

PMETB report on training in Oral and Maxillofacial Surgery (OMFS)



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1. Introduction to the review

The specialty of Oral and Maxillofacial Surgery

1. Oral and Maxillofacial Surgery (OMFS) is the surgical specialty concerned with the management of conditions affecting the anatomical region of the head and neck. The scope of the specialty is extensive and includes the diagnosis and management of facial injuries, head and neck cancers, salivary gland diseases, facial disproportion, facial pain, temporomandibular joint (TMJ) disorders, impacted teeth, cysts and tumours of the jaws, as well as numerous problems affecting the oral mucosa such as mouth ulcers and infections.¹
2. The specialty evolved from the need to treat complex facial injuries sustained during the first and second World Wars, and continued beyond this period to support the increase in facial injuries in members of the public due, in part, to the increase in ownership of motor vehicles. The introduction of seatbelts (and the later supporting legislation) reduced the number of facial injuries sustained in road-traffic accidents, but the amount of injuries continued to be high in other areas of society. A national survey conducted by the British Association of Oral and Maxillofacial Surgeons (BAOMS) of 163 Emergency Medicine departments showed that 500,000 facial injuries occur every year in the UK, with 180,000 of these being classified as of a serious nature. Of this number, 25% of injuries were caused by assault.²
3. Despite surgeons originally needing only to be qualified in dentistry to practise in OMFS, many consolidated their skills by studying medicine as a second degree, with dual qualification eventually becoming mandatory in the UK in the late 1980s. The requirement of dual qualification is common across the European Economic Area (EEA).
4. There are currently 364 consultants in OMFS in England, Scotland and Wales. The NHS Information Centre recorded a total of 1,137 staff at all grades in OMFS in England at the last census in September 2007.³ Modernising Medical Careers' (MMC) competition ratios for 2008 suggest that there are 8.8 applicants per post in OMFS, which highlights a continuing interest in careers in the specialty.

Review background

5. In June 2006, the Department of Health wrote to PMETB to request that the Board lead a review of the specialty training programme for Oral and Maxillofacial Surgery across the four nations of the UK. Unique in its requirement for undergraduate qualifications in both medicine and dentistry, it takes between 16-20 years to qualify for a Certificate of Completion of Training (CCT) or a Certificate of Eligibility for Specialist Registration (CESR) in OMFS.
6. The primary purpose of the review has been to determine whether the current OMFS training programme is fit for purpose – that is, to deliver highly trained consultants who are able to serve the needs of the population – and to consult with OMFS patients, the service and trainees as to what those needs are.

¹ <http://www.baoms.org.uk/landing.asp?id=3>

² <http://www.baoms.org.uk/page.asp?id=56>

³

<http://www.ic.nhs.uk/webfiles/publications/nhsstaff2007/med%20and%20den/Revised%20Med%20and%20Den%20Detailed%20Results%2007%2004-04-08.pdf>

7. The group's terms of reference were:

To review and make recommendations as to:

- the diagnostic and surgical services required by patients with congenital and acquired disabilities affecting the mouth, jaws and face;
 - the content and outcomes of training required by staff providing these services;
 - the pathways to a career in Oral and Maxillofacial Surgery including undergraduate and postgraduate training.
8. In this context, the working group was asked to consider the implications of the current training programme on those who wish to become OMF surgeons. A potential training period of 20 years requires an enormous investment from trainees, so it is important that the training programme maintains an appropriate balance in respect of content and efficient delivery to ensure that time in training is used to best effect.

Working group membership

9. The review group was jointly chaired by PMETB Chairman, Professor Peter Rubin, and the Chief Dental Officer for England, Dr Barry Cockcroft. The membership of the group was as follows:

Mr Rajiv Anand, Oral and Maxillofacial Fellows in Training representative

Mr Andrew Carton, Chair, Specialty Advisory Committee (SAC) in Oral and Maxillofacial Surgery

Ian Cumming, Deputy Chairman, PMETB and Chief Executive, North Lancashire PCT

Professor John Frame, Lead Postgraduate Dental Dean, Oral Surgery

Mr Ian Martin, Chairman of Council, British Association of Oral and Maxillofacial Surgery (BAOMS)

Professor Graham Ogden, Chair, Specialist Advisory Committee in Oral Surgery

Jerry Read, Project Leader, Oral Health and Dental Education, Department of Health

Miss Wendy Reid, Lead Postgraduate Dean, Oral and Maxillofacial Surgery

Miss Margie Taylor, Chief Dental Officer, Scotland (Miss Taylor joined the group for its final meeting on 7th December 2007)

Dr Richard Taylor, BMA Junior Doctors Committee

2. Evidence

Collecting evidence

10. In order to obtain a comprehensive picture of the current perception of the appropriateness of training and the delivery of service in OMFS, PMETB undertook a number of evidence-gathering exercises to inform the review.

Consultation

11. In the summer of 2007, PMETB consulted on eight questions to ascertain the current training requirements and service needs in OMFS. The questions cover the fundamental issues that are key to developing a detailed picture of the current service requirements in OMFS, and to assist in the identification of those areas where training and service delivery can be improved.
12. The consultation ran from 5th July to 5th October 2007, and was advertised on PMETB's website. All interested parties were written to prior to the launch of the consultation and in total, 121 responses were received.
13. A list of respondents can be found at Annex A of this document.

Consultation questions

1. What is it that Oral and Maxillofacial Surgeons uniquely do?
2. What is the added value of undertaking undergraduate medical training and dental training as opposed to one or the other?
3. What knowledge, skills and competencies should be acquired during postgraduate training in OMFS?
4. Are these competencies best achieved by the current, dual-primary qualification approach, or could they be more efficiently achieved by having a postgraduate training programme entered from either medicine or dentistry, with special modules for those without the requisite undergraduate knowledge or skills?
5. Are there alternatives for streamlining training?
6. What are the requirements of OMFS for:
patients;
the service.
7. Are these requirements currently being met as efficiently as possible?
8. Is there a continuing need for specialists to hold dual registration?

Visits

14. Members of the working group visited six OMFS and OS units across the UK:
 - Royal Lancaster Infirmary
 - Great Western Hospital, Swindon
 - The Royal Sussex, Brighton
 - Sunderland Royal Hospital
 - The Royal London
 - Southern General, Glasgow

15. The purpose of the visits was to enable the working group and secretariat to meet with service providers in departments of differing composition and serving different population needs, and to ascertain what they consider to be the important components both of a successful unit, and of an effective training programme. The original programme of visits was extended at the suggestion of working group members and contributors, to ensure that the working group saw an appropriate balance of type and size of unit. The terms of the review do not extend to formal reporting on the visits, thus detail of individual visits will not be contained in this report.
16. The programme for each visit was set by the individual unit, giving staff the opportunity to present to the working group what they saw to be relevant to the review. PMETB has been keen to ensure that the outcomes of the review are balanced and, therefore, representatives both of OMFS and related disciplines (e.g. ENT, Neurosurgery and Emergency Medicine) were given the opportunity to participate in open discussion with the visiting members of the working group.
17. It became clear early in the cycle of visits that a 'one size fits all' model for the configuration of services in an OMFS department is not appropriate. The configuration is entirely dependent on the population served, and the types of procedures undertaken in each unit.

