



Faculty of General Dental Practice (UK)  
The Royal College of Surgeons of England



## *Department of Health/Faculty of General Dental Practice (UK)*

Guidelines for the appointment of Dentists  
with Special Interests (DwSIs) in Orthodontics



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# Executive Summary

## 1. Introduction

Orthodontics is the branch of dentistry concerned with growth and development of the face, development of the dental occlusion and the correction and prevention of occlusal abnormalities.

- Levels of provision of orthodontic care vary widely. The introduction of DwSIs in Orthodontics can improve access to orthodontic assessment and care to meet local needs. Quality assurance of the DwSI service will be underpinned by clinical governance and audit.
- From October 2005, Primary Care Trusts (PCTs) will contract directly with primary care dentists for orthodontics, either by means of specialist orthodontic Personal Dental Services (PDS) contracts or for small numbers of cases within the base contract.
- The contract will be based on need and not demand.

## 2. Clinical network

- The local orthodontic managed clinical network should liaise with the PCT to establish appropriate clinical pathways and be responsible for standards of clinical care. Where there is an unmet need for orthodontic care, the PCT, in conjunction with the local clinical network, should use an appropriate skill mix to assess needs and priorities for care.

## 3. Assessment of needs, treatment care and outcomes

- Treatment care provided by the DwSIs will be defined through the competency framework for a DwSI in Orthodontics.
- Index of Treatment Need (IOTN) will be used to assess the need for treatment within the clinical network and only those patients falling into categories of IOTN 5, 4, and down to 3.6 would have a demonstrable need for treatment and have access to treatment.
- Peer Assessment Rating (PAR) Index will be used to assess outcome.
- Outcome monitoring will be based on national and locally determined clinical governance to ensure best treatment outcomes.

## 4. Orthodontic practice requirements

- There will be a practice visit to ensure that the practice meets requirements for best clinical practice and clinical governance necessary for the provision of orthodontic treatment.

# Introduction

The *Guidelines for the appointment of Dentists with Special Interests (DwSIs) in Orthodontics* is one of a series of framework documents jointly developed by the Department of Health and Faculty of General Dental Practice (UK).

The frameworks aim to provide guidance to Primary Care Trusts (PCTs) on the development of local DwSI services, and include the competencies for the scope of treatment that can be undertaken by DwSIs.

The orthodontic guidance has been written in conjunction with the British Orthodontic Society, primary care dentists, specialists, consultants, university departments, dental faculties, PCT managers, Strategic Dental Health leads and patients.

The guidelines apply to England and should be read in conjunction with *Implementing a Scheme for Dentists with Special Interests (DwSIs) May 2004*, and *A Step by Step Guide to Setting up a Dentist with a Special Interest (DwSI) Service* available on the Chief Dental Officer's section of the Department of Health website at [www.dh.gov.uk/cdo](http://www.dh.gov.uk/cdo) and the FGDP(UK) website at [www.fgdp.org.uk](http://www.fgdp.org.uk).

## Why do we need DwSIs in Orthodontics?

1. In some parts of the UK there is a lack of availability of orthodontic care to meet the need for orthodontic treatment. An accessible primary care orthodontic service is required, with treatment outcomes matching the best achievable. Authors consistently report the following relationship:

33% need no treatment (IOTN Grade 1)

33% have a slight to moderate need of treatment (IOTN Grades 2&3)

33% have a great or very great need for treatment (IOTN Grades 4&5)

2. Approximately 50% of 12 year olds would fall into the IOTN categories 3.6 and above and would benefit from a needs assessment for orthodontic care and possibly treatment.<sup>1</sup> There is also a shortage of orthodontic specialists with an uneven geographical spread<sup>2</sup> with some primary care dentists carrying out a significant amount of orthodontic treatment. There is a need to manage and recognise where appropriate the contribution of primary care dentists to orthodontic services.
3. In future some primary care dentists may wish to develop their orthodontic skills and have them recognised. PCTs may wish to develop their clinical network in orthodontics using a skill mix to meet local clinical needs. It will also be important to establish an appropriate training process for the future, which is sensitive to local needs.

