

Title Page

Primary care training for Oral Surgery: Challenges and Possibilities

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Stand first

This article aims to highlight funding, regulation, governance of dental specialist training and raises some advancing issues that we need to consider.

Since Lord Darzi's NHS paper 2000¹ the aspirations of modifying NHS health care were to establish a health care system that is;

- **Fair:** equally available to all, taking full account of personal circumstances and diversity;

- **Personalised:** tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice;
- **Effective:** focused on delivering outcomes for patients that are among the best in the world;
- **Safe:** as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive;
- **Locally accountable:** so that staff are empowered to lead change and innovate locally, ensuring that this is based on the best clinical evidence, meets local needs, and is the product of engagement with patients and the public.

Introduction

There are considerable changes in delivery of NHS health care.²⁻⁹ In line with the Darzi report medical and dental services should be provided in a suitable environment accessible to all mainly in primary care providing in essence;

- Right patient
- Right Care
- Right time
- accessible

Quality was not specifically alluded to, however, the development of the CQC overseeing registration and continued monitoring of the provision of health care we hope will ensure the best possible standards of care not just delivering 'acceptable care'.⁹

In Training for the NHS workforce⁷ a Health Minister Lord Hunt said:

"It is important that the NHS has the freedom to manage training so that workforce development reflects the healthcare needs of the local population. However we expect this

agreement to put training plans on a much firmer footing so that the investment we have made will enable Strategic Health Authorities and their local universities to work together to produce a well-trained NHS workforce that can deliver improved patient care.

Uniquely the NHS is structured like a layer cake, with primary care as the base, secondary care in the centre and tertiary care at the top. Most patient pathways do not need to progress beyond the bottom layer, and may involve non-NHS organisations like schools, care homes or charities. Currently investment in medical and dental education and training is, however, largely based on the top two layers. Universities are the main provider of medical and dental student education in the UK; however, its delivery, especially the clinical years, often takes place in National Health Service hospitals.

What's happened in medicine? The NHS Plan (DoH, 2000)¹ identified that the majority of people with mental health problems are managed in primary care.

General medical practice has seen the development of doctors with special interests are well established¹⁰ with specialised training courses for doctors¹¹ [GP's, GPSI's, GP Registrars], as well as other Primary Care Practitioners including Nurses, Podiatrists, Chiropodists and Pharmacists. Minor surgery skills courses are run and all courses are delivered by enthusiastic highly experienced trainers. The Minor Surgery Courses are fully accredited for CPD by CORAS and have also been approved by the local Post-Graduate Deanery, with PMETB¹² registration and funding. One must bare in mind that in general Medical practitioners are not so well rehearsed and trained in surgery compared with their dental practitioner colleagues, thus their surgical specialism in primary care is likely to be far less complex than the dental specialists portfolio.

With modifications in NHS care delivery shifting patient care out of secondary care into primary care settings, there a significant need for more integrated teaching and training to be undertaken in primary care. Investment in primary care specialist medical workers, both

doctors and nurses, aims to reduce pressure on secondary Care Trusts weighed down by the pressures of mounting GP referrals by provide an additional workforce trained in guided self-help to provide greater treatment choice to people with health problems.⁹ This process may be facilitated with the development of Local Education Commissioning Boards (LETBs)¹³ allowing commissioning of teaching and training in appropriate settings. The changes in dental education and training must take place within existing structures (regulatory, governance and financial) likely driving changes in commissioning, delivery and environment.¹³⁻¹⁶

Governance and structure of Post Graduate (PG) dental specialist training

Regulation and governance of PG training. Post graduate training and undergraduate teaching for the health care professionals is regulated by the professional bodies (General Dental Council [GDC] for dentistry).¹³ For post graduates the GDC regulate training up to and only specialist level, which does not include consultant training, the training and appointment of which is overseen and standard set by the specialist associations and colleges. The governance and structure for the PG dental training is provided by post graduate deaneries¹⁵ and Royal Colleges via Deanery Surgical Training committees (STCs) chaired by Training Programme Directors and at the Colleges' Specialist Advisory committees (SACs) who liaise, via the Joint Committee for Specialist Training in Dentistry (JCSTD), with the Dental education board of the GDC.¹⁶