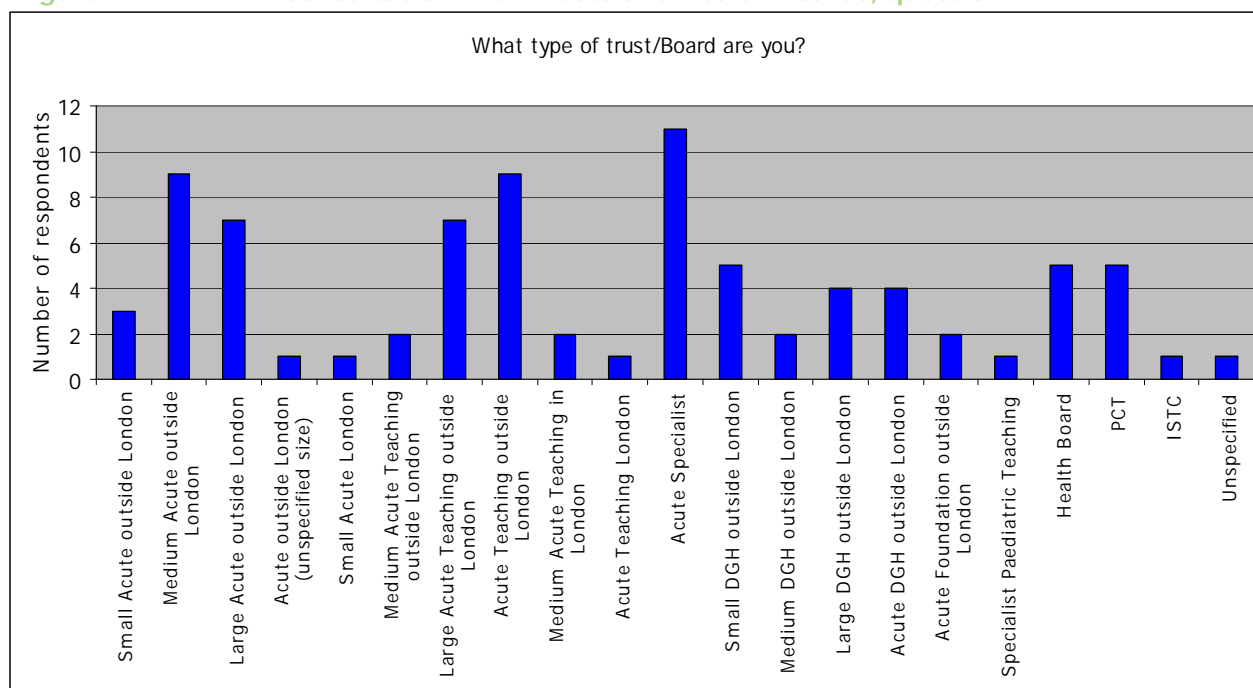
Evidence day

18. In September 2007, working group members participated in an oral evidence day. Representatives from the professional associations, trainee and patient groups, and the Specialty Advisory Committee (SAC) in OMFS and the Specialist Advisory Committee in Oral Surgery (OS) were invited to present to the review group to provide a range of information on the requirements for training, the balance between OMFS and other specialties, and the needs of patients.
19. Attendees on the day were:
 - The British Association of Oral and Maxillofacial Surgeons (BAOMS)
 - The British Association of Oral Surgeons (BAOS)
 - Changing Faces
 - Saving Faces
 - The British Medical Association (BMA)
 - The Association of Surgeons in Training (ASiT)
 - The Specialty Advisory Committee in OMFS
 - The Specialist Advisory Committee in OS
20. The day provided a useful opportunity for these groups to feed directly into the review, and enabled the working group members to engage directly with those affected by the outcomes of the review.

Service questionnaires

21. In order to ascertain current service needs, the working group drafted two questionnaires which were sent to Directors of Commissioning, Trust Chief Executives, and their counterparts in the Devolved Administrations.
22. 89 responses were received to the Acute Trust and Health Board questionnaire, the classifications of which can be found in the graph below. All graphs used in this report are taken from the evidence gathered in this consultation exercise.
23. Copies of the questions can be found at Appendix B of this document.

Figure 2.1 – PMETB consultation with Trusts and Health Boards, question 1



Summary of responses

Q1. What is it that Oral and Maxillofacial Surgeons uniquely do?

24. Responses received to this question have been sharply divided; some respondents argued that OMF surgeons provide an unrivalled level of holistic patient care, along with access to highly trained specialists, whereas others are of the opinion that there is little that OMF Surgeons do that could not be done by an appropriately skilled multi-disciplinary team (MDT) of singly qualified clinicians.
25. Addressing the latter point first, the Specialty Advisory Committee (SAC) in OMFS define such common surgical skills as “areas of overlap with other specialties, such as the surgical specialties of ENT, Plastic Surgery and Neurosurgery and the newly-established, dental specialty of Oral Surgery.” These areas of overlap were also included in the response from the SAC in Oral Surgery.
26. The Association of British Academic Oral and Maxillofacial Surgeons (ABAOMS):
 “This broad spectrum of work includes spheres of activity undertaken by dentists in practice, oral surgeons in both practice and hospitals, and oncological work undertaken by ENT, plastics or ‘head and neck’ specialists. As such, it could be argued that there are few areas of surgery that OMF Surgeons uniquely do.”
27. The Committee of Postgraduate Dental Deans and Directors (COPDEND):
 “It is difficult to identify specific practises which are unique to OMFS. Thus much of the work undertaken is part of other dental and medical specialties which could be undertaken by appropriately trained individuals who have shorter training programmes without any reduction in the quality of care.”
28. What *is* unique about OMFS, an Emergency Medicine trainee argued, is the ‘huge benefit’ to patients of having one consultant undertaking their surgery, and patients’ particular need for confidence in an individual involved in facial surgery.

29. An OMFS Consultant stated that “what OMF surgeons uniquely do is bridge the gap between the dental and medical skills of hospital clinicians...They cement these two diverse areas of clinical competence (medicine and dentistry), gaining a clear understanding of the strengths of each.” This point was supported by the British Society for Oral Medicine, which described OMF surgeons as “qualified by education, training and experience to deliver quality surgical care to patients who require surgery that is beyond the competence of surgeons from either a dental or medical background only.”
30. The SACs in OMFS and OS, and the Dental Council of the Dental Faculty of the Royal College of Surgeons of Edinburgh expand on this point by listing those practises they see as being unique to OMFS:
- Cranio-maxillofacial trauma;
 - Acquired and congenital facial deformity;
 - Head and neck cancer;
 - Acute infection of the head and neck;
 - Deformity and functional problems associated with cleft lip and palate.
31. It was noted in numerous submissions – and particularly those from patient groups - that the ability to manage the full scope of cranio-maxillofacial conditions under the roof of one specialty (OMFS) results in better patient care. While it was acknowledged that a team composed of ENT, Plastic, Orthopaedic, General and Oral surgeons could combine to provide a similar service to that currently delivered by OMFS, each specialty lacks the broad training to be able to deliver the current standard of service in *all* cases, without reliance on the other specialties. What is unique about OMF surgeons is that they are able to provide a comprehensive level of care and unrivalled continuity for patients from diagnosis through to rehabilitation. “OMFS is unique in that it represents the convergence of the two major independent healthcare professions of medicine and dentistry. The trained OMF surgeon uses knowledge and skills gained from both backgrounds to provide a comprehensive diagnostic and treatment service to patients for the management of a large range of both simple and highly complex conditions that present within the defined anatomical area of the mouth, face and jaws.”⁴
32. The BDA developed this point by highlighting other areas of surgery which require the particular skills of OMFS:
33. “Whilst nothing that OMFS consultants perform is uniquely in their remit, they make an important contribution in the following areas:
- i. repairing and managing dentoalveolar trauma – occasionally, dental procedures can result in complications such as oral-antral communications, usually repaired by OMF surgeons;
 - ii. managing diseases of the oral cavity not dental in origin and head and neck, especially where an academic oral medicine department does not exist. Examples are red and white patches and other lesions of the oral mucosa;
 - iii. managing tumours of the head and neck, especially those of the oral cavity;
 - iv. managing large facial swellings in patients who display signs of pyrexia and require hospitalisation;

⁴ Consultation submission, Specialist Advisory Committee in OMFS

- v. bone grafts to the oral cavity for various reasons. This could be for cleft palate, pre-prosthetic surgery such as implant placement, or both;
 - vi. craniofacial deformity correction, skull base and other neurosurgical access surgery and facial aesthetic surgery;
 - vii. orthognathic surgery in conjunction with orthodontists;
 - viii. training of undergraduate dentists and those in other forms of specialty training, in complex extractions, providing treatment under general anaesthesia, as well as managing patients with multiple co-morbidities. Many general dentists and most specialist trainees take up at least one post in OMFS which broadens their experience and ability to treat patients, especially those with complex medical histories;
 - ix. quality of life and rehabilitation following cancer surgery.
34. Although there has been some difference of opinion on the procedures unique to OMFS, it is clear that the management of particularly complex procedures sits well within OMFS. If we interpret the question literally – i.e. ‘what do OMF surgeons do that other surgeons do not?’ – these procedures are indeed unique to the specialty. 95 consultation respondents agree that OMFS provides a unique service, with 17 of the opinion that there is little or nothing that is uniquely performed by OMF surgeons.
35. As noted above, it is the convergence of medicine and dentistry that many see as being crucial to the delivery of service in OMFS, with a widely held belief that this comprehensive knowledge of the head and neck leaves OMF surgeons better equipped than any combination of singly-qualified surgeons to manage all of the conditions that present in this specialty.