### What is a DwSI in Orthodontics?

4. A DwSI in Orthodontics is a primary care dentist with all round experience and training in general dental practice, who has developed a special interest in orthodontics but is not a specialist. He or she will have gained additional training and/or experience in orthodontics.
5. A DwSI in Orthodontics will have to demonstrate a continuing level of competence in their generalist activity and an agreed minimum level of competency in orthodontics.
6. The role of the DwSIs within the clinical network is to treat cases within their competence and to refer patients outwith their competence. This may be to a consultant orthodontist for advice and treatment planning so that they can treat the case themselves. Complex cases will be referred for treatment to a specialist orthodontist or into the hospital orthodontic services. If treatment is not progressing as planned the patient should be referred to the local consultant for advice. The treatment may be taken over within the hospital service or by an orthodontic specialist practitioner.
7. Whilst not offering the same range of clinical activity, the DwSI will be required to practise to a standard consistent with that expected from established specialists in the discipline.

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1 Holmes A. *The prevalence of orthodontic treatment need*. Br J Orthod 1993; **19**: 177-182

2 Willmot D, Robinson PG, Parkin N, Hall A. *An Orthodontic Workforce Survey of the United Kingdom. The Preliminary Report. The Available Orthodontic Workforce and its Distribution*. School of Clinical Dentistry, University of Sheffield; July 2004

## Orthodontic clinical network

8. The orthodontic clinical network is a group of orthodontic practitioners providing orthodontic care. This will consist of consultant orthodontists, orthodontic specialist practitioners, primary care dentists with a special interest in orthodontics and a representative of referring dental practitioners. The university orthodontic department will be represented when appropriate. The lead will usually be a consultant or specialist.
9. The make up and balance of the network will vary within PCTs and Strategic Health Authorities depending on the local orthodontic workforce, as there will be a geographical variation in the distribution of orthodontic specialists and DwSIs.
10. The orthodontic network will work with the PCT to ensure appropriate needs assessment, development of the service and monitoring standards of delivery and outcomes of care.

# Competency Framework for a DwSI in Orthodontics

## CORE KNOWLEDGE

11. **The DwSI in Orthodontics will be expected to have knowledge of:**
  - The normal and abnormal development of the dentition.
  - The interrelationship between soft tissues, skeletal pattern arch form, tooth size variation that contribute to developing and manifest malocclusions and the limitations they may impose on treatment outcomes.
  - The physiology of tooth movement and how this affects treatment
  - The need for appropriate records to monitor development and treatment.
  - The attributes and limitations of active removable appliances.
  - The attributes and limitations of functional appliances.
  - The material science of orthodontic wires, bonding material and cements and how these effect treatment.

- The theories of bracket design and how this affects treatment.
- Knowledge of retention and stability

12. **The DWSI will be expected to treat cases within their competency**

- Recognise developing and manifest malocclusions.
- Orthodontic case assessment, including space assessment in mixed and permanent dentition.
- Be able to recognise those cases outside their competency (ref 3).
- Interpret appropriate radiographs.
- Apply IOTN to the cases they see and advising patients on the need or otherwise for orthodontic intervention.
- Advise patients on the risks and benefits of orthodontic interventions.
- Obtain informed consent for orthodontic treatment.
- Obtain appropriate clinical records.
- Timely referral to specialist or hospital consultant for treatment planning and/or treatment.
- Carry out or arrange appropriate referral for orthodontic extractions.
- Manage active removable appliance therapy.
  - Obtaining impressions for active removable appliances and providing detailed design prescriptions for their construction.
  - Fitting and routine adjustment of active removable appliances.
  - Monitoring the progress of active removable appliance therapy and identifying when it is not proceeding appropriately and intervening as necessary.
- Manage functional appliance therapy.
  - Obtaining impressions and functional occlusal records for functional appliances and providing detailed design prescriptions for their construction.
  - Fitting and routine adjustment of functional appliances.
  - Monitoring the progress of functional appliance therapy and identifying when it is not proceeding appropriately.
  - Intervening as necessary when progress is unsatisfactory.