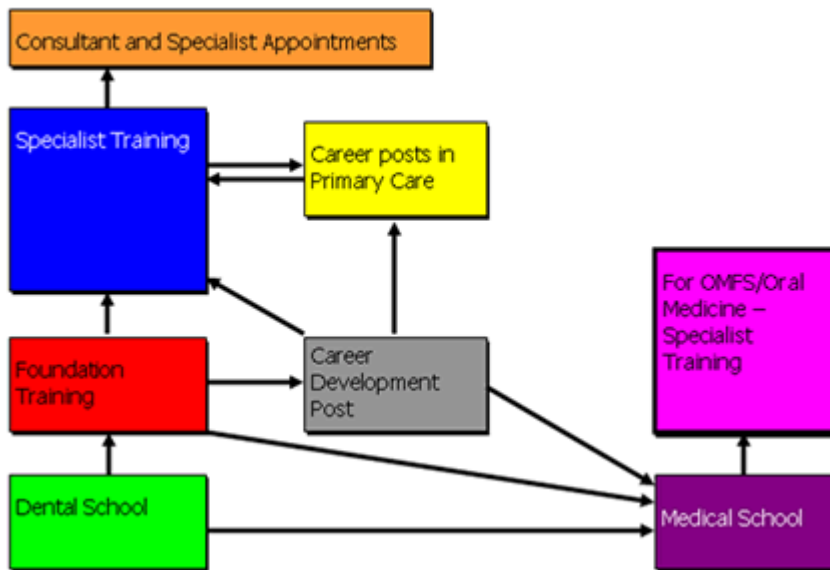
Through their Training Programme Directors, Postgraduate Deans (or their nominated deputies) are responsible for developing appropriate specialty training programmes within educational provider units that meet curriculum requirements.¹⁵ The Specialist Dental Education Board (SDEB), usually in liaison with college SAC, quality assures deanery processes to ensure that the training programmes meet the required standards. These are based on Health Education England (HEE) standards. Medical post graduate training is

regulated and monitored by post graduate medical education and training board (PMETB).¹²

In contrast dental PG training is overseen by 3 bodies

1. **General Dental Council** is the sole competent body via the Education committee oversees approval of the structure of UG¹³ and PG training programmes.¹⁴
2. The SDEB approve curriculae¹⁴ of new specialist programmes in liaison with the **SAC** (Specialist advisory board) based at the RCSs.
3. The **Dental Deanery** quality assures the education during the PG training funding the training numbers with MADEL monies and ensuring that the curriculum is delivered by appropriately trained providers. The dental gold guide lays out the structure for the trainees.¹⁵ Assessment of PG training is performed via the ARCP process and oral surgery has piloted mandatory competencies using the ISCP¹⁷ (Intercollegiate Surgical Curriculum Programme) which involves online registration by the trainee of work based assessments with validation and rating by trainers. The ISCP involves an annual fee and informs the ARCP. Providers of dental education are tiered into 3 categories (1=VT trainer, 2= primary care specialist trainer (equivalent to Training Programme Director- requiring a PG Certificate and Training the trainers training, requiring mandatory training and Equality & Diversity training) and 3 Consultant /specialist educational and programme leads.

Figure 1 Diagram illustrating training pathways



A qualitative study examined the views of clinical governance leads in South West England on the development of clinical governance in education and training, and its relationship to education in primary care¹⁸ and concluded that existing educationalists will need to change their role within the new structures, and this should be an evolutionary rather than a revolutionary process.

Training and Education funding

Health care professional education funding occurs via Health Education England (HEE) the Universities receive a Higher Education Funding contribution for delivering undergraduate education (HEFC), which has been significantly decreased over the last 2 years. NHS Trusts are also paid for the privilege of education undergraduate health professionals through service increment for teaching (SIFT). This may be for medical or dental (D SIFT and medical training for dentists).