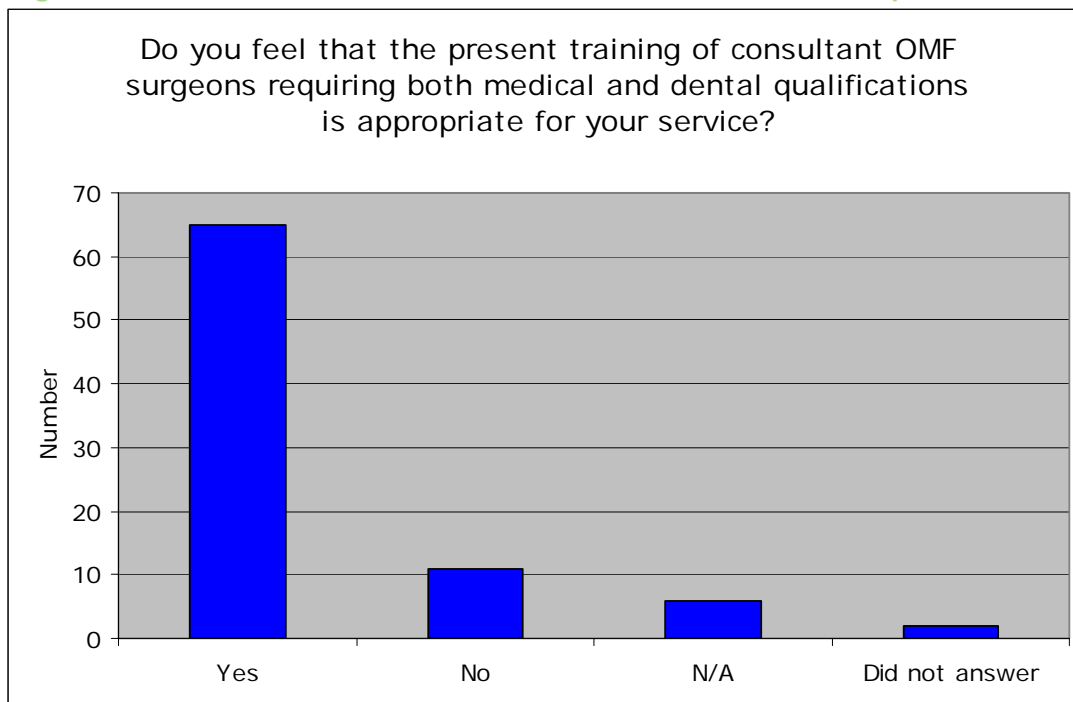
Q2. What is the added value of undertaking undergraduate medical and dental training, as opposed to one or the other?

36. In order to award a CCT or CESR in OMFS, registerable qualifications in both medicine and dentistry are currently required. This question aims to gauge perception on whether this requirement adds value to the provision of service in OMFS.
37. The BMA support the idea that within the current system, training in both disciplines is required. Patient safety was cited as a concern by numerous respondents who agreed that the medical management of patients can only be undertaken by a qualified doctor, and thus there will always be a need for medical training for OMF surgeons:
38. “We believe that whilst dental training offers some basic medical training, it does not allow trainees to meet the required competencies to make the transition from an undergraduate dental student to the medical training grades. By qualifying as a doctor, we believe OMFS trainees are more likely to have a holistic approach to patient care to understand how the management of patients is influenced by other factors, including co-morbidity. It is vital that OMFS professionals have gained adequate training, skills and competencies in all diseases and conditions to ensure they are able to provide the best possible level of medical care to patients in their care.”⁵
39. The European Association for Cranio-Maxillofacial Surgeons (EACMFS) offered the following response, supporting the need for dual qualification:

⁵ Consultation submission, British Medical Association

40. "It is now internationally recognised that undergraduate training in both disciplines is essential as a foundation for the development of a competent specialist in OMFS. The factors underpinning this include a need for:
- detailed and specialised knowledge of the basic sciences relating to the head, neck, mouth, jaws and teeth to complement those of the body as a whole;
 - technical training from a very early stage in complex manual skills, working to very low tolerances for error which is a feature unique to OMF surgeons when compared to other surgical specialties;
 - working knowledge and skills in the clinical dental disciplines and also dental technology;
 - comprehensive education and training in medicine, not only to ensure competence in evaluating and managing the whole patient, but also to provide for the graduate the only possible avenue to postgraduate core surgical training."
41. There is broad support from respondents of the need for dual qualified specialists who are able to manage the full scope of conditions presenting in OMFS. However, the other side of this argument is that whilst there is a need for dental and medical *training*, this need not constitute two full undergraduate degrees. The SAC in Oral Surgery acknowledges that some dental training is required for a career in OMFS, but not necessarily a full dental undergraduate degree:
42. "With the advent of specialist care practitioners and the extended roles of health professionals, (the need for two full degrees) is no longer the case. A deep understanding of dental and oral anatomy, function, disease diagnosis and pathology is required for the management of this patient group, and particularly to permit optimal reconstruction. Some form of dental training is therefore required."
43. The evidence gathered from PMETB's consultation with Trusts and Health Boards suggests that the service is satisfied that the requirement for dual qualification provides the appropriate level of service for patients:

Figure 2.2 – PMETB consultation with Trusts and Health Boards, question 4



44. Building on this point, the British Society for Oral Medicine (BSOM) cites the “inherent differences in UK undergraduate medical and dental degrees” as the reason for the continuing need for dual qualification:
45. “A degree in medicine provides a broad understanding of human health, disease and how these link to healthcare in very general terms...By contrast, dental undergraduate degrees place emphasis on a small part of the body from the outset...The aims and outcomes of dental and medical undergraduate degrees are very different...and at this time, the only way to acquire the benefits that dental and medical undergraduate programmes bring to patient care is to undertake both degrees.”
46. OMFS evolved from a dental specialty into the current model of dual qualification. This evolution of the specialty is of key importance to this question. As one individual responded:
47. “The specialty did not evolve by accident but was responding to cognisant criticism of its ability to manage the patient medically or surgically.”
48. The SAC in OMFS responded; “If the specialty of Oral and Maxillofacial Surgery did not exist, the majority of uncomplicated dentoalveolar surgery could be undertaken by Oral Surgeons, although there would remain a number of complex dentoalveolar cases including odontogenic tumours, which would require additional skills that this group of surgeons does not possess...It is the SAC’s view that team working between the specialties of OMFS and OS can only serve to enhance patient care. Staff and Associate Specialist (SAS) grades already work in OMF units as part of the team carrying out a significant proportion, but by no means all, of the dentoalveolar surgery. Many of these specialists do not wish to work independently and enjoy their role working within the team. It is, however, essential that there are mechanisms for career progression for the SAS grades. Appointment to consultant Oral Surgery posts would be acceptable to OMF surgeons, particularly if team working were maintained; however, becoming a consultant would fundamentally change the working relationship the SAS grades currently enjoy within the OMF departments. Ultimately, the decision to appoint to the consultant grade for any specialty rests with the employing Trust.”
49. (PMETB would like to clarify that the appointment of SAS grades to consultant posts in a medical specialty would require individuals to apply for assessment to determine their eligibility for entry into the Specialist Register under Article 14 of *The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003*. For dentists, the route is Article 9).
50. Ninety one respondents to the consultation agreed that undertaking medical and dental training was invaluable to OMFS. Eleven disagreed on the basis that the current system is wasteful of time, with some stating that there is sufficient overlap between OMFS and OS to enable singly qualified dentists to take on some of the tasks currently performed by OMF surgeons.

Q3. What knowledge, skills and competencies should be acquired during postgraduate training in OMFS?

51. The responses from the British Association of Oral and Maxillofacial Surgeons (BAOMS) and the SAC in OMFS outlined the core knowledge, skills and competencies to be acquired during postgraduate training as including (but not restricted to);

- specialist knowledge of the embryology, anatomy, physiology, pathology, pharmacology etc. relevant to conditions affecting the teeth, mouth, jaws and face;
- generic skills in surgical technique, tissue handling, control of blood loss, management of infection, fluid balance, care of the surgical patient etc;
- relevant, more advanced surgical skills, such as emergency airway management, design and execution of local and regional skin flaps, vascular and neural repair, bone grafting etc;
- management of complex dentoalveolar conditions such as impacted and unerupted teeth, cysts and benign odontogenic lesions and tumours of the jaws;
- management of serious cervicofacial infections, including emergency airway management;
- management of diseases of the oropharyngeal mucosa, including those conditions that arise as local manifestations of systemic diseases;
- management of craniomaxillofacial trauma, including trauma to the hard and soft dental tissues, and traumatic injuries to the complex anatomical structure of the neck;
- management of congenital and acquired facial deformity (competencies for cleft and craniofacial deformity are limited to diagnosis and knowledge of management. Advanced surgical skills are now covered in the post-CCT cleft and craniofacial multidisciplinary fellowships);
- management of neck lumps and diseases and tumours of the salivary glands;
- management of temporomandibular joint problems and complex facial pain, including psychological aspects;
- management of malignant disease of the face, mouth and jaws, including diagnosis and surgical management of primary tumours and neck metastases together with the principles of advanced surgical ablation and reconstruction (advanced management and reconstruction are now covered in the H&N oncology multi-disciplinary fellowships);
- management of ill patients and in particular the assessment and management of patients requiring major surgery who have multiple medical co-morbidities;
- exposure to, and team working with, allied disciplines in medicine.