- Manage fixed appliance therapy.
  - Choosing and fitting bands and brackets.
  - Placement of arch wires in an appropriate sequence
  - Adjusting and coordinating arch wires to appropriate intercanine width and arch form.
  - Placing appropriate Curves of Spee for overbite reduction.
  - Managing intra arch traction for space management and centre line correction.
  - Managing inter arch elastics for incisor relationship correction and buccal segment interdigitation, including cross elastics.
  - Managing anchorage control and recognising when problems are developing and seeking appropriate advice.
  
- Construct, fit, adjust and supervise appropriate retainers.

## Evidence of Maintenance of Competencies

13. The DwSI will be expected to maintain his/her competencies through continuing professional development (CPD) and education. It is recommended that he/she undertakes CPD relevant to their special interest area, as part of the general and verifiable CPD requirements laid down by the GDC.

## Accreditation of DwSIs in Orthodontics for PCTs

### Contract Specification

14. The contract for a service provided by a DwSI should specify:
  - 14.1 The core activities and the competencies required.
  - 14.2 The types of patients and clinical problems suitable for the service including age range, Index of Orthodontic Treatment Need (IOTN) for treatment, minimum caseload, medical status and reasons for referral.

- 14.3 The facilities and staffing that must be present to deliver that service (Appendix 1).
- 14.4 The clinical governance, accountability and monitoring arrangements, including links with other orthodontic practitioners working in primary care, at PCT level and in Acute Trusts.
- 14.5 The baseline contract will normally be for three years, because of the time taken to treat orthodontic cases.
- 14.6 Remuneration at an appropriate level

## Appointment of DwSIs in Orthodontics with PCTs

15. In appointing a primary care dentist with a special interest in orthodontics, the PCT should consider:
  - 15.1 The development of a managed local clinical network appropriate for the delivery of the necessary services and need for orthodontic care.
  - 15.2 The views of key people in delivering the orthodontic services locally, including the consultant orthodontist, specialist orthodontic practitioners and clinicians and managers in other relevant Acute and Primary Care Trusts, and local general dental practitioners. It is important that the primary care dentist with a special interest in orthodontics commands the support and respect of others involved in delivering orthodontics and of potential service users.
  - 15.3 Evidence of generalist primary dental care competencies. The DwSI will be able to demonstrate a continuing level of competence in their generalist skills. Evidence of training and experience in generalist skills should be provided through a portfolio approach and should demonstrate competence in the following areas:

Clinical Record Keeping

Infection Control

Legislation and Good Practice Guidelines

Medical Emergencies

Radiography

Risk Management and Communication

Team Training

- 15.4 The FGDP(UK)'s *Key Skills in Primary Dental Care* is one means by which generalist skills can be demonstrated and independently assessed. The Key Skills assessment is part of the MFGDP(UK) coursework module which provides a portfolio approach to the validation of general fitness to practice. The case and audit requirement of the MFGDP(UK) coursework module can be met through the overall requirements for the assessment of special interest competencies.
- 15.5 Evidence of successful acquisition of the defined special interest competencies. While an appropriate diploma or proper formal training process would usually be a credible source of evidence of the acquisition of competencies, many applicants will offer other experience based evidence. (This is dealt with in paragraphs 22 to 24.)
- 15.6 Before the service can be delivered, the following should be in place:
- The support of the local population, primary care dentists, the consultant orthodontist, specialist orthodontic practitioners, PCTs and Acute Trusts.
  - Induction, support and continuing professional development arrangements for the DwSI and team.
  - The facilities and staffing to allow satisfactory delivery of orthodontic care (refer to Appendix 1).
  - Local guidelines on the use of the service should be developed by the PCT in consultation with the clinical network.
  - Monitoring and clinical audit arrangements.
  - Appropriate indemnity cover. If the primary care dentist is employed directly by the PCT or Acute Trust, they will be covered by the Clinical Negligence Scheme for Trusts run by the NHS Litigation Authority. The PCT should notify or discuss their proposed scheme with the NHS Litigation Authority and their own legal advisors. If the primary care dentist is an independent contractor, then he/she will normally be covered by his/her professional indemnity provider. However, in all circumstances the primary care dentist should notify his/her defence organisation.