The history of where the training monies for post graduates are allocated is complex: The Multi Professional Education & Training (MPET) budget was created in 1996.¹⁹ The Service Increment for Teaching (SIFT) component of Medical post graduate education training

(MPET which includes dental monies)²¹ covers the costs to the NHS of supporting the teaching of medical and dental postgraduates. It is not a payment for teaching as such but for the provision of infrastructure; facilities, support staff, appointments system etc. For example, consultants in an outpatient clinic or a GP in a surgery generally see fewer patients if students are present. This funding from HEE is intended to meet this sort of excess cost, rather than pass it on to healthcare purchasers. Medical and Dental Education Levy (MADEL), supports the basic salary costs, and some non-pay costs of medical and dental trainees.²² An excellent overview of current funding of medical and dental education is provided by a recent University Focus paper.²¹

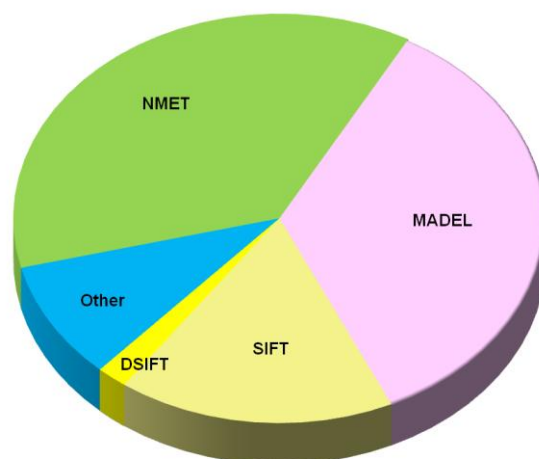
Thus in summary the funding streams supporting the practice experience of health care professionals undergoing post graduate clinical training may consist of the following three elements:

1. Non-Medical Education and Training (NMET), the majority of which is spent on pre-registration training for nurses, midwives and allied health professionals.¹⁹
2. Medical and Dental Education Levy (MADEL)²⁰, which supports the basic salary costs, and some non-pay costs, of junior doctors and dentists in training, as set out in EL(92)63. However study leave and the infrastructure costs of providing Postgraduate Medical and Dental Education are also funded. Funding for the salary element is based on the number of training posts accredited with the appropriate educational approval. Additional posts are funded via the Workforce Numbers Advisory Board's process of projecting national consultant requirements. These monies are currently allocated and governed by medical and dental deaneries (currently 10 in England). However this structure is undergoing significant change and in addition the health Workforce is undergoing further scrutiny.

3. National Institute of Health Research (NIHR) part funds integrated academic training posts contributing 25% towards Academic clinical Fellows [ACFs] for 3 years and 50% towards Academic Clinical lecturer posts [ACLs] for 4 years.
4. Self funded programmes. Already many Restorative mono-specialties training posts are self funded and there have been recent appointments in other Training programmes for self funded trainees.

Example of the distribution of the various funding streams for PG healthcare training is illustrated in Figure 2.

Figure 2 Example of education and training funding distribution for West Midlands (2010)²²



Developments in clinical governance, Care Quality Commission (CQC) structures within the NHS have meant that there is now increased scrutiny and transparency in the funding of clinical services. However lack of similarly robust educational governance structures has led

to the risk of educational funds being used to deliver clinical services. One paper examines the current role of SIFT funding for training in psychiatry and the possible ways forward, using a case study.²³

The Department of Health (DoH) has centralised commissioning of dental clinical care commissioning based on agreed specialist care pathways.^{9,24} Local education boards will commission funding for learning and development for the healthcare workforce and be reorganised on an interdisciplinary basis, ending the rigid demarcations between NMET, MADEL and SIFT.²¹ This change is likely to be accompanied by a new name for MPET. LETBs will work in partnership with higher education institutions and NHS bodies in their area in order to plan their investment in education and workforce development based on the workforce needed to deliver services required by patients. Challenges facing health education and training has been well summarised in July 12 by Universities focus group.²¹

