td>1530-1730</td>
<td>Variable</td>
<td>Clinical research/teaching prep</td>
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<tr>
<td>Saturday</td>
<td>9am-1pm</td>
<td>St Elsewhere</td>
<td>Operating</td>
<td>Private</td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

Additional agreed activity to be worked flexibly

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Location</th>
<th>Work</th>
<th>Categorisation</th>
<th>No. of PAs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Variable</td>
<td></td>
<td>Clinical governance, management meetings, regional/national duties, teaching prep CPD</td>
<td>SPA/Other duties</td>
<td>1</td>
</tr>
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<td>On-site, at home on the telephone and traveling to and from site</td>
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Predictable emergency on-call work

<table>
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<th>Time</th>
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<th>Work</th>
<th>Categorisation</th>
<th>No. of PAs</th>
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<td>Variable</td>
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| TOTAL Pas | 11 |

Programmed activity

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<tr>
<td>8</td>
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<td>Supporting professional activities</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Other NHS responsibilities</td>
</tr>
<tr>
<td>External duties</td>
</tr>
<tr>
<td>TOTAL PROGRAMMED ACTIVITIES</td>
</tr>
</tbody>
</table>

Notes
(a) There are four time blocks set out for each day. Not all blocks need to be filled in. It is feasible that consultants will have 1, 2, 3 or even more PAs on any one day.
(b) Under ‘additional agreed activity’ the consultant might agree, for example, with the employer that they will undertake a certain proportion of regular patient administration equating to x PAs, at an unspecified time and location during the week. This section might also be used to set out the number of PAs for any unpredictable external duties.
(c) Predictable on-call work: where this work follows a regular pattern each week, consultants should identify within the weekly schedule when and where this takes place. Where such work does not follow a regular pattern, for example due to the variability of the on-call rota, consultants should assess an average level of activity per week and identify it in the predictable activity box at the bottom of the form.
(d) The location and timing of unpredictable emergency work cannot be completed, therefore only the categorisation and number of PAs should be completed.
(e) Location can be the principal place of work or any other agreed location e.g. the consultant’s home for some duties.
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APPENDIX 3
Consultants in Restorative Dentistry

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

Role of the Consultant

Clinical
The Consultant in Restorative Dentistry aims to improve and maintain the oral health of adults (and some children in conjunction with Consultants in Orthodontics and Paediatric Dentistry) through appropriate preventive, educational, diagnostic and treatment services. This includes assessment and advice for GDPs and other consultant colleagues in all specialties including those within medicine. The Consultant will be particularly involved in the management and treatment of patients falling within Group 3 of the Complexity Index.

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

Research
NHS consultants and Senior academic staff holding honorary consultant contracts will be actively engaged in research leading to peer reviewed publications and a greater body of knowledge which will increase understanding of disease processes and their management. The Consultant may be a Research supervisor for trainees registered for a higher degree with the University.

Education and Training
Consultants make a significant contribution to education and training.
  a. This commitment is primarily concerned with SHOs and Specialist Registrars whereby consultants will have formal responsibilities as either Educational Supervisors and/or Training Programme Directors.
  b. Consultants in restorative dentistry have always been actively involved in the provision of postgraduate training such as teaching of General Dental Practitioners (e.g. Section 63 courses), and university programmes such as for taught Masters' degrees in aspects of Restorative Dentistry.
  c. Further involvement with education of undergraduates and PCDs (nurses, hygienists, therapists) will add to this activity.
  d. Act as consultant supervisors for overseas dentists in Dental Attachment posts.

Revalidation
To ensure that all specialists maintain the knowledge, skills and attributes for effective clinical practice, the GDC has introduced its scheme “Lifelong learning: Recertification for the dental profession”. All members of the Dental Faculties of the Surgical Royal Colleges have been required to register for CPD since 1996. All specialists are therefore required to “Keep up to Date” by attending appropriate courses and scientific conferences. The consultant must provide evidence about standards of clinical practice by taking part in Annual Appraisal, external peer review and Personal Development Plans (PDP).

The nature and scope of the specialty
The specialty provides a comprehensive diagnostic and treatment planning service for a wide range of congenital and acquired diseases/disorders affecting the mouth, face and jaws. Furthermore, the consultant will provide treatment for patients under his or her care. An expanding area of service provision is related to the dental care of the patients with special needs: patients with disability or medical problems too difficult to manage in Primary Care or Community Service.

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

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

The relationship to monospecialties of Restorative Dentistry

Restorative Dentistry is the parent discipline or umbrella specialty for the monospecialties of Prosthodontics, Endodontics and Periodontology. Consultants in Restorative Dentistry may provide services in all monospecialties.

A major role of consultants in restorative dentistry is the advisory service for general dental practitioners. While these patients will proceed to receive their treatment within primary care many may be reviewed by the consultant through to the completion of their treatment. In some cases part of the care is best provided within the hospital dental services (HDS).

The long-term management of dental trauma, minor alveolar and palatal clefts, hypodontia, some surgical endodontics, complex or advanced periodontal cases will require close co-operation between the GDP, hygienist and consultant. Whilst many GDPs are prepared to treat patients with moderate physical learning disabilities they may need help from the hospital and community dental services with parts of treatment and planning. Patients with profound learning disabilities may require advanced sedation techniques or general anaesthesia for dental treatment.

