

Review of training in oral and maxillofacial surgery

Background

- 1 Our evidence base for oral and maxillofacial surgery (OMFS) includes data from the following sources:
 - the national training survey (NTS)
 - quality assurance (QA) visits to deaneries and local education and training boards (LETBs)
 - biannual reports from deaneries and LETBs
 - annual reports from the Joint Committee on Surgical Training (JCST).
- 2 This data is limited because of the small number of doctors in training in the specialty.
- 3 Our review took place during 2012 and 2013. We met the lead dean for the specialty and specialty and college representatives. We visited the West of Scotland (Glasgow), West Midlands, and Oxford training programmes and spoke with doctors in training and trainers from these regions. At each location we met training programme directors and the deanery or local education and training board (LETB) and NHS Education Scotland (NES) quality management teams. In addition, we also met with doctors in training in London, Northampton and the South West.

Summary

- 4 The team were pleased with what they saw across the training programme in the UK, and found that the training programme was fit for purpose. Doctors in training and trainers were committed to the specialty, and the Lead Dean (at the time of the review) and the Specialty Advisory Committee (SAC) Chair were enthusiastic and very

committed to developing training and delivering improvements in the specialty. We found that the SAC responded proactively to concerns raised about training and achieved positive results.

- 5** Based on what the team heard when speaking with a range of people involved in OMFS training in the UK we found the training programmes that our visits covered to be well managed and delivered. Highly motivated trainers are working within the specialty and are having a positive impact. Trainers, doctors in training and leaders in the specialty recognise that there are challenges (for example in managing isolation and supporting trainer development) and local issues do arise but appeared to be effectively managed and monitored. Some variation is expected by doctors in training but the overall consensus was of access to high quality clinical training. On the whole we also found that doctors in training said they were well supervised clinically and educationally.
- 6** We found that not all trainers had time identified in their job plans for education and that some trainers needed more support in identifying and managing doctors in difficulty. We also found that some trainers and doctors in training needed more support in raising concerns about others' practice and that some doctors in training needed guidance and reassurance on how they would be supported if concerns were raised about their own progress.
- 7** We found that organisations, including the SAC, GMC, General Dental Council (GDC) and others should do more work to see if the length of training for OMFS could be reduced.
- 8** As part of the review we identified examples of effective practice that we encourage (see good practice section) and challenges and opportunities for improvement (see requirements and recommendations section).

Areas of good practice

We generally note good practice where we have found exceptional or innovative examples of work or problem-solving related to our standards that should be shared with others and/or developed further.

Number	Paragraph in <i>The Trainee Doctor</i>	Areas of good practice
1	1.2, 5.1	At the sites visited we found close clinical supervision of doctors in training in appropriate procedures from the start of their training programme. This approach allowed trainers to become familiar with and assess the capability of their doctors in training at an early stage (paragraph 9).
2	5.1	In Oxford and the West Midlands we found that doctors in training were gaining a broad range of clinical experience including operating on head and neck but also other areas of the body, supervised where appropriate by other surgical specialists. This clinical experience provides opportunities for doctors in training to increase their experience (paragraph 9).
3	2.2, 5.4	In Oxford, Wessex and West of Scotland we found that there are some very good courses available for non-clinical aspects of training. Attendance at these courses is encouraged in these regions (paragraph 34).
4	5.4	We found a very good pan-Scotland training programme with compulsory monthly attendance incorporating clinical governance, formal teaching, mortality and morbidity and a journal club (paragraph 34).

Requirements

We set requirements where we have found that our standards are not being met. Our requirements explain what an organisation has to address to make sure that it meets those standards. If these requirements are not met, we can begin to withdraw approval.

Number	Paragraph in <i>The Trainee Doctor</i>	Requirements
1	8.4	<p>We require all deaneries and LETBs providing OMFS training programmes to ensure that all staff with responsibility for educational and clinical supervision have:</p> <ul style="list-style-type: none"> ■ allocated time for education in their job plans ■ support, guidance and advice, to recognise and manage doctors in difficulty at an early stage ■ support to effectively use tools for education supervision, such as online workplace based assessment approaches. <p>This is in line with the programme of work taking place to prepare for the recognition and approval of trainers in July 2016.</p> <p>We found inconsistent support for trainers, and many trainers felt at risk and worried about taking action when doctors in training were underperforming for fear of not being supported by their deanery or LETB. Where necessary, some trainers may require additional training and support to effectively use internet-based workplace based assessment (WBA) approaches (recommendation 7 and paragraphs 40-42).</p>

Recommendations

We set recommendations where we have found areas for improvement related to our standards. Our recommendations explain what an organisation should address to improve in these areas, in line with best practice.