Commissioning of care will be based upon Pathways for health care delivery, local patient needs and workforce requirement.²⁴ Clinical Care Pathways for dental specialists are currently being drawn up by specialist panels in liaison with the department of health all chaired by Professor Paul Brunton (Oral Surgery, Paedodontics, Endodontics in development). Therefore providing an opportunity for education and training to be commissioned more closely defined by applying a learning architecture model to care pathways whilst simultaneously informing workforce needs.^{25,26} The Map of Medicine palliative care pathway,²⁷ for instance, takes place entirely in primary care, which is often in accordance with patient choice. It involves multiple agencies, which can often be a negative factor in patient experience. An analysis of the pathway reveals many potential training and learning needs, which would be difficult to meet using traditional models of health care education.²⁵

Some changes include;

- The Strategic Health Authority, or their replacements (NHS Trust Development Authority [NTDA]) will encourage LETBs (local education training boards) to use the multi-professional education and training (MPET) levy to commission training and learning inputs which support evidence based care pathways.
- Training and learning inputs, including investment in the learning infrastructure, will be multi-professional where appropriate, and will be delivered across sectors where there is an identified patient need, mainly primary care for dentistry.
- Training and learning strategies to support care pathways will be commissioned by LETBs and will be linked closely to plans to deliver world class commissioning, in which case for dentistry will be nationally based.
- Consideration must be given to self funded programmes, particularly as it is acknowledged that many specialists will undertake a mainly private workload which supports focussing NHS funded programmes for NHS commissioned care pathways.

Health care commissioners and training commissioners (LETBs) must ensure that local Learning and Development Agreements properly reflect the requirements of providers' workforce delivery plans and are aligned with the agreed clinical vision for service provision'.⁹ The key principles of the Learning and Development Strategy will also have to be reflected in the Learning and Development Agreements between the Strategic Health Authority and NHS Trusts.²¹

The challenge now is to work towards incremental change of this investment pattern, so that education and training is commissioned and delivered to enable the workforce to operate within the 21st century health care environment, and deliver patient specified, personalised care, as described in Lord Darzi's vision.⁹

A key principle for the NHS will be the alignment of education and training commissioning with agreed clinical vision, in line with the guidance given by the Operating Framework 2008/09 (see 1.2 above). Agreed clinical vision will be based on best evidence, presented in

the form of a care pathway and confirmed by commissioners, working to the Department of Health's strategy for World Class Commissioning.⁹

Current PG dental training in primary care includes;

Dental Foundation training- The concept of a two-year dental foundation programme builds on the UK Departments of Health white paper "Creating the Future: Modernising Careers for Salaried Dentists in Primary Care"²⁶ that is broadly comparable to the structured two year General Professional Training (GPT) programme which has been available for a proportion of graduates in the UK.²⁶ The availability of dental VT is provided for all UK qualifying dentists. However due to ingress of European dentists to the UK and the new VT entry assessment some UK dental graduates have been unable to access VT training. It is imperative that this process is informed by workforce developments in dentistry.²⁷ Vocational Training (VT) curriculum, portfolio is provided and quality assured by the Deanery, in line with HEE regulations and structure (Figure3).^{28,29} Estimated costs for VT are £150K per year of training (including 29-30K for the VT salary, 15% on costs, 80K trainer salary, 4000 additional UDAs and support costs for clinics and nursing). Interestingly in medicine the training of General Medical Practitioners and Specialists do not have such prohibitive training costs as there is no patient on cost just the trainee's salary. The structure of the programme includes;

- **Foundation Year 1 (DF1)** For the majority of foundation dentists this will equate to one year vocational training based in general dental practice. However, a minority of programmes may have a HDS/SDS post in DF1.
- **Foundation Year 2 (DF2)** For the majority of foundation dentists this will involve 6 or 12 month posts in HDS/SDS. Other models may include experience in primary care.
- **Section 63** Dental Act the Dental Deaneries are allocated £160 per NHS dentist

registered within the deanery for free continued education at the point of delivery.³⁰

Figure 3 Figure outlining requirements for clinical health care training.²¹



As yet commissioning of dental care is not co-ordinated with education and training and is surely a missed opportunity. Perhaps with the LETBs development, more opportunities may arise for alignment of health care delivery and training. The structure of PG training is illustrated in Figure 4.

