IN BRIEF

- Temporary registration in primary care provides a transition for overseas-qualified dentists planning to work in the UK and helps them prepare for the IQE.
- The scheme allowed the dental attachments to become familiar with the requirements of primary care NHS dentistry in a supervised and protected training environment.

Temporary registration in primary care for dentists moving to the UK from outside the EU: an evaluation of a national pilot scheme

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Introduction An evaluation of a pilot scheme offering temporary registration with the General Dental Council (GDC) for up to six months in primary care for overseas-qualified (non-EU) dentists studying for the International Qualifying Examination (IQE) Part C. **Methods** In all five pilot sites dental attachments and supervisors were interviewed at the start (n = 10) in 2005. At six months, supervisors were interviewed again (n = 4), and dental attachments were surveyed (n = 5). Patient (n = 15) and staff (n = 27) views were elicited through questionnaires. **Results** Hands-on clinical practice was the prime motive for involvement. Patient safety was safeguarded through close supervision of attachments' dental treatment. The value of clinical experience, development of patient management skills, work in a dental team, and familiarity of NHS procedures was highlighted. Feedback from patients and staff was positive: attachments' enthusiasm, approach, willingness to take responsibility, and follow protocols were rated highly. The National Advice Centre for Postgraduate Dental Education (NACPDE), England coordinated the pilot (including selection and matching of candidates to supervisors). They established good links with pilot sites and maintained training standards. **Conclusion** Temporary registration with the GDC provided valuable educational opportunities, specifically hands-on experience in primary care beneficial in preparing for IQE Part C. The evaluation demonstrated scope to consolidate the pilot and its expansion has been approved by the GDC.

INTRODUCTION

To practise dentistry in the UK, dentists must be fully registered with the regulatory authority, the General Dental Council (GDC). For UK graduates, and those dentists from within the European Economic Area (ie European Union countries and those within the European Free Trade Association), registration is through recognition of their basic dental qualification. However, overseas-qualified dentists must first pass the International Qualifying Examination (IQE).

The IQE is under revision[1] but at the time of the study, it was structured into three parts and comprised written, oral and practical tests. A key element of the final part (Part C) involved the practical clinical examination and treatment of a patient. However, preparation for Part C presented a particular challenge, since candidates are unable to treat patients in the UK unless they have obtained *temporary* registration with the GDC. Temporary registration has previously been restricted to those working in approved hospital posts for training, teaching or research purposes.[2]

In 2004, a significant new development extended temporary registration for up to six months in the primary care setting. Introduced on a pilot basis, dental attachment (DA) posts in primary care aimed to support preparation for IQE Part C. This was compatible with the provision of additional examination sittings to accelerate progression through the IQE which was part of the Department of Health's drive to recruit additional NHS dentists.[3]

The temporary registration in primary care pilot scheme was managed by the National Advice Centre for Postgraduate Dental Education (NACPDE), in accordance with an agreed template supported

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Table 1 A profile of the temporary registration periods

Site	Start of DA post	Date of attempts at IQE Part C after starting DA post	Completion of DA post	Outcome of IQE Part C
A	February 2005	July 2005	July 2005	Pass
B	February 2005	July, Oct 2005	July 2005	Fail
C	March 2005	July 2005	June 2005	Pass
D	May 2005	July 2005	August 2005	Pass
E	May 2005	July, Oct 2005	October 2005	Pass

by the Department of Health, the Faculty of General Dental Practitioners (FGDP) and the Conference of Postgraduate Dental Deans and Directors (COPDEND). Eligibility criteria were specified: applicants had to have achieved Parts A and B IQE, be preparing for Part C, hold British Citizenship or have Indefinite Leave to Remain in the UK, and have a certificate of eligibility for temporary registration from the GDC. Evidence of health record and arrangements for dental indemnity were also required.

Attracting potential sites to provide a placement for the pilot was led by NACPDE, and routed through the Postgraduate Dental Deans. Supervising dental practitioners (SDPs) appointed to work with each DA required: inspection by the Faculty of General Dental Practice (UK), or demonstration of a current inspection certificate as a vocational training practice, and satisfactory completion of at least one year as a clinical trainer of undergraduate dental students or of a vocational dental practitioner within the last five years.

DAs were established on an unpaid, supernumerary basis: the intention was to focus on 'training for the IQE Part C, and not for service provision'.[4] In the spirit of a supportive training environment, SDPs were required to be within the premises whenever the DA was treating patients, were instructed not to delegate the supervision of other staff to the DA, and to make all treatment plans for patients.

In Spring 2005, five temporary registration DAs were appointed into primary care settings across England. This paper reports key findings from the evaluation of this pilot scheme.