Number	Paragraph in <i>The Trainee Doctor</i>	Recommendations
1		We recommend that the GMC works with the General Dental Council (GDC), the UK Foundation Programme Office, universities and other relevant organisations on how the length of training for OMFS might be reduced (recommendation 3 and paragraph 14).
2		We recommend that the GMC works with the GDC on how fitness to practise processes can be clarified for doctors in training in OMFS undergoing proceedings with both bodies (paragraph 13).
3	2.2-2.3, 4.1, 5.1-5.2	<p>We recommend the specialty pursue and roll out its planned pilot of run-through training , alongside curriculum and programme review, and discuss with stakeholders any potential alternatives for the future training programme.</p> <p>The duration of training is considered too long. Most people we spoke with found the two undergraduate degrees to be essential, although thought that the degrees and the foundation period might be compressed for people pursuing a career in OMFS (recommendation 1 and paragraphs 19-22).</p>
4	5.2-5.4	<p>We recommend that deaneries and LETBs ensure trainers are fulfilling their responsibility for building the confidence and competence of doctors in training in management and leadership, by promoting available courses and on-the-job learning.</p> <p>We found significant variation in the extent to which non-clinical competences such as management, leadership and advanced communication skills, are embedded and</p>

		promoted within training. In the West Midlands there was very little awareness amongst trainers of relevant courses for doctors in training or of their benefits, although competences are included in the OMFS specialty curriculum. This said, in other parts of the UK this type of training was well attended by doctors in training and promoted by trainers (paragraph 34).
5	6.34, 7.1	<p>We recommend the continued invitation of training programme directors (TPDs) to attend SAC meetings when their region is not represented on the committee, and the continuation of regular training days to support and develop local faculty.</p> <p>We acknowledge the work by the chair of the SAC and the Lead Dean to improve the relationship and communication between the SAC and TPDs (paragraph 40).</p>
6	6.30, 6.34-6.35	We recommend the SAC includes sessions for trainers in the regional training days on dealing with especially challenging situations, including the management of doctors who require additional support (requirement 1 and paragraphs 41-42).
7		We recommend that all LETBs and deaneries providing OMFS programmes ensure that there are clear processes and support mechanisms in place so that doctors in training know they will be supported if concerns are raised about their progress or they experience issues during their training and feel confident that they will be supported if they raise concerns about others (paragraphs 11 , 41-42).

Findings

- 9** Overall from the evidence we reviewed and the people we spoke to, we heard that doctors in training are mostly satisfied with the quality of their training and their ability to demonstrate the required competences prior to completing their specialty training. This report focuses on highlighting a number of key themes across the UK where we heard concerns, where there is room for improvement, and where issues are being effectively identified and addressed.

Patient safety and raising concerns

- 10** We did not hear anything that identified immediate patient safety concerns in OMFS training in the areas we visited. Nor did we hear that there were any concerns about doctors in training working beyond their competence. Long and challenging working hours and on-call arrangements were reported and largely seen as to be expected within the programme, but doctors in training said they did not extend to being unsafe. This is a specialty where operations can be very long, for example more than 12 hours, and doctors in training sometimes need to be present longer than accepted hours in order to gain appropriate experience.
- 11** We heard from doctors in training, trainers, quality management teams and the SAC about processes for identifying and managing concerns about doctors in training and trainers. It can be difficult managing such concerns in a small specialty; we heard from trainers that they would like more help when managing doctors who require additional support. The SAC chair is very active in following up any problems raised by doctors in training, and in a case where doctors in training needed to be moved due to issues with a training programme there was evidence that the SAC had continued to monitor the progress of the doctors in training affected. We were pleased to note through scheduled deans' reports that the SAC and the dean involved were working together on this collaboratively.
- 12** We heard from the JCST and regional management teams about how they used college and NTS results, and how they sought input from doctors in training. However, we did hear scepticism from some doctors in training about the usefulness of the NTS because of the small numbers and subsequent constraints on reporting where there are fewer than three doctors training at one site. Doctors in training were surprised to hear that the results of the NTS were regarded as important by the GMC, deaneries and LETBs and were widely used. In Oxford we heard from doctors in training who thought that comments given through the NTS from their specialty were disregarded because of the small numbers and would not be acted on. Fear of being identified or comments they make having a negative impact on training and career progress was a disincentive to be forthcoming with information, or even to fill in the survey. This wariness about raising concerns and worry about how proportionate and balanced any reaction would be was also said to be a barrier to raising any issues locally. We heard a suggestion that a post-CCT assessment would capture valuable feedback and we strongly support this.