Specialist dental services in primary care Since 1 April 2006,⁴ primary care trusts have had responsibility for commissioning primary dental services to reflect local needs and priorities. This includes agreeing and monitoring local contracts with dentists or corporate bodies for the delivery of primary dental services and the development of salaried primary dental care services dentists with a special Interest. However with recent changes in government commissioning for dentistry may well be centralised for England. Based on audit undertaken in the South West Deanery (2011) only 10% of GDPs regularly undertake extractions in primary dental care.³¹ This alarming low rate of willingness to undertake this care probably reflects lost opportunities in undergraduate education and foundation training

but mainly perverse incentives in the 2000 dental contract that paid dentists UDAs for referring cases (mainly ending up in secondary care).³²

The introduction of the new dental contract currently being trialled will prevent the inappropriate referrals by GDPs to secondary care.³³ Primary dental care can also include more specialist services, such as orthodontics, minor oral surgery, domiciliary care, and sedation. These services are usually provided by referral to another general dental practitioner and commissioned via local process for specific type and volume of service. Previously PCTs have provided funding for contracted services for about 300-500 cases (typically £100-350 per UDA/treatment [including pre assessment, surgery, radiography, post operative care and occasionally sedation] as against £60 for LA extraction provided by a general practitioner). The indemnity is provided by the primary care dentist unlike those in secondary care who benefit from NHS indemnity.

Dentists with a Special Interest The framework for accrediting and appointing Dentists with Special Interests, out with Deanery training QA, is proposed to give PCTs additional flexibility in deciding how to commission specialist dental services such as orthodontics, endodontics, periodontics and minor oral surgery (Department of Health/Faculty of General Dental Practice (UK). Guidelines for the appointment of Dentists with Special Interests (DwSIs) in Minor Oral Surgery) were published by FGDP (2006).³⁴ A dentist wanting to provide specialist practice may approach a PCT, however these will be replaced by central commissioning from April 2013)⁹ or the deanery may commission additional training, with funding from LETBs informed by workforce requirements and patient need.

Problematically there is no established quality assurance or structure for the provision of training for these posts. It is proposed that the dental advisor will be responsible for appointment of the clinician, who may have MFDS but may not be on the specialist list and the deanery may fund additional training for the practitioner. One example of this training is the Diploma in Primary Care Orthodontics RCS (Eng) A joint BOS/FGDP(UK) orthodontic

training programme aimed at the busy dental practitioner.³⁵ This programme, developed jointly by the British Orthodontic Society and Faculty of General Dental Practice (UK), is designed for primary care dentists wishing to enhance their skills in orthodontics and/or for those wishing to develop a special interest in orthodontics taking place over a three-year period, with academic teaching and clinical supervision.

Problems have arisen in the deficiency in ability of DwSIs applying for IMOS contracts and services provided by DwSIs discussed in separate papers within this supplement.