DESIGN AND METHODS

This study evaluated the implementation of the five pilot sites over a six-month period in 2005. A case study design was adopted, using interviews and questionnaires. In Phase 1 each DA and their supervising dental practitioner (SDP) were interviewed. These were conducted at the end of the attachments' first month in practice and sought early impressions of the scheme, their plans for the attachment period and initial concerns or issues. DAs' and SDPs' background and motives for taking part in the scheme were also explored.

In Phase 2, undertaken part way through the six-month period, a sample of patient and staff questionnaires was distributed at each site. These questionnaires were drafted with advice from participating SDPs and informed by the literature.[5] Specifically, they sought views of the DA and focussed on patient management, communication skills, and overall impressions of performance. Both questionnaires contained mainly closed response option (6-point Likert-type rating scales), but were complemented with opportunity for open comments.

In Phase 3 telephone interviews were held with the supervisors (four of the five, as one had left his/her post) and a questionnaire was distributed to all five dental attachments towards the end of the six-month study period. This follow-up contact explored later reflections of the learning achieved, views towards the IQE Part C examination, and sought overall views of the scheme. In this phase, the research team also met with NACPDE. In all three phases, a mix of qualitative and quantitative data was collected; these required different types of analysis. The quantitative data, sourced from the questionnaire tools, were analysed using SPSS. The primacy afforded to qualitative data in this study is fitting given the small number of cases. Interview transcripts (n = 14) and open comments on the questionnaires were thematically coded.[6]

Four themes are used to report the main findings: features of the pilot sites; supervision and support; benefits; and patient and staff feedback. A full report is available from the authors.[7]

RESULTS

Key features of the pilot sites

Five DAs commenced clinical work in salaried or managed services across different English deaneries between February and May 2005; most (4/5) were appointed to Access Centres. Appointed on a part-time basis, and granted an initial three-month period of temporary registration, the number of clinical day(s) in each site ranged from one to three days a week.

Different start dates for clinical work reflected unavoidable delays experienced by NACPDE in identifying and appointing eligible dentists and reviewing appropriate documentation (Table 1). These included: checking eligibility in terms of having passed IQE Parts A and B, dental indemnity, criminal record bureau check, health record and immigration status. In addition, some candidates passed IQE Part C whilst waiting for the completion of checks. There was some surprise and frustration from SDPs and DAs about the length of time the appointment process took.

Number of clinical days per week was constrained by local factors (including supervisors working part-time in the clinic, maintaining other responsibilities beyond clinical practice, and insufficient clinic space on days). To extend their experience, some attachments worked in more than one clinic, observed clinical practice elsewhere, and worked as a dental nurse. For two attachments, who travelled up to 100 miles each way for the attachment post, the availability of limited days made travelling less onerous. As sites were identified by

Table 2 Staff views of the dental attachment

To what extent do you agree or disagree with the following statements?	Mean	Strongly agreed	Valid number
Treats patients politely	5.5	24 (89%)	27
Speaks courteously to the staff	5.4	23 (85%)	27
Is approachable	5.3	24 (89%)	27
Shows enthusiasm for his/her work	5.3	23 (85%)	27
Follows agreed protocols	5.2	19 (76%)	25
Doesn't shirk duty	5.2	20 (74%)	27
Appears willing to take on new ideas	5.1	20 (77%)	26
Is punctual in arrival	5.0	20 (74%)	27
Makes efforts to ensure the patient has understood	4.9	20 (74%)	27
Recognises the contribution of others in dental team	4.9	18 (69%)	26
Communicates clearly verbally and in writing	4.8	19 (70%)	27
Appears to cope well under pressure	4.5	16 (59%)	27
Keeps to expected appointment times	3.9	11 (41%)	27

Postgraduate Dental Deans, the geographical spread partly reflected the response of Deans to this new initiative as well as the availability of appropriate settings with suitably qualified SDPs. Notably, one of the motives for becoming involved in the initiative was the potential to satisfy recruitment needs.

Feedback suggests a minimum of two days per week was acceptable to supervisors and attachments, since it provided sufficient opportunity for the supervision relationship to develop, to experience a range of treatments, and to integrate with the team. Nonetheless, it is important to note that attachments were positive about even restricted amounts of clinical experience. Of the three DAs who passed their IQE Part C in July 2005, two of them (Sites C and D, Table 1) required only three or four months' temporary registration within the pilot period.

Supervision and support

Daily supervision of the clinical work was the responsibility of the SDPs whose role was formative, providing feedback and guidance and offering help in clinical work.