52. The BDA has categorised the requirements it considers to be essential, as follows:

General:

- Critical evaluation of dental and other scientific literature;
- Competent in the use of common computer software packages;
- Understanding of the relationships between primary and secondary care and Universities and the NHS.

Research and development:

- Identification of appropriate areas of research and development;
- Understanding of research and development methodology;
- Application of scientific principles to research Policy development;
- Skills in the conduct of audit.

Teaching and training:

- Ability to provide appropriate undergraduate and postgraduate teaching;

- Ability to respond appropriately in multi-disciplinary/multi-agency settings;
- Knowledge of the organisation and planning of dental education;
- Acquisition of skills to provide a foundation for acting as a trainer.

Effective communication:

- Appropriate skills in written, oral and non-verbal communication;
- Appropriate skills in negotiation and influencing people;
- Appropriate counselling and listening skills.

Management:

- Managing change, people, resources, time and support;
- Understanding principles of management as applied within the NHS;
- Effective time management;
- Leadership skills and problem solving;
- Planning and organisational skills;
- Skills in conflict management and management of change.

Management of conditions and practical skills:

- Preprosthetic conditions including implantology (management of patients requiring implants and the restorative requirements);
- Other non-surgical conditions affecting the face, mouth and jaws;
- Aesthetic facial surgery and facial dermatologic surgery."

53. Dentoalveolar procedures are the main crossover point between the two specialties of OMF and Oral Surgery, and numerous respondents have offered opinions on where such procedures should be managed.

54. The SAC in OMFS state that "while OMF surgeons and trainees undertake a relatively small volume of dentoalveolar surgery when viewed against the breadth and depth of the OMF curriculum, the skills acquired during this part of training are fundamental in the evolution of an OMF surgeon. Without this aspect of training, surgeons would not develop the current level of surgical skill or expertise in the management of complex dentoalveolar surgery, trauma, orthognathic surgery and cleft lip and palate. It must be remembered that dentoalveolar surgery forms an integral part of all of these surgical procedures."

55. The Committee of Postgraduate Dental Deans and Directors (COPDEND) suggested that a compromise could be reached on the type of services delivered by OMF surgeons; "Much of the work undertaken (by OMF surgeons) is part of other dental or medical specialties which could be undertaken by appropriately trained individuals who have considerably shorter training programmes. If the scope of the specialty was refined and perhaps restricted to highly complex surgery, the overall service could be provided by a network of appropriately trained clinicians working together in a managed clinical network."

56. Patient opinion is helpful in shaping a rounded view of the necessary knowledge, skills and competencies required to practise in OMFS, acknowledging that such skills extend beyond the need for surgical competence. The patient organisation Changing Faces highlighted the following as the vital skills to be acquired during training in OMFS:

- an understanding of the meaning of disfigurement, the impact of an altered facial appearance and what it involves psychologically and socially, and the impact of an individual's body image on both their own life and their families;

- understanding of 'patients in society' and how, with appropriate support, patients can learn to 'adjust' their appearance and manage others' reactions;
 - understanding of adjustment and how it can be achieved;
 - confidence to understand the psychological and social needs in all settings;
 - confidence to address psychological and social needs e.g. developing a fully integrated care plan, a range of interventions including facilitating understanding of condition, attitude-building, counselling and social interaction training;
 - the ability to comfortably manage a patient-centred care programme;
 - the ability to provide realistic information – patients need to be fully informed about different treatment options, timing of treatment, and involved in the decision-making process;
 - leadership skills to deliver bio-psycho-social and physical-functional interventions;
 - the ability to lead a multi-disciplinary team (MDT) to be engaged with and appropriately skilled in psycho-social care.
57. Respondents agreed that the current scope of OMFS requires trainees to be skilled in a broad range of dental and medical procedures. Beyond these surgical skills, patient input into the review highlights that excellent communication, an understanding of the psychological impact of disfiguring conditions, and the ability to work with patients throughout the care pathway are highly valued skills.

Q4. Are these competencies best achieved by the current, dual primary qualification approach or could they be more efficiently achieved by having a postgraduate training programme entered from either medicine or dentistry with special modules for those without the requisite undergraduate knowledge or skills?

58. The main argument for the dual primary qualification system is that it provides OMF surgeons with the 'breadth and depth' of knowledge necessary for 'total safe patient care'. Medical training is required both for the development of surgical skills and to enable the safe management of patients with co-morbidity, with a dental undergraduate degree ultimately equipping the OMF surgeon with a detailed and appropriate understanding of oral anatomy.
59. The Faculty of Dental Surgery of the Royal College of Surgeons of England states; "The skills of both medicine and dental education are needed to manage many of the conditions which are treated (in OMFS). Dental education provides a sound knowledge of the teeth and surrounding structures and the management of intra-oral disease. Medical education provides a sound knowledge of diseases of the human body which cannot be treated in isolation and the ability to manage patients who have undertaken major surgery or who have been subject to major trauma."
60. Further to this, the Faculty outlined their perspective on the suitability of postgraduate modules to train OMF surgeons:
- "It is our view that special modules of either medical or dental training bolted onto a primary qualification will not provide the broad basis for managing the full spectrum of patients referred with conditions of the head, neck, mouth and jaws. In practise, it has been found that sufficient knowledge can be acquired in a three-year, tailor made second qualification, such that a registerable qualification can be obtained rather than a "second best" partial knowledge of a subject. In practise in the UK, obtaining a second degree has been fraught with difficulty and many years can be lost during

training, trying to obtain experience and qualifications as a necessary requirement to undertake a second degree. This faculty believes strongly in a three-year second qualification which can be started shortly after obtaining a primary qualification. This provides a full training whilst the committed individual is young and is less likely to have a family and domestic commitments. It should, for example, be possible to obtain two registerable qualifications by the age of twenty-six. Currently, many individuals do not obtain their second qualification until their early or even mid-thirties.”

61. The consultation responses indicated that there is broad agreement that pre-registration dental training in particular can be delivered in a period shorter than the standard five years. Three and four year dental courses for medical graduates are already available, but such courses are not widely available throughout the UK. Four year medical courses are available for graduates, but again, competition for these places is high. As the BDA highlights:
62. “Although these competencies are adequately covered using the dual qualification approach, a streamlined specific postgraduate qualification could satisfy the training requirements of dentists and medical doctors. Currently, medics find it difficult to get a shortened dental course. A modular system could benefit all trainees, allowing them to take core common modules with options in line with their individual training needs...Ideally, these programmes should be funded by the postgraduate deaneries, reflecting that cost savings will be realised elsewhere...Trainees should be on full Specialty Registrar salary, with any banding relevant to their normal rota, during the course of their training.”
63. The SAC in OS offered the following opinion on training:

“The progressive polarisation of the “oral” and “maxillofacial” sections of OMFS indicates that the suggestion of a postgraduate training programme entered from either medicine or dentistry would have considerable merits. Special modules could be tailored for those with different primary qualifications and targeted toward different end points, at each end of the spectrum. The current pathway for OMFS results in an appointment to consultant level at approximately 38 years [of age]. In the dental specialties, for example in Orthodontics, this can be achieved by the age of 30. Even in medicine it is possible to be trained as a Surgical Urologist by the age of 31. OMFS is another branch of surgery, so does it really need another seven years of training?”
64. Evidence from a recent study undertaken at Addenbrooke’s Hospital in Cambridge suggests that age of appointment to consultant posts in OMFS (37.69 years) is consistent with other branches of surgery such as Neurosurgery (37.35 years) and Cardiothoracic Surgery (38.22 years)⁶. Age of appointment has thus far not been cited as a major concern for respondents, and although it is an aim of the review to reduce this if possible, this will not be recommended at the expense of the quality of training.
65. None of the responses called for a return to single qualification, yet there have been numerous suggestions as to how training can be streamlined for those wishing to practise OMFS (see question 5).

