Improving oral health and dental outcomes: Developing the dental public health workforce in England

Full Report
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**Description**  
This report gives guidance on developing the dental public health workforce to enable PCTs and SHAs to promote oral health, increase access to dental services and secure safe, high quality dental services which meet the needs of the local population.

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*Primary care and community services: Improving dental access, quality and oral health* (Gateway 11000)  
*Choosing better oral health: An oral health plan for England* (Gateway 4790)  
*NHS dental services in England: An independent review led by Professor Jimmy Steele*  
*Improving oral health and dental outcomes: Developing the dental public health workforce in England – Short Report – Summary of key issues for PCTs and SHAs* (Gateway 13937)

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Improving oral health and dental outcomes: Developing the dental public health workforce in England

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Foreword by Ann Keen, Parliamentary Under-Secretary for Health

Much has been achieved in primary care dentistry since the April 2006 devolution of responsibility for the commissioning of dentistry to PCTs. PCTs have generally responded well to the challenges associated with this fundamental change to dentistry. Nevertheless, the NHS needs to develop its expertise further. Primary care and community services: Improving dental access, quality and oral health provides best practice guidance to the NHS, and particularly PCTs, in becoming world class commissioners. The guidance recognises the need for some PCTs to develop greater capacity and capability in their dental commissioning teams. We welcomed the publication of the independent review, NHS dental services in England, led by Professor Jimmy Steele, which reinforces the need to develop the dental public health workforce to support world class commissioning of dental services.

Improving oral health and dental outcomes: Developing the dental public health workforce in England – Full Report provides best practice for developing the dental public health workforce. Doing so will enable PCTs and SHAs to develop the right professional expertise and leadership to promote the dental public health agenda. In this way they will shape the provision of NHS dentistry in their area so that it meets patient needs in regard to patient experience, patient safety, and clinical effectiveness, and ensure that oral health inequalities are reduced.

This report sets out our vision and strategy for dental public health, and the goals that will help achieve this vision. It sets out what capacity and capability the NHS needs to realise this vision, and so support:

- quality improvement;
- greater productivity;
- effective commissioning;
- health and service improvement;
- innovation, including a move from treatment to prevention services; and
- patient safety and effective governance of dentistry.
Meeting this ambitious agenda will require collaboration across health and social care and wider afield, to share ideas and foster greater innovation.

This collaboration has been demonstrated in the development of *Improving oral health and dental outcomes*. This report has benefited from the views of a wide range of external stakeholders. I should like to thank everyone who gave their time and expertise as part of the Stakeholder Reference Group, members of which are listed at Appendix 1, and to Barry Cockcroft CBE, Chief Dental Officer (England), for initiating this review.

The NHS has a responsibility increasingly to focus on the oral health preventive agenda. I am confident that by acting on this report we can all play a part in developing the dental public health workforce, increasing both capacity and capability and, by so doing, reduce oral health inequalities and improve dental outcomes.

Ann Keen
Parliamentary Under-Secretary for Health
Preface by Barry Cockcroft CBE, Chief Dental Officer (England)

_Improving oral health and dental outcomes_ describes the contribution to commissioning competence of a specific part of the public health workforce: that concerned with dentistry and oral health. In following this best practice guidance, PCTs and SHAs will have the dental public health advice needed to improve commissioning and quality assurance in dental services, and promote oral health improvement.

_Improving oral health and dental outcomes_ also reinforces the importance of education and research in dental public health. These functions are integral to ensuring that the dental workforce meets the future oral health needs of the population, and require strong links between the service and academia.

The focus on transformational leadership is critical to realising the vision set out in this report. Just as the wider health service will benefit from the increased focus on clinical leadership introduced through the _NHS Next Stage Review: A high quality workforce_, this new approach will build on the successes of dental public health staff to date. It is expected that this will significantly increase the effectiveness of the dental public health workforce in ensuring that the oral health needs of the population are met and that safe, effective and high quality NHS dental services are available to all who need them.

The report recognises the need to quality assure the whole of the dental public health workforce by further developing appraisal, performance improvement and continuing professional development arrangements and ensuring that these are established within robust professional regulatory frameworks. In time, these developments will need to cover those members of the dental public health workforce who are outside current arrangements, and we will work closely with colleagues to consider how best to take this forward. In doing so, we will further strengthen the dental public health workforce, enhance the professionalism of the team and increase the confidence of the public in their work.

The wide scope and number of best practice recommendations, directed towards an extensive range of stakeholders within and outside the NHS, speaks volumes for the ambition expressed in _Improving oral health and dental outcomes_. It aims to place dental public health considerations at the centre of dental policy and practice in England, ensuring that prevention is at the heart of dental service provision in this country. It is to be warmly welcomed.
I would like to thank everyone involved in the Stakeholder Reference Group for their creativity, resourcefulness and tenacity in developing the vision and the pathway to achieve this vision. I look forward to the prospect of continuing to work together with the many stakeholders who can contribute to realising this vision, together with all members of the dental public health workforce.

Barry Cockcroft CBE
Chief Dental Officer (England)
Improving oral health and dental outcomes – Full Report

Dental public health

Oral and dental health matters to everyone. Much dental disease is preventable. A healthy mouth and teeth are fundamental to eating, appearance and well-being. Having the right dental services is a hugely important factor in meeting the needs and aspirations of the public for good oral health and well-being.

Dental public health is the branch of dentistry that is primarily concerned with preventing oral disease and promoting oral health, and improving the quality of life for whole populations. It is concerned with the design and assurance of safe high quality dental services for all. It does so in collaboration with public and private organisations, communities and individuals.

The need for an increased focus on dentistry and oral health improvement

Patients value and want to access high quality NHS dentistry. Ensuring year-on-year improvements in the number of patients accessing NHS dental services based on assessments of local needs continues as a national priority for local delivery in the NHS Vital Signs in 2010/11. The NHS Constitution handbook affirms the commitment by the NHS to ensure by March 2011 that anyone who seeks access to NHS dentistry can get it.

The challenge for the NHS is to deliver improved dental services effectively, address oral health inequalities and realise the potential for health improvement and disease prevention. Strategic health authorities (SHAs) have the responsibility to lead, develop and manage the performance of the NHS in their region. Primary care trusts (PCTs) have the statutory responsibility to provide, or secure the provision of, oral health needs assessments and oral health improvement programmes, as well as specialist and primary dental services, to meet all reasonable requirements within their area.

PCTs and SHAs need to have the necessary capability (competencies, skills, knowledge and experience) in their organisations to enable them to fulfil their responsibilities for dentistry and oral health improvement. They also need appropriate capacity in that workforce (the right number and level of staff) to tackle the level of work flowing from the responsibilities. The necessary workforce will be multidisciplinary and include commissioning managers, finance and information staff, as well as dental public health staff. It will be diverse, better reflecting the local population it serves.

The presence of an effective local dental public health team is likely to be one of the key factors in enabling a PCT to become a world class commissioner of dentistry.
The review was therefore commissioned to support and assist the NHS in England in securing the necessary capacity and capability in the dental public health workforce in order that it can commission appropriate dental services and improve oral health and dental outcomes. The review was undertaken with an external Stakeholder Reference Group.

**A vision for dental public health**

The Department of Health, advised by the Stakeholder Reference Group, has developed a vision and goals for dental public health looking ahead some 10 years.

**The framework for change – current policy and action**

Much is already happening that will contribute to realising this vision:

- The NHS Next Stage Review, led by Professor the Lord Darzi of Denham, has set out the future direction for the NHS, with implications for dentistry and for dental public health. A high quality workforce sets out new arrangements for workforce planning, education and training with PCTs and SHAs at the heart of planning for workforce capacity and capability, and SHAs for educational commissioning and quality assurance.

- The independent review, *NHS dental services in England*, led by Professor Jimmy Steele, makes a range of recommendations to bring the quality of dentistry commissioning to the highest standards. This will lead to better use of the resources invested through a focus on quality, innovation and prevention.

- World class commissioning is developing the competence of PCTs in commissioning to improve oral health and the availability and quality of dental services in England. This will focus more on prevention, not just treatment. *Improving dental care, quality and oral*
Improving oral health and dental outcomes – Full Report

• SHAs working with PCTs and local communities have the opportunity to extend water fluoridation schemes in areas of high dental need.

• The publication of *Choosing better oral health* identified the potential to improve both oral health and general health through a focus on the common risk factors for both oral health and other diseases. It recognised that a diverse and skilled workforce is needed and referred particularly to the roles of consultants in dental public health and to those engaged in oral health promotion.

• *Choosing health: Making healthy choices easier* has led to an ambitious strategy to strengthen workforce capacity and capability for health improvement, in the NHS and its partner organisations.

The current dental public health workforce

The dental public health workforce in England is very thinly spread, with around one-third of PCTs without any current access to consultant advice and around one-fifth without input from a dental practice adviser (DPA). Even in those PCTs with some measure of consultant and/or input, the level of input in most places is low with an average whole-time equivalent consultant input to PCTs of less than two days a week (within a range of less than one session a week to full-time working), and an average DPA input of around one day a week. Academic staffing in most universities is also variable, as is the distribution of oral health improvement practitioners with PCTs.

This workforce level represents a historical legacy from a time when the NHS had a peripheral relationship with dentistry and oral health. This has changed since the devolution to the NHS in April 2006 of responsibility for local commissioning of NHS primary care dental services.

Although there are some specialist registrar training posts, they are only adequate in number to replace retiring consultants; the current number of training opportunities is insufficient to grow the workforce to the levels needed to secure better coverage of the NHS and a robust academic infrastructure.

Staff in dental public health practitioner-level roles, for example DPAs, currently have no formal development pathway or governance arrangements. Others, for example some of those working in the field of oral health improvement, also have no access to a relevant and appropriate registering body. From April 2010 one university will be offering a postgraduate certificate for DPAs.
In summary, there are risks in the current situation for both organisations and individuals. The dental public health workforce represents an area long overdue for attention.

**Defining best practice**

This report sets out the key developments that will enable realisation of the vision goals by supporting NHS organisations to achieve their responsibilities for dental public health, in partnership with other stakeholders.

To improve dental outcomes it will be necessary to develop the dental public health workforce. The report sets out the key actions that the Department will take to build greater capacity and capability in a more diverse dental public health workforce. It also sets out recommendations for other national, regional and local stakeholders.

The guidance sets out advice on configuring dental public health teams. It outlines the leadership role of the consultant in dental public health in drawing together the skills and contributions of practitioners in dental public health, the wider dental team and others.

**Developing capacity and capability in the dental public health workforce**

The report sets out what the Department will do to support the NHS in developing capacity and capability in the dental public health workforce. It highlights areas of interest and action for wider groups of stakeholders to take forward, including PCTs, SHAs, the General Dental Council, the dental and public health faculties of the Royal Colleges, the universities, and the Specialist Advisory Committee in Dental Public Health.

We recommend that SHAs, working with PCTs, review their dental public health capacity and capability in accordance with this guidance. Given the priority attached to improving NHS dental services, and the contribution of dental public health to the quality and productivity challenge, we recommend they produce a regional workforce development plan during 2010 to inform regional education commissioning plans.

The Department, working through the Dental Programme Board of Medical Education England, in conjunction with the Public Health Leadership and Workforce Development section of the Department, supports the increase in supply of dental public health professionals, encouraging the expansion of the number of both
service and academic training places in dental public health available. Workforce modelling indicates the need to build the workforce over time to provide around an additional 50 whole-time consultants and six whole-time DPAs for England. Other dental public health practitioners will be needed to complete the team; those numbers will need to be determined locally. This investment should result in higher quality, more productive primary care dental services, and improvement in oral health in England.

Detailed recommendations for SHAs, PCTs and other stakeholders are provided in Section 5 of the report. *Improving oral health and dental outcomes: Developing the dental public health workforce in England – Short Report – Summary of key issues for PCTs and SHAs*, a companion publication to this report, summarises the findings of the review in specific guidance for PCTs and SHAs. Developing the dental public health workforce locally to support better commissioning of primary care dental services will improve dental outcomes.
1.1 The need for an increased focus on dentistry and oral health improvement

Oral health – why bother?

Oral and dental health matters to everyone. A healthy mouth and teeth are fundamental to eating and to appearance, and to all the health and social consequences of these. We all start life with a full set of teeth and there is no intrinsic reason why we should not still have a full set of natural teeth when we die. Yet for many people that is not the case; most of us still suffer at some point in our lives from one or more of the common dental diseases – tooth decay and gum disease – and most of us do so repeatedly throughout life.