Discussion of professional development was seen as an important feature of the first meetings but these were not formalised into a training plan. All SDPs described these meetings as *ad hoc* and opportunistic. Planned tutorials were not a regular part of the supervision. Although at the outset several of the SDPs intended to provide routine tutorials, time constraints and the emphasis on hands-on clinical experience were cited as the main barriers. All contrasted the limited time available for tutorials with that allocated in full-time vocational training.

All SDPs adopted remarkably similar approaches to the clinical supervision. The SDPs' role initially involved close supervision; strategies included the attachment nursing for the supervisor (and vice versa) and close observation of the dental attachments' performance in the surgery. Such close supervision was gradually withdrawn although the SDP remained present on the premises. Gradual distancing confirmed the supervisors' confidence about patient safety. It was the rigour of the supervision coupled with the quality of the relationship between attachment and supervisor which proved central to safeguarding patient safety.

There was a significant degree of consensus amongst the SDPs about the attributes required to fulfil the role. Flexibility, experience as a trainer, an open and communicative style, and readiness to provide feedback were central. However, although they were all experienced trainers, they lacked confidence about this new role, and expressed difficulty in judging whether their approach had been 'acceptable' to NACPDE. They also lacked knowledge about the IQE examination requirements, and how their role could best support candidates in their revision for Part C. It was disappointing that two of the five DAs failed the Part C examination at their initial

sitting in the pilot period (July 2005), and this disappointment was particularly felt by the SDPs.

Benefits

Opportunity to gain clinical practice was the prime motivation for this period of temporary registration. Preparation for the *written* papers of Part C could be undertaken independently, but DAs lacked confidence for the practical part of the examination. All had qualified within the last eight years, but their clinical experience in the UK ranged from about a year to approximately three and a half years. Two had worked overseas as dentists within the previous six months, but others had been out of practice for up to five years.

In Phase 3 an open question asked attachments to comment on the three *main benefits from working as a dental attachment under temporary registration*. Most of the five respondents provided three different types of response and made a total of 14 comments.

Most (4/5) considered that their experience of temporary registration had helped to develop their clinical skills, and their management/treatment of patients. Comments included: *'Gained confidence in treating patients'*; *'Better understanding of the management of patients in the UK'*. Most respondents (4/5) also noted that they had greater understanding of UK dentistry, for example: *'Getting familiar with the system, how it works';* and *'Introduced to the new system'*. In interviews, supervisors and attachments mentioned the specific areas of: cross infection control, health and safety regulations, material trade names, record keeping, radiography, use of computer systems.

Other comments made by attachments were about improved communication skills with staff and/or patients, support in preparing for the exam (for example, *'Be more confident for the exam'*) and one noted that the experience had: *'Built up on the confidence'*.

The importance of gaining confidence was particularly highlighted by SDPs whose attachments had not worked in dentistry for several years. Their role in confidence-building and being patient about the slower rate of treatments was mentioned. Communication skills also featured. Most of the attachments and supervisors observed the importance of developing colloquial language skills, in order to explain clinical treatments and reassure patients about treatments.

'I keep saying that you've got to talk to them more because you know this is not just a tooth, it's a tooth attached to a person and the person is the only important thing really.' (SDP Interview 1)

The clinical experience was broader than the technical practice of skills and included the development of a range of non-clinical skills.

Table 3 Patients' views of the dental attachment

To what extent do you agree or disagree with the following statements?	Mean	Strongly agreed (5,6) n (%)	Valid number
Was approachable	5.9	15 (100%)	15
Spoke courteously to the staff	5.9	15 (100%)	15
Treated me politely	5.9	14 (93%)	15
Helped me understand what was going on	5.8	15 (100%)	15
Talked clearly	5.6	15 (100%)	15

Patient and staff feedback

Fifteen patient and 27 staff questionnaires were completed and returned to the research office. Only three sites participated in the distribution of patient questionnaires: one SDP did not feel it appropriate to ask patients; in another site, the supervisor had earlier vacated his/her position.

Staff questionnaires were received from all five sites. Most were completed by women (20/27 – 74%), and by dental nurses (16/27 – 59%) or dentists (9/27 – 33%). The other two staff included a receptionist and a practice manager.

Approximately even proportions of men and women completed a patient questionnaire (8/15 male – 53%). Most patients surveyed had visited the temporary registration dentist once (7/15 – 47%), or twice before (5/15 – 33%).

The results for the 13 attributes which staff rated on a 6-point scale are provided in Table 2.

The DAs' approach to patients and staff, enthusiasm, punctuality, willingness to take responsibility, and follow protocols were rated highly by staff (with mean scores above 5.0). Lower rated attributes were the ability to keep appointment times, working under pressure and recognising the contribution of others in the dental team (although these were still high).

The results for the statements presented to patients are provided in Table 3.