⁶ Cameron and Westcott, *Maxillofacial training is no longer than other surgical specialties*, Ann R Coll Surg Engl 2008; 90: 000-000

Q5. Are there alternatives for streamlining training?

66. Responses to this question can be split into two groups; those who believe that the shortening of postgraduate training will decrease the quality of future consultants and that it is not possible, and those who think that training can be streamlined through a revision of both undergraduate and postgraduate training.
67. BAOMS suggested the following:

“One model would be the introduction of an interchangeable health sciences programme covering those preclinical topic areas common to both medicine and dentistry. This would potentially have significant economies across the whole of both medicine and dentistry. A diploma of pre-clinical sciences of BSc could then be used interchangeably across medicine, dentistry and possibly other healthcare-related degree subjects. With regard to the craft skills and knowledge acquired within clinical medicine and dentistry, there is also some overlap. For example, the entire medicine and surgery section of the dental curriculum could be subsumed into medicine and surgery within the relevant medical curricula.
68. For medical graduates studying dentistry, directing craft skills toward exodontia, basic dentoalveolar procedures, orthodontics and prosthodontics and away from large volumes of basic restorative procedures, would streamline both undergraduate training and minimise basic postgraduate dental training.
69. “At present, it is possible for dental graduates to acquire a registerable medical qualification after a three year programme, and also for medical graduates to acquire a registerable dental qualification after three years. With acceptance of the principle of transferable educational credits, it should therefore be possible to produce an integrated programme, by building suitable modules from medicine and dentistry which would lead to the acquisition of knowledge and skills which in turn would satisfy the regulatory requirements of both the GMC and GDC. This would lead to the acquisition of registerable medical and dental qualifications whilst at the same time providing a streamlined undergraduate training, which is fit for purpose. This could reduce the time taken to acquire both qualifications, from the existing eight to ten years to approximately seven years. Further reduction in ‘core specialist training’ would be inappropriate, and the European Working Time Directive (EWTD) restrictions leave little scope for any reduction in the length of time required to achieve competence in these core areas.”
70. The Dental Council of the Dental Faculty of the Royal College of Surgeons of Edinburgh proposed core medical training with a programme of dental modules including; dental anatomy, oral pathology, oral surgery and oral medicine, with some restorative dentistry, and this “might suffice for the OMFS trainee.” It was suggested that this could reduce dental training to a two-year programme.
71. There is no consensus as to the minimum amount of time to be spent at undergraduate level, but the shortened graduate courses that are currently available provide a more streamlined option for those wishing to pursue a career in OMFS. There is general agreement that the time spent at undergraduate level should be appropriately configured to facilitate seamless progression to the foundation programme and specialty training. Other suggestions as to how undergraduate training can be optimised included promoting close linkages between those undertaking their second degree and maxillofacial units to assist in the development of competencies, and standardising the duration of the second degree across the UK.

72. On the subject of length of time spent at undergraduate level, it is interesting to note that during the visits, OMFS staff were asked if they thought that duplication across medical and dental undergraduate degrees was an unnecessary delay to their studies. The majority thought that repeated study of similar modules enhanced and cemented their knowledge of the subject in question.
73. 69 respondents (of which 15 were institutional) indicated that there should be streamlining of training at undergraduate level, with a reduction in the length of the second undergraduate degree to three years, where possible. 14 (of which four were institutional) felt that postgraduate qualifications built onto a medical degree could achieve streamlining. Eight respondents (three of which were institutional and included ABAOMS, the SAC in OS and BAOS) indicated that streamlining should occur by extending competencies on a dental qualification and avoiding the need for a medical qualification altogether. Only two respondents suggested a reduction in the specialist training time.
74. Any reduction in the duration of pre-registration education would have to be compliant with the European Professional Qualifications Directive 2005/36, which determines the minimum length of such courses.

Q6. What are the requirements of OMFS for;

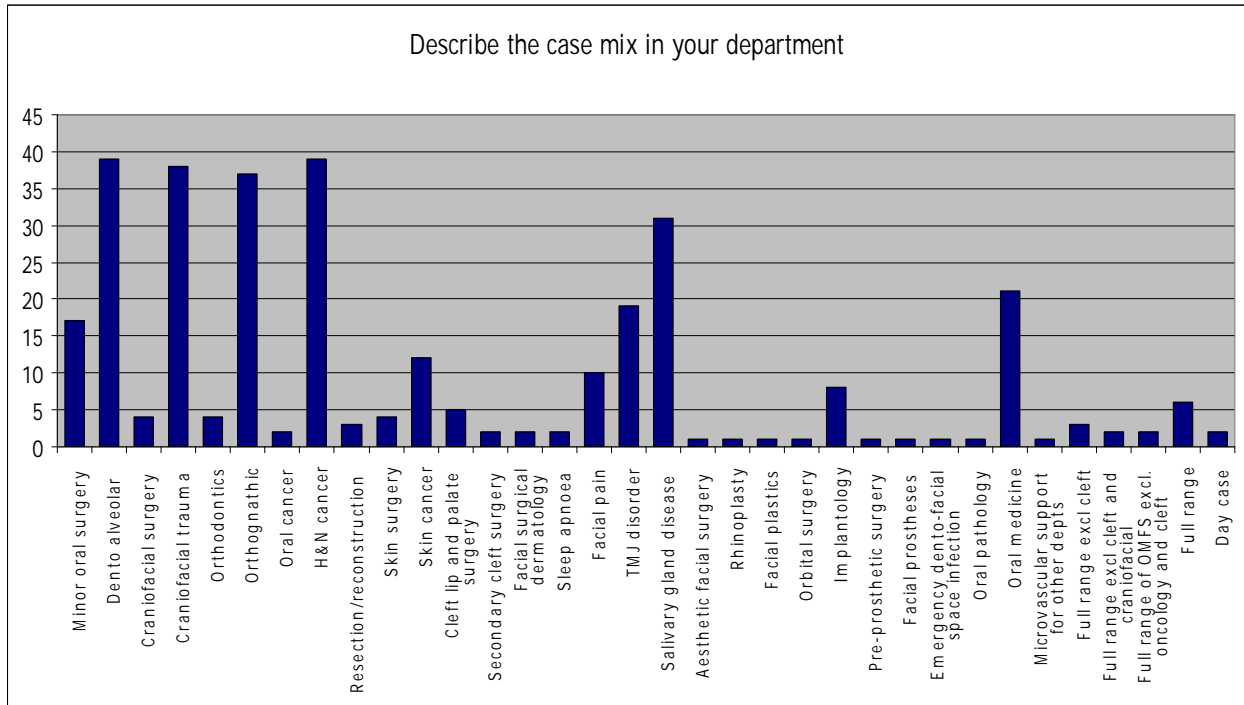
- a) patients
- b) the service

a) Patients

75. The key needs of patients as outlined by respondents can be summarised in the following points:
 - availability of appropriately trained, skilled surgeons who have a combined skill-set to manage the full scope of conditions under the remit of OMFS;
 - wherever possible, they should have a choice of service provider;
 - they should enjoy seamless transfer of care between primary, secondary and tertiary care;
 - they should have ease of access to high quality elective and emergency care in a convenient location.
76. The above requirements are applicable to all patients, irrespective of the complexity of the condition or duration of treatment. However, for individuals living with facial disfigurement, Changing Faces outlined the following patient concerns:
 - facial disfigurement has been linked to psychosocial problems (e.g. social anxiety, depression, social isolation);
 - psychological problems are often linked to social interaction difficulties;
 - individuals experience a loss of social anonymity and yet simultaneously experience a sense of social isolation;
 - the objective severity of the disfigurement is not positively correlated to distress, but the perceived/subjective severity is.
77. Positive factors in patient rehabilitation include;
 - good quality social support from friends, family and professionals to build self-esteem;
 - realistic information about treatment options;
 - effective coping strategies (especially to manage social anxiety).

78. A holistic approach to care – combined with the requisite levels of surgical competence - is therefore required to provide appropriate treatment to patients, and beyond this, services need to be appropriately configured to ensure that they are easily accessible to all.