Governance, management and improvement

- 13** Doctors in training and trainers were frustrated by what they see as insufficient communication and coordination by the GMC and General Dental Council (GDC) for dual registration and practice that is required for OMFS. The additional cost of dual registration and different demands and expectations for training were criticised. We spoke to individuals who thought training could be better integrated and be potentially shortened at undergraduate level, followed by more streamlined foundation training. The GMC and GDC need to explore urgently ways in which they could work more closely together in this specialty.
- 14** Doctors in training and trainers were concerned about the risk of being reported to both regulators on fitness to practise grounds, and subject to hearings and judgements by one regulator even if cleared by the other.
- 15** In meetings with college and specialty representatives, the Lead Dean, and during visits to regional training locations, we were satisfied that there are structures and processes in place to manage the specialty locally, regionally and across the UK. TPDs at the locations we visited were committed, and their expertise and management of training within each of the regions was highly valued. There has been intervention by TPDs on some serious training concerns, and we saw evidence of the follow-up from the deanery/LETB and SAC with doctors in training that have needed to be moved. However, the SAC does need to be aware of the limits of its remit, as it does not have direct responsibility for regional training programme management.
- 16** We heard from the JCST and SAC about the use of the college's own survey and the NTS to identify any areas of difficulty, and of initiatives by the SAC chair and Lead Dean to make improvements. For example, they identified weak linkages between TPDs and the SAC. The Lead Dean and SAC have therefore started development days for regional specialty advisors and TPDs. We observed one of these training days, and the agenda stimulated good discussion among the trainers of challenging situations they face and sharing ideas about improving training.
- 17** The specialty will need to think carefully about how to ensure momentum is maintained and new leaders are developed nationally and regionally when the current SAC chair, Lead Dean and TPDs complete their terms of office.

Equality, diversity and opportunity

- 18** There was broad consensus among doctors in training, trainers, and local and UK representatives that the structure and duration of OMFS training might be a disincentive to women entering and continuing in the profession. Female consultants and doctors in training thought that it was a challenging specialty but that it was still possible to have a family, although most were not aware of doctors in training working less than full time.

Training structure and content

- 19** OMFS training requires two undergraduate degrees and foundation training for both dentistry and medicine. There were a range of experiences reported as some doctors in training had progressed through early training some time ago when the arrangements were more flexible and compressed. Doctors in training were frustrated by what they saw as continual changes to the structure and duration of their training. They felt there should be a more systematic and stronger link with the training programme during the second degree.
- 20** Doctors in training noted changes that had taken place for ST3 entry which has moved from a run-through programme to a core and higher training model, and is now subject to a run-through pilot in 2014. Doctors in training reported that these changes were unsettling. There was also felt to be lack of clarity with GMC and European rules around shortened dental and medical degrees and shortened post-graduation training (foundation/CT1). Doctors in training did think additional time in training was beneficial in terms of their exposure, experience and maturity, and range of surgical experience. However, they thought that posts should be better coordinated and focused in core and foundation training to ensure that the posts had value and benefit for the OMFS training pathway. A joint/combined foundation training pathway was suggested as a means of reducing duplication in training and barriers faced because of the extra time, education and training required.
- 21** Doctors in training and trainers appreciated the breadth of the training programme and opportunities to develop in-depth skills. We repeatedly heard that doctors in training and trainers saw value in their unique programme as compared to other European countries and other countries such as the US, Canada and Australia. They felt, for example, that doctors at an equivalent stage of training from other countries have less experience and expertise. The dual qualification was thought to be important, and added value to the specialty. The doctors in training also felt that OMFS provided skills in a range of allied areas including head

and neck surgery and beyond, so they were confident in multi-disciplinary teams and dealing with other surgery including micro-surgery, full range of reconstructive options from other areas of the body, and the acutely injured or unwell patient. They were aware that dentists want to expand their surgery remit but said that as dually qualified OMFS surgeons they were better able to deal with complications arising from procedures. Doctors in training commented that they did not feel their expertise was always acknowledged by colleagues and in career progression, including access to fellowships.

- 22** Trainers were also concerned that the length of training (particularly the obligation to complete foundation/CT1 training twice) added to the costs of the additional training time which could discourage potential trainees, and that the specialty might not recruit the best candidates as a result. Trainers also thought that the length and cost of training could discourage women, although the female doctors in training we spoke with felt they were treated equally. Trainers suggested a streamlined shortened pathway and felt that a bursary to go through the additional training could be helpful with specific arrangements to support OMFS candidates when they are in foundation posts. The Lead Dean and SAC recognised that engaging doctors in training during their second degree and foundation training was an area for improvement. The British Association of Oral and Maxillofacial Surgeons offer membership and support for those planning to enter OMFS specialty training.
- 23** We heard concerns from doctors in training that programmes could be mapped better to the curriculum so that for those units where some experience was unavailable, training could be planned to include access outside the unit. The Chair of the SAC reported that this was currently being considered so that TPDs had information about coverage nationally and could take action to ensure doctors in training were able to fill in experience and training gaps. Doctors in training felt that addressing curriculum gaps was expected to be self-led, but that deaneries and LETBs would try to accommodate their needs.
- 24** There was a range of opinions from doctors in training and trainers about the value and use of the Intercollegiate Surgical Curriculum Programme (ISCP) online; the Lead Dean and chair of the SAC acknowledged the difficulties with the ISCP but said that TPDs and trainers (particularly newer trainers who are more used to the systems) were beginning to use it as a more robust tool to promote education as well as monitor doctors' progress.

- 25** Face to face annual reviews of competence progression (ARCP) were thought to be beneficial, and doctors in training were largely satisfied with the ARCP processes. There were regional differences in ARCP and WBA processes, and some regional requirements were thought not to be relevant for OMFS doctors in training. For example, doctors in training in London questioned the standard WBA numbers required by the LETBs, and the amount of publications doctors in training were required to achieve. There is a requirement of 80 WBAs which was in place for all surgical specialties, and they felt this added unnecessary pressure. An expectation to publish work annually was seen as less relevant for surgery where 'hands on' time was the key.