Certain categories of patient need long-term treatment and supervision within the HDS. These include patients with bleeding disorders, immuno-suppression, leukaemia, endocardial lesions requiring IV antibiotic prophylaxis, some forms of drug therapy. Demographic changes and the longer retention of natural teeth by the elderly are likely to increase the number of patients requiring complex treatment planning in view of potential medical complications. Patients with severe systemic disease (ASA III, IV) may require treatment in a hospital setting where there are critical care facilities. This is particularly evident in phobic patients who have serious medical conditions that can be exacerbated by stress (e.g. uncontrolled angina).

Patients with congenital facial defects or major dental abnormality require carefully planned treatment which should be an integral part of a combined orthodontic/oral surgical and restorative therapy. The restorative consultant must be fully integrated with consultant colleagues in the other dental specialties. Similarly patients with acquired defects either through trauma or as a result of therapy for head and neck tumours require restorative management of a high standard.

The restorative dentist has a particular role as a member of a multidisciplinary group involved in the care of patients treated with radiotherapy and chemotherapy. The restorative consultant must be able to liaise with radiation and medical oncologists, surgeons, Macmillan nurses and dental hygienists to provide a functional head and neck cancer team. Consultants must lead clinical audit.

There is no role for the restorative consultant as a provider of primary dental care but where there is a training commitment for junior staff there will be a need to obtain for treatment a suitable range of patients of varying complexity including some of the type usually treated in primary care.

Restorative consultants have a significant contribution to teaching. There is a commitment to clinical training of junior NHS staff, postgraduate education of GDPs, undergraduate education, taught postgraduate courses, supervision of research degrees and auxiliary training. The burden of educating dentists wishing to obtain CCSTs in endodontics, fixed and removable prosthodontics and periodontology is likely to fall on restorative consultants for many years to come.

The majority of postgraduate courses provided for general dental practitioners are in restorative dentistry. The job plans of restorative consultants working within the teaching hospitals should reflect the substantial commitments which exist in addition to clinical loads.

Examples of the distribution of sessions:

**Workload**

Referral rates vary between conservative, periodontology and prosthetic dentistry.

The various number of patients seen per clinic:
- Consultation clinic: 4-10
- Review clinic: 8-12
- Treatment: 2-6

It must be recognized that the number of patients seen on any one clinic depends upon several variables such as the presence of other staff (SpRs, SHOs), the need to teach students, SHOs/SpRs themselves, complexity of caseload, etc.

Based on a working year of 40 weeks (6 weeks annual leave, 2 weeks bank holidays, 2 weeks study leave), 2 consultation sessions per week and the average patients seen per session are:
- New Patient clinics: 6x2x40=480 An average of 500 new patients per year
- Review clinics: 10x2x40=800 An average of 800 review patients per year
- Treatment clinics: 4x2x40=320 An average of 320 patients

Most new patients require radiographs. These are usually interpreted by the clinician at the consultation appointment, to allow a diagnosis and treatment plan to be arrived at. This can account for the longer initial consultation times. This can differ with other disciplines when tests are requested and diagnoses only made at follow-up visits.

**ALLOCATION OF TIME IN THE JOB PLAN (New Contract)**

See examples for Restorative Dentistry
It is accepted that there will be wide individual variation but an attempt should be made to ensure that the proportions of 7.5 for Direct Clinical Care to 2.5 of Supporting Professional Activity is broadly maintained.

**Direct Clinical Care:** Work directly related to the prevention, diagnosis or treatment of illness. This includes time spent directly with patients in clinics and time arising from the time spent e.g. writing up notes, dictating letters, reporting on radiographs, lab. work, clinical diagnostic work, multi-disciplinary meetings.

**Supporting Professional Activities:** Activities that underpin direct clinical care. This may include participation in training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, committee meetings, clinical management and local clinical governance activities. It should include an appropriate allowance for keeping up to date with relevant dental journals and literature.

**Additional NHS Responsibilities:** Special responsibilities – not undertaken by the generality of consultants in the employing organization – which are agreed between a consultant and the employing organization and which cannot be absorbed within the time that would normally be set aside for supporting professional activities. These include being a medical director, director of public health, clinical director or lead clinician, or acting as a Caldicott guardian, clinical audit lead, clinical governance lead, undergraduate dean, postgraduate dean, clinical tutor or regional education adviser. This is not an exhaustive list.

**External Duties:** Duties not included in any of the three foregoing definitions and not included within the definition of fee-paying services or private professional services, but undertaken as part of the job plan by agreement between the consultant and employing organization. These might include trade-union duties for the BMA/BDA, undertaking inspections for the Commission for Health Improvement (or its successor body), acting as an external member of an Advisory Appointments Committee, undertaking assessments for the National Clinical Assessment Authority, reasonable quantities of work for the Royal Colleges, the Association of Consultants and Specialists in Restorative Dentistry or a specialist society, in the interests of the wider NHS, reasonable quantities of work for a government department, or specific work for the General Medical Council or General Dental Council. This list of activities is not exhaustive.

**On-Call Categories:**
- **Category A** Where the consultant is typically required to return immediately to site when called or has to undertake interventions with a similar level of complexity to those that would normally be carried out on site, such as telemedicine or complex telephone calls.
- **Category B** This applies where the consultant can typically respond by giving telephone advice and/or by returning to work later.