Figure 2.3 – PMETB consultation with Trusts and Health Boards, question 6



b) The Service

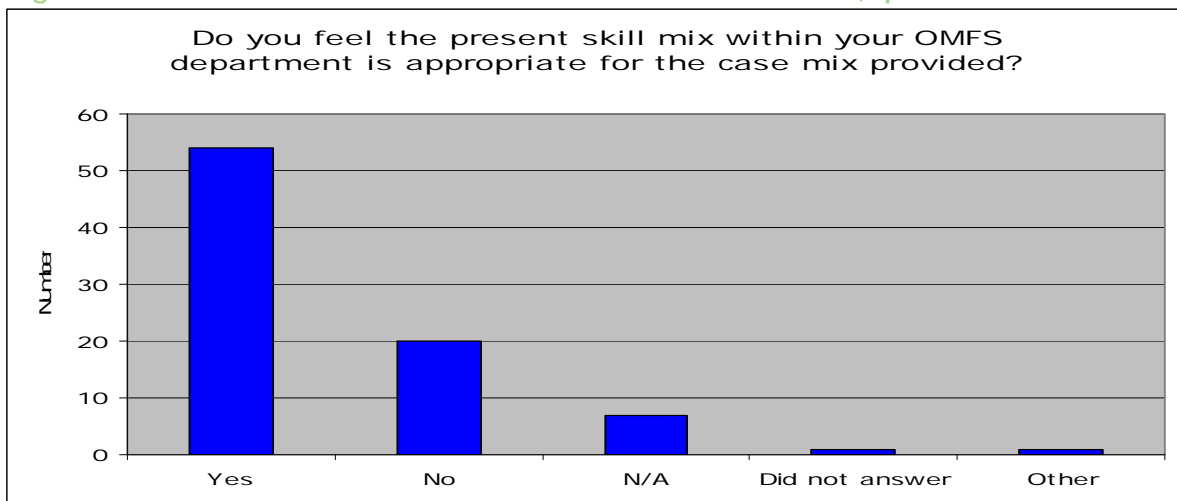
79. Respondents agreed that the service needs to:
- train and retain surgeons of the highest quality;
 - ensure that care is accessible;
 - provide a high standard of service to patients presenting with head and neck oncology, dentofacial/craniofacial deformity, cleft lip and palate, facial trauma and salivary gland pathology;
 - provide treatment that is delivered by an appropriately staffed team.
80. The SAC in OMFS are of the opinion that “the service should be provided by an appropriately constituted, balanced team, which will usually include dually qualified OMF surgeons and dentally qualified Oral Surgeons. Ideally, the service will be configured on a ‘hub and spoke’ basis, permitting economies of scale for the management of common conditions and a critical mass for the management of the rarer conditions. This, importantly, also permits structured and efficient training with credible audit of outcomes.
81. “Appropriately trained clinicians can provide outreach services for ambulatory care in primary and secondary care sectors. This might involve Oral Surgeons who have undertaken appropriate postgraduate dental training in line with the GDC-approved, essential competencies specified for the specialty of Oral Surgery.
82. An integrated service provided along this model permits effective clinical governance while facilitating continuing professional development and peer support.”

- 83. Most importantly, fundamental in all responses was the need to build on the requirements of patients to ensure that care is adapted to meet the needs of the service user.
- 84. BAOMS' Junior Trainees Group went further and highlighted the needs of OMFS trainees, "who for a long time have been in a great disadvantage compared to any other trainees, not because of the length of training, but rather the multiple obstacles and the gamble of undertaking a second degree before any form of official selection process or appraisal which would secure their huge personal investment."

Q7. Are these requirements being met as efficiently as possible?

- 85. BAOMS suggested a need for mergers and rationalisation of services in some areas to ensure that teams are configured with the appropriate skill mix. BAOMS expanded this point by commenting that there are already numerous examples of "well-organised services...integrated across primary care medicine and dentistry, secondary care medicine and dentistry, and specialist multi-disciplinary teams. Common conditions are managed in spoke units and/or primary care facilities, providing timely and local access, whilst rarer conditions are managed in hub units housing well-developed multi-disciplinary teams."

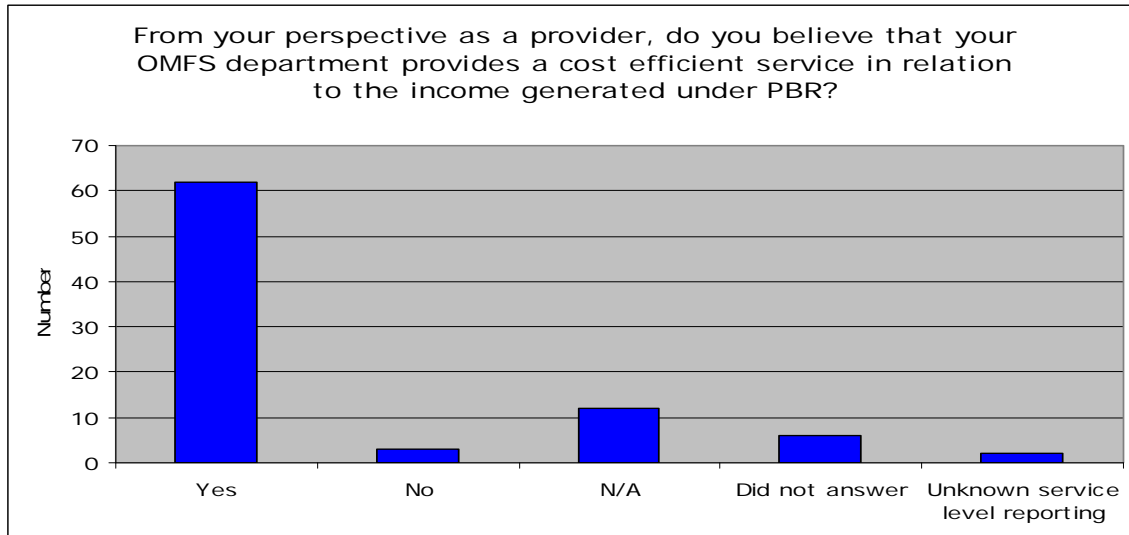
Figure 2.4 - PMETB consultation with Trusts and Health Boards, question 3



- 86. Responses to question five provides more detail on some of the perceived inefficiencies in the delivery of training.
- 87. As evidenced in the responses to other questions, respondents agreed that OMFS provides a high quality service, but to some, the length of time spent training individuals to provide this service contributed to its perceived inefficiency. However, the Faculty of Dental Surgery of the Royal College of Surgeons of Edinburgh commented that, "there are enough volunteers for the current system, suggesting that even with a lengthy training time, attracting high quality applicants is not a problem."
- 88. The NHS Workforce Review Team (WRT) advise that "there is an anecdotal belief that much work in OMFS units is minor oral surgery, a service that can be and is provided also by (singly qualified) Oral Surgeons or those in Staff and other grades as well as competent primary care dentists. This work may be provided in a primary care setting which may be more appropriate and convenient for patients."
- 89. Faculty of Dental Surgery, Royal College of Surgeons of England – "Within metropolitan areas, most of these requirements are being met. However, there is a

general shortage of members of the team to work in hospitals such as orthodontists, restorative dentists and hygienists. One of the most important principles of managing emergencies should be a large team of OMFS surgeons working together at a hub hospital and sharing the on-call duties. Each OMF surgeon should have the required skills to deal with major trauma and also the emergency management of post-operative complications following major surgery."

Figure 2.5 - PMETB consultation with Trusts and Health Boards, question 5



90. The above graph highlights that the overwhelming majority of Trusts and Boards are content that their OMFS departments provide an efficient service, suggesting that there is no perceived need for change in the way services are delivered.
91. Overall, 40 respondents to the consultation indicated that requirements are being met efficiently, although some improvements were suggested, including better rationalisation of the service, and in particular, better use of primary and secondary care Oral Surgeons. 38 indicated that efficiency could be improved, again, by better rationalisation of service, which included suggestions for better hub and spoking, with more defined roles for Oral Surgeons working within OMFS teams, and better use of primary dental care. 20 indicated that the service was not efficiently delivered and suggested that primary care could be better organised to improve delivery. Eight indicated that there should be greater use of singly qualified Oral Surgeons in both primary and secondary care.

Q8. Is there a continuing need for specialists to hold dual registration?

92. The majority of respondents to this question agreed that there is not a continuing need for OMF surgeons to hold dual registration with both the GMC and GDC, but recognised that *registerable qualifications* remain a legal requirement.
93. Both bodies responded to the consultation and supported a move to a system of single registration for OMFS:
94. GDC – "It is the GDC's position that a specialist in OMFS, practising only within the scope of that (medical) specialty, should not be required to register with the GDC, as patients will be protected by virtue of their GMC registration. We do not believe that it adds value to these specialists to be registered with the GDC (unless they wish to practise dentistry separately, in addition to their specialist duties)."