Concerns about the FRCS Part 1 exam

- 26** Many doctors in training spoke of their concerns about the Intercollegiate Fellowship of the Royal College of Surgeons (FRCS) Part 1 exam in Oral and Maxillofacial Surgery, noting a drop in a previously very high pass rate. The doctors in training were aware that there had been a number of changes to the content of the examination, an expanded number of questions in the question bank, and changes to standard-setting.
- 27** We heard from the SAC that previously questions from the exam had been circulated by former doctors in training and that issue had contributed to the need for the question bank to be expanded. The SAC noted that the expanded question bank may have resulted in a drop in pass rate. Doctors in training acknowledged that there may have been some circulation of questions to previous cohorts. They noted that there were now no practice questions available for the exam and suggested that it would be helpful if practice papers and questions were available.
- 28** There was concern from doctors in training that the reduced pass rate might not only be due to a change in the calibre of candidates. A few doctors in training criticised the quality of the exam content, including badly-written questions which were repetitious and used subjective language, and questions about rare conditions. We note that the JCIE have recently made the quality assurance processes for this exam more robust and have worked to improve the quality of questions, removing those which are not of adequate quality.
- 29** Doctors in training in Scotland were much less concerned about the changes, and we were aware that there was a doctor in training representative on the group that discussed and agreed changes to the exam.

- 30** We heard from trainers who held the view that national recruitment, the ISCP and rigorous ARCP processes had helped to increase the quality of recruitment and identification of doctors in training that should not progress. We noted that TPDs sign off when candidates are ready to sit the exam, and doctors in training thought that this was an indicator of the correct level of competence for the doctor in training.
- 31** We heard from the Joint Committee on Intercollegiate Examinations (JCIE) and the specialty representatives that they were aware that changes to the examinations had caused some unease, but they were confident it was passing and failing the correct candidates. To some extent the examination changes have been required to ensure that the examination remains fit for purpose and that it adopts the best possible processes for standard setting. The specialty intends to work with TPDs to ensure that they are aware of the changes to the exam, increases to the number of questions in the question bank, and improvements to standard setting. Also, that they do not recommend doctors in training sit the exam until their trainers are confident they are competent to the level required.
- 32** We consider that all doctors in training should have an outcome 1 at ARCP ST5 before being put forward to sit the examination, as per the OMFS examination regulations¹. We would be concerned if we found that trainers were using this exam as a way of managing doctors in training who were struggling to progress.
- 33** We acknowledge the concerns raised by doctors in training regarding the pass rate for the FCRS Part 1 exam. We will work with the JCIE to monitor the results of this exam and identify and investigate any concerns.

Quality and availability of teaching

- 34** Doctors in training were satisfied with the quality of local and regional teaching and said that they were released for it and expected to attend. They said study leave was also supported, but that it was mostly self-funded, and could be expensive. There was variation between the amount of time available to different doctors in training for study, and general agreement that doctors in training pay for courses themselves. There was wide variation in the awareness of and attendance at non

¹ Joint Committee on Intercollegiate Examinations – Structured Reference Form (guidance for referees) <http://www.jcie.org.uk/content/content.aspx?ID=22>

clinical training (for example in advanced communication skills and in leadership and management). There was particularly high awareness about courses and appreciation of the benefits of teaching in these areas in the West of Scotland and Oxford, among doctors in training and trainers, and the deanery/LETB publicised and encouraged attendance of a range of relevant courses. However, in other regions awareness about the courses available and their benefits was much lower.

- 35** Doctors in training said that although they were released for regional and local teaching, and encouraged to go to other regions for relevant teaching, in practice it could be difficult to attend. The East of England OMFS training scheme links with London's training days once a month, and the Oxford and Wessex programmes join up which means, for example, that a doctor in training from Northampton may have to travel to Poole or Southampton. Travelling can be expensive, difficult and tiring, particularly prior to or after a shift. One doctor in training had worked out it costs £800 annually to travel to the regional training days (which exceeds their yearly study budget), and that this is self-funded.

Working patterns and intensity

- 36** We heard that doctors in training felt it could be difficult to meet education needs and comply with rotas, and that doctors in training can be allocated a rota that may not enable them to meet targets for training as well as to meet service needs. We did hear across the UK about experience of long hours, multi-site on-call cover, cross-cover for other specialties, and on-call nights followed by day shifts. Some of these service pressures were thought to be due to insufficient numbers of medically qualified doctors in training in a department (as some doctors in training were dentally qualified only). These pressures did concern doctors in training to varying extents but were largely accepted, although they acknowledged that it was not always appropriate for learning. Doctors in training appeared to fill training gaps actively themselves and found the rotas and service versus training demands challenging. Most thought that it remained hard to get sufficient experience and hands on time within the constraints of the WTR and service pressures.
- 37** There was a lot of discussion in Oxford about the amount of clerical and administrative tasks required, and that these tasks were crucial for doctors in training and consultants to undertake in order for surgery lists to run and patients to attend. Trainers felt pressure from the LEP and medical colleagues to prioritise service over training but were resisting this to ensure that doctors in training had sufficient hands-on time, even if it meant lists overran. They knew of the excessive administrative

demands as this was also an issue for them. It is important for training that doctors are not required to spend an excessive amount of time on administrative tasks that do not contribute to learning, and we strongly support the efforts of the TPD and DME to address this by appointing sufficient numbers of appropriately skilled staff.

