COPDEND: Consultation on the Dental Foundation Training Competency Framework.

We very much welcome your feedback. This may be provided in any format, although responses to the questions below would be appreciated.

Alternatively, responses can be provided online at the following link: http://fluidsurveys.com/surveys/lindapc/copdend-dft-curriculum-national-consultation/

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Name of individual providing feedback:

Please indicate whether feedback is being provided on behalf of an organisation, or on an individual basis.

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Consultation questions

1. Is the content of the competency framework appropriate (please consider each Domain)? Are there any gaps?

1.1 The revised framework appears to be comprehensive and appropriate for a dentist at this stage of their career. We would also consider the content to be suitable and robust for a one-year programme. However, we wish to make some comments, and have identified some gaps in the content that require some consideration for inclusion.

1.2 We would sound a note of caution on the feasibility of having a system in place that is able to measure all the learning outcomes included within the framework. It is essential that outcomes are measured using reliable and quality-assured assessment processes that are standardised and peer assessed.

1.3 The framework makes no mention of minimally invasive dentistry, a competency that is increasing in its importance and may form part of the new dental contract for the provision of NHS dental services.

1.4 With regard to the clinical domain, it is difficult to capture all elements that would be expected at this level, and so consequently the content appears to be fairly generic in this area.

1.5 Some aspects of the framework may be considered rather vague, such as dentofacial aesthetic requirements (clinical domain, patient examination and diagnosis, competency
1.14). With regard to the latter, we would suggest that a basic understanding at DFT level is appropriate, and that a more comprehensive knowledge would be expected of an experienced practitioner, together with enhanced accredited training in this area, to enable a robust assessment of the patient’s needs (including, for example, appropriate orthognathic referral where necessary).

1.6 Following on from 1.5, we would suggest some of the competencies are amended to allow the trainee to understand where it is appropriate to refer rather than to discuss options and potential treatment outcomes with the patient.

1.7 Competency 15 on clinical records (within the patient examination and diagnosis of the clinical domain) should be amended to include the taking and recording of notes. The current phrase of ‘keep clinical records’ is ambiguous, and could be interpreted as simply how records are stored. We would also suggest that this competency makes reference to specific standards rather the vague term of ‘recognised standards’.

1.8 The periodontal therapy and management component of the clinical domain needs to reflect consistency between the use of the terms antimicrobials and antibiotics (competencies 6.5 and 6.12).

1.9 We suggest that the communication and the professionalism domains may benefit from having a broader, more outward-facing context in terms of wider considerations for society/the general public.

1.10 We would urge that the personal and practice organisation components of the management and leadership domain should make mention of updating knowledge, developing skills and lifelong learning. It should be stressed that the DFT framework is not an endpoint, rather a beginning or basis upon which to develop skills and knowledge within the context of continuing assurance.

2. Are the competencies within the DFT curriculum achievable, within 1 year postgraduate training in a General Dental Practice?

2.1 The competencies could be considered ambitious and challenging within a one-year period, but may be achievable providing that the DFT practice is a suitable learning environment, is appropriately staffed, and there is the necessary support for the trainee. However, meeting the competencies is an ongoing process, and it is important that support is provided for practitioners beyond the DFT period.

2.2 Specifically, the clinical competencies may only be achievable based on the practice’s patient mix, the type of foundation training practice, the extent of the trainee’s workload (as well as that of the practice team), and the range of the trainee’s clinical experiences during the year. The practice needs to be able to provide the trainee with a wide variety of training experience and access to patient types, which may be difficult to achieve in some areas. For example, it may not be possible for a trainee to have practical experience of performing a biopsy (see competency 23, patient examination and diagnosis, clinical domain) due to lack of clinical situation in general practice.

2.3 The ability to achieve the non-clinical competencies may depend on the type of educational training programme, particularly since there is a wide variation in areas covered between
schemes and deaneries. For example, a knowledge and understanding of all drug interactions and side effects may be difficult without a comprehensive educational programme. In this case, for example, it may be better to highlight the most important and common drugs within the framework, and for the competencies to demand an ability to understand the mechanisms for accessing relevant information.

2.4 It is also worth highlighting that many training practices do not yet have the necessary IT systems in place to enable effective risk screening, which may impact on the trainees ability to meet competencies in the context of the proposed new dental contract.

2.5 Furthermore, the ability of a trainee to meet the competencies can be influenced by the training provided at undergraduate level, including both theory and practice. Some UK Dental Schools describe significant challenges in delivering adequate levels of structured clinical training.

2.6 In view of the points above, it may be appropriate to consider planning for a review of the feasibility of meeting the competencies within a one -year period, perhaps at two years post introduction. We would urge that there is sufficient scope to reassess extending the training period to two years if necessary.

3. What are the barriers to the implementation of the curriculum

3.1 Availability of resources, particularly with respect to assessment of competency and support for training practices may be a barrier to implementation, as well as the necessary ongoing quality assurance of the process.

3.2 Further detail is required around assessment prior to implementation of the curriculum so that satisfactory completion of training can be determined and quantified. We would refer COPDEND to the excellent work carried out in Scotland regarding assessment of vocational practitioners (see: http://www.nature.com/bdj/journal/v190/n1/abs/4800879a.html). In this system, the certificate of completion is only awarded once training has been completed satisfactorily, and assessment is via a range of mechanisms.

3.3 Other issues that may represent a barrier include:

- Type of training practice
- Commitment of trainers
- Patient mix
- Workload
- Educational programme
- Length of training
- Clinical and non-clinical experiences
- Reluctance to embrace change from within relevant organisations
- A lack of suitably trained tutors
- Ensuring widespread awareness of the curriculum.

4. Should this curriculum apply to all routes to a foundation training certificate (i.e. ‘by equivalence’ and traditional routes).
4.1 Yes, we believe that this should be the case because:

- this is necessary to ensure patient safety.
- standards need to be consistent regardless of where and how an individual achieved initial qualification.
- it is not reasonable to assume that ‘equivalence’ covers all necessary competency areas.
- foundation training should not be seen as an endpoint, rather the basis for continued practice at Level 1.

5. **Does this curriculum reflect what might be expected of a dentist delivering routine General Dental Practice (tier / level 1)?**

5.1 Tier/Level 1 is an NHS contracting term and does not refer to a defined standard or level of competency recognised by the General Dental Council. Furthermore, it is unclear what is meant by ‘routine general dental practice’. As such, it is difficult to comment on this question.

5.2 Notwithstanding the above, it is worth noting that a Level 1 dentist may be able to offer Level 2 care without referral at a slightly later stage of their career. Also, Level 1 care is a minimum standard and one that is being increasingly provided by dental hygienists and therapists.

5.3 The GDC expects dentists to make an appropriate assessment of their level and application of knowledge and competency, and to work within this. It also recognises that skills can be improved and new skills learnt by further education, training and clinical experience.

5.4 We would say that the draft curriculum reflects the necessary outcomes ‘to produce a competent, caring reflective practitioner able to develop their career in any branch of dentistry to the benefit of patients’, and also to demonstrate competencies appropriate to independent practice irrespective of the funding system (as per the COPDEND definition of the existing curriculum).

5.5 Ultimately, we believe that it is important to establish a defined end point to mark successful completion of DFT in the form of a structured, summative assessment. The FGDP(UK) and FDS Eng joint membership diploma, the MJDF, represents a highly suitable assessment of knowledge, skills and competencies at this stage of training, and we would urge that it is considered as marking the end of DFT (as stated in previous consultation responses from the FGDP(UK)).

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