## Monitoring of the Orthodontic Service

16. The PCT, in reviewing the service and the DwSI's work (through clinical governance, annual appraisal, annual review of the contract and future revalidation requirements), should seek the following:

- 16.1 Evidence that the guidelines for use of the service are being followed.

- 16.2 Evidence that the caseload is appropriate.
  - 16.3 Evidence of relevant continuing professional development in general and special interest area, clinical audit, exploration of the views of patients, carers and other health professionals, peer observation and compliance with future revalidation requirements.
  - 16.4 Evidence of involvement in appropriate clinical governance arrangements, including when appropriate in the local Acute Trust(s).
  - 16.5 Evidence of satisfactory process and outcomes of care i.e. IOTN and PAR measurements, including patient views. (Refer to Appendices 3&4.)
  - 16.6 Evidence that the individual's generalist service is not being adversely affected.
- 17 Dentists who are appropriately registered in EU countries and who apply for DwSI posts or contracts will need to demonstrate the competencies through equivalence.

## Primary Care Trusts – needs assessment and delivery

18. Primary Care Trusts will want to identify their priorities in the context of key national policies (e.g. NHS Plan, National Service Frameworks), local needs and local service delivery. In order to meet a priority, a service may require reconfiguration. PCTs in an area should work together or singly to consider the options for service development. These options will include hospital outreach, community based clinics, orthodontic specialists or the appointment of a primary care dentist with a special interest. In deciding how to develop the service the PCT may also wish to consider the views of other trusts and of the current orthodontic service providers. Dental public health colleagues may provide an assessment of needs and demands to determine if the service is a priority for development.
19. If it is decided to appoint a primary care dentist with a special interest in orthodontics as part or all of a service development, then the PCT (acting singly or as a lead PCT for local PCTs) should make an appointment after due process in line with this guidance and in collaboration with relevant stakeholders including clinicians and providers.
20. In the circumstances where there are no appropriately skilled candidates, the PCT (acting singly or as a lead PCT for local PCTs) may consider sponsoring a suitably motivated local primary care dentist on an appropriate programme to acquire the necessary competencies.

21. As in all commissioning decisions, the PCT should review the appointment annually. In the case where the PCT is both commissioner and provider, there is a special responsibility to review service quality rigorously. In doing so, it will wish to take into account the views of the local health community and service users, clinical governance and audit data, and the outcomes from appraisal. It will need to be satisfied that the post continues to meet a local priority.
22. Any such service development needs to be sensitive to teaching and training requirements in the locality and should not prejudice undergraduate and postgraduate teaching and training.

## System of Assessment and Evidence required to demonstrate Competency

23. It is important that the DwSI service provided meets local needs and that the knowledge, skills and experience of the DwSI are appropriate to the service requirements.

### Sources of Evidence

24. Applicants will be able to offer a range of evidence as confirmation of competency which may include both formal qualifications and experiential evidence. This will be in addition to and development of GDC's First Five Years and Dental Vocational Training. Experience and knowledge gained in General Professional Training will be considered if undertaken.

### Requirements

25. **The DwSI in Orthodontics will be expected to:**
  - Have an understanding of occlusion and its development.
  - Be able to diagnose and recognise malocclusion and know when to intervene
  - Be able to assess the need for orthodontic care
  - Know when to refer or provide treatment within their competency
  - Understand the limitations of appliance therapy and be able to demonstrate clinical skills

Table 1

Requirements	Suggested sources of evidence
Understanding of occlusion and its development	BDS, DVT, GPT if undertaken
Be able to diagnose and recognise malocclusion and know when to intervene	Structured clinical assistant training scheme, hospital/orthodontic specialist practice clinical attachment or other experience-based evidence
Be able to assess the need for orthodontic care, use IOTN and refer or treat within competency	Structured training as part of a local orthodontic clinical network
Understand the limitations of appliance therapy and be able to demonstrate clinical skills	Have satisfactorily completed cases within the NHS, using indices such as PAR to validate the standard. Peer group assessment. Present treated cases on request
Maintain quality of treatment and standards	Have verifiable relevant CPD and attendance at orthodontic courses. Be a member of appropriate orthodontic study groups and societies
Demonstrate evidence of formal monitoring and its outcomes	DPB, Clinical audit
Clinical Governance	In practice and clinical network governance activities, within current good practice. Evidence of peer review e.g. mentoring arrangements

26. In future, training for DwSIs should be developed by representatives from the Faculty of General Dental Practice (UK), the Faculties of Dental Surgery, the British Orthodontic Society and clinical teachers. The future appointment of DwSI trainees to training programmes should be sensitive to the treatment needs of local communities throughout England and should be made in consultation with the relevant orthodontic clinical network and the PCTs.