**Frequency Supplements:** *(as amended by national agreement)*

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<th></th>
<th>A</th>
<th>B</th>
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<tr>
<td>Medium:</td>
<td>1 in 5 to 1 in 8</td>
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<tr>
<td>Low:</td>
<td>1 in 9 or &lt;3%</td>
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Faculty of Dental Surgery, the Royal College of Surgeons of England
### Guidance to Regional Advisers involved in approving Person Specifications for NHS or Honorary Consultants in Restorative Dentistry

**CONSULTANT IN RESTORATIVE DENTISTRY – PERSON SPECIFICATION**

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#### ESSENTIAL

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<th>HOW ASSESSED</th>
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<td><strong>Registration</strong></td>
<td>Full registration with the United Kingdom General Dental Council (GDC)</td>
<td>CV and Documentation</td>
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<tr>
<td><strong>Specialist listing</strong></td>
<td>On the GDC Specialist Register in Restorative Dentistry or within three months of eligibility for inclusion</td>
<td>Possession of a Certificate of Accreditation or eligibility for a CCST in Restorative Dentistry</td>
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<tr>
<td><strong>Professional Qualifications</strong></td>
<td>Fellowship in Dental Surgery or Membership of the Faculty of Dental Surgery, or equivalent.</td>
<td>MSc or equivalent</td>
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<tr>
<td></td>
<td>Intercollegiate Fellowship Examination in Restorative Dentistry or equivalent.</td>
<td>CV and Documentation</td>
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<tr>
<td></td>
<td>Higher Degree by Thesis (Honorary Consultants for Academic Appointments only).</td>
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<table>
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<tr>
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<tr>
<td><strong>Successful completion of an SAC – approved five-year minimum training programme in Restorative Dentistry or within six months of completion or equivalent</strong></td>
<td>CV/Interview</td>
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<tr>
<td><strong>Current holders of an NHS or honorary NHS consultant contract in Restorative Dentistry are eligible to be shortlisted.</strong></td>
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<tr>
<td><strong>Applicants who are Nationals from another European country or elsewhere overseas would have to show equivalence to the five years’ minimum training period in the NHS required for Restorative Dentistry</strong></td>
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<table>
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<td><strong>Training in teaching</strong></td>
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<td>Publications in refereed journals</td>
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<td>Management of clinical service</td>
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<td>PERSONAL</td>
<td>Work independently</td>
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<td>Good communication skills</td>
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<td></td>
<td>Team skills</td>
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<tr>
<td>GENERAL</td>
<td>Satisfactory pre-employment health screening</td>
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Footnotes:
# Model job plan for Mr Phil McAvity, Consultant in Restorative Dentistry, based in a single Hospital

## 1. Job content

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Location</th>
<th>Work</th>
<th>Categorisation</th>
<th>No. of PAs</th>
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<tr>
<td>Monday</td>
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<td>Hosp</td>
<td>Operating</td>
<td>DC</td>
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<td>Hosp</td>
<td>Pt admin</td>
<td>DC</td>
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<td>DC</td>
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<td>Operating</td>
<td>DC</td>
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<td>1-2pm</td>
<td>Hosp</td>
<td>Journal Club</td>
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<td>DC</td>
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<td>Hosp</td>
<td>Pt admin</td>
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<td>Management meetings/ teaching admin working groups National duties modules/units Examining, CPD Service development</td>
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<td>Direct clinical care</td>
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<td>Unpredictable emergency on-call work</td>
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<td>TOTAL PAs</td>
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<td>Direct clinical care (including unpredictable on-call)</td>
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<td>Other NHS responsibilities</td>
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<td>External duties</td>
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</tr>
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<td>11</td>
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2. On-call availability supplement

<table>
<thead>
<tr>
<th>Agreed on-call rota, e.g. 1 in 5:</th>
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<tr>
<td>Agreed category (delete):</td>
<td>A / B</td>
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<tr>
<td>On-call supplement e.g. 5%:</td>
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APPENDIX 4
Consultants in Dental and Maxillofacial Radiology

Dental and maxillofacial radiology is the newest of the dental specialties and is still evolving. While the majority of consultants in the specialty hold NHS contracts most are academic post holders with honorary consultant status. In both groups there is a wide range of duties undertaken. The post may be exclusively in radiology or include responsibility in other clinical areas such as oral diagnosis/primary dental care; links with other specialties may exist (eg. Oral medicine). The amount of and access to facilities for advanced organ imaging varies. Because NHS posts are located within dental teaching hospitals they all carry an undergraduate teaching load and both NHS and academic post holders undertake a substantial but variable amount of postgraduate and continuing education. At present there is no specific guidance from either the British Society of Dental and Maxillofacial Radiology or the Royal College of Radiologists. The following allocation of clinical time for a whole time NHS consultant in oral and maxillofacial radiology should be interpreted flexibly according to the local circumstances.

1. **Fixed Commitments**

   - **Reporting**
     - 3 – 4 NHDs
   - **Radiological investigations**
     - 1 - 2 NHDs
     - These could include sialography, dacrocystography, arthrography, ultrasound, fluoroscopy (video swallows, speech assessments), CT and MRI. This is quite variable throughout the UK. Ultrasound guided FNA and interventional sialography may also account for some sessions.