Dental public health is the branch of dentistry that is primarily concerned with preventing oral disease and promoting oral health, and improving the quality of life for whole populations. It does so by undertaking oral health needs assessments and transforming research evidence into oral health strategy and policy. It does so in collaboration with public and private organisations, communities and individuals. This forms the basis for best practice strategic advice to underpin:

- dental commissioning, including increased access;
- oral health improvement;
- patient safety;
- innovation and quality improvement;
- productivity; and
- clinical and public involvement processes.

There are two compelling drivers for NHS organisations and their partners to concern themselves with dentistry; the first health-related, the second patient-related.

The health agenda

Despite the fact that oral health has improved considerably since the creation of the NHS, and that both tooth decay and gum disease are largely preventable, the main dental diseases remain among the most widespread diseases experienced in the UK. Oral cancer, the prognosis for which is very poor unless detected early, is too often spotted late. As with many diseases, the main dental and oral conditions are most prevalent in the poorer and more deprived parts of the population, as well as in black and minority ethnic (BME) communities. There remain very significant inequalities in dental health in England; between regions, within regions, and within PCT populations.
The public agenda

The public value and want to access high quality NHS dentistry.

A lot of people use NHS dental services – around 27.5 million people attended an NHS dentist in the two years to March 2009. With anticipated patient charge contributions, the NHS has commissioning power approaching £3 billion in 2009/10. The public feel strongly about the availability of dentistry as part of the NHS. Many people feel it needs further improvement.

Delivering year-on-year improvements in the number of patients accessing NHS dental services based on assessments of local needs is a national priority for local delivery in the NHS Vital Signs for 2010/11. This intention has been reinforced in the NHS Constitution handbook in which the NHS commits, by March 2011 at the latest, to provide dentistry for anyone who seeks help in accessing it. This has been supported by the above-average increase in funding to PCTs for dentistry in 2008/09 and in 2009/10.
1.2 Improving oral health and dental outcomes – policy context

The Government has set in train a major programme of reform to make NHS dentistry fit for purpose, responsive to local needs, and increasingly focused on the health gains which will come from a health-improving, disease-preventing approach. This reform will be reinforced by implementation of the recommendations made in the recently published independent review, *NHS dental services in England*, led by Professor Jimmy Steele, which has been welcomed by the Secretary of State.

*NHS dental services in England: An independent review led by Professor Jimmy Steele*

The wide range of recommendations in this review focus on dental commissioning of oral health improvement as well as dentistry, and on strategies for disease prevention rather than just treatment of disease. The recommendations are built on the foundation of a strong co-ordinated dental public health system.

The review emphasises the need for PCTs to develop good organisation, structures, leadership and clinical engagement. It highlights the role of the consultant in dental public health in providing clinical leadership, stressing the need for PCTs to have access to consultant advice. It also identifies the role of SHAs in overseeing and supporting PCTs in this, and of SHA workforce deaneries in aligning their educational programmes with PCTs to develop the dental workforce of the future.

Implementing the recommendations will further ensure that NHS dental services meet the needs of patients across different groups and communities. The Department will be working with SHAs, PCTs and dental practices to pilot implementation of the review recommendations.

**Reform of NHS dentistry**

The 2006 reforms devolved the funding of and responsibility for NHS dentistry to PCTs. The purpose of the reform programme is to make NHS dentistry more responsive to patient and population needs locally, and to shift from a delivery focus on items of treatment to one focused on prevention and oral health improvement.

This reform programme introduces by far the most substantial change to NHS dentistry since the inception of the NHS in 1948 and is a challenge both for the commissioning PCTs and for dentists and their teams. PCTs can and must take action on dentistry to fulfil their statutory responsibilities and deliver the Operating Framework priority.

**Water fluoridation**

In line with the drive towards evidence-based practice, changes in legislation alongside these reforms have given
SHAs the opportunity to extend water fluoridation schemes in areas of high dental need, working with PCTs and the local community.

**NHS Next Stage Review**

*High quality care for all: NHS Next Stage Review final report* sets out the future direction for the NHS and specifies a number of themes and actions to deliver high quality care for patients and the public. There are to be new measures to:

- create an NHS that helps people to stay healthy;
- put quality at the heart of the NHS; and
- work in partnership with staff.

It identifies three dimensions of quality – patient experience, patient safety, and clinical effectiveness – which apply as much to dentistry as to other parts of healthcare.

The NHS Next Stage Review report, *A High Quality Workforce*, recognises that high quality care can only be provided through a high quality workforce. It sets out new arrangements for workforce planning, education and training, with PCTs and SHAs at the heart of planning for workforce capacity and capability, and SHAs for educational commissioning and quality assurance.

**World class commissioning**

Having good oral health and being able to eat and enjoy food, communicate properly, and have pride in facial appearance all contribute to improving the quality of life. This addresses one of the central objectives of world class commissioning – adding life to years.

PCTs are now under a statutory obligation to secure dental services for those who want them, and to undertake certain dental public health functions. The Department and NHS Primary Care Commissioning have published a substantial suite of guidance, including particularly the best practice guidance *Primary care and community services: Improving dental access, quality and oral health*. This will help PCTs with their new dental commissioning responsibilities for both primary dental care and for specialist services outside hospitals.

World class commissioning will be based on a local assessment of the current performance of NHS dentistry, a vision for the future, and an oral health strategy and commissioning plan that meets the needs of local communities, including a stronger focus on commissioning preventive and oral health improvement services.
The Operating Framework for the NHS in England 2010/11

The NHS Vital Signs 2010/11 include as a national priority for local implementation “Primary dental services, based on assessments of local needs and with the objective of ensuring year-on-year improvements in the number of patients accessing NHS dental services”.

The importance of delivering improvements in dentistry for patients and the public is emphasised by the inclusion of dentistry as a national priority for local action in the NHS Vital Signs. To provide a consistent measure of whether PCTs meet the NHS Constitution dentistry access commitment, the NHS Operating Framework 2010/11 also includes the intention to establish a new indicator of public experience of accessing dental services from April 2011 (paragraph 2.17).

The NHS Operating Framework requirement necessitates PCTs to have robust commissioning strategies for primary dental services, based on an assessment of local needs. SHAAs are tasked with the performance management of PCTs’ delivery of these strategies.

Choosing health: Making healthy choices easier

Choosing health has led to an ambitious strategy to strengthen workforce capacity and capability for health improvement within the NHS and its partner organisations.

Choosing better oral health: An oral health plan for England

Dentistry is a service which can help patients by preventing as well as treating disease. Those health improvement opportunities extend beyond the field of oral and dental disease; dental frontline teams see many members of the public who would not otherwise be in contact with NHS services and can, opportunistically, play an important role in wider public health programmes.

Choosing better oral health provides a framework for improving oral health through a focus on the common risk factors for both oral and other diseases, thus integrating oral and wider public health agendas.

It also identifies the need for a diverse and skilled workforce, ideally reflecting the population it serves, to support this strategy. It refers particularly to the roles of consultants in dental public health and of those engaged in oral health promotion, who come from a wide range
of backgrounds including dentistry, health visiting, school nursing and midwifery and who operate in a wide range of settings.

**NHS Constitution**

The NHS Constitution handbook affirms the commitment by the NHS to ensure by March 2011 that anyone who seeks access to NHS dentistry can get it. It also requires that all services respect the human rights of all and are made available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. It implies a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population. The NHS Constitution handbook affirms the commitment by the NHS to ensure by March 2011 that anyone who seeks access to NHS dentistry can get it.
1.3 The role of SHAs and PCTs in improving oral health and dental outcomes

The challenge for the NHS is to address oral health inequalities effectively and realise the potential for health improvement and disease prevention, at the same time ensuring the availability of safe, high quality dental services.

PCTs have the statutory responsibility to provide, or secure the provision of, oral health needs assessments and oral health improvement programmes, as well as specialist and primary dental services, to meet all reasonable requirements within their area. They are also responsible for developing oral health strategies based on a local oral health needs assessment and five year vision for the future, ensuring NHS provider organisations have addressed the workforce implications of their service plans. Best practice indicates that they will do this with reference to the development of a local vision for dental services and an assessment of service provision against that vision.

The forthcoming Department of Health guide to commissioning for BME oral health will provide further guidance to PCTs in meeting their duties in regard to equality and diversity.

SHAs have the responsibility to lead, develop and manage the performance of the NHS in their region, including holding PCTs to account through the world class commissioning assurance process. They also have statutory responsibility for water fluoridation in their region.

“We recommend that SHAs... should be responsible for ensuring that PCTs have appropriate [dental] commissioning teams in place and should provide robust support and advice about appropriate organisational structures.”

*NHS dental services in England*, p78

SHAs, including their postgraduate dental deans, have a central role in workforce development in their region, including the commissioning, approval, oversight and quality assurance of key training programmes in dental public health and the clinical dental specialisms.

“Commissioners have a legal duty to secure the best services, in terms of quality and productivity, for the people they serve. We expect commissioners to do this through robust contract management and benchmarking, including patient experience information.”

Professor Steele’s review found that ready access to advice from a consultant is essential in all PCTs. Strengthening their dental public health team in this way will enable PCTs and SHAs to develop commissioning of oral health and dental services, ensuring that they:

- have professional leadership to deliver strategic change;
- make informed decisions about dentistry, oral health and related health inequalities;
- are alerted to issues which impact on oral health or the delivery of dentistry;
- field an authoritative spokesperson in response to enquiries from the public or media; and
- have their own professional evidence-based advice on views and positions taken by clinicians.
1.4 Developing the dental public health workforce

The health and patient needs and aspirations described in Section 1.1 will be fulfilled by NHS organisations which have the capability and capacity to commission the right services, and by a dental profession which is enabled and motivated to practise high quality, preventively orientated dentistry. Neither will happen by chance, and both need a public health population approach to empower them. These, in turn, require the right dental public health workforce.

However, the current dental public health workforce is not able to meet these requirements in all parts of England. Current capacity does not reflect the substantially increased responsibilities of the local NHS for dentistry which have flowed from the 2006 reforms. The 2008 Health Select Committee report on dentistry and the 2008 Assessment of workforce priorities from the NHS Workforce Review Team have both identified the need for dental public health advice to be available to inform the commissioning process. Primary care and community services: Improving dental access, quality and oral health and Professor Steele’s review have recognised the need for greater capacity and capability within the dental commissioning team generally.

The Government, responding to the Health Select Committee report, stated that “we recognise that at present there is a national shortage of dental public health specialists, and that many existing specialists have sessions spread very thinly across a number of PCTs” (paragraph 34).

“The Government agrees with the [Health Select] Committee that PCTs should use dental public health specialists to… help commission services that are effective, safe and that promote oral health. Such specialists can also provide professional leadership locally. The Department has commissioned a review of the dental public health workforce, with the aim of ensuring that the requisite number of specialists will be available to support local commissioning.”

Government response to the Health Select Committee report on dental services 2008, paragraph 17

Improving oral health and dental outcomes seeks to rectify this by defining best practice in dental public health workforce capacity and capability.

This best practice is built on having the right number of consultants in dental public health doing the right things. Consultants, based within PCTs and SHAs, provide clinical leadership. They give evidence-based and best practice strategic advice to underpin dental commissioning for oral health improvement, patient safety, increased productivity and greater innovation, as well as providing expertise to the process of clinical and public involvement.

A properly resourced dental public health infrastructure will be a significant factor in enabling PCTs to maximise productivity and outcomes from the services they commission.
Figure 1: The dental public health workforce contribution to improved commissioning

Improved oral health

Population

Improved oral health

Patients

PCTs

Dental PH practitioner-level staff (e.g. DPAs, OHI practitioners, epidemiology staff)

Wider workforce including clinical teams

DENTAL PUBLIC HEALTH WORKFORCE

Commissioning

KEY
DPA = DENTAL PRACTICE ADVISER
OHI = ORAL HEALTH IMPROVEMENT
PH = PUBLIC HEALTH
WCC = WORLD CLASS COMMISSIONING

IMPROVED COMMISSIONING OF:
• POPULATION PROGRAMMES
• CLINICAL SERVICE PROGRAMMES

IMPROVEMENTS:
• DISEASE PREVENTION
• HEALTH PROMOTION
• EVIDENCE-BASED
• SAFE
• HIGH QUALITY
• INCREASED ACCESS
• IMPROVED PRODUCTIVITY
1.5 The purpose of this guide

Developing the dental public health workforce will require significant action at national, regional and local levels. Action at national level will need the involvement of agencies such as the General Dental Council (GDC), and the dental faculties of the medical Royal Colleges. These actions are being taken forward by the Department through the Dental Programme Board of Medical Education England.