Support for doctors in training

- 38** We heard from the SAC about a Severn-based peer mentoring programme pilot that they were expanding. Only a small number of doctors in training we met were aware of it, although they thought it was only for foundation doctors in training and second degree students, but said they had informal peer support and networks and there was a network within the BAOMS. They knew people they would go to if they had any problems or concerns about colleagues or aspects of their training.
- 39** We heard repeatedly that doctors in training did not think there was a problem with bullying across the specialty. Doctors in training expected variability in the culture of units, but would expect their TPD to act if they were consistently flagging up issues. We heard examples where doctors in training had raised issues and found their deanery/LETB to be responsive, and had seen change happen when required and promptly, so felt that the safety mechanisms usually work.

Support for trainers

- 40** The Lead Dean and SAC have started faculty development days for TPDs twice a year, and both trainers and doctors in training said that the SAC had improved in recent years and was helpful in developing the specialty. They are also working to get more protected time in job plans aligned with the GMC's recognition of trainers work, and working with medical directors to support implementation.
- 41** There was some unease from trainers about removing doctors from training. The preferred option for trainers was to address problems directly with doctors in training and consultants, and a documented process for dealing with issues was not always followed. Trainers did think that doctors in training might be fearful of raising concerns about their own or colleague's practice.
- 42** A clear process and support mechanisms are required so that doctors in training know they will be supported when concerns are raised and understand what they need to do in terms of addressing issues they

themselves or peers may experience during training. We heard that the Lead Dean and the SAC are working with the deaneries/LETBs to improve openness and communication, and to put in place clear agreed and publicised procedures and guidance to inform and support trainers and doctors in training going through any concerns process.

Acknowledgement

- 43** We would like to thank the Specialty Advisory Committee, the Lead Dean, and all the people we met during the visits for their cooperation and willingness to share their learning and experiences.

Appendix 1: Visit team and visit dates

Visit team

Team leader	Stuart Macpherson
Visitor	Andrew Beggs
Visitor	Rosie Luszkat
Visitor	Suzanne Shale
GMC staff	Alison Lightbourne, Kate Gregory
Visit Dates	<p>13 July 2012: meeting with College representatives and Lead Dean</p> <p>12 December 2012: meeting with College representatives and Lead Dean</p> <p>17 April 2013: meeting with doctors in training</p> <p>15 May 2013: meeting with College representatives and Lead Dean</p> <p>17 June 2013: meeting with management team, trainers and doctors in training in Health Education West Midlands</p> <p>24 June 2013: meeting with management team, trainers and doctors in training in the West of Scotland Deanery</p> <p>12 July 2013: meeting with management team in Health Education Thames Valley</p> <p>24 September 2013: meeting with trainers and doctors in training in Health Education Thames Valley</p>

Appendix 2: OMFS Specialty Training Pathway

OMFS training pathway with dental primary degree

When training is described as optional, minimum or essential, this is in relation to the current person specifications for entry into higher training in OMFS.

	Primary Degree	Foundation 1	Core training 1	Second Degree	Foundation 2	Core training 2
Details	Dental Degree (BDS)	Dental Foundation	Dental (OMFS) Core Training (DCT)	Medical Degree(MB BCH)	Medical Foundation Training	Core Surgical Training
Duration (years)	5	1	0-2	3-5	2	1-2
Milestones	Registration with GDC at end of degree	Working in dental practice and attending formal education 1 day per week.	MFDS exam OMFS Core Dental Competencies	Provisional Registration with GMC at end of degree	Full Registration with GMC after first year Completion of Foundation competencies	Pass MRCS Acquire Core Surgical competencies
Notes		Not essential for OMFS Required to join NHS dentistry "Performers List"	DCT and MFDS optional but needed for most shortened medical courses	Most OMFS trainees work in OMFS units during their second degree	In past, successful OMFS trainees have progressed after 1 year of foundation	12 months minimum (prior training allowed to shorten time in CT)

	ST1	ST2	ST3	ST4	ST5	ST6	ST7	Interface Fellow	Award Of CCT In OMFS
Details	Core surgical training	Core and OMFS Themed						Pre-CCT fellowships	
Milestones	Core training competency Pass MRCS					ARCP 1 for ST6, apply for FRCS (OMFS)	Pass FRCS (OMFS)		
Notes	Pilots of run-through training are taking place in Mersey, North East, KSS and Manchester	Only Needed if milestones not met in ST1 or if the trainee needs to meet OMFS core competencies	Trainees who have completed MRCS and 12 months of core training and achieved core training competency enter here				OMFS is different from other surgical specialties having 5 years rather than 6 of higher training	Head and Neck is 12 months. Cleft may extend beyond 12 months (until consultant post). Trauma and Aesthetic Fellowships are < 4 months	