2. **Flexible Commitments**

   - **Special interest**
     - 0.5 – 1 NHD
   - **Administration/Audit**
     - 0.5 – 1 NHD
   - **Teaching**
     - As already stated, the majority of posts are academic. Therefore the staff are heavily involved in delivering undergraduate curriculum to satisfy IRMER 2000. In addition, there will usually be involvement in teaching postgraduates and running IRMER courses for general dental practitioners. There are a number of SpR posts throughout the country but a number of consultants have no trainee and there are limited attachments for House Officers and SHOs, however, most will be involved in some teaching of the House Officers and SHOs in other specialties.

3. **Estimated average clinical throughput**

   - **Reporting:** 10 minutes per case. Approximately 20 cases per session plus dictation of correspondence etc.
   - **Radiological investigations:**
     - Sialogram: 30 minutes. 4-5 per session
     - Arthrograph: 40 minutes. 2-3 per session
     - MRI scans: 3-4 patients per session
     - Ultrasound scan: 20 minutes
     - CT scan: 5-6 patients per session plus time spent on post-acquisition manipulation
   - **Fluoroscopy:** 15-45 minutes
**Model job plan for Ms Imogen Ray, Consultant in Dental and Maxillofacial Radiology**

**1. Job content**

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Location</th>
<th>Work</th>
<th>Categorisation</th>
<th>No. of PAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>8.30am-9.30am</td>
<td>St Swithins</td>
<td>Clinrad meeting</td>
<td>Direct care</td>
<td>0.25</td>
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<tr>
<td></td>
<td>9.30-12.00</td>
<td>St Swithins</td>
<td>MRI/CT list</td>
<td>Direct care</td>
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<tr>
<td></td>
<td>8.00-8.30am</td>
<td></td>
<td>Travel</td>
<td>Direct care</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>12.00-12.30</td>
<td></td>
<td>Travel</td>
<td>Direct care</td>
<td>0.75</td>
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<tr>
<td></td>
<td>2pm-5pm</td>
<td>Dental Hosp</td>
<td>Reporting</td>
<td>Direct care</td>
<td>0.75</td>
</tr>
<tr>
<td>Tuesday</td>
<td>7.30-8.00</td>
<td>St Judes</td>
<td>Travel</td>
<td>Direct care</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>5.00-5.30</td>
<td>St Judes</td>
<td>Travel</td>
<td>Direct care</td>
<td>0.75</td>
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<tr>
<td></td>
<td>8am-9am</td>
<td>St Judes</td>
<td>Patient admin</td>
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<tr>
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<td>9am-12pm</td>
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<td>Supporting</td>
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<td>8am-9am</td>
<td>Dent Hosp</td>
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<td>Direct care</td>
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<td></td>
<td>9am-12.00pm</td>
<td>St Anywhere</td>
<td>Stialography</td>
<td>Direct care</td>
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<tr>
<td></td>
<td>1.00pm-5.00pm</td>
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<td>Reporting</td>
<td>Direct care</td>
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</tr>
<tr>
<td>Thursday</td>
<td>8am-9am</td>
<td>Dent Hosp</td>
<td>Admin</td>
<td>Supporting</td>
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<tr>
<td></td>
<td>9am-12.00pm</td>
<td>Dent Hosp</td>
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<tr>
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<td>Dent Hosp</td>
<td>Patient admin</td>
<td>Direct care</td>
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<td>Reporting/</td>
<td>Direct care</td>
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<td>Patient admin</td>
<td>Direct care</td>
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<td>Sunday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional agreed activity to be worked flexibly</td>
<td>Variable</td>
<td>Clinical governance, management meetings, regional / national duties, teaching prep CPD Audit</td>
<td>Supporting</td>
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<td></td>
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<tr>
<td>Predictable emergency on-call work</td>
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<td>Direct clinical care</td>
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<tr>
<td>Unpredictable emergency on-call work</td>
<td>Variable</td>
<td>On-site, at home on the telephone and traveling to and from site</td>
<td>Direct Clinical care</td>
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<tr>
<td>TOTAL PAs</td>
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Programmed activity

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<th>Number</th>
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<tr>
<td>Direct clinical care (including unpredictable on-call)</td>
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<tr>
<td>Supporting professional activities</td>
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<tr>
<td>Other NHS responsibilities</td>
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<td>External duties</td>
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<tr>
<td><strong>TOTAL PROGRAMMED ACTIVITIES</strong></td>
<td>11</td>
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</tbody>
</table>

Notes

(a) There are four time blocks set out for each day. Not all blocks need to be filled in. It is feasible that consultants will have 1, 2, 3 or even more PAs on any one day.

(b) Under ‘additional agreed activity’ the consultant might agree, for example, with the employer that they will undertake a certain proportion of regular patient administration equating to x PAs, at an unspecified time and location during the week. This section might also be used to set out the number of PAs for any unpredictable external duties.

(c) Predictable on-call work: where this work follows a regular pattern each week, consultants should identify within the weekly schedule when and where this takes place. Where such work does not follow a regular pattern, for example due to the variability of the on-call rota, consultants should assess an average level of activity per week and identify it in the predictable activity box at the bottom of the form.