Within the NHS, PCTs and SHAs are encouraged to work locally and regionally to further develop the dental public health workforce. *Improving oral health and dental outcomes* provides best practice guidance to inform local decisions about the capacity (the number and level of staff) and capability (the competencies, skills, knowledge and experience) required in the dental public health workforce to enable them to work with commissioning managers, finance and information staff to commission appropriate dental services and improve oral health.

**Who this report is for**

This report is therefore intended to guide and support many people in PCTs, including:

- professional executive committees and PCT boards;
- commissioning managers;
- primary care managers;
- health improvement managers;
- workforce development managers;
- those with responsibilities for patient safety and clinical governance;
- clinicians; and
- those in public health.

It is also for many in SHAs, including those in:

- public health;
- workforce development;
- deanery roles;
- commissioning; and
- performance management.

Achieving the right workforce and optimising the contribution of the wider workforce requires a partnership between the NHS and a number of external bodies, for example universities, medical Royal Colleges and others. This report is therefore also intended for other partners, especially:

- the NHS Business Services Authority;
- local authorities, whose actions can help to improve the dental health of patients and the public;
- the GDC, which sets standards for dental practice and conduct and assures the quality of dental education and dental care;
• the Specialist Advisory Committee in Dental Public Health;

• the dental and public health faculties of the medical Royal Colleges of England;

• universities and the further education sector, whose teaching and research capacities are essential to achieving the objectives of the review; and

• NHS Employers.

As all these stakeholders play their part, the NHS in England will be enabled to use its dental commissioning resources more effectively and productively.
A vision for dental public health
The Department, advised by the multidisciplinary external Stakeholder Reference Group, has developed a vision, aims and goals for dental public health looking ahead some 10 years. These focus on developing quality, meeting the challenges of the wider policy context and utilising the opportunities afforded by this growing emphasis on prevention-focused services.

**Vision**

Dental public health will contribute to health improvement and significantly improve oral health, reduce oral health inequalities, ensure patient safety and improve quality in dentistry.

**Aims**

This contribution will be enabled through an increased focus across England on:

- effective health promotion and prevention of oral disease;
- provision of evidence-based oral and dental care; and
- effective dental clinical governance.

In liaison with healthcare, local government and education partners and other stakeholders.

PCTs, in developing a dental vision as part of their five-year strategic plans, may wish to consider the implications and priorities of this national vision in their local context.

**Goals**

These aims will in turn be achieved through a health, social care and education system in which there is appropriate dental public health capacity, capability, leadership and skill mix, especially in the NHS and the higher education/research sector, such that:

1. Dental public health informs the development of healthcare policy at all levels of policy-making.
2. The NHS commissions to improve the oral health and well-being of the population, to reduce oral health inequalities and to make oral health services available for all and tailored to meet the needs of each individual.
3. The wider dental team works collaboratively with other healthcare workers and other agencies to promote health and prevent disease, including through a common risk factor approach.
4. There are robust systems to ensure patient safety and promote high standards of effective clinical performance in dentistry.
5. The education and training of dental and healthcare professionals and others contribute to oral health improvement.
6. High quality research supports oral health improvement and the delivery and organisation of high quality, evidence-based dental care.
3 The current dental public health workforce
3.1 Roles

The Chief Medical Officer has categorised the public health workforce in terms of specialists (who are predominantly consultants), practitioners, and the wider public health workforce. The dental public health function requires executive leadership throughout the NHS, particularly in SHAs and PCTs. Those who contribute daily to improving oral health include consultants, dental public health practitioners, and the wider dental public health workforce practising principally in the NHS and academic environments.

Dental public health consultants

The General Dental Council (GDC) maintains a Specialist List in dental public health. Specialists in dental public health have high-level skills relating to oral health improvement and the delivery of dental services.

The majority of specialists work as consultants at PCT and at SHA level, delivering both public health and medical director type functions within dentistry. Others work in the Department or in academic institutions, especially university dental schools.¹

Consultants in dental public health provide expert advice and professional leadership in the processes of:

- oral health needs assessment;
- development and implementation of local oral health strategies;
- dental commissioning;
- oral health improvement;
- the development of clinical pathways;
- patient safety;
- innovation and quality improvement;
- productivity improvement;
- clinical and public involvement;
- addressing oral health inequalities;

“Clinical leadership typically comes from consultants in dental public health, who are effectively the patients’ advocates and should have responsibility for ensuring that PCTs have plans in place to meet their population’s needs. Ready access to advice from a consultant is essential in all PCTs. Dental practice advisors offer recommendations to PCT commissioning managers about clinical issues and also have important roles to play.”

NHS dental services in England, p77

¹ There are 10 dental schools in England.
• improving governance systems for dentistry and oral health;
• evaluating oral health services;
• teaching and training; and
• research.

Academics in dental public health play a vitally important role in influencing the education and training of all dental professionals and, beyond, contributing to oral health improvement. They provide academic training, support NHS training, pursue high quality research to contribute to evidence-based healthcare and contribute to research-informed policy and practice. The key challenge is to enhance the academic capability of the wider dental public health workforce, through the creation of networks involving staff from the wider workforce.

Research evidence informs clinical practice, service delivery and organisation, the promotion of oral health and healthcare policy. It is therefore in the interests of the whole dental public health team that high quality research is integrated into service policy and delivery, ensuring high quality evidence-based dental care. Academics in dental public health will provide the necessary research skills, knowledge and understanding.

Dental public health practitioners

Dental public health practitioners have skills and competencies in defined aspects of the specialty of dental public health, and may spend part or all of their professional life working in that area of practice. There are a number of current examples of practitioner-level dental public health staff.

Dental practice advisers (DPAs) are normally local dentists in general practice who are employed part-time by PCTs primarily to monitor and advise local general dental practitioners about the safety, quality and governance of their services, often through a programme of practice visits. They are likely to be involved with the promotion of peer review and clinical audit in general dental practice, and in promoting effective dental practice through pastoral support. Their working knowledge of dental practice also helps to inform the commissioning process.

DPAs provide an important, but significantly underdeveloped and often unsupported, role. They currently have no NHS-defined role or necessary competencies to do the job, beyond the widely accepted principle that they are first and foremost practising primary care dentists in independent practice who carry out their DPA role on a part-time basis. The core of their role is in clinical governance and quality improvement, normally with
a focus on a pastoral approach in assuring patient safety. This is informed by making practice visits and investigating cases identified by NHS Dental Services. Interpretation of the clinical data set in relation to contract monitoring is an expanding role for the DPA.

Some personnel from the salaried primary dental care services and PCT oral health improvement practitioners have developed dental public health skills and hold relevant postgraduate qualifications. They play a key role in a number of important aspects of dental public health, for example in the conduct of epidemiological surveys and in the design and delivery of oral health promotion and improvement programmes; others have responsibility within their service for patient safety and clinical governance.

Dental reference officers of the NHS Business Services Authority, like DPAs, play an important role in patient safety and clinical governance and are working increasingly closely with PCTs and SHAs.

**The wider dental public health workforce**

Many healthcare professionals can contribute beneficially to delivering dental public health functions, particularly disease prevention and oral health improvement and protection. These include all members of the dental team in clinical practice and other healthcare professionals, such as health visitors and district nurses, as well as people from outside the healthcare sector, such as teachers.

Within PCTs and SHAs, commissioning and performance managers who have been allocated a lead role in dental issues have the opportunity to influence improvements in oral health and in the safety and quality of dental services.
3.2 The NHS dental public health workforce in England

Data on the dental public health consultant and practitioner workforce is in short supply; the annual medical and dental census contains very limited information on specialists who hold consultant posts, and other members of the dental public health workforce are not captured at all by that census.

Consequently the data used historically for workforce planning purposes in dental public health has been derived from ad-hoc surveys, mostly undertaken under the auspices of the national dental public health consultants’ group. Those surveys have tended to focus primarily on consultant and training posts.

Because of the significant organisational change in the NHS in England in the period 2005/06, an ad-hoc survey of the dental public health workforce was undertaken by the specialty in autumn 2007.

Reliance on ad-hoc surveys is not a robust process and work has been done to incorporate dental public health staff into the 2008 ad-hoc public health workforce census undertaken by the Department, and will be followed through into the development of the Electronic Staff Record (ESR) as the future data source for workforce planning information. This needs to capture consultant and practitioner-level dental public health staff.

The ad-hoc surveys of the dental public health workforce in England undertaken by the specialty in the period 2003 to 2007 paint a bleak picture of the dental public health workforce. The detail of those surveys is in Appendix 3.

The survey of autumn 2007 identified key concerns in the dental public health workforce, which are detailed below.

The consultant workforce

- Around one-third of PCTs were without any consultant advice in dental public health.
- Of the two-thirds of PCTs with consultant advice, the average consultant input was low, at less than four sessions a week, with some PCTs having less than one session a week.
- The overall head-count of consultants remains static.

In 2007, around one-third of PCTs were without any consultant advice in dental public health, and of those PCTs with consultant advice, the average input was critically low – on average around four sessions a week, but with a range from full-time to less than half a session a week per PCT.
• The gender balance is shifting towards women, with women constituting half of all consultants and three-quarters of trainees.

• The age distribution of consultants is unhelpful in ensuring the required capacity – those in consultant posts are predominantly aged over 45, and half are aged over 50.

• The number of training places in England is low, with a total of 18 trainees, of whom 6 were academic trainees. There were also 2 Walport trainees.³

• Given a four-year GDC approved training programme, the output from training equates to about three or four whole-time equivalent (WTE) staff a year eligible for a consultant post.

• In head-count terms, training capacity is currently just balancing loss from the specialty. In WTE terms this is likely to mean a further shortfall against the existing position, without considering unmet need.

The practitioner-level workforce

In 2007, around 20% of PCTs were without any DPA input. There was very limited data on other practitioner-level staff such as oral health improvement practitioners.

• Around one-fifth of PCTs were without any DPA sessions.

• Of those PCTs with a DPA, the average input was around two sessions a week.

• Oral health improvement staff were only reported working in some PCTs, and few of those were working at a strategic level, undertaking partnership working to improve oral health.

The academic workforce

• There is low capacity in academic dental public health within the 10 academic institutions involved in undergraduate education in England.

• Only around half of senior academic staff (professorial and senior lecturer) were on the Specialist List of the GDC.

• Academics contribute to the NHS, to workforce education and training, research, evidence-development and wider health policy, but with limited capacity to do so.

• Of the 20 training posts, 8 were held by academic trainees in dental public health, for whom the training programme is extended by 2–3 years.

• There is some evidence of difficulty in appointing to senior academic posts in dental public health.

³ A clinical academic trainee in a dedicated training post which focuses primarily on research. The post will have a national training number.
Chapter 4: Developing best practice
4.1 Achieving the vision

The vision for dental public health reflects the imperatives arising out of the wider policy context, including world class commissioning, the NHS Next Stage Review and the recommendations from Professor Steele’s review. It will be achieved by focusing on six associated goals. Each goal has implications for dental public health workforce capacity and capability.

**Vision goal 1**

*Dental public health informs the development of healthcare policy at all levels of policy-making.*

Preventing dental disease needs to take a common risk factor approach with prevention of other significant disease groups in the population. Dental services can assist with the achievement of other health improvement programmes, and benefit from consideration in a wider health policy context.

Policy development and deliberation can only be informed and influenced if there is an awareness within policy-making bodies of oral health and dental services, and if there is an appropriate level of dental public health resource embedded in the various policy-making levels in healthcare – national, regional (SHA), and local (PCT) levels.

**National**

Best practice at national level means that the Department has incorporated dental public health professionals within the Chief Dental Officer’s team and they contribute to wider departmental public health and policy teams.

The Department will promote dental public health involvement in the development of wider healthcare policy, by membership of relevant policy teams within the Department and the opportunity to comment on draft policy documents during their development.

The Department will ensure that the NHS Business Services Authority has dental public health advice in supporting PCTs in the effective commissioning and contracting of high quality dental services.

**Regional**

Best practice at regional level will mean SHAs ensuring they have dental public health advice, both in the development of oral health strategy and contributing to wider SHA policy work.

**Local**

In the same way, best practice at local level will mean PCTs ensuring they have consultant dental public health advice to lead the development of the oral health strategy, and to contribute to wider PCT health policy.
Vision goal 2

The NHS commissions to improve the oral health and well-being of the population, to reduce oral health inequalities and to make oral health services available for all and tailored to meet the needs of each individual.