Similar to the staff results, patient satisfaction with the temporary registration dentist was high. Again, although numbers are small, patients considered that the dentist was approachable, spoke courteously and clearly, and helped them understand what was going on.

Staff (16/27 – 59%) and patients (10/15 – 66%) made comment about the temporary registration dentist's attachment to their workplace. The staff comments were positive (eg *'Thoroughly enjoyed working with her'* or *'fitted in well with the dental team'*). Similarly, patients were very satisfied with the service received.

DISCUSSION

The evaluation of this small-scale pilot suggested great potential in developing this scheme and in February 2006, the GDC announced the continuation and expansion of temporary registration in primary care.[8] Although the five overseas-qualified (non-EU) dentists had valued the opportunity to practise hands-on clinical skills, the educational benefits were more holistic than this: they were able to become familiar with the requirements of primary care NHS dentistry in a supervised and protected training environment. On the narrow measure of IQE Part C pass rate, three passed immediately after the DA

experience, one probably entered the examination too soon after taking up the DA post and failed, but then completed the DA post and passed. However, it was disappointing that one DA was not successful even after the temporary registration experience. These results are in line with national figures[9] and the initiative should be seen in the broader terms of developing overseas-qualified dentists' professional practice in NHS primary care dentistry.

NACPDE's role in managing the pilot in accordance with an agreed protocol had ensured compliance on the principal requirements of the scheme (eg CRB checks, eligibility of supervisors, attachments, and site inspections). This helped to assure the suitability and safety of the dental attachment's placement. Given the specific challenge of appointing and placing attachments at sites within a limited time-frame, the need for NACPDE remains.

The clinics provided a supportive, unpressured environment for temporary registration and had the following features:

- Experienced supervisors and staff
- Sufficient time allocated for patients, and no financial pressure
- Breadth of clinical experience
- Chair space.

It was disappointing that local conditions constrained the chair space and the available days for clinical supervision in some of the sites. However, the appointment of experienced supervisors helped ensure the quality of the training environment. Potential sites might consider being more explicit about the availability of chair space and supervision and be encouraged to plan for additional or joint supervision by another experienced trainer within the same clinic or Primary Care Trust (PCT).

The supervisors were the principal educators in this scheme and were therefore instrumental to the success of the attachment period. Although they were experienced trainers, their lack of confidence was understandable given that this role was new and underdeveloped in primary care. Written guidance available for supervisors could be further developed and reinforced. The value of meeting other supervisors, or establishing a local network system for new supervisors, could also be explored. Supervisors expressed interest in extending their knowledge of the IQE examination process and standards required. This is particularly relevant given changes to the IQE. The revised IQE no longer requires candidates to perform a clinical task on a patient, but instead incorporates actors and dental manikins to test candidate's technical skills.[1] Although treatment of a patient will no longer feature in the IQE, there are many still progressing through the system studied in this pilot. Moreover, the educational benefits of this experience are broad and give candidates a supported introduction into NHS primary care dentistry. NACPDE could consider ways of informing supervisors about the IQE format and its recent revisions, perhaps by an induction seminar.

The expansion of the temporary registration scheme retains the substance of the protocol with the exception of two specific developments. One is to ease the restriction on the number of dental attachment posts (from five to 25); and the other is to extend temporary registration in primary care for up to 12 months. These significant changes are to be welcomed: additional posts offer opportunities for more overseas-qualified (non-EU) dentists to apply for posts that offer a supervised experience prior to passing IQE. Allowing temporary registration for up to 12 months enhances the likelihood of a sufficient number of days in clinical practice to establish the supervisor relationship and a productive educational experience. In light of the new commissioning of primary care dental services, temporary registration in primary care could offer overseas-qualified dentists educational opportunities prior to applying for a vocational training (VT) post or provide a way of developing competence towards VT equivalence.[10]

For NACPDE, the challenge will be attracting potential PCTs to become involved and identifying appropriate supervisors. Achieving this will be influenced by workforce demands, financial constraints on PCTs' scope to develop primary dental services within their areas, overcoming problems of dentists getting their name on a PCT Performer's List and may be more successful in geographical areas where dentists are in short supply.

CONCLUSION

The scheme has had a positive impact on the dental attachments' learning and professional development without compromising patient safety. Clear links between the pilot sites and NACPDE were maintained; these enabled NACPDE to coordinate the pilot and ensure standards established in the template for the scheme were upheld.

It is encouraging that the GDC has agreed to extend this scheme. Thoughts for possible future developments include: a confirmed role for NACPDE in coordinating and monitoring the scheme; more detailed and explicit documentation to sites and applicants; further exploration of potential sites; and greater support for supervisors.

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