(d) The location and timing of unpredictable emergency work cannot be completed, therefore only the categorisation and number of PAs should be completed.

(e) Location can be the principal place of work or any other agreed location e.g. the consultant’s home for some duties.

(f) In the ‘work’ column, a description of the duty should be completed, e.g. outpatient clinic, ward round, operating list.

(g) The ‘categorisation’ column should define whether the work is direct clinical care, supporting professional activity, additional NHS responsibility or external duty.

(h) The number of PAs should specify the number of PAs allocated to the duty. This can be a full PA or broken down into smaller units. If the work is in premium time after 1 April 2004, 3 hours of work is one programmed activity.

(i) Regular private practice commitments should be identified broadly in terms of timing, location and type of work.

(j) In addition to regular duties and commitments, the consultant might have certain ad-hoc responsibilities. These would normally but not exclusively fall into the ‘additional NHS responsibilities’ or ‘external duties’ categories of work, for example member of an Advisory Appointments Committee or work for a Royal College. Such duties could be scheduled or agreement could be reached to deal with such work flexibly (see section 5 below).
APPENDIX 5
Consultants in Paediatric Dentistry

The specialty of Paediatric Dentistry provides comprehensive and therapeutic oral health care for children from birth to adolescence, including care for children who demonstrate intellectual, medical, physical, psychological and/or emotional problems. It encompasses a variety of disciplines, techniques and skills that share a common basis with other dental specialties. However, as with the medical specialty of Paediatrics, Paediatric Dentistry is age-rather than technique-, disease-, or region of the body- specific. Consultants in Paediatric Dentistry may work either within the hospital service or in primary care.

Responsibilities

Advice

Clinical advise is provided to Primary Care Practitioners, (Medical and Dental), Paediatricians and social service workers. The Consultant in Paediatric Dentistry works closely with colleagues in other dental specialties, paediatric specialists, and other care agencies to deliver multidisciplinary and multiagency care for children. Advice is offered to commissioners, public health practitioners and other colleagues concerned within service development and review.

Treatment

The provision of dental care for children from birth to adolescence including children with:

- special needs
- social and/or family problems
- complex medical conditions
- oral and dental developmental diseases and disorders

and

- children presenting with challenging behaviour (including anxiety)
- those requiring a general anaesthetic for the delivery of care.

Interdisciplinary/Multidisciplinary Treatment

- In conjunction with Orthodontic, Restorative, and Oral Surgery consultants the problems of unerupted, ectopic and malformed teeth and the effects of trauma and pathology in the dento-alveolar structures of the child and young adult.
- In conjunction with consultants in Orthodontics and Restorative Dentistry problems where careful planning is required to ensure a smooth pathway from the dental care necessary in childhood into adulthood. This will include various forms of facial deformity. Specific disorders include cleft lip and palate, and children with fewer than the normal teeth – hypodontia.
- In conjunction with consultant Paediatricians the oral health needs of sick children (children with special needs) including those with cancer, heart defects, cerebral palsy, autoimmune disease, physical disability etc.

Education / Training / Examining / Accreditation

- Provision of training for future specialists and consultants
- Provision of education and training for undergraduates and postgraduates
- Participation of teaching programmes for dental therapists, hygienists, nurses and technicians (professions complementary to dentistry).
- Provision of dental education for healthcare professions.
- Provision of CPD for Primary Dental care practitioners, including professions complementary to dentistry.
- Provision of remedial training for dental practitioners and PCDs whose competence has lapsed.
- Participate in Examinations for Undergraduates and Postgraduates: locally and nationally.
- Participate in College inspection and quality assurance processes e.g. SAC visits.

Research

Develop personal and departmental research interests at a local and national level. Where possible to establish links with research active units to foster research in paediatric dentistry.

Management

- Contribute to local management decision making to improve the delivery of oral health care for the child patient.
- To comply with clinical governance requirements.
- To lead and/or play an active part in sub-regional and departmental Clinical Audit.
- To liaise with other providers of Paediatric Dental Care in Clinical Audit projects.
- To participate in annual appraisal and job planning to benefit children’s oral health.
Oral Health Care Strategy

- Work with Consultants in Dental Public Health to ensure provision for the dental needs of the local and national child population and to ensure access for all who require dental care. Ensure that care is delivered in the most appropriate manner.
- Influence public health measures to improve the oral health of children.
- Actively participate in local, national and international initiatives to improve children's health and well being.

National Responsibilities

- Contribute to local and National committees particularly in areas such as education, research and clinical governance.
- Contribute to Specialist conferences and regional meetings concerned with all aspects of delivery of care for the child.
- Participate in examinations, inspections and other College responsibilities.

Leadership

- To promote and develop the specialty of paediatric dentistry to benefit all children.
- To raise the profile of paediatric dentistry with local and national commissioners of health care.
- To raise the profile of paediatric dentistry within the dental profession in general.
- To raise the profile of paediatric dentistry within the College system.
- To inspire young dentists to become specialists and consultants in paediatric dentistry.

Workload

Programmed Activities

The weekly programme will depend on the annual job planning process, informed by annual appraisal.

Programmes will vary according to:

- Geographical Location.
- Service location – primary care, secondary care, tertiary care or combined.
- Undergraduate/Postgraduate/both.
- Level of teaching and research carried out.
- Management, administration and committee activities undertaken.
- Quality assurance requirements.