World class commissioning for oral health will begin with a needs assessment and a local vision. Needs assessments will be up to date, accurate and evidenced-based, using data from local epidemiological surveys and a range of sources including patient/consumer feedback and patient-reported outcome measures, and they will identify any areas of unmet need. They will be carried out with the relevant local authority through the Joint Strategic Needs Assessment (JSNA). This will enable a PCT to plan for and address the needs of its whole population, including vulnerable groups and those with long-term conditions.

The vision should set out a clear ‘patient offer’ focusing on access to services, which addresses patient expectations and responsibilities.

Having assessed oral health needs and developed a vision, a PCT/SHA will then wish to set out its long-term strategic intentions for the improvement of oral health and dental services in an oral health strategy. This will set the strategic direction and outline the high-level commissioning intentions of reducing oral health inequalities and developing high quality, accessible NHS dental services.

The strategic plan will then shape a commissioning plan within organisational business planning processes which is reflected in wider plans. Both longer-term oral health strategies and more time-limited commissioning plans are likely to include:

- prevention and health promotion models of care;
- the delivery of primary care and specialised treatment services;
- assurance of patient safety and the governance of dentistry; and
- workforce implications.

Issues for specific consideration will include:

- the desired configuration of primary care;
- patient care pathways though primary care, specialist and secondary dental care;
- the development of specialised services in a primary care setting to shift services closer to home;
- a governance framework to promote high quality care;
- innovative approaches to service delivery, with increasing use of skill mix in dental practices to promote productivity; and
- evidence-based clinically effective practice.
Primary care and community services: Improving dental access, quality and oral health provides further practical guidance to enable PCTs to achieve this goal.

**Vision goal 3**
The wider dental team works collaboratively with other healthcare workers and other agencies to promote health and prevent disease, including through a common risk factor approach.

The dental public health function is generally funded by and managed within the NHS. However, most of the factors affecting oral and dental health are social, material, environmental and lifestyle. In order to influence these factors, best practice in dental public health necessitates working collaboratively with other statutory and non-statutory agencies, for instance local authorities, water companies, food manufacturers, and so on.

By contributing to other agencies’ agendas, and adding benefit to their work through the common risk factor approach, the reach of dental public health interventions will be extended. Only by working in this way will the desired impact of reducing inequalities be achieved. An improvement in oral and dental health will become more realistic and achievable.

In addition to the national partnership agenda, local health policy is taken forward through Local Strategic Partnerships – a partnership of the NHS, local authorities, other statutory organisations, the business sector, and community, voluntary and faith organisations. These agencies sign up to common local priorities through Local Area Agreement (LAA) targets selected from a national list.

Best practice means that the dental public health team will seek to ensure that dental health is included in the LAA as part of the public health agenda within a PCT, increasing the focus on prevention. This will facilitate engagement with other stakeholders to ensure they are aware of the commonalities between dental and wider health priorities. The result will be a combined effort in order to deliver shared health (including dental public health) priorities.

**Vision goal 4**
There are robust systems to ensure patient safety and promote high standards of effective clinical performance in dentistry.

Clinical governance assurance arrangements are currently less systematically developed in dentistry than in many other comparable sectors of healthcare.

Best practice will lead to patients receiving consistently safe, high quality dental services, delivered through a governance framework which assures both safety and quality.
Patients are entitled to expect that commissioned services will be safe and of good quality. This can be ensured by PCTs using their powers to specify standards and establish clinical governance arrangements through the contracting process.

There is much to support PCTs and dental practices in developing best practice in their clinical governance arrangements in dentistry:

- There are a number of well-developed sets of standards produced by nationally recognised professional bodies which dental teams can choose to utilise, such as the Faculty of General Dental Practice (UK) publication *Standards in Dentistry* (October 2006).

- All registered dental care professionals (DCPs) have to operate within the professional and ethical standards set by the regulatory body, the General Dental Council (GDC).

- All dental providers will have to register with the Care Quality Commission and comply with essential levels of safety and quality as set out in Registration Regulations from April 2011.

- Primary Care Commissioning has produced best practice guidance for PCTs about the content of clinical governance frameworks for primary care dentistry.

- Under local commissioning arrangements, PCTs have the power to set explicit contractual requirements in respect of standards and clinical governance.

It is essential that an assurance system includes a fair but rigorous process to manage and reduce poor performance and minimise risk to patient health and well-being.

A number of agencies and routes are available to manage poor performance in dentistry, including:

- the GDC Fitness to Practise regime;

- PCT action via Performers List action and/or NHS contract action and Serious Untoward Incident investigation reporting;

- SHA action via Professional Alert Notices and Serious Untoward Incident reporting; and

- the Care Quality Commission (from April 2011).

Agencies which can help practitioners and PCTs include:

- the Dental Reference Service of the NHS Business Services Authority;

- the National Patient Safety Agency;
• the National Clinical Assessment Service; and
• SHA workforce deaneries.

The dental public health team will enable the PCT to successfully navigate the complex regulatory framework to address poor performance. Members of the dental public health team will fulfil complementary roles in doing so.

The consultant in dental public health will usually undertake a quasi-medical director function for dentistry in interpreting and applying the principles of the recognised external frameworks and in managing serious instances of poor performance. The dental practice adviser (DPA) is more likely to fulfil a supportive role to promote improvement.

**Vision goal 5**

*The education and training of dental and healthcare professionals and others contributes to oral health improvement.*

All dental and other healthcare professionals can make an effective contribution to improving oral health by utilising, where relevant, a common risk factor approach. An evidence-based dental public health approach will underpin the planning of all education, training and research. Best practice professional training will have multidisciplinary elements.

Further, the education and training of dental professionals at undergraduate and postgraduate levels (dentists and DCPs) will involve evidence-based oral health promotion and mechanisms for addressing inequalities in health, undertaken in health-promoting environments. Dental public health principles and teaching will be integrated into the design of courses rather than being isolated from clinical aspects.

Education and training programmes that equip all healthcare professionals to contribute to oral health improvement will be based on recognised standards, including national occupational standards where these exist. They will enhance career progression through accredited prior learning.

The Department will work with the Dental Schools Council, the Council of Postgraduate Dental Deans and SHA workforce directorates to ensure that NHS investment in education and training supports the improvement of NHS dental services and oral health improvement.

**Vision goal 6**

*High quality research supports oral health improvement and the delivery and organisation of high quality, evidence-based dental care.*

Best practice dictates that research and an enhanced evidence base underpins all
education, training and service provision in dentistry and oral health improvement.

The Department will therefore seek to ensure that:

- research institutions are encouraged to develop internationally excellent research programmes relevant to the prevention of oral disease and delivery of high quality, appropriate primary dental care at individual and population levels;

- dental public health research training capacity is increased to enable future or current dental public health specialists to obtain higher research degrees early in their careers; and

- dental public health research allows more collaborative work with researchers in the following areas:
  - primary dental care;
  - behavioural science;
  - clinical care;
  - biomedical sciences; and
  - wider public health.
4.2 Developing workforce capability

Achieving the vision for dental public health must focus on enhancing the capacity and capability of the dental public health workforce.

The capabilities required may be framed in terms of world class commissioning competencies, which describe the commissioning capability required of PCTs. PCTs need to be world class commissioners in dentistry if they are to fulfil their responsibilities for dentistry and oral health improvement.

Within each of those business areas a number of high-level key dental tasks can be identified for the organisation, each of which need a competent, knowledgeable and skilled workforce if the organisation is to be able to discharge its responsibilities properly.

Table 1 outlines the key roles of the consultant and dental public health team in enabling the PCT to achieve world class commissioning competency in dentistry.

Table 1: Key contribution of the consultant in dental public health and team members

<table>
<thead>
<tr>
<th>World class commissioning competencies</th>
<th>Consultant in dental public health – key contribution and team members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recognised as the local leader of the NHS</td>
<td>Set the strategic direction in dentistry/oral health improvement and influence policy, priorities and performance in the wider health agenda.</td>
</tr>
<tr>
<td>2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities</td>
<td>Engage with strategic partners in other sectors (e.g. local authorities) to promote policies and commission services which will improve oral health and reduce inequalities. <em>(With the oral health improvement practitioner (OHIP).)</em></td>
</tr>
<tr>
<td>3. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health</td>
<td>Work in partnership with communities and key stakeholders (e.g. MPs, LINks, PALS) to plan how to improve oral health and well-being and obtain their views about service delivery and service priorities. <em>(With OHIP)</em></td>
</tr>
<tr>
<td>World class commissioning competencies</td>
<td>Consultant in dental public health – key contribution and team members</td>
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<tr>
<td>4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation</td>
<td>Work in partnership with dental practitioners and their teams and secondary care clinicians to improve the delivery of safe, high quality services which meet the needs of patients, promote oral and general health and reduce dental/oral disease. (With the DPA, OHIP and dental reference officer of the Dental Reference Service (DRO).)</td>
</tr>
<tr>
<td>5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements</td>
<td>Maintain a contemporary knowledge base through the assessment, analysis and interpretation of epidemiological and other data to establish the dental/oral health needs of the population and identify inequalities. (With the dental epidemiology lead in the salaried primary dental care service.)</td>
</tr>
<tr>
<td>6. Prioritise investment according to local needs, service requirements and the values of the NHS</td>
<td>Develop a framework for, and advise on, the setting of priorities within the commissioning process and the evaluation of services to ensure best value for money. (With the DPA.)</td>
</tr>
<tr>
<td>7. Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes</td>
<td>With stakeholders, support procurement and market development by developing clinical pathways and evaluating outcomes for primary and specialist dental services, and develop the specification of quality standards. (With the DPA.)</td>
</tr>
<tr>
<td>8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration</td>
<td>Develop quality improvement programmes in dentistry through championing innovation and using the evidence base to challenge inappropriate clinical practice, and contribute to the further development of the evidence base. (With the DPA and DRO.)</td>
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Improving oral health and dental outcomes – Full Report

<table>
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<th>World class commissioning competencies</th>
<th>Consultant in dental public health – key contribution and team members</th>
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<tbody>
<tr>
<td>9. Secure procurement skills that ensure robust and viable contracts</td>
<td>Define clinical standards, develop service specifications and provide a clinically based assessment of procurement bids. <em>(With the DPA.)</em></td>
</tr>
<tr>
<td>10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes</td>
<td>Develop, implement, monitor and evaluate strategies, systems and policies to promote high standards of effective clinical performance and ensure patient safety in dentistry. <em>(With the DPA.)</em></td>
</tr>
<tr>
<td>11. Make sound financial investments to ensure sustainable development and value for money</td>
<td>Provide professional advice to inform investment strategies, develop business cases and develop governance structures in dentistry and oral health to ensure a sustainable improvement in access, quality and productivity, while ensuring value for money. <em>(With the DPA.)</em></td>
</tr>
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</table>

The role contribution described in Table 1 is based on the best practice scenario. At present, deficiencies in capacity may necessitate individuals working outside their skills and competencies.

**Team-working and leadership**

A number of key workers are involved in the provision of dental public health services and expertise, especially in PCTs. As in all other areas of workforce design, the appropriate use of skill mix should be a feature of the dental public health workforce. The benefits of skill mix will be maximised where dental public health staff work together in structured teams with clear lines of accountability and transformational leadership within PCTs. The power of those teams will be magnified if senior staff also come together in regional networks.

The leadership function of the consultant is critical to the success of the whole dental public health team in shaping the provision of NHS dentistry in their area to meet patient needs and wants and ensure that oral health inequalities are reduced. This may require clear leadership standards and qualities, with associated development, to help shape this leadership role.
“In our review we have found some examples of excellent commissioning of services at a local PCT level. Where this occurs there is often a clear infrastructure in the PCT, supported by demonstrable leadership – both clinical and executive.”

NHS dental services in England, p77

We recommend that PCTs are held to account… particularly with regard to the PCT’s leadership, public engagement and clinical engagement (specifically using consultants or specialists in dental public health).”

NHS dental services in England, p78

A model dental public health team

The membership of a model dental public health team in an area will include:

- consultants and other specialists in dental public health; and
- dental public health practitioners:
  - DPAs;
  - oral health improvement practitioners;
  - the dental epidemiology lead in the salaried primary dental care service;
  - dental reference officers of the Dental Reference Service working within the region; and
  - practitioners with a special interest (PwSI) in dental public health (where created by PCTs).