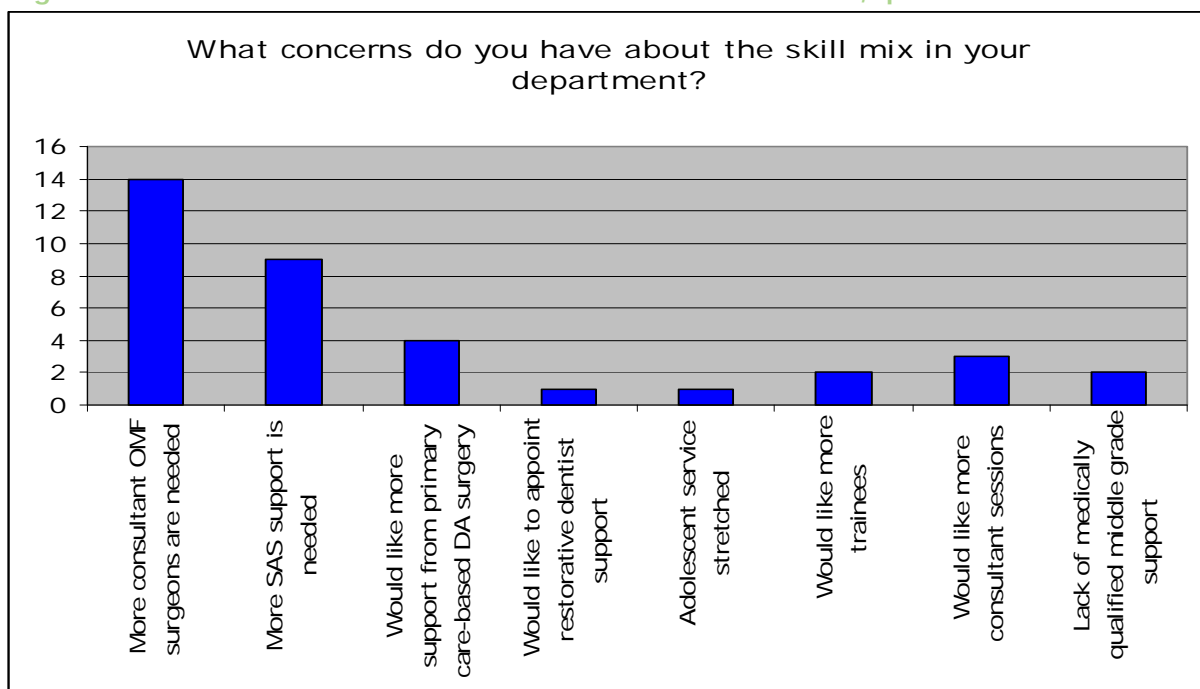
95. GMC – “We do not consider that the current requirement for OMF surgeons to hold dual registration with both the GMC and GDC adds any value in terms of public protection. We therefore agree that it should be discontinued. (PMETB) may wish to note that we have also conveyed this view to the Department of Health in connection with its recent consultation on the European Qualifications (Health and Social Care Professions) Regulations consultation.”
96. Other responses received included:
97. SAC OMFS – “Yes and no.
98. It is important to draw distinction between registration, and the acquisition of registerable qualifications. Both the GDC and GMC have agreed, in principle, that they would be content for OMFS specialists holding dual registerable qualifications to be registered solely with the GMC which currently maintains the specialist list in OMFS. This would avoid unnecessary duplication of bureaucracy for recertification and relicensure, and remove the potential exposure of OMFS specialists to the “double jeopardy” of disciplinary proceedings. This would require amendments to primary and secondary domestic legislation but could be achieved without jeopardising our obligations under EU law.
99. Notwithstanding this, OMF surgeons are proud of their dental links and have concerns that removing the need for registration with the GDC might diminish these. An agreement between the GMC and GDC to have the former “responsible” for OMFS with continuing professional development (CPD) and disciplinary requirements determined accordingly is seen by many as a more satisfactory arrangement.”
100. BMA – “OMFS is a medical specialty under the remit of PMETB and the GMC. We believe that OMFS professionals must hold full medical registration with the GMC. Currently there is no independent regulator for postgraduate basic and higher specialist education and training in dentistry separate from the body regulating the profession of dentistry. At the present time we believe that there is a need for OMFS professionals to hold dual registration.”
101. The Faculty of Dental Surgery, Royal College of Surgeons of England – “No, currently, OMF surgeons have to be registered medical practitioners. They do not have to be registered dental practitioners but do require a dental qualification which is potentially registerable.
102. In the past, it has been interpreted that OMF surgeons need to be registered with both the GMC and the GDC. This has caused considerable duplication of bureaucracy, the payment of registration fees and even the management of disciplinary procedures. The Faculty would recommend that all OMF surgeons must be registered as medical specialists but should also have a dental qualification which may or may not be registered. The GMC and GDC should work together to minimise the bureaucracy and inconvenience to which individuals are subjected when they are registered with both organisations.”
103. BDA – “Dual registration is essential for the specialty of OMFS, given the hybrid nature of the training and related responsibilities.”
104. An amendment to *The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003* means that basic dental training is sufficient to allow practise in OMFS, and that registration with the GDC is no longer a pre-requisite.⁷
105. The majority of respondents to the consultation– 65% - support a move to a system of single registration, with the specialist list held by the GMC.

⁷ www.opsi.gov.uk

3. Points to consider and conclusions

106. It is acknowledged that in OMFS, as throughout medicine, there are areas of commonality which leave certain specialists equipped with a skill set that would enable them to work in areas of other specialties. The range of conditions which present in the specialty of OMFS range from impacted teeth to complex congenital conditions which require multiple procedures from birth through to adulthood, and can currently best be managed by dual-qualified OMF surgeons. The patient perspective on this point suggests that what is most important is that a competent surgeon or team of surgeons is able to undertake a procedure safely, that they are equipped with specific knowledge of how to deal with emergencies, as well as being appropriately skilled to manage the patient throughout their period of rehabilitation.
107. The majority of respondents to all of the evidence-gathering exercises agreed that it was important for OMF surgeons to maintain the current level and standard of knowledge in medicine and dentistry but agreed that the delivery of training - particularly at undergraduate level – could be more efficient (question 5).
108. Responses to the Trust and Health Board consultation showed that the service is content with the care provided by its OMFS departments, but that some have plans to change their department’s configuration. The majority of these changes are related to staffing levels, suggesting that there may be concerns in some areas about the availability of appropriately qualified staff to deliver the service, but not of the quality of service provided. This, however, seems to be the case in a relatively small number of departments.

Figure 2.6 - PMETB consultation with Trusts and Health Boards, question 7



109. Departments were clear in the articulation of their needs in terms of staffing levels, with 14 considering the appointment of one or more dual-qualified consultants, and nine considering an expansion in numbers of SAS-grade staff. This evidence suggests that areas of the service are content to expand on the current model, as opposed to offering a radically revised service.

110. As demonstrated in MMC's predicted competition ratios for 2008, OMFS remains a popular career choice, with the current training pathway seemingly not too great a deterrent for many undergraduates. The working group are convinced of the need for maintaining current high standards and maximising efficiency in the delivery of training at both under- and postgraduate level to ensure best patient care, which is reflected in the group's recommendations. Beyond this, there is a need for greater exposure to OMFS at undergraduate level to promote awareness of the specialty and its training requirements.

4. Recommendations

111. The working group propose the following recommendations:

Recommendation 1: The need for dual qualification

112. There should be no change to the current statutory requirement for those training in OMFS to obtain primary qualifications in both medicine and dentistry.

Recommendation 2: The duration of training

113. Discussions should take place with medical and dental schools and the regulators to explore ways of streamlining the education and training of those dentists or doctors who wish to pursue a career in OMFS. Any reduction in the length of training leading to a primary qualification must be compatible with the European Professional Qualifications Directive 2005/36

Recommendation 3: The training pathway; when should training begin?

114. Since OMFS is unique in requiring two primary qualifications, we recommend that all those responsible for training in the specialty explore the feasibility of beginning specialist OMFS training at the start of the second degree course.

Recommendation 4: Registration

115. Those on the specialist register in OMFS need be registered only with the GMC.

Recommendation 5: The relationship between Oral and Maxillofacial and Oral Surgery

116. There should be a separate review of the specialty of Oral Surgery.

Recommendation 6: Foundation programme

117. Dually qualified individuals who can demonstrate to PMETB that they meet foundation year 2 (F2) competencies have the option to move directly into competition for specialty training programmes without completing F2. This does not alter the requirement to complete F1, which remains compulsory.

118. PMETB notes that the Department of Health for England intend to publish a review of the foundation programme later this year, and this may be subject to some change.