Notes

- Shortest total training time is 18 years (or 13 years after completion of first degree)
- OMFS trainees will do **either** Core Training (CT1 CT2) **or** the first year(s) of Specialty Training (ST1). Medicine first may do two years of CT, but dual degree CT/ST is usually one year if the trainee can pass their MRCS and acquire all CT competencies in 12 months. This reduction is in recognition of surgical training acquired working in OMFS during previous 7-10 years of work and studies.
- A minimum of 12 months of core training, completion of OMFS core dental competencies and a pass in the MRCS examination is required for progress to ST3 from Core Training (CT1-2) or to move from Specialty Training (ST1-2) to ST3.
- Trainees may apply from Foundation 2 (medical foundation training) to ST1 run-through posts. (Red arrow ←)

OMFS training pathway with medical primary degree

When training is described as optional or essential, this is in relation to the current person specifications for entry into higher training in OMFS.

	Primary Degree	Foundation 1	Core training 1	Second Degree	Foundation 2	Core training 2
Details	Medical Degree(MB BCh)	Medical Foundation Training	Core Surgical Training	Dental Degree (BDS)	Dental Foundation	Dental (OMFS) Core Training Or Re-enter CT if CT not completed before dental degree
Duration (years)	5	2	1-2	3-5	1	6/12 – 2 years
Milestones	Provisional Registration with GMC at end of degree	Full Registration with GMC after first year Completion of Foundation competencies	Pass MRCS Acquire Core Surgical competencies	Registration with GDC at end of degree		Pass MRCS if not already passed. Acquire Core OMFS competencies
Notes			Some trainees apply for their second degree after medical foundation or during core. They must complete core after their dental degree	Most OMFS trainees work in OMFS units during their second degree	Most OMFS trainees do not do this. Required to join NHS dentistry "Performers List"	There is no lower limit on OMFS core experience. Trainees can apply for ST after 6 months or direct from dental school.

	ST1	ST2	ST3	ST4	ST5	ST6	ST7	Interface Fellow	Award Of CCT In OMFS
Details	Core surgical training	Core and OMFS Themed						Pre-CCT fellowship	
Milestones	Core Training Competency pass MRCS					ARCP 1 for ST6, apply for FRCS (OMFS)	Pass FRCS (OMFS)		
Notes	Pilots of run-through training are taking place in Mersey, North East, KSS and Manchester	Only Needed if milestones not met in ST1 or if the trainee needs to meet OMFS core competencies	Trainees who have completed MRCS and 12 months of core training and achieved core training competency enter here				OMFS is different from other surgical specialties having 5 years rather than 6 of higher training	Head and Neck is 12 months. Cleft may extend beyond 12 months (until consultant post). Trauma and Aesthetic Fellowships are <4 months	

Notes

1. Shortest total training time is 18 years (or 13 years after completion of first degree)
2. OMFS trainees will do either Core Training (CT1 CT2) or the first year(s) of Specialty Training (ST1). Medicine first may do two years of CT, but dual degree CT/ST is usually one year if the trainee can pass their MRCS and acquire all CT competencies in 12 months. This reduction is in recognition of surgical training acquired working in OMFS during previous 7-10 years of work and studies.
3. A minimum of 12 months of core training, completion of OMFS core dental competencies and a pass in the MRCS examination is required for progress to ST3 from Core Training (CT1-2) or from run-through Specialty Training (ST1-2) to ST3.

Action Plan for the review of Oral and Maxillofacial Surgery

Requirements

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/year)	Leads
Req. 1	Dec 2015	<p>We require all deaneries and LETBs providing OMFS training programmes to ensure that all staff with responsibility for educational and clinical supervision have:</p> <ul style="list-style-type: none"> - allocated time for education in their job plans - support, guidance and advice, to recognise and manage doctors in difficulty at an early stage - support to effectively use tools for education supervision, such as online workplace based assessment approaches. 	<p>Health Education West Midlands</p> <p><u>Job Plans</u></p> <p>Discussed at Training Committee, June 2014.</p> <p>Concerns will feed into the School Board; September 2014.</p> <p><u>Doctors in Difficulty</u></p> <p>At National Recruitment, every six months, development days are held for programme directors and supervisors.</p>	<p>Health Education West Midlands</p> <p><u>Job Plans</u></p> <p>This will continue to be discussed at the Training Committee; January 2015.</p> <p>Discussions from the Training Committee are then fed into the School Board and ultimately the Post Graduate Dean will contact the relevant Trust Board if specific concerns are not addressed.</p> <p><u>Doctors in Difficulty</u></p>	<p>This requirement will be monitored through the Dean's reports</p>	<p>Leads to be nominated by LETBs and deaneries providing OMFS training programmes</p>