OUTPATIENTS

New Patient assessments
Reviews

The concensus view of the Consultants in Paediatric Dentistry Group is that:

The minimum time interval required for a patient review appointment is 15 minutes.
The minimum time interval required for a New Patient consultation is 30 minutes.

These times take no account of other simultaneous duties including teaching, supervision, research and/or administration.

The time is needed to:

- Talk with and examine the patient
- Talk with the parents
- Make notes, complete data entry sheets, obtain consent
- Where applicable: teach, train and supervise junior staff / undergraduates
- Comply with governance requirements

It is recognised that clinics may extend beyond a single programmed session.

Joint interdisciplinary clinics, involving the regular schedules use of hospital resources and staff, may be included in programmed sessions.

OPERATING LISTS

Much of this work is on a Day-care basis. Where an in-patient commitment is included, ward work and on-call should be considered.
CLINICAL TREATMENT

Specific time intervals vary depending on the health of the child, nature of treatment delivered, age of patient, child’s level of anxiety, experience of Consultant etc. As such no guidance is offered as to the suitable length of an outpatient treatment appointment where operative care (surgical/restorative) is provided for a child.

INTERDISCIPLINARY CLINICS

These will include new patients assessments and reviews for children with –

- Cleft lip and palate
- Hypodontial
- Complex medical needs
- Complex dental needs
## CONSULTANT IN PAEDIATRIC DENTISTRY – PERSON SPECIFICATION

**Post:** Consultant in Paediatric Dentistry  
**Hospital:** (Name of NHS Hospital Trust)

<table>
<thead>
<tr>
<th>ATTAINMENTS</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
<th>HOW ASSESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration</td>
<td>Full registration with the United Kingdom General Dental Council (GDC)</td>
<td>Possession of a Certificate of Accreditation or eligibility for a CCST in Paediatric Dentistry</td>
<td>CV and Documentation</td>
</tr>
<tr>
<td>Specialist listing</td>
<td>On the GDC Specialist Register in Paediatric Dentistry</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please refer to the *note under TRAINING REQUIREMENTS and the footnote at the end of this document, as inclusion on the specialist list above does not make an individual eligible for consultant appointment*

<table>
<thead>
<tr>
<th>Professional Qualifications</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
<th>HOW ASSESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fellowship in Dental Surgery or Membership of the Faculty of Dental Surgery, or equivalent.</td>
<td>MSc or equivalent</td>
<td>CV and Documentation</td>
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</tr>
<tr>
<td>Specialist Membership in Paediatric Dentistry or equivalent</td>
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<tr>
<td>Intercollegiate Fellowship Examination in Paediatric Dentistry or equivalent.</td>
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</tr>
<tr>
<td>Higher Degree by Thesis (Honorary Consultants for Academic Appointments only).</td>
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</table>

<table>
<thead>
<tr>
<th>TRAINING</th>
<th>ESSENTIAL</th>
<th>HOW ASSESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAINING</td>
<td>Successful completion of an SAC – approved three-year minimum training programme in Paediatric Dentistry</td>
<td>CV/Interview</td>
</tr>
</tbody>
</table>

* Successful completion of an SAC – approved minimum two-year training in a Fixed Term Training Appointment (FTTA) which follows on from the pre-CCST training period of three years, or within six months of completion, or equivalent for other European Economic Area (EEA) Nationals

Current holders of an NHS or honorary NHS consultant contract in Paediatric Dentistry are eligible to be shortlisted.

Applicants who are Nationals from another European country or elsewhere overseas would have to show equivalence to the 5 years minimum training period in the NHS.
<table>
<thead>
<tr>
<th>Category</th>
<th>Requirement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEACHING</td>
<td>Experience of postgraduate and undergraduate teaching</td>
<td>CV/Interview</td>
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<td>Training in teaching</td>
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<tr>
<td>AUDIT</td>
<td>Effective participation in clinical audit</td>
<td>CV/Interview</td>
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<tr>
<td>RESEARCH</td>
<td>Research relevant to the specialty</td>
<td>CV/Interview</td>
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<td></td>
<td>Publications in refereed journals</td>
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<tr>
<td>MANAGEMENT</td>
<td>Management of clinical service</td>
<td>CV/Interview</td>
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<td>PERSONAL</td>
<td>Work independently</td>
<td>CV/Interview</td>
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<td>Good communication skills</td>
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<td></td>
<td>Team skills</td>
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</tr>
<tr>
<td>GENERAL</td>
<td>Satisfactory pre-employment health screening</td>
<td>CV/Interview</td>
</tr>
</tbody>
</table>

Footnotes:

These are the core requirements that need to be in any personal specification. There will be additional requirements suited to local circumstances. It was agreed at the meeting of the Committee of Senior Officials for Public Health (CSOPH) in Brussels that “for some high level posts, or senior posts for which there are specific management and/or training functions, a two years’ additional training period will be requested for access to these posts”. This refers to post-CCST training. It was made clear that this additional training would not be mandatory for an individual who had trained in another Member State but that that individual would have to show equivalence to the two years’ additional post-CCST training period.