Key characteristics of the consultant-led team will include:

- working closely with PCT staff from the fields of public health, health inequality, clinical governance, public and patient involvement, commissioning and primary care development, and equality and diversity;
- providing a leadership focus for dentistry and oral health improvement;
- utilising the full range of skills and experience of all members of the team;
- having academic links to reinforce the evidence and research base in order to translate clinical evidence into service delivery;
- working with the wider general and dental public health workforce in the area, which includes front-line clinicians in dentistry and others outside the healthcare system, for example teachers;
being networked effectively with other dental public health teams and dental commissioning teams in the region to maximise and share specific expertise and interests across the region, to enable robust audit and peer review and to encourage innovation; and

- having appropriate levels of administrative and information analyst support.

Governance and quality assurance of the work of the team and its members

High standards in dental public health are achieved by professional training and accreditation prior to employment, and by sound organisational governance arrangements in employment.

Professional training and accreditation

Consultants in dental public health follow a four-year full-time specialist training pathway managed on behalf of the GDC by SHA workforce deaneries with advice from the Specialist Advisory Committee in Dental Public Health.

Successful completion of this programme results in the award of a formal Certificate of Completion of Training entitling the individual to entry onto the GDC Specialist List in dental public health and eligibility to apply for consultant posts.

Some practitioner-level staff in dental public health may have undertaken a relevant postgraduate degree, diploma or certificate.

Governance

The foundation of good governance is role clarity, with clearly established accountability and working arrangements underpinned by effective performance management systems. This is true for each individual role within the team, and for the whole team within the PCT.

Best practice in designing governance arrangements would include, as a minimum, for each role:

- a clear role profile and person specification, with essential and desirable criteria relating to relevant postgraduate qualifications, experience and competence;
- a requirement to be involved in clinical audit designed for the dental public health role;
- regular appraisal relevant to each individual's dental public health role; and
- active participation in continuing professional development (CPD).

Consultants have nationally specified standards for their posts. They are expected to participate regularly in audit activities appropriate to the practice of dental public health, and to undertake relevant CPD.
They are also subject to annual appraisal of their professional practice through the NHS consultant contract process.

Practitioner-level staff who are both registered dentists and working in NHS clinical dental practice are under a mandatory contractual requirement to participate in clinical audit. This audit will normally be designed to support and assure their personal clinical practice. It will not necessarily be directly relevant to their dental public health work. All dental public health practitioners should have an annual appraisal relevant to their role.

Practitioner-level dentists who hold employment contracts in the salaried primary dental care service, for example someone with epidemiological responsibilities, are now required to undertake appraisal as part of the 2008 national salaried dentists contract. This is normally undertaken within the salaried dental services where the role includes a defined dental public health component. The additional involvement of the consultant in dental public health in the dental public health aspects of the appraisal will make the process more meaningful and robust.

At team level, effective governance arrangements will be based on a clear work programme agreed between the team and the organisation(s) for which they work, with reporting arrangements established to ensure accountability for delivery against that programme. This process should actively engage all organisations involved, as well as the host organisation.

Good governance will also ensure that individuals are able to meet the requirements of the GDC for recertification and, in the future, revalidation.

**Education and training**

In considering workforce capability it is critical to examine the extent to which team members have the training, skills and competencies to fulfil the roles they are expected to play.

Within the current core dental public health workforce the only role for which there is a set of defined competencies, a mandatory training programme, summative assessment at exit and registration is that of the GDC-registered specialist in dental public health. Specialist registration enables appointment to consultant posts in dental public health within the NHS and to senior academic posts with honorary consultant status.

Practitioner-level dental public health staff, such as DPAs and oral health improvement practitioners, may have some relevant post-qualification training and qualifications. But this is not universal.

For the protection of the public and employing organisations, the capability of the workforce should be assured through
the development and implementation of appropriate competency frameworks, ongoing training, and assessment for each role.

Primary care trusts have the opportunity to develop PwSI roles in dental public health and sub-specialisms of dental public health, such as dental epidemiology or patient safety/clinical governance, in line with national guidelines.4 The area of patient safety and clinical governance in dentistry currently undertaken by DPAs represents an example of an important dental public health area of interest which could be developed through the PwSI model.

The DPA role is very akin to that of a PwSI in that they are part-time in that role while also undertaking personal clinical practice in dentistry. The Department and the Faculty of General Dental Practice (UK) have already published both generic guidance5 and guidance about the competencies needed for a number of clinically focused areas of special interest.

These could help to set the dental public health practitioner roles, including DPAs, within a clear local and national service framework. It would provide an opportunity for practitioners to gain recognition and accreditation for additional competencies gained through further training and experience. This would at the same time contribute to quality assurance of the service by establishing local practitioner roles within a national framework.

Developing the consultant as a leader of the dental public health team within wider talent management and leadership development plans will:

- ensure that SHAs and PCTs maximise the potential of the dental public health team; and
- enhance professional leadership and clinical engagement within dentistry.

**Career development, professional regulation and workforce flexibility within dentistry**

Workforce development includes the principles of workforce flexibility and opportunities for career development, enabling the systematic acquisition and utilisation of additional skills. Career development can be further promoted through the accreditation of prior learning. These offer significant organisational benefits as well as enhancing career satisfaction and staff morale. Professional regulation provides an over-arching governance framework to protect the public by setting educational standards and ensuring high standards of professional conduct. The statutory professional regulator

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5 See www.dh.gov.uk/en/Healthcare/Primarycare/Dental/DentistswithSpecialInterestsDwSIs/index.htm
in dentistry is the GDC, which registers dentists and most other members of the dental team, the latter regulated group being known collectively as DCPs.

Within dentistry, registered dentists may progress from newly qualified dentist through to registered specialist/consultant in a range of specialties, including dental public health. The advent within dentistry of PwSI and of the new competence-based contract for dentists working within the salaried primary dental care service has expanded the career opportunities available to registered dentists. Both are relevant to the development of the dental public health practitioner-level workforce.

Registered DCPs have, as a result of recent reforms by the GDC, an increasing degree of career flexibility and opportunities for competency and career development, but only within the DCP arena. Some of those opportunities are relevant to dental public health.

For both dentists and DCPs, recognition of relevant previous training, experience and qualifications (accredited prior learning) will be necessary to support and enable meaningful career progression through a ‘skills escalator’ and to support top-up training to defined levels of competency, whether at consultant or practitioner level. The PwSI framework may be helpful to this and is relevant to both dentists and DCPs.

An obstacle to career development within the dental team is the absence of undergraduate programmes which recognise previous training and experience in the field of dental care. In addition, educational credits and professional credits are not provided by many DCP programmes. This presents a substantial barrier, which discourages most DCPs from further progression from DCP to dentist.

The need for registration as a dentist as a mandatory precursor for entry to specialist training is a further barrier to those registered DCPs who aspire to develop specialist competencies in the field of dental public health or sub-sets thereof, such as oral health improvement. Such barriers either disenfranchise individuals or result in them moving elsewhere – outside dentistry – for their personal and career development and advancement.

This lack of recognition of acquired prior learning, and the need for registration as a dentist to be eligible for specialist training, are to the disadvantage not only of the individuals affected but of dentistry and the cause of oral health improvement. A skills escalator enabling progression through skills acquisition and evaluated experience from DCP to specialist training would be of great benefit in addressing the complementary needs of dental public health and the dental public health workforce.
Barriers and obstacles of equal significance exist for the wider workforce. Some members of the dental public health workforce, primarily in the field of oral health improvement, have come from professional backgrounds outside dentistry, for example teaching. Such staff cannot currently achieve registration with the GDC as members of the dental team and have effectively been without a formal professional ‘home’ or structure within which they can develop their careers. Registration with the GDC would bring all the benefits of registration for these staff as well as providing the same access to training opportunities as might be established for the other DCP groups.

Skills for Health has worked with key stakeholders from the sector to test out a set of existing public health national occupational standards (competencies) for their application and appropriateness to the dental public health workforce.\(^6\) The work has identified a set of competencies with a variety of uses including assessment, the design of training and workforce development. The competencies are relevant to a number of people working in dental public health but will be of particular benefit to oral health improvement practitioners. In the first instance these competencies are geared primarily towards the needs of front-line oral health promotion staff working in clinical practice and in the public health delivery system.

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\(^6\) See, for example, dental nursing competencies at [https://tools.skillsforhealth.org.uk/suite/show/id/45](https://tools.skillsforhealth.org.uk/suite/show/id/45)
The dental public health capacity needed by NHS organisations

There is a need to develop the capabilities in each dental public health role at both consultant and practitioner level. In most areas of the NHS in England it is equally necessary to increase capacity within the dental public health team to realise the dental public health vision and successfully achieve the organisational responsibilities outlined earlier.

“"The Workforce Review Team identified as a priority the need to expand the public health workforce, including that in dental public health."”

Assessment of workforce priorities, 2008

All PCTs and SHAs will need to have ready access to effective consultant expertise. Best practice indicates a presence of a minimum of a half-time consultant in each organisation. Capacity may need to be greater where the volume or complexity of consultant input increases due to factors such as:

- the number of dental service providers (primary care, specialist and hospital) within the area;
- the population size of the area to be covered by the team;
- the geography of the area;
- the demographics of the area, including socio-economic, black and minority ethnic and age profile of the population; and
- the number of other key stakeholder organisations (for example local authorities, water companies and university dental schools) within the area.

As a best practice guide, the degree of work to be undertaken suggests that a single team led by a full-time consultant would cover no more than two average-sized PCTs (except where those PCTs are operating a formal collaborative commissioning arrangement through a single hub). A larger scale of other key characteristics outlined above would necessitate a corresponding increase in staffing.

Illustratively, the model of a team covering two average-sized PCTs and led by a full-time consultant would suggest a current shortfall in England of around 53 whole-time equivalent NHS consultants, and a shortfall of around 6 whole-time equivalent (27 head-count) DPAs. Shortfalls are also anticipated in the oral health improvement workforce. Appendix 4 illustrates how the shortfall in the dental public health workforce may be addressed.
In contrast to training in medicine, where there has been a decision to expand GP training rather than hospital specialist training, the Department accepts the need to continue to expand dental specialty training in the small dental specialties including dental public health.

Building service capacity will take time because specialist training currently takes around four years on average, and because there is only a finite quantum of training capacity. But there may be limited opportunities for accelerated training and accreditation for some individuals with relevant experience. More specific staffing guidance is included at Appendix 2 for the information of workforce planners and those designing specific teams and jobs.

Current supply arrangements for the dental public health workforce are inadequate to provide the level of staffing needed, and a significant expansion of training capacity is also required. The Department, through the Dental Programme Board of Medical Education England, will address the means of improving supply, working closely with the NHS and other key stakeholders. In particular, this will support SHAs in undertaking their lead responsibility for developing local workforce plans in dental public health which meet both the needs of the service and the aspirations of the vision for dental public health.

The dental public health capacity needed by dental schools

The dental public health capacity in dental schools and other academic organisations extends beyond those who are formally trained, on the GDC Specialist List or otherwise registered with the GDC. The requirements for professional development to senior academic positions are increasingly high and this challenge is reflected in the workforce data in Appendix 3. There is a shortfall in the academic workforce to meet the opportunities for workforce education and training, respond to the wide research agenda and work with the NHS in line with the vision for dental public health. The need to facilitate appropriate career development should be taken into account in building academic capacity and capability.

Key issues for academic institutions include the need to:

- build effective collaborations between basic, behavioural and clinical sciences departments, wider health services and local populations in support of research, education and training;
- seek research funding and build further capacity to address key oral health challenges;
- mentor and build general capacity in dental public health in students;
and junior staff through education programmes at diploma and masters level;

• build clinical academic capacity in dental public health with training in research, teaching and specialist (consultant level) skills;

• contribute to the evidence base through high quality research that can be used to inform clinical practice, service delivery and organisation, promotion of oral health and healthcare policy; and

• develop national and international links for teaching, research and policy.

This will need to be addressed in collaboration with the NHS.
4.4 Conclusion

Increasing capacity and capability in accordance with this guidance will enable PCTs to improve access to dentistry and enhance the quality, safety and effectiveness of services. It will improve productivity in dentistry and ensure effective commissioning to provide value for money, promote innovation and develop the dental market. An increased focus on health improvement will reduce the need for treatment and further improve the efficient use of financial resources and the oral health of the nation. Members of the dental public health team are ideally placed to oversee implementation of this more prevention-focused model of dental care.