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/year)	Leads
			<p>November 2013 – development day about managing doctors in difficulty with attendance and input from senior staff at Severn Deanery.</p> <p>Discussions take place at the School Board and Training Committee.</p> <p><u>Support for trainers</u></p> <p>Helpline team for the ISCP are always available.</p> <p>In 2012 STC Chair provided three workshops on WPBA for consultant supervisors in conjunction with the Royal College of Surgeons.</p> <p>Health Education Thames Valley</p> <p>Job plans: The OUH Director of Medical Education has confirmed that all Educational Supervisors have appropriate time allocation within their job plans to support this role. Support, Guidance & Advice 1) Training provided for all</p>	<p>Continue monitoring through ARCPs and annual appraisals of trainers Presentation to be provided at School Board in 2015 from the Professional Support Unit, this will then feed into the Training Committee and ultimately disseminated to Trust level.</p> <p><u>Support for trainers</u></p> <p>STC Chair to scope the requirement for further training to be provided to update trainers since the 2012 sessions.</p> <p>Health Education Thames Valley</p> <p>HETV will recommend that the Training Programme Director and Head of School of Surgery should meet with DMEs at provider organisations. In addition, HETV will look to ensure that all Trusts have signed up to the HETV policy for time in</p>		

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/year)	Leads
			<p>ESs and TPDs in supporting “doctors in difficulty” in their training via CDU (PSU) workshops commissioned by Educator Development AD, and online TPD training package</p> <p>2) Trainee Support Policy in place and disseminated through training schools and by training described at (1).</p> <p>3) CDU (PSU) provides advice and support to educators about management of individual cases of trainee doctors “in difficulty”.</p> <p>Educational Supervisor Training: Educational Supervisor training is provided for all trainers in OMFS and this includes training in responding to doctors in need of support. The medical education team have good links with the Professional Development Unit at the LETB.</p>	<p>job plans to supervise postgraduate trainees.</p>		

Recommendations

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/year)	Lead staff
Rec. 1	Dec 2015	We recommend that the GMC works with the General Dental Council (GDC), the UK Foundation Programme Office, universities and other relevant organisations on how the length of training for OMFS might be reduced (paragraph 14).	The GMC and GDC met in August 2014 to discuss the OMFS training pathway and length of training. Further meetings will be needed to explore the issues in the light of the GDC's consultation on standards for specialty education which closed in July 2014.	The GMC and GDC will meet when the outcome of the GDC's consultation on standards for specialty education has concluded and will also consider the interim and final outcome of the run through training pilot for OMFS (paragraph 20)	Late 2014 and throughout 2015.	Emily Saldanha (GMC)
Rec. 2	June 2015	We recommend that the GMC works with the GDC on how fitness to practise processes can be clarified for doctors in training in OMFS undergoing proceedings with both bodies (paragraph 13).	The GMC and GDC are currently working on a Memorandum of Understanding which will clarify fitness to practise procedures for doctors in training in OMFS who are registered with both bodies.	The Memorandum of Understanding should be finalised and published in late 2014 or early 2015.	Late 2014 – early 2015.	Emily Saldanha (GMC)
Rec. 3	August 2015 and onwards	We recommend the specialty pursue and roll out its planned pilot of run-through training, alongside curriculum and programme review, and discuss with stakeholders any potential alternatives for the future training programme. (recommendation 1 and paragraphs 19-22).	Run through training is being piloted in five training regions – the North West, Mersey, Wessex, the North East and KSS. Training posts have been allocated and approved by the GMC for training. The first ST1 trainees will begin training in August 2014.	This will be an ongoing period of evaluation. The first evaluation will take place in August 2015, when the initial run through trainees complete ST1 level training. The evaluation period will continue for a period of two to three years, at the end of which the specialty will make a decision about whether to adopt run through training permanently.	This recommendation will be monitored through the annual specialty report from the Joint Committee on Surgical Training.	Central Recruitment Lead (SAC in OMFS)

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/year)	Lead staff
Rec. 4	Dec 2015	We recommend that deaneries and LETBs ensure trainers are fulfilling their responsibility for building the confidence and competence of doctors in training in management and leadership, by promoting available courses and on-the-job learning (paragraph 34).	<p>Health Education West Midlands</p> <p>At the 3rd June 2014 School of Surgery School Board leadership initiatives were disseminated and discussed by the Head of School, Leadership and STC Chair.</p> <p>Leadership presentation took place at Training Committee in June 2015.</p> <p>Health Education Thames Valley</p> <p>CDU (PSU) provides personal coaching support for individual doctors in training who need to improve their management and leadership in order to progress satisfactorily through their training.</p> <p>Trainee engagement is a standing agenda item at all Education Quality Visits [EQV] to Trusts [Postgraduate Dean level].</p>	<p>Health Education West Midlands</p> <p>Continue to monitor at ARCPs.</p> <p>All new initiatives to be discussed at The School Board, Training Committee and promoted through the Trainee Newsletter.</p> <p>Health Education Thames Valley</p> <p>The Associate Dean for Educators will look to suggest that OMFS trainees register for Edward Jenner programme via NHS leadership Academy as endorsed by PGME Executive of HETV.</p> <p>EQV already include a trainee representative on the panel but following a trainee presentation at a 2014 EQV, HETV will encourage the Trusts being visited to include trainee presentation at future EQVs.</p>	This requirement will be monitored through the Dean's reports	Leads to be nominated by LETBs and deaneries providing OMFS training programmes