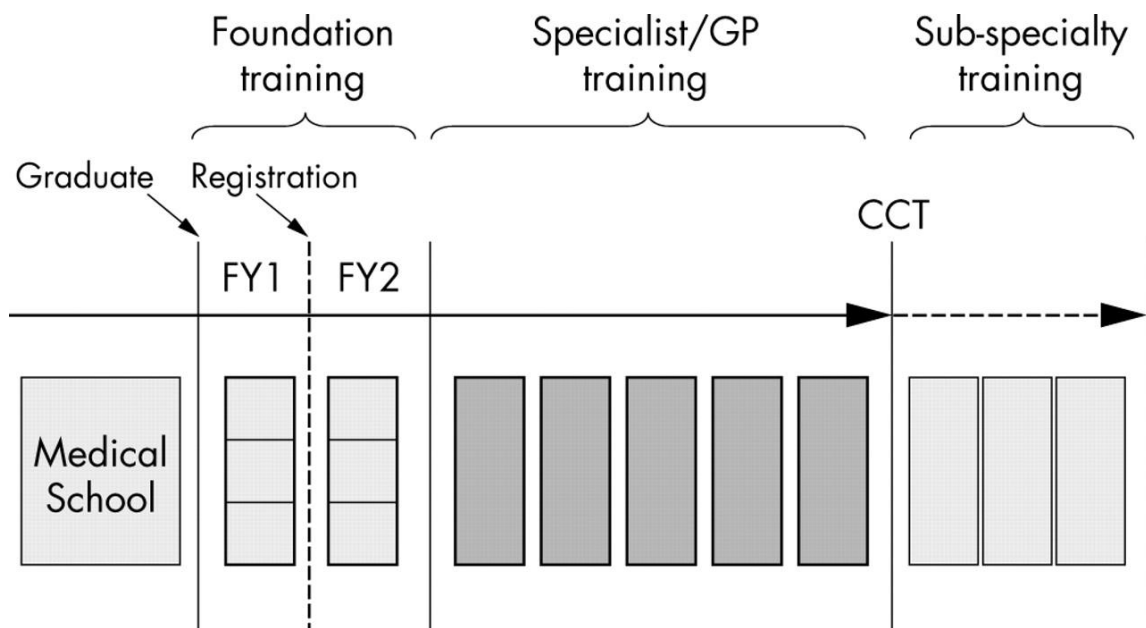
Salaried primary dental care services (SDS) In March 2006,^{36,37} the Department announced steps to take forward modernisation of salaried primary dental care services, following a wide-ranging review and consultation. There was overwhelming support in the consultation for continuing with a salaried option for dentists working in primary care and for developing a new pay spine for salaried generalists. The Department has invited NHS Employers and the British Dental Association to negotiate new pay arrangements for salaried dentists that will support the conclusions of the review and consultation. The restructuring into three grades A, B and C the latter being specialist practitioner. The SDS have set up specific training to provide C SDS practitioners, allocated by the director of the SDS, for IV sedation (courses currently provided in Newcastle, Liverpool and Glasgow), Special care dentistry and oral surgery (none formalised yet). Similar to the NHS SDS specialist training is covered by study leave budgets out of a specific education budget currently from the Deanery but in the future by LETBs.

In addition the **British Association of dental nursing** provide funding in conjunction for nurse training for IV sedation, health educator and orthodontics.

Pilot Specialist training for orthodontics Several years ago Southport PCT funded a GDP as an SPR in orthodontic training (PT over 5 years) and their training contract tied them into a post training 5 year contract for provision of specialist services to the PCT who funded the

training. Interestingly it has been announced at the national association of dental advisors that funding for commissioning of orthodontics will cease in 2012 as there is no demonstrable benefit in health care or improvement in a disease category (as defined by WHO). A Diploma I Orthodontics set up by the FGDP provides structured learning for DWSIs in orthodontics there is no recognised training for the equivalent in Oral Surgery. Deficiencies of dental foundation trainees training in oral surgery is discussed in a separate article within this supplement. These training opportunities may radically alter the funding for PG dental training in the near future, as it facilitates vertically integrated training, 'on the job'.

Figure 4 Figure illustrating structure of possible vertical integrated training in primary care from Dental Foundation Training to specialist training.



Oral Surgery specialist training in primary care

Most dentists are reluctant to even undertake simple extractions and this may be addressed by further training in VT/SHO training. Most 'specialist' practitioners in primary care are not specifically CCST trained specialists. This is due to recent changes in specialist lists many oral surgery clinicians have been grandfathered onto the surgical dentistry and oral surgery

specialist lists by the GDC. The subsequent merger of these lists has resulted in further huge variation in the relevant experience of these practitioners.

The shift of oral surgery service into primary care has been proven to be effective.³⁸ Primary care programmes for oral surgery training is evolving for example OS trainees in Northern Ireland rotate between secondary and primary specialist practice facilitated by an established OS integrated care network with multiple specialist practices. A recent pilot in Cambridgeshire has taught GPs additional OS skills within a specialist primary care community dental service. Development of these programmes requires a significant cultural shift and oral surgical specialist primary care training will also depend upon removing significant hurdles including;

- the availability of appropriately trained staff
- appropriate treatment tariffs
- longevity of commissioned contracts
- the availability of appropriate IV sedation necessary settings.