Development of the dental public health workforce will need investment and time by both SHAs and PCTs. However, the resultant enhanced role of the dental public health workforce can lead to cash-releasing savings in expenditure on NHS dentistry, for instance through more appropriate recall rates for examination, in line with National Institute for Health and Clinical Excellence guidelines. This increased involvement of dental public health will enable the NHS in England to use its dental commissioning resources approaching £3 billion7 more effectively and productively, and thereby deliver improved dental outcomes for everyone.

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7 In 2010/11. Includes anticipated patient charge contributions.
5 Recommendations
The Department of Health is committed to the development of dental public health. The Department will work to ensure that:

- dental public health influences dental and wider health policy development, including through the work of the NHS Business Services Authority;
- NHS investment in education and training is directed to its priorities of improving NHS dental services and the oral health of the nation; and
- funding is directed at research that addresses priority issues for understanding factors that measurably improve oral health.

This report identifies the capacity and capability increases that would be required to realise the dental public health vision and enable NHS organisations to meet their responsibilities.

The Department, working through the Dental Programme Board of Medical Education England has identified a need to increase the supply of dental public health professionals and wishes to encourage the expansion of the number of both service and academic training places in dental public health.

In considering the need for dental public health staff in PCTs, the Dental Programme Board of Medical Education England will also take into consideration the need for dental public health staff in SHAs, academic institutions and the Department. The work of the Dental Programme Board will be informed by dental public health workforce plans in the regions.

The Department will ensure dental public health advice is provided to the NHS Business Services Authority (see page 35).

The Department will also seek to ensure that the best possible workforce data on directly employed members of the dental public health team is captured via the Electronic Staff Record (ESR).

The Chief Dental Officer will monitor progress in implementing the review, and will consider any implications for future dental policy.

To ensure the success of these actions, partner bodies will need to contribute in the following manner:

**Strategic health authorities (including workforce deaneries)**

SHAs will benefit from having dental public health advice available to ensure they carry out their dental public health responsibilities effectively and take into account the oral health implications of all relevant policies.

We recommend that SHAs:

- ensure they have consultant advice in dental public health to provide them with expertise and leadership across the region. A minimum half-time appointment is recommended (see page 50); and
- work with PCTs to review their dental public health capacity and capability in accordance with this guidance. Given the priority attached to improving NHS dental services, and the contribution to be made by dental public health to
quality and productivity improvements, we recommend they produce a regional workforce development plan during 2010 to inform regional education commissioning plans.

An effective regional workforce development plan will address:

- the optimal configuration for each team in the region to enable their PCTs to competently fulfil their responsibilities for dentistry and for improving oral health, including the numbers, roles, governance and education of each dental public health role, and the shape of the team in the PCT(s);
- the benefits of meeting the requirement to promote equality and diversity within the dental public health workforce;
- the need to provide leadership development support for consultants and other members of the dental public health team, where such development provided for the consultants will result in increased capacity and capability across the whole dental public health team;
- the benefits of sponsoring networks of dental public health teams within their region to optimise collaboration and skills and knowledge management; and
- the dual challenge of an older and more part-time workforce, and the increasing demand on, and need for, dental public health. The development plan should therefore ensure:
  - there are adequate additional training posts and training capacity in dental public health for specialists in order to expand the consultant workforce, as well as academic specialist and practitioner-level needs – with the rate of expansion influenced locally by the availability of suitably qualified trainers and training placements;
  - there is provision for accelerated training through accreditation of prior learning, subject to General Dental Council (GDC) agreement (see page 59);
  - training programmes support flexible working;
  - the wider dental public health workforce is developed to help secure organisational objectives;
  - undergraduate dental education contributes to the achievement of dental public health goals; and
  - F2 training posts with a dental public health element are commissioned or delivered.

SHAs will benefit from discussing the implications of this report with universities. SHAs in commissioning elements of workforce education will wish to ensure that healthcare is focused on promoting
health through evidence-based practice at individual and population levels, and that all dental public health trainees have the opportunity to develop and use their teaching competencies and gain relevant teaching qualifications.

Dental postgraduate deans should work closely with deans of dental schools in building specialist academic capability in dental public health by providing training in research, teaching and assessment, as well as specialist skills. In the interim, it would be beneficial to provide support so those in existing academic posts can gain top-up training enabling them to achieve consultant status. For those in junior academic posts holding NHS consultant status, further professional development may enable them to gain a PhD.

**Primary care trusts**

An effective multidisciplinary local dental public health team is likely to be one of the key factors in enabling a PCT to become a world class commissioner of dentistry. Where these do not already exist, we recommend that PCTs develop integrated dental public health teams, led by the consultant in dental public health, with clear roles for each member of the team (see page 31). This may require PCTs to invest more resources over time. An appropriately resourced team may operate across two PCTs.

To operate best practice, PCTs may wish to secure professional advice and expertise across the whole of dentistry, from both consultants and practitioner-level dental public health staff. PCTs may do this on an individual basis or through collaborative arrangements with neighbouring PCTs, taking into account guidance on job size and complexity (see page 50 and Appendix 2).

Best practice indicates the presence, as a minimum, within each organisation of a:

- consultant: half-time appointment; and
- dental practice adviser (DPA): two sessions per week.

The required capacity for oral health improvement practitioners and senior dentists (epidemiology) will be determined locally, informed by the regional workforce development planning process for dental public health. This will provide a forum for local benchmarking and assessment of the adequacy and appropriateness of staffing in this area.

Capacity may need to be greater where the volume or complexity of consultant input increases due to factors identified earlier. Benchmarking of workforce levels will be facilitated in future through the development of the ESR (see page 32).
For each member of the dental public health team, the PCT will wish to assure itself that it is appointing healthcare professionals who are demonstrably competent for the required role. PCTs should provide appropriate development opportunities for all staff in line with the regional workforce development plan (see page 56).

It is not only about workforce investment. Quality and effectiveness can be enhanced by developing the team in line with best practice.

PCTs should ensure good governance, including role clarity, with clearly established accountability and working arrangements underpinned by effective performance management systems.

Effective governance arrangements will include as a minimum, for each role:

- a clear role profile and person specification, with essential and desirable criteria relating to relevant postgraduate qualifications, experience and competence;
- a requirement to be involved in clinical audit appropriate to the role;
- regular and relevant appraisal; and
- a relevant personal development plan and a requirement for active participation in continuing professional development (CPD).

To maximise the effectiveness of dental public health resources, teams will benefit from networking with other teams in the region, dental public health academics and the Dental Reference Service.

The NHS Constitution requires that all services respect the human rights of all and are made available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. The forthcoming Department of Health guide to commissioning for oral health of black and minority ethnic communities will provide further guidance to PCTs in meeting their duties in regard to equality and diversity.

**NHS Business Services Authority**

The NHS Business Services Authority should ensure the involvement of dental reference officers in regional dental networks to maintain strong links with SHAs and PCTs.

**Local authorities**

Local authorities are encouraged to contribute to dental health policy through Local Strategic Partnerships.
General Dental Council

The GDC can contribute to the development of the dental public health workforce by:

- considering ensuring pre-registration training for dentists and dental care professionals (DCPs) includes an understanding of the principles and practice of dental public health, and that this is reinforced in the Council’s advice and guidance for CPD;

- being mindful of the training outcomes required by this report when accrediting the curriculum for specialist training submitted by the Specialist Advisory Committee (SAC) in Dental Public Health (see below);

- accrediting prior learning towards training to specialist level in dental public health;

- considering quality assurance arrangements for oral health improvement practitioners who cannot currently register with the GDC, to ensure that these important members of the dental public health team are provided with the opportunities and the safeguards associated with a regulatory framework; and

- exploring the feasibility of piloting and evaluating specialty training in dental public health for appropriately experienced GDC-registered DCP. Among the issues for exploration will be entry requirements to specialty training and the potential, following successful completion of training, for such DCPs to be enabled to enter the GDC Specialist List in dental public health.

Specialist Advisory Committee in Dental Public Health

The SAC, in advising the GDC on the content of the dental public health curriculum for specialist training will be mindful of the role of dental public health training in meeting the needs of employers, in line with this report.

The SAC is well placed to lead the development of educational frameworks for a more flexible and skilled practitioner-level workforce, based on the general guidance on the establishment of practitioner with a special interest (PwSI) posts. In doing so, it will be important to work closely with the Faculty of General Dental Practice (UK), the Faculty of Dental Surgery, the Faculty of Public Health and other stakeholders, for example the National Association of Dental Advisers, the British Association for the Study of Community Dentistry, and NHS Employers.

This would be facilitated by developing:

- a specific set of competencies for a dentist with a special interest in dental public health or its sub-sets. PCTs could then use these competencies as the
minimum requirement for appointment to the roles of, for example, DPA or senior dentist (epidemiology) in the salaried primary dental care service. Examples of dental public health competency sub-sets include:

- clinical governance and patient safety, including the inspection and operation of dental practice premises;
- oral health needs assessment; and
- oral health improvement;

- dental public health competencies for DCPs, with the creation of a role of DCP with a special interest; and
- the role of oral health improvement practitioners.

Subject to GDC approval of the accreditation of prior learning, the SAC is encouraged to facilitate the early introduction of quality-assured top-up training to specialist level through a structured approach.

The SAC can also make a significant contribution to the development of a model job description and person specification for the role of dental public health consultant. This will reflect the needs specified in this report and be produced in collaboration with NHS Employers and the faculties of the medical Royal Colleges of England (see below).

Faculty of Dental Surgery of the Royal College of Surgeons of England

The Faculty, working with the specialty and NHS Employers (representing SHAs and PCTs), is well placed to develop a model job description and person specification for the role of consultant in dental public health, reflecting the best practice content of this report. These will include disease prevention and health promotion.

The Faculty is asked to promote the inclusion of dental public health topics in wider clinical specialist audit programmes.

Faculty of Public Health

Equivalence arrangements already exist between the Faculty and the GDC on specialists in dental public health. This can enable further development of the dental public health workforce at both consultant and practitioner level, working with the SAC, in line with this report.

Faculty of General Dental Practice (UK)

The Faculty is asked to ensure the inclusion of relevant dental public health skills and competencies in postgraduate Faculty qualifications, to include:

- oral health improvement and disease prevention;
• clinical governance and patient safety;
• the critical evaluation and audit of clinical procedures; and
• research methodologies appropriate to primary dental care.

The Faculty is further asked to work with the SAC and other relevant bodies on the development of competency frameworks for PwSI in areas of dental public health.

Universities and the further education sector

Academic providers have an important role to play in supporting best practice in competency and role development as identified in this report.

They are encouraged to build senior academic capacity in dental public health to provide leadership with respect to the education, training and research agendas, as well as to local and national health policy (see page 51). This may be undertaken through new appointments or additional training to facilitate career progression.

Academic providers are encouraged to develop academic dental public health capability through:

• building general dental public health capability – by contributing to the education, training and assessment of all dental professionals;
• building specialist academic capability in dental public health through formal structured and focused training programmes;
• building additional capability in the wider workforce through delivering masters in dental public health programmes or contributing a dental module to masters in public health programmes;
• mentoring and supporting junior academic staff to gain PhDs early in their careers;
• supporting top-up training for suitably qualified academics to gain entry to the GDC Specialist List; and
• building teaching capability through links with the wider dental public health workforce, enabling them to gain teaching qualifications.

More generally, all training programmes and educational contracts could support the vision for dental public health by giving greater prominence to the oral health improvement aspects of healthcare training.

Interested academic providers are encouraged to develop academic dental public health research capacity by:

• building research competencies through PhD studentships and fellowships;
• contributing to the evidence base through high quality research to inform clinical practice, service delivery and organisation, promotion of oral health and healthcare policy; and

• supporting the delivery of research competencies through all dental public health training programmes, both NHS and academic.

**NHS Employers**

NHS Employers is asked to contribute to the work of the faculties and the SAC in developing model job descriptions and person specifications for consultant and practitioner-level dental public health staff to meet the needs of their constituent organisations, in line with this report.
Appendix 1

Stakeholder involvement in the review

Stakeholder Reference Group meetings were chaired by John Langford, Senior Dental Adviser, Department of Health (Dental and Eye Care Services Branch), the review project lead.