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/year)	Lead staff
Rec. 5	Ongoing	We recommend the continued invitation of training programme directors (TPDs) to attend SAC meetings when their region is not represented on the committee, and the continuation of regular training days to support and develop local faculty (paragraph 40).	<p>For the previous two years TPDs from training regions otherwise unrepresented on the SAC have been invited to attend SAC meetings.</p> <p>The first Development Day for TPDs was held in July 2012. These have been held twice per year since then.</p>	Continue	This recommendation will be monitored through the annual specialty report from the Joint Committee on Surgical Training.	<p>SAC Chairman (SAC in OMFS) for SAC meetings</p> <p>Lead TPD (SAC in OMFS) for Development Days</p>
Rec. 6	Ongoing	We recommend the SAC includes sessions for trainers in the regional training days on dealing with especially challenging situations, including the management of doctors who require additional support (requirement 1 and paragraphs 41-42).	During recent Development Days for TPDs, sessions have been held on the role of SAC Liaison Members, the role of the Assigned Educational Supervisor and setting learning agreements, management of the struggling trainee, and clinical reasoning and professional judgement.	Ongoing programme events	This recommendation will be monitored through the annual specialty report from the Joint Committee on Surgical Training.	Lead TPD (SAC in OMFS)
Rec. 7	Dec 2015	We recommend that all LETBs and deaneries providing OMFS programmes ensure that there are clear processes and support mechanisms in place so	<p>Health Education West Midlands</p> <p>1. ARCP – SAC liaison member asks trainees about their experience within their post, this forms part of the documentation. If anyone</p>	<p>Health Education West Midlands</p> <p>Continue to monitor through ARCPs.</p>	This recommendation will be monitored through the Dean's reports	Leads to be nominated by LETBs and deaneries providing OMFS training programmes

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/year)	Lead staff
		<p>that doctors in training know they will be supported if concerns are raised about their progress or they experience issues during their training and feel confident that they will be supported if they raise concerns about others (paragraphs 11, 41-42).</p>	<p>from the trainees' trust is on the panel they are excused for this section.</p> <ol style="list-style-type: none"> 2. Trainee newsletter circulated to all trainees three times a year and provides details on the Professional Support Unit (PSU) and ways to access the services. 3. The Educators' Conference on 20th November 2014 has a section dedicated to the PSU. <p>Health Education Thames Valley</p> <p>CDU (PSU) provides support to doctors in training either referred by educator or self-referred.</p> <p><input type="checkbox"/> CDU (PSU) website provides more information and is linked from HETV-PGME (Oxford Deanery) website home page</p> <p><input type="checkbox"/> HETV Trainee Support Policy is in place, and available through Deanery website</p> <p><input type="checkbox"/> School Visits to LEPs occur on a triennial basis. Visits provide trainees with the opportunity to meet face-to-face with senior educators from outside of their current training location, to highlight areas of good practice and to raise individually, or</p>			

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/year)	Lead staff
			<p>collectively matters of concern without fear of disadvantage. Any concerns reported are anonymised and not attributable to any particular trainee.</p>			

SPECIALTY ADVISORY COMMITTEE IN ORAL AND MAXILLOFACIAL SURGERY

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Ms Kate Gregory
Joint Head of Quality
Education and Standards Directorate
General Medical Council
350 Euston Road
LONDON NW1 3JN

17th July 2014

Dear Ms Gregory,

Re: Small Specialty Review of Oral and Maxillofacial Surgery

The SAC has welcomed the opportunity to work with the GMC in its review of the Oral and Maxillofacial Surgery training programme. We support the findings of the report and the requirement and recommendations highlighted in the action plan.

Some small changes have been made to the action plan to reflect the fact the Joint Committee on Surgical Training (JCST) is an intercollegiate body representing the three UK Royal Colleges (plus the Royal College of Surgeons in Ireland) and not one single College.

The SAC looks forward to continuing to work with the GMC to deliver the terms of the action plan and further develop and improve specialty training in Oral and Maxillofacial Surgery.

Yours sincerely,



Mr M S Dover
Chairman
SAC in Oral and Maxillofacial Surgery

GMC Review of training in oral and maxillofacial surgery 2012 – 2013

Thank you for asking for our view on the report and action plan.

The GMC met with representatives from Health Education Thames Valley [HETV] on the 12 September 2013, and with trainees, educators and Trust representatives on 24 September 2013.

Health Education Thames Valley recognises the challenges of quality managing small specialties, and those with fewer numbers of doctors in training in a particular local education provider.

HETV welcomes the findings of the GMC Review of training in Oral and Maxillofacial Surgery, particularly the noted areas of good practice for Thames Valley, and supports the areas identified as needing improvement.

**Quality Assurance Manager
July 2014**