As a result many PCTs have introduced managed referral systems which triage all oral surgery referrals based on specifically designed proforma. These referrals are dealt with identified oral surgery 'specialists' in primary care. In Croydon³⁸ this resulted in a 90% drop in Max Fac referrals providing a more economic and efficient service (over 3400 patients treated a year), with no resultant hospital admissions as a result of care in the primary sector (the only available outcome measure of quality of care which is a very crude estimate of treatment outcomes and quality of service). Similar specialist oral surgery primary care pilots in Northern Ireland have also been very successful with extremely low rates of complications, hospital admission and high patient satisfaction.

The development of managed care pathways³⁹ in dental specialties will be underpinned by developing a consultant led care (both educational and clinical care delivery) working with specialists (in both primary and secondary care), DWSIs and GPs. There is no reason as to

why the teaching of UGs and training of dental foundation and specialist trainees is not simultaneously commissioned and provided. The quality of care, accessibility of service, cost-effectivity and efficiency of service would be improved by the alignment of **training with funding for commissioned care** (ideally with research too) in primary interfaced with secondary care where required. Significantly more OS specialists will be required to provide quality assured care possibly by;

- Identify lead specialists / consultants (team leaders) who organise and oversee an managed specialist clinical networks (MCNs) in both primary and secondary care with teaching and training;
 - identified agreed care pathways
 - referral agreements
 - regular team meetings
 - integrated team training
- Facilitate the development of primary care specialist NHS practices with aligned training and teaching
- Increase the number of established OS programmes within MCNs
- Encourage 'earn as you learn' strategy
- Allow self funded programmes
- Develop integrated vertical training aligned portfolios that allow prior learning and clear identification competency development and learning within the practitioners daily service delivery
- Maximise the use of the ISCP competency framework for Oral surgery and allow access to registered trainees out with current STR programmes
- Expand the SAC role to include these additional trainees

This model of training 'in hand' with service would support and facilitate the implementation

of oral surgery services recommended by MEE.⁴⁰

So how do we set up primary care specialist training?

There will be several requirements which include;

- Utilising the agreed specialist curriculae for the dental specialties
- Identify national training numbers via the Deanery/LETB funding either new posts (no current funding) or from other specialities negotiated based on current local needs. Increase the available MADEL funding support NIHR academic trainee posts as future educationalists and researchers.
- Identify team leaders in clinical service or teaching and training. These would be 2 consultants based in both primary and secondary care working with additional primary care specialists. All potential trainers will need to be tier 2 dental educators with appropriate training again implicating further training costs by the deanery. Additional negotiation would be required with the PCT for additional UDAs (similar to VT scheme), nurses salary and clinical space. These additional costs will be based on whether the trainees will be 1on1 trained (probably necessary for 1st year) and or in separate surgery partially supervised (appropriate based on case selection for years 2 and 3).
- Agreed timetabling with all involved in the integrated network team delivering care within the specialty based both in primary and secondary care.

Thus in all aspects of developing primary care dental specialist training, redirection of and additional funding would be required in adjunct to change in perceptions of how training can be delivered. Within the current financial climate, this may prove challenging. However there would be significant efficiency with provision of teaching and training aligned to commissioned clinical care. In addition other hurdles to the provision of high quality OS care include:

- Funding Financial allocations for primary care dentistry specialism
- Artificial division and funding structures between primary and secondary care
- Lack of understanding of dentistry as it is 'small fry' when compared with medicine and non medical training activity and funding
- Future changes in commissioning dental care
- Cultural changes in the light of patient choice and patient empowerment
- Governance processes and quality assurance
- Improved diagnostic, treatment (aligned to NICE which existing codes currently not) and outcome coding would provide local and national audit for quality of care.

Thus a massive cultural change is required on many fronts, along with appropriate and aligned funding, to provide primary care specialist dental training. Nationally centralised dental commissioning and the development of LETBs will hopefully maximise the opportunity of aligning clinical care commissioning with teaching and training. This development may destabilise existing university based courses allowing the bidding for teaching training by independent dental bodies and groups with increasing emphasis on in-practice clinical training and online learning.

The future of disease prevention and disease reduction based on WHO recommendations will be facilitated by the new dental contract, informed evidence base for workforce development, understanding of local and national population needs with high quality clinical care delivery aligned with teaching training and research. This is a unique and very positive opportunity, which mustn't be missed

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