Thus an individual who is on the Specialist List in Paediatric Dentistry **is not eligible** for a consultant post unless he or she has done additional training either as a Senior Registrar or in a Fixed Term Training Appointment (or equivalent for other EEA nationals) and **must not be shortlisted**. Human Resource Departments do not often appreciate this, as in medical specialities inclusion on the appropriate specialist list indicates potential eligibility for consultant appointments. All individuals who have been shortlisted are potentially appointable.
## Model job plan for Mrs C A Child, Consultant in Paediatric Dentistry

### 1. Job content

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Location</th>
<th>Work</th>
<th>Categorisation</th>
<th>No. of PAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>9.00-12.00</td>
<td>Dental Hospital</td>
<td>Outpatient Treatment Session</td>
<td>Direct care</td>
<td>0.75</td>
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<tr>
<td></td>
<td>12:00 – 1:00</td>
<td>Dental Hospital</td>
<td>Patient Admin</td>
<td>Direct care</td>
<td>0.25</td>
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<tr>
<td></td>
<td>1:00 – 5pm</td>
<td>Dental Hospital</td>
<td>Teaching MSc/ Undergraduate/PCD Seminar</td>
<td>Supporting</td>
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<td>Tuesday</td>
<td>9am-12:00</td>
<td>Dental Hospital</td>
<td>Joint Clinic e.g. Hypodontia</td>
<td>Direct care</td>
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<tr>
<td></td>
<td>12:00-1pm</td>
<td>Dental Hospital</td>
<td>Patient Admin</td>
<td>Direct care</td>
<td>0.25</td>
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<tr>
<td></td>
<td>1:30 – 5pm</td>
<td>Sick Children’s Hospital</td>
<td>In-Patient or Day Care Theatre Session</td>
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<td>5:00-8:30pm</td>
<td>Sick Children’s Hospital</td>
<td>Ward Work Discharging patients etc.</td>
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<td>Wednesday</td>
<td>9am-1pm</td>
<td>St Elsewhere</td>
<td>Outpatient Treatment Session</td>
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<td></td>
<td>1.30pm-5.30pm</td>
<td>Variable</td>
<td>Patient admin</td>
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<tr>
<td>Thursday</td>
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<td>Dental Hospital</td>
<td>NP Clinic</td>
<td>Direct care</td>
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<td>Trauma Clinic</td>
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<td>11am-1pm</td>
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<td>Departmental Meeting 1:2 Journal Club 1:2</td>
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<td>Sick Children’s Hospital</td>
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Appendix 6
Consultants in Dental Public Health

The dental public health contribution to the work of Primary Care Organisations (PCOs), Strategic Health Authorities (SHAs) and Government Offices is now normally being provided by consultants in the specialty who have been appointed following the appropriate statutory advisory procedure and who may be supported by a Specialist Registrar and/or SHO. As the specialty develops further all PCOs should have access to consultant level skills and expertise. Consultants in the specialty (CsDPH) work closely with their counterparts in Public Health, and Specialist Registrars and SHOs will usually undertake much of their training within the framework of a Public Health department led by the Director of Public Health. Dental Public Health is a specialist public health function which will need to be provided through a managed network normally across the SHA area. The network will be led by one or more consultants in dental public health and may include others with relevant dental and/or public health skills.

Dental public health responsibilities at PCO level include:

- assessment and surveillance of the oral health needs of the population;
- managing, analysing and interpreting oral health and dental service information and statistics to support the PCT planning and commissioning roles;
- managing knowledge and getting research into clinical practice;
- collaborative working for oral health through local strategic partnerships;
- policy and strategy development and implementation, through local HIMPs and community plans;
- developing quality and risk management in dentistry within an evaluative culture.

Internal management arrangements are determined at the local level, but it is necessary to ensure a close working relationship with the Chief Executive and Director of Public Health of the relevant authority. Access to appropriate meetings of the PCO and senior officer meetings is essential to enable the consultant to perform his or her duties. Linkages with other key departments within the relevant health authority are also necessary. This will include amongst others, information, finance, purchasing and commissioning functions. Professional accountability will generally be to the authority with management accountability normally to the Chief Executive or Director of Public Health.

Dental Public Health Responsibilities at SHA level include

- supporting the performance-management function with SHAs in relation to the dental issues, including the management, analysis, and interpretation of epidemiological and dental service information and statistics, in relation to both primary and secondary dental care;
- developing and ensuring leadership of a dental public health-managed network to ensure PCTs have access to high quality advice;
- ensuring the development and quality of effective dental clinical networks to deliver health-improvement and service-improvement and redesign;
- advising on tertiary dental services, water fluoridation programmes, and dental teaching hospitals and workforce issues.

Dental Public Health Responsibilities at Government Office level include

- providing strategic leadership of the dental public health function in the region;
- promoting cross-sectoral initiatives to reduce inequalities in oral health;
- contributing to the development of national policy on oral health and dentistry and mechanisms for its implementation and supporting the Chief Dental Officer, and Regional Director of Public Health;
- advising the teams of the Government Office in relation to dental issues in the region;
- providing professional leadership on serious concerns about clinical standards in dentistry.

Teaching and training responsibilities of Dental Public Health Consultants

Each consultant has a responsibility to teach and to train junior staff working under his/her supervision. Time should be allocated where relevant in each working week for this purpose and identified in the job description.