## Process

27. The process will usually be an evaluation of the evidence presented in the applicant's portfolio of evidence
28. The evaluation should be carried out by a local accreditation panel, which would normally include a consultant and or specialist in the clinical area, an FGDP(UK) representative, representing primary care dentistry, a Local Dental Committee representative and a PCT representative.
29. PCTs may consider it appropriate to interview potential candidates for accreditation as DwSIs.

# Appendix 1

## Orthodontic Practice Requirements

PCTs that place a contract for service with a dentist with a special interest in orthodontics need to ensure that the service they commission is, in all its aspects, fit for purpose – the commissioner, in the event of any untoward incident, having a vicarious liability. This includes ensuring that the standards of facilities and support staff available for a particular service at each site meet contemporary standards.

Many of these standards will have been checked via the local general dental practice inspection system, but additional requirements for the practice of a DwSI in Orthodontics will need to be defined and monitored on an annual basis.

To provide orthodontic treatment the practice needs additional facilities and equipment as follows:

1. Access to radiographic equipment for panoramic x rays and access to lateral cephalometric X-rays is desirable.
2. Photographic equipment is desirable.
3. There should be storage and retrieval systems for orthodontic study casts.
4. There should be an adequate supply of orthodontic instruments and materials to carry out orthodontic treatment and cross infection control procedures.
5. The support staff, in particular the dental nurses, should have additional training in orthodontic techniques.

6. There should be an ongoing training programme to develop and maintain skill levels of all members of the orthodontic team.
7. There should be practice literature and patient information leaflets for orthodontic treatment.
8. There should be a designated appointment time for the provision of orthodontic treatment within the contract and time available for orthodontic non-medical emergencies.
9. There should be administrative and secretarial support.
10. There should be access to a laboratory for the provision of orthodontic appliances to an appropriate standard.

## Appendix 2

### Treatment Protocol, British Orthodontic Society, 2005

#### TREATMENT PROTOCOL

Treatment will normally be completed with fixed orthodontic appliances in both arches. Treatment of a single arch should only be undertaken where this would be sufficient to achieve the requisite quality of outcome. Removable orthodontic appliances may be used for minor tooth movements and as an adjunct to fixed appliances. Functional orthodontic appliances will be used when necessary to correct antero posterior occlusal discrepancies. Anchorage reinforcement with lingual arches, palatal arches and extra oral traction should be used when appropriate.

A high standard of outcome is expected. The following principles indicate the features to be aimed at in treating a case:

- The dental arches should be fully aligned with all rotations and mesiodistal inclinations corrected.
- The occlusal planes should be levelled.
- The overjet and overbite should be corrected to give cingulum contact between the incisors.
- The buccolingual or labiolingual inclination of the teeth should be within the normal range except where dentoalveolar compensation for skeletal discrepancies is necessary.
- The centrelines should be coincident.

- The buccal segments should interdigitate fully.
- Extraction spaces should be closed with roots of adjacent teeth parallel.
- Crossbites should be corrected.
- Centric occlusion should correspond closely with centric relation.
- The lower intercanine width should not be increased. Lower incisors should not be advanced if they are already proclined, and in general should not be advanced more than approximately two millimetres unless there is evidence that they are abnormally retroclined. Expansion beyond these limits should be the exception and only undertaken with informed consent regarding the risk of instability and the need for long term retention.

Retainers should be fitted and supervised as required to maintain tooth position.

Treatment outcome in individual cases will be assessed according to the above principles. It is acknowledged that it is not possible to achieve an ideal occlusion in every single case and the PAR index or an alternative index will therefore be used additionally to allow a profile of the practitioner's overall treatment standards to be drawn up.





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