Appendix A – Consultation respondents

119. Responses received from individuals include grade, title and specialty where this information was provided.

From:

Organisations:

British Society for Oral Medicine

Faculty of Dental Surgery of RCS Edinburgh

General Dental Council (GDC)

General Medical Council (GMC)

British Medical Association (BMA)

Workforce Review Team

School of Dental Sciences – Newcastle University

NHS Education for Scotland

The Surgical Forum of Great Britain and Ireland

British Dental Association

Faculty of Dental Surgery

Committee of Postgraduate Dental Deans and Directors (COPDEND)

Department of Health, Social Services and Public Safety (DHSSPS)

Scottish OMFS Society (SOMS)

British Society for Maxillofacial Research (BSMR)

Association of British Academic Oral and Maxillofacial Surgeons

European Association for Cranio-Maxillo-Facial Surgery (EACMFS)

British Association of Oral and Maxillofacial Surgeons Junior Trainees Group

Specialty Advisory Committee in Oral and Maxillofacial Surgery

Specialist Advisory Committee in Oral Surgery

Fellows in Training (FiTs)

British Association of Oral and Maxillofacial Surgeons

Department of Oral and Maxillofacial Surgery (CELWEX)

Kings College London (Dental Institute – Oral Surgery)

Surrey and Sussex

Sheffield Teaching Hospital

City Hospitals Sunderland

Poole Hospital NHS Trust

University Hospital Aintree NHS Foundation Trust

British Association of Oral Surgeons

European Association for Cranio-Maxillo-Facial Surgery

The Federation of Surgical Specialty Associations

The Royal College of Surgeons of England

Combined Responses

Specialty Registrars (StRs) in OMFS, Northern Deanery

West of Scotland Consultants and Higher Surgical Trainees in OMFS

Individual Responses

Andrew Carton, Consultant, OMFS

Kavin Andi, FiTs

Manjinder Jandu, Consultant, Department of Oral and Maxillofacial Surgery, Barnsley

Ray Reed, Consultant Orthodontist

Dr. Samit Shah, GP, StR in Dental Public Health

Jane Parker

Mr. Mark F. Devlin, Consultant OMFS

Mahesh Kumar, Consultant in Oral and Maxillofacial Surgery

Craig Wales, StR OMFS

David Smith

Phillip Ameerally, Consultant Surgeon

Clive Pratt, Consultant OMFS

Helen Spencer, Oral Surgeon & Educational Supervisor Oral Surgery StR Training Programme

James Brown, Chairman of the Intercollegiate Examining Board in OMFS,

Liverpool and Warrington

Mr. Benedict Davies, StR Oral Surgery

Miss Daljit Dhariwal, Consultant OMFS

Tara Renton, Professor in Oral Surgery, Kings College London Dental Institute

Dr. Tom W.M. Walker, SHO Emergency Medicine

Mr. R. Banks, Trainee Representative to OMFS SAC

Mr. N M C Renny, Consultant OMFS

Vikas Sood, StR OMFS

Mr. Joseph McManners, Consultant OMFS

Vyomesh Bhatt

Dr. Caroline King, Specialist in Orthodontics

Helen Spencer, Associate Specialist OMFS, Educational Supervisor StR Training Programme Oral Surgery

Mr. Keith Smart

Mr. F. Ryan, Consultant OMFS

Sathesh Prabhu

Roderick Morrison, Consultant OMFS

Mr. T. Lowe, Consultant OMFS

G.A. Ghaly

Richard Kerr, Associate Specialist, Oral Surgery

Mr. David A. Koppel, Consultant OMFS

Ewen Thomson, Consultant OMFS
Mr. Mahesh Kumar, OMFS Surgeon
Mr. M.C. Bater, OMF Specialist Registrar
Helen Witherow, Consultant OMFS
Bhavin Visavadia, Consultant OMFS
Mr. Douglas Kennedy, Consultant OMFS
Mr. Iain McVicar, Consultant OMFS
Mr. Peter Ramsay-Beggs and Mr. Michael Perry, Consultants OMFS Surgeons
Mr. Michael Perry, Consultant OMFS
Brian Castlin, Oral and Maxillofacial Surgery Consultant
Sorcha Mackay
Tim Boye, StR OMFS
Andrew Sidebottom, Consultant OMFS
Mr. David Pagliero Specialist in Oral Surgery
James Gallagher, Consultant OMFS
Peter Brennan – Consultant OMFS
Michael Fardy
Christopher Avery – Consultant OMFS
John Stenhouse, Consultant OMFS
Christine Linn, ST2
Andrew Cronin – Consultant OMFS
David Patton – Consultant OMFS
Nicholas Grew, Consultant OMFS
John Devine, Consultant OMFS
Greg Knevil, StR Oral and Maxillofacial Surgery
Scott Rice
Victoria Beale, StR OMFS
David Sutton, Consultant OMFS
Ian Holland, Consultant OMFS
Antony Patterson, Consultant OMFS
David Mitchell, Consultant OMFS
Ian Sharp, OMFS
Patrick Magennis
Dr. Kevin O'Hare, Consultant Anaesthetist & Lead Clinician
Mrs Rebecca Hierons, Associate Specialist in OMFS
Mr Tim Blackburn

Anonymous responses

GP Response

Trainee Response

Associate Specialist

Clinical Fellow Response

Consultant Response

Consultant Response

Consultant Response

Unspecified Response

Unspecified Response

Unspecified Response

Unspecified Response

Unspecified Response

Unspecified Response

Unspecified Response

Unspecified Response

Unspecified Response

Unspecified Response

Appendix B

NHS Acute Trusts Questionnaire PMETB Review of Oral & Maxillofacial Surgery (OMFS)

1. What type of trust are you? (Use DoH classification of cluster types e.g. Acute specialist, Acute teaching [in/out] London, large, medium, small [in/out] London etc.)
2. Do you provide OMFS as a Hub or Spoke provider? Please specify your relationship with other trusts and whether you hold contracts for the service, or act as third party provider:
3. What is the skill mix of professional staff within your OMFS department? E.g. numbers of consultant OMFS surgeons/SASs and trainees:
4. Briefly describe the on call arrangements and whether you have adopted a Hospital at Night programme. Include: details of on call tiers and rotas, and qualifications of the on call staff.
5. What is the TOTAL population served by your OMFS unit?
6. Briefly describe the case-mix provided by your OMFS department.
7. Do you feel the present skill-mix within your OMFS department is appropriate for the case mix provided? Yes/No

If No describe why not, and what changes you would like to see.
8. Do you feel that the present training of consultant OMFS surgeons requiring both medical and dental qualifications is appropriate for your service? Yes/No

If No what alternative would you propose:
9. From your perspective as a provider unit, do you believe that your OMFS department provides a cost efficient service in relation to the income generated under PBR Yes/No

10. Do you have any plans to change the configuration of your OMFS department in the foreseeable future Yes/No

If yes please describe.
11. Score the quality of the OMFS service you commission at present (1 being poor, 10 being excellent) _____
12. Do you have any suggestions for improving the service provided by your unit?

Commissioners Questionnaire

PMETB Review of Oral & Maxillofacial Surgery (OMFS)

1. Population Served by you _____
2. What volume of activity do you contract for OMFS per year?
 - New Outpatients _____
 - Review Outpatients _____
 - Outpatient procedures _____
 - Elective Day Cases _____
 - Elective In-Patients _____
 - Non-elective In-Patients _____
3. How many acute trusts do you commission from?
Describe what type hospitals provide this service e.g. large teaching, dental hospital, large acute, small acute etc
4. Briefly describe the skill mix of professional staff within the departments from which you commission e.g. numbers of consultant OMF surgeons, SASs, SpRs, SHOs and other grades of staff.
5. Briefly describe the casemix which you commission:
6. Do you have any specific exclusions? Yes/No
If yes describe:
7. Do you provide or commission any oral surgery services from within primary care ? Yes/No
120. If Yes please describe volume and casemix and type of service providing this e.g. GDP, Community, Specialist Practice, ISCT.
8. Do you have any access problems for any aspect of OMFS Yes/No
If yes please describe.
9. Do you have any plans to change your commissioning of OMFS in the foreseeable future. Yes/No
If yes please describe.
10. Score the quality of the OMFS service you commission at present
11. Do you have any suggestions for improving the service which you presently receive?
12. In the light of your experience in commissioning, do you believe that the training of consultant OMFS surgeons, involving both medical and dental qualifications is appropriate? Yes/No
If No describe what changes you would like to see.

**Postgraduate Medical Education
and Training Board**

PMETB/Policy/April 08

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