Stakeholder Reference Groups represented in the Reference Group included the following (individuals’ role titles correct at the time of the Reference Group work):

- **Association of Directors of Public Health**
  - Dr Dympna Edwards, Deputy Director of Public Health, Halton and St Helens PCT

- **British Association for the Study of Community Dentistry**
  - Dr Sue Gregory, Chair, Consultants in Dental Public Health Group
  - Dr Jenny Gallagher, Chair, Teachers and Researchers Group
  - Dr Liana Zoitopoulos, Honorary Secretary

- **British Dental Association**
  - Chris Allen, Central Committee for Community and Public Health Dentistry

- **Committee of Postgraduate Dental Deans and Directors**
  - Prof Stephen Lambert-Humble, Lead Dean for Dental Public Health, supported by Helen Falcon

- **Department of Health**
  - Catherine Frew Brown, Head of NHS Commissioning, Dental and Eye Care Services Division
  - Yvonne Dailey, Specialist Registrar in Dental Public Health, North West Deanery
  - Tony Jenner, Deputy Chief Dental Officer

- **The Faculty of Public Health**
  - Nick Kendall, Consultant in Dental Public Health

- **National Association of Dental Advisers**
  - Sean Bradley, Chair (supported by Mike Williams and Geoff Brown)

- **National Oral Health Promotion Group**
  - Charlotte Jeavons, Chair

- **NHS Confederation and NHS Employers**
  - Graham Saunders, Policy Adviser

- **NHS Primary Care Contracting**
  - Elaine Maggs and Angela Moon

- **PCT representatives**
  - Barry Picken, Chair of Wolverhampton City PCT and John Bennett, Director of Commissioning at Halton and St Helens PCT

- **SHA Workforce Directors**
  - Derek Marshall, Education Commissioner, NHS North East

- **Skills for Health**
  - Karen Walker

- **Specialist Advisory Committee in Dental Public Health, Joint Committee for Specialist Training in Dentistry**
  - Karen Elley, Chair

- **Workforce Review Team**
  - Nicola Spillane, Dental Adviser

Meetings of the Reference Group were facilitated by Andy Coombe, Kairos Consultancy Ltd, London.
Appendix 2

Dental public health workforce planning guidance

Consultant posts
A number of key factors influence the effectiveness of an NHS consultant job in dental public health (assuming that there is an adequate dental public health team, including support staff).

In order of impact those factors are as follows:

1. The number of NHS organisations (PCTs and SHAs) for whom the post-holder works, which may be mitigated if PCTs are operating formal collaborative commissioning through a single ‘hub’.

2. The population size of the area to be covered by the team.

3. The number of dental service providers (primary care, specialist and hospital) within the area.

4. The geographical size of the area covered by the post.

5. The demographics of the area, including socio-economic, black and minority ethnic and age profile of the population.

6. The number of other key stakeholder organisations (for example local authorities, water companies and university dental schools) within the area.

Recommended minimum staffing guidance for consultant posts
For PCTs the requirement is for:

- a minimum of 0.5 whole-time equivalent (WTE) per individual PCT (irrespective of size) to enable the post-holder to operate effectively within the organisation and relate effectively to external stakeholders. Note: if the post-holder had dental public health duties with another NHS organisation of the same function that minimum could be 0.4 WTE per organisation;

- plus an additional 0.1 WTE for each additional 100,000 PCT population above 250,000;

- plus an additional 0.2 WTE for PCT responsibilities associated with lead commissioning of clinical services from a dental teaching hospital.

For SHAs the requirement is for:

- a minimum of 0.5 WTE per SHA.

Jobs planned to cover more than one organisation should be designed to take account of the practical impact of geography and travelling time between organisations and providers.

In calculating the overall workforce requirement for consultant-level posts, there is need to factor in a requirement for academic posts reflecting the size of the
dental school, with an absolute minimum of one consultant-level academic post per school.

**Dental practice adviser posts**
A number of key factors influence the effectiveness of a dental practice adviser (DPA) post (working as part of a wider dental public health team with access to appropriate support).

In order of impact those factors are as follows:

1. The number of dental service providers, including specialist providers, operating in primary care within the area.
2. The geographical size of the area covered by the post.
3. The number of PCTs for whom the postholder works, which may be mitigated if PCTs are operating formal collaborative commissioning through a single ‘hub’.

**Recommended minimum staffing guidance for DPA posts**
- A minimum of 0.2 WTE per individual PCT (irrespective of the number of providers and size) to enable the postholder to operate effectively within the organisation and relate effectively to external stakeholders, particularly dental practices.
- Additional time as determined locally in the light of the factors identified above.

**Oral health promotion/improvement posts**
Although the review of the dental public health workforce has identified a clear need for oral health promotion and improvement activity, the range and diversity of staff currently working in this area means that it is not yet practical to give guidance on specific staffing levels. Decisions about staff numbers and grade will need to be taken locally in the light of an assessment of organisational capacity and capability to effectively deliver the oral health improvement agenda.

The regional workforce development planning process for dental public health will provide a forum for local benchmarking and assessment of the adequacy and appropriateness of staffing in this area.

**Dental epidemiology lead in delivery arm**
PCT commissioners need to be satisfied that providers with whom they contract to deliver dental epidemiological fieldwork have an appropriately trained workforce for this role. In particular, there should be an identified epidemiology lead in the delivery arm with the postgraduate training and experience to fulfil this role, unless, by local agreement, it is undertaken by the consultant in dental public health. This individual must be able to operate as part of the wider consultant-led dental public health team, and this requirement should be explicit within the commissioning specification for this service.
Appendix 3

Profile of the dental public health workforce

The first specialist posts in dental public health were established in the mid-1980s, and a handful of training posts had been created by the end of the decade. However, significant expansion did not occur until the early 1990s, when health authorities were given freedom to establish posts and to appoint candidates assessed through an equivalence process. By 1993 there were 20 specialists (16 whole-time equivalent (WTE)) in consultant posts in England of whom 7 were female. There was then a gradual expansion until the year 2000, when there were 56 consultants (41 WTE) in England. During that period the proportion of women consultants fell, from 35% in 1993 to 18% in 2000. By 2003 the consultant head-count had fallen to 52, the WTE to 36, and the proportion of women consultants had risen again, to 44%. The changing gender balance was even more marked in the specialist registrar workforce with 73% of that workforce in 2003 being women. The changing gender balance among the (younger) trainee workforce was not unexpected, given the significant change in the gender balance increasingly seen in the whole dental profession.

The gender balance in the dental practice adviser (DPA) workforce was quite different to that in the consultant and specialist registrar workforce, with some 89% of DPAs being male, in large part reflecting the profile of the profession in that older age-group.

Workforce profile in 2007

Given the paucity of routinely available NHS data on this workforce, an ad-hoc survey was undertaken by the specialty in autumn 2007 which focused on the specialist and practitioner elements of the dental public health workforce.
Dental public health consultants

Around two-thirds (104) of the 152 PCTs in England had some level of input from a consultant in dental public health, as did 9 of the 10 SHAs. The number of PCTs with consultant input are shown in summary, by region, in Figure A1.

This input to PCTs and SHAs was provided in autumn 2007 by 48 (head-count) dental public health consultants. Of those, 27 (55%) were female so there had been a further shift in the gender balance since 2003. The majority of the consultants were in the age range 45–54 years (see Figure A2) and described themselves as belonging to the ethnic category of White British.
Figure A2: Age profile of consultants in dental public health in England – autumn 2007

Measured on a simple head-count, there was a significant variation in the distribution of the consultant workforce between regions, as shown in Figure A3.

Figure A3: Dental public health consultants (head-count), by SHA area, 2007
At that time, the work pattern of those 48 head-count consultants equated to a WTE of 41.2 consultants (including consultants working more than 10 planned activities (PAs) a week to cover multiple organisations), as shown in Figure A4.

Of those holding consultant contracts, 58% worked at least 10 sessions (PAs) per week for the NHS. Twenty-seven per cent worked for the NHS for more than 10 sessions (PAs) a week, equating in their additional work to two additional whole-time consultants. By contrast, 21% worked for the NHS for five sessions or less a week. Some of those working less than full-time for the NHS also worked for other organisations, such as universities, or undertook other NHS duties outside dental public health, as shown in Figure A5.
Of those 41.2 WTE consultants, 2.83 WTE were working for SHAs, usually on a part-time basis with other commitments in a PCT. There was considerable variability in the level of consultant input to SHAs, as shown in Figure A6.
Population coverage by consultants
The NHS Workforce Review Team, in its 2008 Workforce summary for dental public health, modelled consultant supply and requirement on the basis of one WTE consultant per 600,000 people.

Using that planning estimate, and on a simple assessment based on head-count rather than WTE, the population per PCT consultant was, on average across England, just over 1.3 million – twice that planning target. There was significant variance between SHA areas (Figure A7) with PCTs in southern parts of England particularly poorly staffed.
Because some dental public health consultants work part-time, the population coverage position in terms of WTE staff in PCTs showed an even worse position, as shown in Figure A8.
Scale of consultant input to SHAs and PCTs
Of those PCTs and SHAs which did have consultant input, the average WTE per PCT or SHA in England was 0.32 with a range from 1.1 WTE per organisation to only 0.03 WTE per week – see Figure A9 for a profile of work patterns across SHAs and PCTs.

A substantial number of consultants, because of their work pattern, had very limited time in individual organisations for which they worked.

Figure A9: Weekly consultant input (sessions) to PCTs and SHAs in 2007
Time availability in PCTs is summarised by region in Figure A10, which shows the average time (WTE) spent in each PCT having a consultant. Across England, the average was 0.37 WTE. PCTs in some regions, especially those in southern England, had markedly lower levels of consultant input than those in the Midlands and north of the country.

**Figure A10: Average consultant WTE in PCTs with consultant**
As previously noted, the 2008 Workforce summary for dental public health had estimated requirements based on a target of one whole-time consultant to 600,000 population. Taking dental public health staffing in PCTs in autumn 2007, the actual ratio in England at that time was one whole-time consultant to 1,322,645 population, with a range by region as shown in Figure A11. No region was close to that staffing level, with all but three needing at least a 100% increase to reach that target.

**Figure A11: Population per PCT consultant (WTE) in 2007, compared with 2005 target**

<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>3,500,000</td>
</tr>
<tr>
<td>North West</td>
<td>3,000,000</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>2,500,000</td>
</tr>
<tr>
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</tr>
<tr>
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<td>1,500,000</td>
</tr>
<tr>
<td>East of England</td>
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</tr>
<tr>
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</tr>
<tr>
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<tr>
<td>South Central</td>
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</tr>
<tr>
<td>London</td>
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</tr>
<tr>
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Specialist training posts in dental public health

There were 18 (head-count) specialist registrars in dental public health in training in England in autumn 2007, of whom two were in part-time training and five in flexible training posts. Six of the specialist registrars were in academic training posts, with a further two Walport trainees.

Of those 18 specialist registrars, 13 were female (72% of the specialist registrar workforce). The age distribution of specialist registrars in 2007 is shown in Figure A12.
A full-time training programme lasts four years; the anticipated profile of completion of training as at autumn 2007 is shown in Figure A13.
Some specialist registrars were undertaking elements of their training in more than one SHA area. The distribution of training placements by region is shown in Figure A14.

![Figure A14: Distribution of training placements by region, autumn 2007](image)

**Academic staff**

In England there are currently 10 university schools of dentistry, each with an academic dental public health presence of some extent, encompassing research and teaching activity as well as engaging with the wider health economy in specialist dental public health practice. The majority of academic dental public health staff are co-located in the management structure of universities, with a range of different disciplines based on shared interests in prevention, patient group, or research. Current capacity is well below acceptable level to cover the range of responsibilities.

A summary of academic staffing, based on a survey undertaken by the specialty in winter 2007 of all university dental schools in England, is shown in Table A1.

Not all the senior academics working in this area were on the General Dental Council (GDC) Specialist List in dental public health, nor were all of them registered dentists. At the time of survey in winter 2007 there were five professors of dental public health, four senior lecturers and four lecturers on the GDC Specialist List. The specialty reported that there had been few successful academic training programmes to date. At the time of survey there were six academic trainees, with a further two in Walport posts.
The specialty reported some difficulty in making suitable academic appointments at senior level.

Table A1: Summary of academic dental public health staffing, England, autumn 2007
Data from 11 institutions including 10 university dental schools

<table>
<thead>
<tr>
<th>Grade of staff</th>
<th>Number in England (head-count)</th>
<th>Number on GDC Specialist List</th>
<th>Contracted whole-time equivalent</th>
</tr>
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<tbody>
<tr>
<td>Professor/consultant in dental public health</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Professor</td>
<td>4</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>Senior lecturer/consultant in dental public health</td>
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<td>5</td>
<td>3.9</td>
</tr>
<tr>
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<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Lecturer/consultant in dental public health</td>
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<td>1</td>
<td>2</td>
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<tr>
<td>Lecturer</td>
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<tr>
<td>Researchers</td>
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<td>Senior teaching fellow</td>
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</tr>
<tr>
<td>Walport trainees</td>
<td>2</td>
<td>0</td>
<td>1.5</td>
</tr>
<tr>
<td>Academic specialist registrar in dental public health</td>
<td>6</td>
<td>0</td>
<td>3.9</td>
</tr>
</tbody>
</table>
Skill mix

*Dental public health practitioner-level staff*

a) Dental practice advisers

In autumn 2007, about four-fifths (125) of the 152 PCTs in England had one or more DPAs working for them (Figure A15).