Consultant in Dental Public Health competencies

The following distinctive competencies are required to allow the satisfactory accomplishment of the above responsibilities:

- epidemiology: derivation of appropriate dental indicators, survey and database design, data analysis including statistics interpretation and application of results.
- health economic analysis: derivation of measures of oral health improvement and application of appropriate economic analysis.
- sociological: ability to interpret oral health and dental practice in terms of social relationships and social contexts.
- research and development (R&D): identification of appropriate areas for R&D and the application to this of research methodology.
- teaching and training: at undergraduate and postgraduate level and in multidisciplinary/multiagency settings.
• effective communication: negotiating, influencing utilizing written, oral and non-verbal, listening and counselling communication techniques
• management: resource management, control, leadership, planning, conflict management, teamwork coordination and organization political: developing policy, political awareness, evaluating policy, strategic opportunism

The work pattern of a Consultant in Dental Public Health is different to that of a clinical consultant and the allocation of time in the weekly programme is therefore markedly different. The weekly programme will reflect the issues of the moment including current urgent issues facing the health organization and the annual contracting/commissioning timetable. It is therefore difficult to set specific schedules and the following is merely a guide for a full time consultant.

**Direct Clinical Care:** work directly related to the prevention, diagnosis or treatment of illness. This covers the majority of the dental public health duties normally undertaken by a consultant in dental public health as part of the responsibilities as set out above. Average 7.5PAs per week.

**Supporting Professional Activities:** activities that underpin the above responsibilities and duties. This may include participation in training, dental education, continuing professional development, formal teaching, audit, appraisal, research, job planning and local clinical governance activities. Average 2.5PAs per week.

**Additional NHS responsibilities:** special responsibilities – not undertaken by the generality of consultants which are agreed between a consultant and the employing organisation. This will vary considerably with each individual and will be reflected in an agreed reduction in the direct clinical care PAs per week.

**External duties:** duties not included in any of the above but undertaken as part of the job plan by agreement between the consultant and the employing organisation. This will vary considerably with each individual and will be reflected in an agreed reduction in the direct clinical care PAs per week.
# Consultant in Dental Public Health – Person Specification

**Post:** Consultant in Dental Public Health  
**Hospital:** (Name of Primary Care Trust / Strategic Health Authority)

## Attainments

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<th>ESSENTIAL</th>
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<tr>
<td><strong>Registration</strong></td>
<td>Full registration with the United Kingdom General Dental Council (GDC)</td>
<td>Membership/Fellowship of the Faculty of Public Health</td>
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<td><strong>Specialist listing</strong></td>
<td>On the GDC Specialist Register in Dental Public Health or within three months of eligibility for inclusion</td>
<td>Possession of a Certificate of Accreditation or eligibility for a CCST in Dental Public Health</td>
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<tr>
<td><strong>Professional Qualifications (See Footnote)</strong></td>
<td>Fellowship in Dental Surgery or Membership of the Faculty of Dental Surgery, or equivalent</td>
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<td>Masters degree in Dental Public Health or equivalent</td>
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<td>Intercollegiate Fellowship Examination in Dental Public Health or equivalent</td>
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<td>Higher Degree by Thesis (Honorary Consultants for Academic Appointments only)</td>
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## Training (see footnote)

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<td>Successful completion of an SAC – approved four-year minimum training programme in Dental Public Health or within six months of completion or equivalent</td>
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<td>CV/Interview</td>
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<td>Current holders of an NHS or honorary NHS consultant contract in Dental Public Health are eligible to be shortlisted</td>
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<td>Applicants who are Nationals from another European country or elsewhere overseas would have to show equivalence to the four years’ minimum training period in the NHS required for Dental Public Health</td>
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## Teaching

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<tr>
<td>Experience of postgraduate and undergraduate teaching</td>
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<td>CV/Interview</td>
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<td>Training in teaching</td>
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## Audit

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<td>Effective participation in clinical audit</td>
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<td>CV/Interview</td>
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| RESEARCH | Research relevant to the Dental Public Health  
| Ability to appraise scientific literature critically | CV/Interview |
| MANAGEMENT | Able to prioritise and deliver high quality work against a background of change and uncertainty  
| Experience of achieving innovation and change | CV/Interview |
| PERSONAL | Strongly held commitment to improving health including dental health, public health ethics and fostering learning environment  
| Articulate and able to advocate for health | Interview |
| Commitment to team working  
| Excellent written, oral and presentation skills  
| Strategic thinker  
| Self-motivated, proactive and innovative | |
| GENERAL | Satisfactory pre-employment health screening | CV/Interview |

**Footnotes:**

The professional qualifications and training requirements listed apply to individuals who are currently undertaking training to consultant level, or have completed specialist training within the last few years. Existing consultants, and other individuals who have gained entry to the specialist list during the mediated entry period, will not be expected to hold all or any of these professional qualifications and might not have followed the established training pathway, which is why the term ‘or equivalent’ is used.
Note:

No model job plan has been provided for Consultants in Dental Public Health, due to the impossibility of providing this kind of standardised documentation for this specialty. This is because Consultants in DPH do not work to a timetable in the same way that clinical consultants do. Under the new consultant contract, individuals do agree the numbers of PAs assigned to supporting activities etc., but the numbers involved vary significantly according to individual posts and responsibilities.