![Figure A15: PCTs with a DPA – autumn 2007](image)

The majority of those 125 PCTs each had 1 DPA; 16 had 2, and 1 PCT had 4.

In total, 97 dentists undertook that DPA role. The majority (63 individuals) each worked for only 1 PCT; 25 worked for 2 PCTs; 6 for 3 PCTs; and 1 for 4 PCTs.

More recent (2009) data from a survey by NHS Benchmarking suggested that in responding PCTs – some two-thirds of all PCTs in England – they had on average just over two sessions a week of DPA time.

DPAs work on a part-time basis in that role, coupling it with a significant amount of clinical work in a dental practice.
Of 35 DPA responders to survey in autumn 2007 (around one-third of the total in post), 31 were male. All but one of those responders were aged 45 or over, with 9 over the age of 60.

Just over half (82) of all PCTs had both a consultant in dental public health (CDPH) and a DPA. Five PCTs had neither. The full team-working profile is in Figure A16.

![Figure A16: Team-working – PCTs with consultants and DPAs, 2007](image)

b) Oral health promotion/improvement staff

Data on staff working in the field of oral health promotion or improvement is extremely limited. What data exists does not differentiate the grade of staff. Most oral health improvement staff work within the delivery arm of the NHS is based predominantly in salaried primary dental care services or in generic health promotion departments.

NHS Benchmarking and Primary Care Commissioning undertook a benchmarking data collection exercise with salaried primary dental care services in England in 2009. They obtained data covering about two-thirds of PCTs. Eighty provider services responded to the survey, of which 55 providers reported employing oral health improvement staff. In those 55 providers, the average WTE (all grades) was 2.18 WTE, with a range from 0.4 WTE to 9.6 WTE.
Standardised to reflect the different sizes of population served by the provider organisations which responded to the survey and reported having oral health promotion staff, the range per 100,000 population is shown in Figure A17. The average for responding provider units in England was 0.53 WTE per 100,000 population.

In an earlier (2007) staffing survey of salaried primary dental care services in provider units, to which there were 49 responses covering 71 PCTs, only 4 oral health promotion staff were reported as holding a masters level qualification in public health/dental public health. By contrast, among the oral health promotion staff reported in that survey, there were 60 holders of the Oral Health Education Certificate awarded by the National Examining Board for Dental Nurses, suggesting that the oral health promotion workforce was largely involved in front-line delivery rather than the strategic design and planning of oral health improvement programmes.
c) Dental epidemiology staff

PCTs have a statutory duty to undertake the epidemiological surveillance of the dental health of their population. The fieldwork for data collection, and often the subsequent analysis of that data, is normally commissioned from salaried primary dental care services within provider organisations. Data on the workforce involved in this epidemiological function is not routinely or readily available. In many provider organisations this work is led by a dentist with one or more postgraduate qualifications in the field of dental public health who is effectively a practitioner-level member of the dental public health team. In those that responded to the 2007 staffing survey mentioned above, a total of 44 dentists held postgraduate qualifications in dental public health. That means, on average, almost all responding providers had one member of staff with a postgraduate qualification in dental public health.
Appendix 4

Dental public health workforce – addressing the shortfall in supply

Addressing consultant shortfall

Shortfall due to retirements
In 2007 there were 18 specialist registrars in training in England. Training programmes are normally 4 years full-time, which suggests that without any wastage, the specialist registrar programme in its current size may deliver 3 or 4 replacement consultants a year on average or, over the next 10 years, would deliver some 40 new consultants.

Given the small numbers of staff currently in the consultant workforce and in training, in any one year there may be an imbalance in new consultants and retirements. However, overall the numbers suggest that broadly there are just about enough national training numbers (NTNs) in the system to maintain current head-count levels of consultants. However, key factors which may affect that assumption include:

- the efficiency of utilisation of existing NTNs;
- the balance between academic and service NTNs (academic trainees are in training for longer than service ones, on average);
- the pattern of retirement of academic and service consultants, which may not match the profile of those emerging from training;
- the age and gender profile of the specialist registrar workforce (predominantly female and young) which may give rise to breaks in training with an overall extended training period;
- the potential for specialist training to be shortened for some candidates if the General Dental Council (GDC) agrees to the principle of accreditation of prior learning for entry to specialist training;
- an increasing trend towards part-time working in the consultant workforce so that, even if the head-count of consultants is maintained, the whole-time equivalent (WTE) may reduce; and
- the extent to which dental public health consultants continue to work within the specialty or develop their careers elsewhere. In recent years three have moved into postgraduate dental education and two into senior mainstream academic administrative posts in universities. Another is a director of public health.

Overall, therefore, the conclusion is that the current level of supply, relative to losses through retirement and other routes, is precarious.
Shortfall in consultants due to service deficiencies

Appendix 3 illustrates the service deficiencies in consultant staffing, with some PCTs and SHAs having no consultant input and others having a very limited input. The shortfall across England can be assessed by comparing the number required to meet the guideline levels in Appendix 2 with the situation in PCTs and SHAs described in Appendix 3.

Basic staffing requirement: minimum of one WTE consultant covering two PCTs, with higher levels in some areas to reflect workload complexities.


Consultants required: not less than 76 WTE to meet that basic standard.

In post in 2007: 38 WTE consultants in PCTs.

Gap in PCTs: 38 WTE consultants to meet that basic standard. In fact, because of the scale and complexity of some PCTs, additional staff would be needed in some areas.

Applying the Appendix 2 staffing guidance, the following scenario presents:

If the one whole-time consultant per two PCT standard outlined in Appendix 2 is translated into a population norm, and based on an England population of 51.5 million, the population staffing ratio in PCTs would be one whole-time consultant per 680,000 population.

However, the planning guidance recommends higher staffing levels in areas with additional complexity factors affecting the workload of a post, for example high deprivation or provider complexity.

If it is assumed that 10% of PCTs (i.e. 15) exhibited the complexities described, and each needed a full-time consultant, then the overall consultant to population ratio in PCTs in England would be one whole-time consultant per 617,000 population.

If it is assumed that 20% of PCTs (i.e. 30) exhibited the complexities described, and each needed a full-time consultant, then the overall consultant to population ratio in PCTs in England would be one whole-time consultant per 566,000 population.

These population staffing norms derived from the staffing guidance are consistent with a population norm of one whole-time dental public health consultant per 600,000 population in England used by the NHS Workforce Review Team in its 2008 Assessment of Workforce Priorities.

Applying the population norm used by the Workforce Review Team in 2008, the following scenario presents:
Staffing requirement as per Workforce Review Team: one whole-time consultant per 600,000 population.


Consultants required: 86 WTE.

In post in 2007: 38 WTE consultants in PCTs.

Gap in PCTs: 48 WTE consultants.

Note: population projections suggest that by 2018, in the absence of interventions, the gap will have grown to 54 whole-time consultants.

In 2007, 2.83 WTE consultants were working for SHAs. One SHA had no input and four had no more than 0.2 WTE each. The planning guidance suggests at least 0.5 WTE consultant per SHA, i.e. a total requirement of at least 5.0 WTE, or a shortfall of just over two WTE consultants.

Other areas needing consultant-level staff are the Department of Health and universities.

Losses to the service contribution made by the specialty have occurred in the recent past in both the NHS and universities as a result of individuals being appointed to other roles, for example as postgraduate dental deans. It must be assumed for workforce planning purposes that some individuals will continue to seek such career choices in the future.

Overall, therefore, at a national level a cautious assumption should be a need to train for an additional consultant requirement of five whole-time staff to cover Department of Health, gaps in SHAs and universities, and likely losses to other work areas.

At a national level, the estimated need for additional whole-time consultants approximates to 53 whole-time staff, at 2008 population levels.
Expansion of the consultant workforce
How many additional training places will be needed to achieve this level of consultant expansion in England will be influenced by a number of key factors, the most important of which are:

- the extent of part-time working in the consultant workforce, the trend for which has been increasing in recent years. This will impact on the number of people who need to be trained, albeit potentially for less than full-time working. It may also influence training capacity;
- the extent to which it is possible to accelerate training, for example via the accreditation of prior learning, subject to GDC approval;
- the extent to which training may take longer, for example because of part-time training; and
- the age-profile of the consultant workforce.

Training capacity
Other than financial resources, the key rate-limiting factor in expanding the consultant workforce is the scope for expanding training, in terms of the availability of suitable training opportunities (locations and trainers) and prospective trainees. This will vary from region to region and will pose particular challenges in those regions which currently have very few consultants.

Taking into account length of training, and availability of trainers, it would be possible to assess the number of additional trainees which could be accommodated over a period of time. The current number of trainees (18 including some academics), and of NHS consultants (48 head-count in 2007) suggests that there is some untapped training capacity in the NHS, although it cannot be assumed that all consultants would be able to undertake viable training roles.

This suggests the potential for an initial expansion of some 10 to 12 additional service training posts across England, which could commence within a year of the release of funding. Contextually, this equates to an average of about one additional trainee per SHA area, although, given the current regional variation in consultant numbers, some regions would be able more easily to provide additional training slots than others. As the consultant body expanded over time, the pool of potential trainers would also expand – but this would only arise after six to seven years following initial expansion (four-year training plus two to three years post-trainee experience before becoming a training consultant).
Looking further ahead, current training capacity indicates it should be possible to train 27 WTE consultants in dental public health by 2016, at which point further training plans will be required to address the remaining shortfall, subject to a formal review of policy and progress to date.

Priorities for action
It is essential in the first instance to ensure that the level of supply from training is adequate to compensate fully for retirements from the consultant workforce. This will require close matching of training output with the age profile of the consultant workforce.

In terms of prioritisation for additional consultants, the first key target must be to concentrate initially on the PCTs and SHAs currently without any consultant input. A next key stage would be to bring the staffing level in the remaining organisations up to recommended minimum standards, where these are not already met.

Staged expansion would therefore meet the highest priority NHS needs while additional training capacity was being developed to provide the longer-term growth which is highly desirable to equip the NHS with the necessary expertise.

For example:
- to provide 2007 average levels of consultant (0.37 WTE) in PCTs without any input would need some 20 additional full-time consultants;
- to increase current consultant levels to nearer the current average in those organisations where the consultant staffing falls short of the average would need about 5 additional full-time consultants; and
- to meet recommended minimum standards in all PCTs and SHAs would need an increase of approximately 50 additional full-time consultants.

As the consultant workforce expands it will be necessary to keep the balance of supply from training and consultant numbers under close scrutiny to ensure that, once desired levels of consultants have been reached, training capacity is reduced to a level which will keep the consultant workforce in balance.
**Dental practice adviser shortfall**
The dental practice adviser (DPA) situation may be summarised as below:

Basic staffing requirement: minimum of two sessions a week per PCT with higher levels in some areas to reflect workload complexities.


DPAs required: not less than 30 WTE to meet that basic standard.

Gap in PCTs in 2007: 27 DPAs (head-count) or approximately 5.4 WTE staff to meet that basic standard. In fact, because of the scale and complexity of some PCTs, additional staff would be needed in some areas.

**Oral health practitioner shortfall**
The data on oral health promotion/improvement practitioners is very incomplete and gives little insight into skill-level. In these circumstances it would be inappropriate to attempt a national assessment of supply and the extent of shortfalls. Such work will need to be undertaken at local level and collated regionally.
Acronyms

BME  Black and minority ethnic
CPD  Continuing professional development
DCP  Dental care professional
DPA  Dental practice adviser
DRO  Dental reference officer of the Dental Reference Service
GDC  General Dental Council
LAA  Local Area Agreement
NTN  National training numbers
OHIP  Oral health improvement practitioner
PCT  Primary care trust
PwSI  Practitioners with a special interest (including dentists with a special interest)
SAC  Specialist Advisory Committee in dental public health
SHA  Strategic health authority

Walport trainee  A clinical academic trainee in a dedicated training post which focuses primarily on research. The post will have a national training number.

WTE  Whole-time equivalent(s)
Bibliography


*Government response to the Health Select Committee report on dental services*. TSO. 2008

